# TIPS FROM OUR CONSULTANT

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## INDIANA CERT EXAMPLES

The Centers for Medicare & Medicaid Services (CMS) developed the Comprehensive Error Rate Testing (CERT) program to improve the processing and medical decision making involved with payment of Medicare claims. Under the CERT program, a random sample of claims is selected from each Medicare Contractor, and medical records are requested from the providers who submitted the claims. These records are then reviewed to determine if the claim was submitted and paid appropriately.

Each practice should have at least two (2) employees sufficiently trained to know how to respond to CERT requests as well as requests for medical records by any Medicare or Medicaid contractor, commercial payers, the Zone Program Integrity Contractor (ZPIC), the Office of Inspector General, etc. Simply not sending the appropriate information can result in a refund demand. Not knowing how to review documentation to ensure the physician's signature is present and not knowing what to do when the document is not signed will result in a refund demand.

We find the vast majority of the documentation deficiencies are simply due to

- not responding to the request for medical records (typically one claim)
- not sending all related documentation supporting the codes submitted on the claim
- not reviewing the information verifying proper signatures are in place

This is the first in a series of articles that will address some of the problems found during the CERT contractor's analysis of Indiana claims. These scenarios may reflect the services you provide. The information included below will allow you to perform a self-audit to ensure your documentation and coding does not include these deficiencies.

### Missing Signatures

The physician billed *CPT* 99215-25. The documentation received was missing a valid provider signature to support the office encounter. The CERT received typed office visit with unacceptable co-signature by an unknown person. The CERT requested additional information and received a duplicate invalid co-signed note. The CERT did not receive any response to its request for a physician signature attestation statement.

The physician billed *CPT* 99222 and 99233. The documentation received was missing signature of the physician who provided the inpatient services for billed dates. The submitted notes for the requested dates of service were not signed and did not include a history or physical exam. The CERT requested valid signed progress notes; and received two notes stating, "Not a patient at this facility" with another note stating, "patient was hospitalized on 11/23/11-11/30/11, attached are the records." The CERT received duplicate records and no attestation statements. Then the CERT received a note stating, "OK send refund request."

### Signature Guidelines

WPS admonition: "Per the *Program Integrity Manual*, if there is no signature of the person providing the service the documentation is not considered in the review process."

*Medicare Program Integrity Manual*, Chapter 3, §3.3.2.4 - Signature Requirements
This section is applicable for MACs *[Medicare Administrative Contractor]*, CERT, and ZPICs *[Zone Program Integrity]*. This section does not apply to Recovery Auditors.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

If MAC and CERT reviewers find reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation that contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead should make use of the signature authentication process. The signature authentication process described below should also be used for illegible signatures.

**Handwritten Signatures**

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, MACs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, MACs and CERT shall disregard the order during the review of the claim (e.g., the reviewer will proceed as if the order was not received).
- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.

**Electronic Signatures**

Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods.

**Potential Fraud Referrals**

At any time, suspected fraud shall result in a referral to the ZPIC for development. If MAC, Recovery Auditor or CERT reviewers identify a **pattern of missing/illegible signatures**, the reviewer shall **refer to the appropriate ZPIC** for further development.

***NCI Helpful Hints***

Remember, no documentation is accepted unless it is personally signed by the physician. The signature can be handwritten or electronically affixed to the document. When using electronic signatures, be sure you have a written Electronic Signature Protocol clearly identifying that your system is password protected and that only the user can use their password to sign a document.

Look at the documentation before putting it in the envelope!! If it isn't signed, DO NOT sign the information! This is altering a medical record.

For progress notes and interpretations, although there is no "mandated" language for a Signature Attestation Statement, why "reinvent the wheel?" NCI recommends completing WPS' example of a Signature Attestation Statement which can be found on the website at http://www.wpsmedicare.com/j8macpartb/forms/_files/2010_0518_attestation_example.pdf

Be sure to complete all the blanks including the date the physician signs the attestation statement! Notice the statement is for one date of service. If you have more than one date of service/document that you are sending to the contractor, complete a separate attestation for each date/document.

The signature attestation statement is not applicable for missing signatures on orders for tests, e.g., tests not performed in your office. In this scenario, if the requisition is not personally signed by the physician, the document will not be sufficient to support the charges for the entity performing the test.

**Diagnostic Tests**

The physician billed *CPT* 36415 collection of venous blood by venipuncture. The CERT received documentation that did not include any orders for any laboratory testing that would require the performance of venipuncture on the billed date of service. The submitted documentation included laboratory reports for hemoglobin A1C and TSH. The CERT requested valid orders and documentation to support the medical necessity for the tests. The CERT received a "problem report phone note" signed and dated by the RN who ordered a TSH and hemoglobin A1C, but there was no signature by the ordering provider. The CERT also received an office visit note that supports medical necessity, a test form signed by an RN, and laboratory reports. The CERT did not receive valid signed and dated orders for the diagnostic tests to support billing the venipuncture.

The physician billed *CPT* 80061 lipid panel and 83036 hemoglobin; glycosylated (A1C). The initial information received was missing a current/valid physician signed/dated order and progress notes to support the plan and necessity/reason for ordering the lipid panel and hemoglobin A1C. Upon request, the CERT received an invalid unsigned lab requisition, test results, a progress note that does not include an order for the billed tests, and a physician signature attestation statement for the date of service 4/21/2011, but the date the attestation statement was signed is missing.

> *NCI Comments: Multiple problems are found in this example, the progress note did not include the exact tests to be performed and, even if this information had been documented, the fact the attestation statement was not dated when it was signed would have made the documentation invalid for both the tests as well as billing the associated visit.*

Physician billed *CPT* 85025 blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count. The documentation submitted includes the physician's order for CBC. The differential was not ordered. The physician submitted the lab results for CBC with differential. Because the order did not include the request for a differential WBC count, the documentation required changing codes from *CPT* 85025 to 85027 blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count). The physician was asked to refund the different in payment between the two (2) tests.

Physician Billed 82947 glucose; quantitative, blood (except reagent strip) performed on 05/11/2011. The CERT received a note dated 05/04/2011 stating the beneficiary is in to follow-up on "...elevated Hgb A1C." The 05/04/2011 note is electronically signed by the physician. The progress note for 05/11/2011 does not include the result of the glucose test. The CERT requested additional information and received duplicate original documentation, with the addition of blood glucose result and provider's signature, without notation of a late entry or addendum. This is considered an alteration of a chart and a refund was requested.

***NCI Helpful Hints***

Per Medicare regulations, only the "treating physician" or "treating practitioner" (nurse practitioner, clinical nurse specialist or physician assistant) can request that a diagnostic test be performed for a beneficiary.

§80.6.1 Chapter 15, Medicare Benefits Policy Manual states that a signed physician's order is not required for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or for physician pathology services. However, there must be clear documentation by the physician in the medical record (e.g. progress note) of his or her intent that the test be performed.

To be considered for Medicare payment, all diagnostic services require a physician order or a progress note which includes the order and documentation supporting the medical necessity for ordering the test. Except for clinical diagnostic tests, an unsigned order or requisition will not be considered during a review. In addition, a signature attestation statement is not acceptable for unsigned orders/requisitions. Payment may not be made for diagnostic tests ordered by ancillary staff, e.g., RN, LPN, medical assistant.

When progress notes are used to support intent for ordering diagnostic tests, the specific test(s) being ordered must be clearly documented. It is insufficient to document "will order labs." Remember, when using the progress note as the order for tests (especially for tests performed in the office setting), if the progress note is unsigned, a signature attestation should be completed by the ordering provider and submitted with the records.

WPS has noted lab ordering systems or forms often do not differentiate between a "CBC" and a "CBC w/Differential." WPS encourages all physicians to review ordering systems and forms to determine if they specifically include both a CBC and a CBC with differential. If the intention is to order a CBC with differential, that distinction must be clearly noted on the order or payment will be adjusted.

**Recognizing the Meaning of "Standing Orders"**
http://www.wpsmedicare.com/j8macpartb/departments/cert/recognizing-standing-orders.shtml

Medicare will consider payment for appropriately documented covered services that are reasonable and necessary for the beneficiary, given his/her clinical condition. Medical necessity is the driving force for the payment of any Medicare service. If a service is not medically necessary, it cannot be paid by Medicare. Providers need be cognizant of the various meanings represented by use of the term "standing orders." Some understand this to mean recurring orders specific to the care of an individual patient, while others understand this as routine orders for services delivered to a population of patients. The following can help you understand the various uses of "standing orders."

Routine Orders
Routine orders are orders for those services and treatments that are applied to patients who have the same or similar medical condition(s). These frequently called "routine, protocol or standing orders" are based on an assessment of the impact of a given condition in the population of patients with that condition (medical illness or injury) and are widely applied to those patients.

Medicare defines any order(s) that does not specifically address an individual patient's unique illness, injury or medical status, as not reasonable and necessary. As is required by law, Medicare does not accept such "standing orders" as supporting medical necessity for the individual patient. Services related to population-based or condition-based orders are not reimbursable.

Recurring Orders
For physician services, Medicare may reimburse "standing orders" that are specific to an individual patient's treatment. For example: the standing order "Evaluate this patient's decubitus ulcer on a daily basis for signs of infection i.e. drainage, odor, size and staging prior to changing dressing."

Reimbursement of tests or services provided under a standing order for a recurring or serial evaluation is subject to medical necessity review.

All such orders must be written for a specific patient, and each instance of the test or service must be necessary. Each result must be reviewed with appropriate action taken by the treating physician, including any appropriate change in the frequency or duration of testing.

Treatment Protocols
Treatment protocols may be reimbursable since these protocols are individualized to each patient. For example, the use of chemotherapeutic drug protocols, that suggest drugs, dosage ranges, frequency and/or duration specifically ordered for an individual patient.

Laboratory Orders
In some circumstances, a "standing order" for a recurring lab test that is specific to the needs of an individual patient may be reimbursable. (See requirements below.)

Preprinted orders are not covered by Medicare. However, preprinted or electronic lists of potential orders are permitted if the provider individually affirms, defines, or otherwise modifies each component as appropriate for an individual patient's clinical circumstances.

Standing orders for recurring diagnostic tests may be appropriate when all of the following conditions are met:

Each ordered test must be appropriate and necessary for the individual patient's clinical circumstances.

- The frequency and number of repeated testing must not be greater than medically necessary.
- The diagnosis must be indicated for each test with sufficient clarity to permit accurate ICD-9-CM coding to the highest level of specificity.
- The treating physician must review each test's result, making any indicated adjustments in frequency and number of repeated studies.
- All lab tests must be reviewed and documentation must support that the appropriate clinical action was taken.

Examples of appropriate, recurring diagnostic tests under Medicare include:

- Repeat cardiac enzymes to rule out acute ischemia.
- Prothrombin times for a patient on chronic warfarin.

In relation to blood glucose monitoring, CMS has specific instructions in Change Request 5443. Medicare separately pays for a blood glucose test only when the service meets all of the conditions of payment for a test payable under the clinical laboratory fee schedule including that the test must be ordered by the physician who is treating the beneficiary and the physician must use the results in the management of the beneficiary's specific medical condition.

WPS regulation states that for payment to be made for a blood glucose test under Medicare Part B, a physician must certify that each test is medically necessary and that a standing order for many tests over a time period is not sufficient documentation.

Payment for hospital and nursing facility glucose monitoring is encompassed under Medicare Part A and other payment methods.

Standing Orders for Consultation
Standing orders for consultations for Medicare beneficiaries admitted to a hospital, observation unit, or a nursing facility are not allowed. There must be medical necessity for any such consultation.
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**Documentation Timeliness**
http://www.wpsmedicare.com/j8macpartb/claims/submission/documentation-timelines.shtml

Question: I am confused concerning the timeliness of my documentation in connection with the provider signature, submitting the claim to Medicare, and the timely filing rule. Can you provide more information?

Answer: There are several provisions that may affect "timeliness" when talking about documentation.

The first is that a provider **may not submit a claim to Medicare until the documentation is completed**. Until the practitioner completes the documentation for a service, including signature, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done.

The second is that practitioners are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record." This statement is from the Centers for Medicare & Medicare Services (CMS) Internet Only Manual (IOM) Publication 100-04, Chapter 12,Adobe Portable Document Format Section 30.6.1. **CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the service itself**.

In addition, CMS has a statement in the IOM Publication 100-08, Chapter 3,Adobe Portable Document Format Section 3.3.2.4 discussing the requirements for practitioner signature, "Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process)

The IOM Publication 100-08, Chapter 3Adobe Portable Document Format, Section 3.3.2.5 discussing late entries. A provider should never add a signature to a medical record after the times discussed above. If a practitioner does not affix a signature at the time of the service (also allowing limited delay due to transcription), then the provider may complete an attestation statement.

CMS may, occasionally instruct the contractors differently than that stated here due to extenuating circumstances. WPS Medicare will publish information to this affect when we receive notification.

The next time discussed is the timely filing limit. This does not apply to the medical record documentation but instead indicates that a practitioner has 1 year from the date of service to file the claim to Medicare. If Medicare does not receive the claim within that year, Medicare does not make payment and the patient is not liable.

**IS YOUR ADDRESS UP TO DATE?**

WPS requested we include the following information in this article.

Recently SafeGuard Services, a CMS contractor, sent multiple Comparative Billing Reports (CBRs) to those providers across the country with the highest outlier billing for evaluation and management services (E/M). As of today, close to 20 percent have been returned as addresses invalid.

WPS Medicare often mails important educational information, requests for medical record documentation and results of claim reviews to providers based on the address listed in their Medicare file. We have noted recent instances where our correspondence is returned as undeliverable because the address on file for the provider is no longer valid. This can result in unnecessary claim denials or missing out on important educational initiatives. We would like to remind providers that changes in practice location must be reported to Medicare within 30 days of the effective date of the change. Failure to comply with this requirement may result in revocation of the provider's Medicare billing privileges.

For more information on Reporting Changes of Information to Medicare, please refer to the article on our Provider Enrollment web page located here: http://www.wpsmedicare.com/j8macpartb/departments/enrollment/breportadd.shtml