



Medicare Part B

Documentation Guidelines for Medicare Services - Revised

Note: This article from "Medicare B News," Issue 236 dated April 17, 2007 is being updated and reprinted to ensure that the NAS provider and supplier community has access to recent publications that contain the most current, accurate and effective information available.

Medical records should be complete and legible and should include:

- The reason for the encounter and relevant history, findings and test results
- An assessment and impression of diagnosis
- A plan of care and the date and legible identity of the observer
- The records should not only substantiate the service performed, but also the level of care required.

By law, Medicare carriers can review any information, including medical records, pertaining to a Medicare claim.

Providers billing Medicare for their services must:

- Document in appropriate office records and/or hospital records each time a covered Medicare service is provided.
- When providing concurrent care for hospital or custodial care facility patients, physicians should identify their specialty in order to help support the necessity.
- Write medical information legibly and either sign each entry with a legible signature, or ensure that the identity of the provider /author/observer is present and legible. The medical information should be clear, concise and reflect the patient's condition.
- Sign progress notes for hospital and custodial care facility patients - all entries should be dated and signed by the healthcare provider who actually examined the patient.
- Provide sufficient detail to support diagnostic tests that were furnished and the level of care billed.
- Not use statements such as "same as above" or ditto marks (" "). These are not acceptable documentation that the service was provided for that date.

NAS recommends provider clinics to maintain a file with the printed name, signature, and initials of each Medicare provider in the office. This information may be requested by other entities (e.g. insurance companies, Medicare contractors [e.g. CERT, RAC or WIC] and or lawyers) in order to verify the provider's identity in determining the medical necessity of the service.

The "burden of proof" is placed on the provider to substantiate services and/or supplies billed to Medicare. During the audit process, if documentation is needed, the physician or supplier must provide the required documentation within the deadlines stipulated in the written request.

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