MLN Matters® — Information for Medicare Fee-for-Service Health Care Professionals

News Flash – The Centers for Medicare & Medicaid Services (CMS) reminds all providers, physicians, and suppliers to allow sufficient time for the Medicare crossover process to work—approximately 15 work days after Medicare's reimbursement is made, as stated in MLN Matters Article SE0909 (*http://www.cms.gov/MLNMattersArticles/downloads/SE0909.pdf*) — before attempting to balance bill their patients' supplemental insurers. That is, do not balance bill until you have received written confirmation from Medicare that your patients' claims will not be crossed over, or you have received a special notification letter explaining why specified claims cannot be crossed over. Remittance Advice Remark Codes MA18 or N89 on your Medicare Remittance Advice (MRA) represent Medicare's intention to cross your patients' claims over.

MLN Matters® Number: MM6698
Related Change Request (CR) #: 6698
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Related CR Transmittal #: R327PI
Implementation Date: April 16, 2010

Signature Guidelines for Medical Review Purposes

Provider Types Affected

This article is for physicians, non-physician practitioners, and suppliers submitting claims to Medicare Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), Carriers, Regional Home Health Intermediaries (RHHIs) and/or Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6698 to clarify for providers how Medicare claims review contractors review claims and medical documentation submitted by providers. CR 6698 outlines the new rules for signatures and adds language for E-Prescribing. See the rest of this article for complete details.

Background

Those contractors who review Medicare claims include MACs, the Comprehensive Error Rate Testing (CERT) contractors, Recovery Audit Contractors (RACs), Program Safeguard Contractors (PSCs), and Zone Program Integrity Contractors (ZPICs). These contractors are tasked with measuring, detecting, and correcting improper payments as well as identifying potential fraud in the Fee for Service (FFS) Medicare Program.

The previous language in the Program Integrity Manual (PIM) required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. CR 6698 updates these requirements and adds E-Prescribing language.

Key Points of CR 6698

The following are the signature requirements that the above listed claims reviewers will apply:

- Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence.
- Definition of a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.
- Definition of a Signature Log: Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. In order to be considered valid for Medicare medical review purposes, the log must be a part of the patient's medical record. Reviewers will consider all submitted signature logs regardless of the date it was created.
- Definition of an Attestation Statement: In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.
- If a signature is missing from an order, claims reviewers will disregard the order during the review of the claim.
- Reviewers will consider all attestations that meet the guidelines regardless of

the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.

- The following are the signature guidelines in section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
    - In the situations where the guidelines indicate "signature requirements met," the reviewer will consider the entry.
    - In situations where the guidelines indicate "contact provider and ask a non-standard follow up question," the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins once the contractor makes an actual phone contact with the provider or on the date the request letter is received at the post office. (Reviewers will not contact the provider if the claim should be denied for reasons unrelated to the signature requirement.)
    - In the situations where the guidelines indicate "signature requirements NOT met," the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.
- Reviewers will accept as a valid order any Part B drugs, other than controlled substances, ordered through a qualified E-Prescribing system. For Medicare Part B medical review purposes, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. To review the official standards for electronic prescribing, *42 CFR 423.160 Standards for Electronic Prescribing,* you may go to *http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf* on the Internet.
- When Part B drugs, other than controlled substances, have been ordered through a qualified E-Prescribing system, the reviewer will NOT require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.
- When reviewing claims for controlled substance drugs, the reviewer will only accept hardcopy pen and ink signatures as evidence of a drug order.
- Reviewers will accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified E-Prescribing system.

Additional Information

If you have questions, please contact your Medicare FI, carrier, A/B MAC, RHHI or DME MAC at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

The official instruction, CR6698, issued to your Medicare FI, carrier, A/B MAC, RHHI or DME MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R327PI.pdf* on the CMS website.