

Importance of preparing and maintaining legible medical records

CMS has come out with a special edition MedLearn Matters (MLN) article that is intended to highlight the importance of legible documentation to avoid claims denials. The information pertains not only to Fee- For-Service Medicare members but for Medicare Advantage members as well.

For Medicare Advantage beneficiaries, accurate, legible supporting documentation in the Medical Record and correct signature authentication in the EMR system (if an EMR system is used), validates ICD-9 diagnosis codes which are critical for accurate RAPS prospective reimbursement under the Risk Adjustment Model of reimbursement based on the health status of enrolled beneficiaries. The MLN Article is information only for Providers and does not alter existing Medicare policy. It also does not introduce new policy.

CMS MLN Matters Bulletin Summary (SE 1237)

The legibility of clinical notes and other supporting documentation is critical to avoiding claim payment denials.

The Centers for Medicare & Medicaid Services (CMS) requires its contractors to deny an item or service if it is not reasonable and necessary. When determining the medical necessity of the item or service billed, Medicare's review contractors must rely on the medical documentation submitted by the provider in support of a given claim. CMS strictly enforces the following requirements when submitting claims and supporting documentation:

1. Medical records should be complete and legible; and should include the legible identity of the provider and the date of service.
2. Documents containing amendments, corrections, or delayed entries must employ the following widely accepted recordkeeping principles:
 - Clearly and permanently identify any amendments, corrections or addenda.
 - Clearly indicate the date and author of any amendments, corrections, or addenda.
 - Clearly identify all original content (do not delete).
3. For medical review purposes, Medicare requires that services provided or ordered be authenticated by the author. The method used shall be a handwritten or electronic signature.
 - If the signature is illegible or missing from the medical documentation (other than an order), the review contractor shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
 - If the signature is missing from an order, the review contractor shall disregard the order during the review of the claim (i.e., the reviewer will proceed as if the order was not received).Signature attestations are not allowable for orders.

Here is the link to the MLN Matters® article highlighting the importance of legibility [SE1237](#) 