Avoiding Medicare Claim Denials

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Palmetto GBA recently reviewed many Medicare claim denials denied by Palmetto and other Medicare contractors. The review unveiled that 54 percent of the denied claims were due to provider documentation related technical errors that can be easily avoided by submitting adequate documentation to support services as reasonable and medically necessary. The denial reasons of these claims can be categorized as following:

Denial Reason #1: No medical record received after request for records
Resolution: When medical records are requested, send the records with a copy of the request within the time frame allowed on the request to the right contractor address.

Denial Reason #2: No signature (or illegible signature) on documents and illegible medical records
Resolution: Progress notes and orders must be legible and signed. If the signature appears illegible, the office can create a signature page identifying the usual signature of the physician and attach it to the materials sent. If the signature is missing, the physician can send an attestation stating he or she actually saw the patient on the date of service in question

Denial Reason #3: No time documented on timed codes
Resolution: When service time is part of a particular code (e.g., for some therapy, mental health claims, infusions, critical care, etc.), the time must be documented on the chart either in the format of 'from-to' or total time.

Denial Reason #4: No record of medications given when medication billed on claim
Resolution: When medications or lab tests are billed, there must be some documentation (or order) to show the medication was administered and the test was wanted or needed.

Denial Reason #5: Incorrect place of service on claim and incorrect use of new patient versus established patient
Resolution: The distinction between a new and an established patient is whether a patient was seen face to face by the provider within the last three years. Since some E/M codes are the same for 'office or other outpatient services', the correct place of service must be on the claim and match the documentation.

You control the documentation describing what services your patients received and your documentation serves as the basis for the services you bill to Medicare. If your documentation does not support the services on the claim, then a payment error exists.

We encourage you to take the proactive approach below to help reduce the payment error rate and avoid future claim denials.

- The response to a request for records should always be reviewed by an individual with clinical experience before submitting it to a Medicare contractor.
- Establish an office process and designate one individual responsible for all record requests
- Use a checklist to verify if the progress notes were signed, legible, had the correct patient name and date, had the correct return address, etc.
- Always keep a record of the company and the contact asking for the record and when it is due. Whatever document was missing could be added by the physician (or other individuals with clinical background) before mailing or faxing the material.