

Nine Tips For Getting Documentation to Medical Review

It still appears that the **number one reason** for denials is *documentation not arriving on time*. How dumb is that? This is followed by insufficient documentation to support the claim. This is so easily rectifiable that there is no excuse for it happening. Just follow the basic process of:

1. Make sure everyone knows that you have had the ADR for that particular patient
2. Make 1 person responsible for oversight and have a timetable for completion (not the day before it's due)
3. Make copies of the clinical record and claim forms
4. Have appropriate individuals do an audit to find any problems/concerns
5. When found, effect the appropriate correction (e.g. illegible, get it transcribed)
6. Supplement with other documentation if the record cannot stand alone (other MDSs, prior evaluations or D/C summaries, notes outside of the period under review, medical necessity statements pulling the whole thing together for the reviewer)
7. Make single sided copies, check for readability and separate them into sections with colored paper inserts (not sticky notes)
8. Add standard abbreviations from your P&P along with interpretations of any tests and measures that might not be familiar to the reviewer
9. Make sure you mail them with enough time to get there and get a signed delivery signature.

AND FINALLY: *There are numerous pre-payment probes being done on the use of the KX modifier, just to let you know!*

Disclaimer:

Encompass Consulting & Education, LLC has produced this article as an informational reference for the readers of our E-Zine. The information contained in this article is current as of the time of publication.

Medicare regulations are constantly changing and it is the responsibility of the provider to remain abreast of the Medicare program requirements. Any regulations, policies and/or guidelines cited are subject to change at any time. Current Medicare regulations can be found on the CMS website at www.cms.hhs.gov

As always, the provider should be aware of other regulations that might supersede the Medicare payment guidelines such as the State Practice Act and the State Administrative Code. In any scenario, the practitioner must go with the most stringent requirement in order to be compliant.

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