



Complying with Medical Record Documentation Requirements



What's Changed?

Note: No substantive content updates.

CMS uses the [Comprehensive Error Rate Testing \(CERT\) program](#) to measure improper payments in the Medicare Fee-for-Service (FFS) Program. Under CERT, we review a random sample of Medicare FFS claims to determine if we paid them correctly under Medicare coverage, coding, and billing rules.

Once the CERT program identifies a claim in the sample, it requests (via fax, letter, or phone call) the associated medical records and other related documentation from the provider or supplier who submitted the claim. CERT medical review professionals then examine the claim and related documentation.

The CERT program is managed by [2 contractors](#):

- The CERT Statistical Contractor determines how claims are sampled and calculates any improper payments
- The CERT Review Contractor requests and reviews medical records from providers and suppliers

Submit enough documentation to support your claims.

Third-Party Additional Documentation Requests

When CERT requests a review, the [billing provider](#) must get supporting documentation (for example, physician's order or notes to support medical necessity) from a referring physician's office or from an inpatient facility, skilled nursing facility, or other location where records (for example, progress notes) are kept to support the services billed, ordered, or provided.

The billing provider should submit the requested documentation because they're the entity whose payment CERT reviews.

We pay for necessary services, but patient medical record documentation must show their medical necessity. Instruct medical record staff and third-party medical record copy services to provide all records that support payment. This may include records for services before the date of services listed on the medical record request. Examples include:

- A signed office note from a previous visit where the provider ordered a diagnostic or other service
- The care plan written by the supervising physician who bills for an "incident to" service
- For incident to services, the care plan written by the supervising physician or non-physician practitioner (NPP)
- Lab orders for recurring tests to meet the specific needs of an individual patient



Insufficient Documentation Errors

CERT reviewers determine claims have errors when the medical documentation submitted is insufficient to support Medicare payment for the services billed (that is, the reviewer couldn't conclude some of the allowed services were actually provided, were provided at the level billed, or were medically necessary).

Reviewers also place claims into this category when a specific documentation element that's required as a condition of payment is missing, like a physician signature on an order, or a form that's not entirely completed.

CERT identifies insufficient documentation errors that may include:

- Incomplete progress notes (for example, unsigned, undated, insufficient detail)
- Unauthenticated medical records (for example, no provider signature, no supervising signature, illegible signatures without a signature log or attestation to identify the signer, and an electronic signature without the electronic record protocol or policy that documents the process for electronic signatures)
- No documentation of intent to order services and procedures (for example, incomplete or missing signed order or progress note describing intent for services to be provided)

Common Procedures with Insufficient Documentation Errors

Vertebral Augmentation Procedures

- Missing signature and date on clinical documentation that supports the patient's symptoms
- No radiographs that support the procedure's medical necessity
- Insufficient medical record documentation (for example, medication administration records, therapy discharge summary) that the provider tried conservative medical management, but it failed or was contraindicated
- No signed and dated attestation statement for the operative report if a physician signature was missing or illegible (or missing the operative report if the statement is electronically signed)

Physical Therapy Services

- Documentation didn't support certification of the plan of care for physical therapy services
- We require the physician's or NPP's signature and date of certification of the plan of care or progress note indicating they reviewed and approved the plan of care

Evaluation & Management (E/M) Services

- CERT identified office visits (established), hospital (initial), and hospital (subsequent) as the top 3 errors in E/M service categories
- High errors consisted of insufficient documentation, medical necessity, and incorrect coding of E/M services to support medical necessity and accurate billing of those services

Durable Medical Equipment (DME)

- Certain DME HCPCS codes (like hospital beds, glucose monitors, and manual wheelchairs) require a valid standard written order prior to claim submission
- The practitioner's name or NPI must be on the valid standard written order
- We'll pay claims only for DME if the ordering physician and DME supplier are actively enrolled in Medicare on the date of service
- As a condition for payment, a physician, physician assistant, nurse practitioner, or certified nurse specialist must document a face-to-face encounter exam with a patient in the 6 months before the written order for certain DME items



Computed Tomography (CT) Scans

- Documentation of the plan or intent to order a CT scan was insufficient to support its medical necessity
- If the handwritten signature is illegible, include a signature log (if electronic, include the protocol)

[Provider Compliance](#) has more information about how to avoid common coverage, coding, and billing errors.

Resources

- [Section 220.1.3 of the Medicare Benefit Policy Manual, Chapter 15: Certification and Recertification of Need for Treatment and Therapy Plans of Care](#)
- [Section 220.4 of the Medicare Benefit Policy Manual, Chapter 15: Functional Reporting](#)
- [Section 220.1.1 of the Medicare Benefit Policy Manual, Chapter 15: Care of a Physician/ Nonphysician Practitioner \(NPP\)](#)
- [Complying with Medicare Signature Requirements](#)
- [Section 3.3.2.4 of the Medicare Program Integrity Manual, Chapter 3: Signature Requirements](#)
- [Section 30.6 of the Medicare Claims Processing Manual, Chapter 12: Evaluation and Management Service Codes - General \(Codes 99202–99499\)](#)
- [Medicare Coverage Database](#)
- [Section 80.6 of the Medicare Benefit Policy Manual, Chapter 15: Requirements for Ordering and Following Orders for Diagnostic Tests](#)
- [Complying with Documentation Requirements for Lab Services](#)

The Medicare Learning Network® and the Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) and Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Outreach & Education Task Force developed this content together to provide nationally consistent education to health care providers.

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