The importance of good documentation in an MSP audit

An article on this topic originally appeared in the November 2014 issue of the *BCMJ*. As this subject continues to pose a problem, the Patterns of Practice Committee decided to revisit the topic.

While physicians may view documentation of services as time-consuming, it is an important requirement of practice. In the process of a billing audit, the physician medical inspector and the Billing Integrity Program will base decisions primarily on the degree of documentation in a medical record.

The MSC Payment Schedule states that "a service for which an adequate medical record has not been recorded and retained is considered not to be complete and is not a benefit under the Plan" (Preamble A.2.vii.). It further defines the requirements of an 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:
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> 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.

Making and maintaining an adequate record of service is required to justify MSP claims.

Based on the documentation contained in the medical record, another physician should be able to readily provide continuity of care to a patient.

Making and maintaining an adequate record of service is required to justify MSP claims. In the event of an audit, medical inspectors look for documentation in patients' records to support that services were provided as claimed for all fee-for-service items. Some examples are:

- For fee items that are time based, start and end times may need to be documented in both the billing record and the chart, depending on the specific billing requirements. Medical inspectors assess this documentation to ensure that fee item criteria have been met.
- For fee items with detailed service provision requirements, such as General Practice Services Committee fee items for family physicians, all components of the service must be provided and documented to support that the service was completed in its entirety, including the provision of appropriate care for the duration of time the fee item indicates.
- For specialist advice fees and telephone fees, all components of the service must be documented as specified in the MSC Payment Schedule.

In the event of an audit, having little or no documentation in the medical records to support a claim or having records that are insufficient to support the nature and extent of the service being claimed may be adjudicated as the service not having been provided or the service not being considered a "benefit" or a billable service to MSP. ■

—Janet Evans, MD
Chair, Patterns of Practice Committee

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 Tara Hamilton, senior advisor, audit and billing, economics, advocacy and negotiations, at 604 638-6058 or thamilton@doctorsofbc.ca.*