The importance of good documentation

While many view documentation of our services as time consuming and annoying, it is one of the most important nonclinical requirements of practice. The Billing Integrity Program (BIP) will base an audit decision primarily on the degree of documentation within a medical record.

The *Doctors of BC Guide to Fees* and the MSC Payment Schedule define the term *adequate medical record* (Preamble C.10) as follows:

Except for referred "diagnostic facility" services, a medical record is not considered adequate unless it contains all information which may be designated or implied in the MSC Payment Schedule for the service. Another medical practitioner of the same specialty, who is unfamiliar with both the patient and the attending medical practitioner, would be able to readily determine the following from that record at hand:

a. Date and location of the service.
b. Identification of the patient and the attending medical practitioner.
c. Presenting complaint(s) and presenting symptoms and signs, including their history.
d. All pertinent previous history including pertinent family history.
e. The relevant results, both negative and positive, of a systematic enquiry pertinent to the patient's problem(s).
f. Identification of the extent of the physical examination including pertinent positive and negative findings.
g. Results of any investigations carried out during the encounter.
h. Summation of the problem and plan of management.

The BIP's working definition of an adequate medical record is the ability of another physician from the same specialty, who does not know either the physician or the patient, to continue care of the patient based on the documentation contained in the medical record.

Making and maintaining an adequate medical record of the encounter that appropriately supports the service being claimed will save you in an audit. Medical inspectors look for proper documentation in the patient's record to support the criteria to bill any fee-for-service fee item. For example, if the fee item is time-based, the medical inspector will look for start and end times to validate the claim. Having little or no documentation in your clinical records to support your claim is interpreted as "no benefit."

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This article is the opinion of the Patterns of Practice Committee and has not been peer reviewed by the BCMJ *Editorial Board. For further information contact Juanita Grant, audit and billing advisor, Physician and External Affairs, at 604 638-2829 or jgrant@doctorsofbc.ca.*