

MEDICARE UPDATE

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UPDATES YOU NEED TO KNOW!

Do you feel Congress and Governmental Agencies can't make up their minds? If you said "Yes" you are not alone. Many "deadlines" continue to be a moving target.

MEDICARE ENROLLMENT – PECOS DEADLINE NOW JULY 6, 2010

In all of our 2010 seminars, we urged physicians and providers not to wait to verify their enrollment. This article is to once again stress the urgency of ensuring you are in PECOS as the effective has changed yet again!

Initially physicians and nonphysician providers ordering any durable medical equipment, prosthetics, orthotics, and supplies had to be enrolled in PECOS effective January 4, 2010. In December 2009, the Centers for Medicare & Medicaid (CMS) extended this deadline for supplier claim denials for services ordered by physicians/providers who were not enrolled in PECOS until April 5, 2010. The deadline was then extended to January 3, 2011 and CMS added denials of claims for all other services that are ordered or referred, including diagnostic tests, if the referring/ordering provider was not enrolled in PECOS.

That last little addition had major impact on physicians/providers. Initially, the need to be in PECOS would only affect DMEPOS claims. With this change, claims for all services requiring an ordering or referring physician/provider would be rejected if that physician/provider was not in PECOS. Still realizing that they had until January 3, 2011, many physicians and providers decided nothing had to be done immediately and put the investigation of whether they were in PECOS on the back burner.

Then Congress passed and President Obama signed the Affordable Care Act and being in PECOS is now an urgent matter. **The NEW deadline is July 6, 2010!!!**

In the May 5, 2010 *Federal Register*, CMS published an Interim Final Rule with Comment Period. Based on changes required by the Affordable Care Act, all physicians and nonphysician providers who order any service (including diagnostic tests) must be enrolled in PECOS by July 1, 2010. Beginning July 6, 2010 claims for **all services ordered or referred by a physician/provider will be denied if the ordering/referring physician is not in PECOS. This includes your professional claims!**

If you enrolled in Medicare or updated your Medicare enrollment information within the past six (6) years, your Medicare enrollment information should already be in PECOS. If you enrolled more than six (6) years ago and have not submitted any updates to your Medicare enrollment information, you need to update your Medicare enrollment information **NOW** and depending on how long your physicians has been a Medicare provider, may actually need to **revalidate** your provider information.

CMS has compiled a list of providers who are in PECOS which can be accessed on their web site. Newby Consulting, Inc. strongly urges you go to this list to confirm each of your physicians/providers are in PECOS. If your physician/provider is on the list of providers, this means he/she is in PECOS and does not need to complete a new CMS-855I enrollment form. The list can be found at the following web site: <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/OrderingReferringReport.pdf>

ACT QUICKLY

If you access the list on the CMS web site and find your physician/provider is not listed, you must update his/her enrollment with Medicare. In order to update the information, a CMS-855I enrollment application must be completed with all the information necessary to initially enroll in Medicare. If you have a separate NPI (type 2) for your organization, the physician/provider will also have to complete a CMS-855R to reassign his/her benefits to the organization/group. This will get the provider or supplier into PECOS and will ensure that their enrollment information is current.

Physicians/providers can revalidate their enrollment via Internet-based PECOS or they can fill out the appropriate paper CMS-855I and if needed the CMS-855R Medicare provider enrollment forms and mail them to the appropriate enrollment contractor.

Instructions on Internet-based PECOS can be found on the CMS website at http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage

MEDICARE TO HOLD CLAIMS

On 5/27/10, CMS issued instructions to all contractors to hold claims for ten (10) business days for claims received with dates of service on or after 6/1/10. Claims with dates of service on or prior to 5/31/10 will continue to process as usual.

Once again, Congress waited until the last minute to act to prevent the -21.3% update to the 2010 conversion factor. On 5/28/10, the U.S. House of Representatives passed legislation providing a positive 2.2 percent update for the rest of 2010 and a 1.0 percent update for 2011. Unfortunately, the Senate had already adjourned for the extended Memorial Day recess. Thus, the Senate will not discuss the House-passed bill until they return on June 7, 2010.

According to the American Medical Association (AMA), if this legislation becomes law as it is currently written, the Sustainable Growth Rate (SGR) formula will once again go into effect in 2012 and payments will be cut by an estimated 33 percent.

RED FLAGS RULES – DELAYED AGAIN!

Yet again, at the request of several members of Congress, on 5/28/10, the Federal Trade Commission (FTC) extended its deferral of enforcement of the Identity Theft Red Flag Rule (Red Flags Rule) through 12/31/10. This extension gives Congress additional time to reach a consensus on the types of businesses that should be covered under the Rule. Included in the FTC's announcement was an explanation of the delay; the FTC did not want to begin enforcement of a regulation that Congress plans to supersede.

In a separate action, after almost two (2) years of trying to convince the FTC that the Red Flags Rule is not applicable to physicians, on 5/1/10 the AMA, American Osteopathic Association (AOA) and the Medical Society of the District of Columbia (MSDC) filed a suit in federal court seeking to prevent the FTC from extending identity theft regulations to physicians.

While both of these actions seem promising, the FTC also stated that if Congress passes legislation limiting the scope of the Red Flags Rule with an effective date earlier than 12/31/10, the Commission will begin enforcement as of that effective date.

SIGNATURE GUIDELINES FOR MEDICAL REVIEW PURPOSES

Have you noticed since last year, CMS has issued a slew of notices about the need for physicians to sign all medical records? We find that many practices reviewed the information, but failed to audit medical record/order documentation to ensure their physicians and nonphysician providers are using acceptable signature formats.

- Kudos to those who found their physicians/providers are in compliance with the signature requirements.
- Great work to those who found deficiencies and have educated and confirmed your physicians/providers now have acceptable signatures.
- You need to get busy if you have put this on your "To Do" list that includes issues you can't find time to get done!

The most recent information release can be found in MedLearn Matters article number MM6698 which was revised and re-issued on 4/26/10. Did you notice that although the article was revised, the effective date in the original article (4/16/10) was not changed? Further, the information clearly reminds us that all signature requirements included in CMS Change Release 6698 were retroactively effective for Comprehensive Error Rate Testing (CERT) for the November

Pertinent portions include:

- For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a handwritten or an electronic signature. Stamp signatures are not acceptable. There are some exceptions, i.e.:
 - EXCEPTION 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.
 - EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and the *Medicare Benefit Policy Manual*, Chapter 15, §80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.
 - EXCEPTION 3: Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, National Coverage Decision (NCD), Local Coverage Decision (LCD), and CMS manuals are silent on whether the signature must be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below (*Not All-Inclusive*) to discern the identity and credentials (e.g. MD, RN) of the signator. In cases where the relevant regulation, NCD, LCD, and CMS manuals have specific signature requirements, those signature requirements take precedence.

The Administrative Contractors (AC), Medicare Administrative Contractors (MAC) and CERT reviewers shall apply the following signature requirements (*Not All-Inclusive*):

- If there are 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 which 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 may make use of the signature authentication process.
- Keep in mind that a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and note the following:
 - If the signature is illegible, the contractor 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, the contractor shall disregard the order during the review of the claim.
 - If the signature is missing from any other medical documentation, the contractor shall accept a signature attestation from the author of the medical record entry.
- If a signature is missing from an order, claims reviewers will disregard the order during the review of the claim.

Definitions

- Handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.
- 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. Reviewers will consider all submitted signature logs regardless of the date they were created.
- 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.


- Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:


“I, _____[print full name of the physician/practitioner]____, hereby attest that the medical record entry for _____[date of service]____ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]____ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”

While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.

Handwritten Signatures

The transmittal included an excellent chart that provides various examples of how physicians “sign” their medical records. We have modified the information for this article. The entire transmittal can be found on the CMS website at <http://www.cms.gov/Transmittals/downloads/R327PI.pdf>

	Signature Scenario	Signature Requirement Met
1	Legible full signature	Yes
2	Legible first initial and last name	Yes
3	Illegible signature over a typed or printed name Example:  John Whigg, MD	Yes
4	Illegible signature where the letterhead, Addressograph or other information on the page indicates the identity of the signator. Example An illegible signature appears on a prescription. The letterhead of the prescription lists 3 physicians' names. One of the names is circled.	Yes
5	Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: a) a signature log, or b) an attestation statement	Yes

6	<p>Illegible Signature NOT over a typed/printed name, NOT on letterhead and the documentation is UNaccompanied by:</p> <p>a) a signature log, or b) an attestation statement</p> <p>Example:</p> 	NO
7	Initials over a typed or printed name	Yes
8	<p>Initials NOT over a typed/printed name but accompanied by:</p> <p>a) a signature log, or b) an attestation statement</p>	Yes
9	<p>Initials NOT over a typed/printed name UNaccompanied by:</p> <p>a) a signature log, or b) b) an attestation statement</p>	NO
10	<p>Unsigned typed note with provider's typed name</p> <p>Example:</p> <p style="text-align: center;">John Whigg, MD</p>	NO
11	Unsigned typed note without providers typed/printed name	NO
12	Unsigned handwritten note, the only entry on the page	NO
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	Yes
14	"Signature on File"	NO

Electronic Signatures

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

Timely Filing Requirements for Medicare Fee-For-Service Claims

Sometimes things just aren't fair!. As part of the *Patient Protection and Affordable Care Act* (PPACA) that President Obama signed into law on March 23, 2010, the time period for filing Medicare fee-for-service (FFS) claims has been changed. This is one of many provisions we will be identifying over the next several months that are aimed at curbing fraud, waste, and abuse in the Medicare Program.

Currently to be considered "timely" claims with dates of service October 1, 2008 through September 30, 2009 have to be filed by December 31, 2010. If the date of service is greater than one year from the date filed, the provider incurs a 10 percent reduction in payment which cannot be passed on to the patient.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one (1) calendar year after the date of service. The law also mandates that claims for services furnished prior to January 1, 2010, must be filed no later than December 31, 2010. The new timely filing periods are as follows:

- Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010.
- Claims with dates of service on or after January 1, 2010 must be filed within one year from the date of service.

The Secretary of Health and Human Services is permitted to make certain exceptions to the one-year filing deadline; however, no exceptions have been established at this time.

This change will require closer identification of Medicare Secondary claims. Your staff needs to carefully question patients about any accident to determine if any liability or no-fault insurance is applicable.

Also, at each encounter, be sure your staff questions all patients about their existing insurance coverage. Contact the local Medicare contractor or the Medicare Coordination of Benefits (COB) Contractor when in doubt whether a commercial insurance plan is primary to the patient's Medicare coverage.

The COB Contractor's Customer Call Center's toll free number is 1-800-999-1118 or TDD/TYY 1-800-318-8782. Customer Service Representatives are available from 8 a.m. to 8 p.m., Monday through Friday, Eastern Time, except holidays.

Based on the findings of these reviews, most errors occurred because the services were billed at a higher level than was substantiated by the documentation.

According to the *CPT Manual*, *CPT 99310* is representative of subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three components:

- a comprehensive interval history;
- a comprehensive examination; and/or
- medical decision making of high complexity

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

Physicians typically spend 35 minutes with the patient and/or family or caregiver.

The CMS *Medicare Claims Processing Manual*, Chapter 12, §30.6.1 states, "...the medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a *CPT* code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a level of service is billed. Documentation should support the level of service reported. Providers should select the code for the service based upon the content of the service."

Providers will receive an additional development request (ADR) letter detailing the specific documentation being requested for the billed services. You must respond within 30 days with the requested documentation. Providers who fail to furnish the requested supporting medical documentation timely will receive a full claim denial. The original ADR letter must be included with the documentation.