Guideline for substantiating that a specific treatment was performed

What you need to know

This guideline outlines what you can do to substantiate that a specific treatment or action was performed as part of the requirements for Medicare Benefits Schedule (MBS) items e.g. 10960, 13757, 30189, 47600 and 85533.

The guideline is not exhaustive, and you can respond to a Medicare compliance audit or review using any documents you think substantiate the concern raised.

However, we may determine more information is needed and request additional documentation to substantiate services you have claimed.

Read the health professional guidelines about substantiating claims for Medicare compliance purposes before proceeding.

Documents you may use to substantiate a claim

Any document you give us should have been created during or as soon as practicable after the treatment occurred. It should include the patient's name and the date the treatment was provided.

To substantiate that a specific treatment was performed, you may provide:

- **an operation report**
- **a diagnostic imaging report**
- **a pathology report,** and
- **an excerpt from the patient's clinical record** - showing the patient's name, the date of the service and sufficient information to indicate that all components of the treatment, procedure or investigation were performed

In most cases, a patient's clinical information will be the only way to confirm that a specific treatment was performed during the service, and substantiate you received the correct Medicare benefit.

If you need to use a patient's clinical information you can censor any details that aren't relevant. You can also choose to provide the information to one of our medical advisers.

Resources

- MBS Online