

# LEGIBLE HANDWRITING: A MEDICARE PERSPECTIVE

Bryan A. Loy, MD, MBA

**L**egible documentation is essential to the administration of the Medicare program. In the medical review department, Medicare depends on submitted documentation to ensure that a service performed on a Medicare beneficiary was reasonable and necessary and in accordance with the Social Security Act, Section 1862 (a)(1)(a). Documentation is usually submitted in a typed or handwritten form.

Handwritten documentation may be difficult to interpret due to illegible handwriting and/or illegible notations. Often we read over provider notes repeatedly and obtain multiple opinions in an effort to decipher what is being submitted. Even consultants may have difficulty interpreting handwriting, uncommon acronyms, abbreviations, and notations. Other important issues include that of content, incomplete sentences, and vague descriptions that can be difficult to interpret. In the case of Evaluation and Management documentation, this can be problematic and can result in possible down coding and/or

denial(s). This, obviously, is not efficient from the standpoint of our review or without risk of financial loss to the provider. Occasionally, providers request permission to rewrite, retype, or otherwise reproduce the medical record. For a variety of reasons, we cannot allow this practice.

Faxed and/or copied documentation can compound an underlying legibility problem. At times, Faxed and/or copied documents become obscured due to the blurring of small print. Additionally, documents are received which apparently have not been properly processed and documentation on the edge of the original is incomplete or omitted.

In short, documentation that is illegible or indecipherable can result in delayed claims processing and in contrast; a legible record with adequate and orderly descriptive content can ensure appropriate reimbursement for the service(s) provided.

Dr. Loy is the  
Carrier Medical  
Director (Kentucky)  
for AdminaStar  
Federal.