KanTime
How better happens.

THE TRUE COST OF MISSING DOCUMENTATION

Missing documentation isn't usually intentional. More often, it's the result of disconnected workflows, limited visibility, or manual processes that just don't work.

BUT OVER TIME, THE TRUE COST OF MISSING DOCUMENTATION COMPOUNDS:

- More rework
- Slower reimbursement
- Higher compliance risk
- Increased team fatigue
- Increased compliance risk
- Increased survey risk

Over time, documentation gaps become more than an inconvenience.

They become a primary source of ***operational drag*** and can trigger audits, citations, and even penalties from CMS and state agencies.

IDENTIFYING COMMON DOCUMENTATION GAPS IN ACTION

The most common gaps in documentation typically stem from small errors and oversights. What begins as a minor workaround upstream, though, can build up into a massive blockage downstream, slowing billing and placing undue strain on teams.

Before you can eliminate documentation gaps, you'll have to spot them. Be on the lookout for common culprits like these:

WHAT IT IS	WHAT IT DOES	REGULATORY IMPACT
Late Notes Visit documentation completed days after care delivery	+ Creates backfill work + Causes billing delays	+ Increases risk of citations during surveys or audits
Incomplete Assessments Partially completed OASIS or hos-pice assessments	+ Requires manual follow-up and correction before submission	+ Possible non-compliance findings and delayed plan-of-care approval
Missing Signatures Unsigned verbal orders or physician certifications	+ Holds claims + Increases audit exposure	+ Violates CMS documentation rules + May trigger denials or penalties
Inconsistent Visit Documentation Visit frequency or care plan details that don't align with what was scheduled or delivered	+ Limits patient care quality	+ May be cited for failing to meet care plan requirements
Plan of Care Discrepancies Clinical updates not reflected in documentation	+ Requires constant QA review and manual reconciliation	+ Noncompliance with clinical standards + Survey risk
Duplicate or Manual Entries Information re-entered across systems	+ Increases the risk of errors + Increases the risk of omit-ted information	+ Creates audit flags and potential payer challenges

THE TRUE COST OF MISSING DOCUMENTATION

Incomplete or missing documentation doesn't just frustrate clinicians or teams; it also costs agencies both financially and clinically. In fact, the true cost often hides beneath the surface, rooted in the time and resources dedicated to workarounds.

+ ***Potential survey citations –*** Each documentation deficiency can contribute to findings in state surveys or payer audits.
+ ***Risk of penalties or denied services –*** Repeated noncompliance may result in fines, loss of reimbursement, or corrective action plans.

8-10 HOURS/ WEEK[1]
Average time clinicians spend on incomplete documentation

3-5% REVENUE LOSS[2]
Estimated annual net revenue loss stemming from incomplete documentation

$25-181 PER CLAIM[3]
Estimated average cost to rework or appeal denied claims

Unforeseen regulatory costs associated with incomplete or inconsistent documentation add up fast, too. Each documentation deficiency can contribute to findings in state surveys or payer audits. Repeated noncompliance can result in fines, loss of reimbursement, or corrective action plans.

$100-$50K[4]
Penalty cost for a single HIPAA violation

$39 BILLION[5]
Amount spent annually by health systems on non-clinical regulatory requirements

CONSEQUENCES THAT FLOW DOWNSTREAM

Documentation gaps or errors at the point of care have impacts that trickle down-stream, eventually impacting the entire organization:

1. ***Delayed or Denied Billing***
Claims held for missing signatures, incomplete assessments, or insufficient clinical support

2. ***Increased QA and Compliance Burden***
As documentation gaps become routine, QA teams shift from quality oversight to continuous chart repair

3. ***Survey and Audit Risk***
Incomplete or inconsistent records increase exposure during state surveys and payer audits

4. ***Risk to Continuity and Quality of Care Delivery***
Delayed documentation reduces visibility across teams, affecting care transitions and plan-of-care accuracy

5. ***Regulatory and Survey Risk***
Incomplete or inconsistent documentation raises flags during CMS and state agency surveys, increasing the likelihood of citations, corrective action plans, or financial penalties.



WHEN DOCUMENTATION BREAKDOWNS BECOME ROUTINE, IT'S TIME FOR A NEW SYSTEM

If clinicians are spending more time repairing charts than delivering care, the issue likely isn't personal performance or policy-breaking decisions. It's systemic friction.

Technology should streamline, not slow, your team's work-flows – and if your system isn't pulling its weight, it's time to shift gears.

BUILDING AN EFFECTIVE POST-ACUTE CARE SYSTEM STARTS WITH INVESTING IN THE RIGHT TOOLS.

Start a conversation with KanTime to see how agencies can prevent missing documentation and reduce downstream risk.

Start the Conversation

1. Gaffney, A. et al. (2022, March 28). Medical Documentation Burden Among US Office-Based Physicians in 2019.
2. Healthcare Financial Management Association (HFMA). (2026, February 18). Hospitals face multiple financial hits from new HOPD requirements.
3. Poland, R. and Heriban, S. (2022, April 25). Claims Denial: A Step-by-Step Approach to Resolution. AHIMA Journal.
4. American Medical Association (AMA). (n.d.). HIPAA violations & enforcement.
5. American Hospital Association. (n.d.) Regulatory Burden Overwhelming Providers, Diverting Clinicians from Patient Care.