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Physician's
VIEW POINT

OCTOBER 2010

Protecting Your Practice

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PRIMARY CONTACT

Now head of our firm's ACS Department and Healthcare Group, Robert Lane has been in practice for over 30 years. He is certified as a Personal Financial Specialist (PFS) by the American Institute of Public Accountants (AICPA) and holds a state of Texas CPA license. In addition, he holds both Texas and federal securities licenses.

For more information about LGT or to speak to a Healthcare Specialist please contact Robert Lane, Partner at 214-461-1450.

INSIDE FEATURES

Medicare
Protecting Your Practice

Signature Guidelines
for Medicare Review Purposes

HINT!

CLICK THE MORTAR AND PESTLE TO
RETURN TO TABLE OF CONTENTS



Medicare

Protecting Your Practice

OBTAINING A NATIONAL PROVIDER IDENTIFIER (NPI)

To bill Medicare, physicians and other suppliers must first obtain a National Provider Identifier (NPI) and enroll with the designated Medicare fee-for-service contractor. The application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes you to bill and be paid for services.

To obtain an NPI, a physician or other supplier may apply for an NPI at <https://nppes.cms.hhs.gov> or by calling the Enumerator at 1-800-465-3202 or TTY 1-800-692-2326.

To enroll in the Medicare program, visit the CMS provider enrollment web site at <http://www.cms.hhs.gov/MedicareProviderSupEnroll/> to access and download the appropriate Medicare enrollment application, find responses to commonly asked questions, or to find telephone and mailing address information for the fee-for-service contractor serving your area. Any misuse of your NPI should be reported immediately.

CLOSING, RELOCATING, CHANGE IN STATUS, OR CHANGES IN MEMBERS

Physicians, non-physician practitioners and physician and non-physician practitioner organizations are required to contact the Medicare contractor to update records, if they decide to close or move their practice or change members of a group within 30 days of the change.

Additional information regarding Medicare enrollment process, including information about the Internet-based Provider Enrollment, Chain and Ownership System, adding/deleting group members, or changes to address is available through the CMS website at www.cms.hhs.gov/MedicareProviderSupEnroll or can be obtained by contacting the designated Medicare fee-for-service contractor.

REASSIGNMENT OF BENEFITS

Generally speaking, Medicare pays the individual physician or non-physician practitioner who performed the service. In certain situations, however, Medicare will allow the individual who performed the service to reassign their Medicare payments to another qualified physician or entity.

This is called reassignment of benefits and requires that a CMS-855R be completed, signed, and submitted to the Medicare contractor. A fully executed CMS-855R, Reassignment of Medicare Benefits, is powerful because it allows another qualified person or entity to bill Medicare on behalf of a physician or non-physician practitioner and receive payment that otherwise would have been sent directly to the individual practitioner. If an individual has authorized someone else to bill and be paid by Medicare for services that he or she renders, both the individual and the entity receiving payment are jointly responsible for ensuring that such billings are appropriate and reflect services actually performed.



TERMINATING REASSIGNMENT AGREEMENTS

Individual practitioners should notify Medicare as soon as reassignment agreements are terminated, since failure to do so allows the previous entity to continue billing Medicare. Individual practitioners and/or suppliers can terminate a reassignment agreement by completing and submitting a CMS-855R to their designated Medicare fee-for-service contractor.

HIRING SOMEONE TO PREPARE CLAIMS

Some physicians and suppliers find it helpful to obtain the assistance of a billing service or consultant to submit their Medicare claims.

While such entities can provide valuable services, physicians/suppliers must clearly understand that delegating this process does not relieve them from responsibility for overpayments received due to claims filed on their behalf.

Therefore, physicians/suppliers should get involved and oversee their billing service or staff. Additionally, before hiring a service or consultant, physicians/suppliers should carefully check references and ensure that the service or consultant:

- Provides periodic reports of claims billed on the physician's behalf and, if the billing service receives the Medicare payments, it should be able to provide data regarding how much Medicare paid.
- Protects the physician's NPI and any other information used to act on the physician's behalf.
- Does not change procedure codes, diagnosis

codes, or other information furnished by the physician without the physician's knowledge and consent.

- Keeps the physician informed of all correspondence received from Medicare.

Physicians should review information submitted by a billing service or consultant regularly to ensure consistency with their records. They should also keep complete administrative records for the claims a billing service files on their behalf.

HIRING EMPLOYEES

The physician is responsible for the actions of his or her billing staff. Therefore, physicians should consider performing background checks before hiring new employees and conduct periodic quality checks of sensitive processes, such as the posting of account receivables.

CONTRACTUAL ARRANGEMENTS

Numerous legal and compliance factors must be considered when contracting with individuals, other entities, billing services, or consultants. The following questions should be considered when planning contractual arrangements:

- What types of agreements and paperwork must be executed between the physician and the other parties?
- Are any agreements/paperwork required between the physician and the insurance companies?
- Do the agreements made between the physician and the other parties conform to ethical standards?



Contracts must be examined in light of confidentiality obligations, including those defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Therefore, physicians should consult with a healthcare attorney when considering a contractual arrangement. Additionally, physicians may obtain information on contractual arrangements by reviewing requirements published by the Medicare Contractor, CMS or the SSA.

REFERRAL OF PATIENTS AND ORDERING OF SERVICES/ITEMS

Physicians or other authorized non-physician practitioners sometimes need to refer patients for specialized medical care or to receive certain diagnostic tests or supplies.

In such cases, physicians should consider the following:

- Implement a process to ensure that only the ordered services or tests were rendered. For example, when reviewing the results of diagnostic tests, note whether the other provider performed additional or more complex tests than those ordered.

- Whenever possible, specify the reason for ordering the services. If diagnostic tests are ordered as part of a routine physical exam, include that fact with the referral. Physicians should not empower the other provider who files the Medicare claim to determine why the tests were needed.
- Never sign blank certification forms that are used by other providers to justify Medicare payment for oxygen, home health services, wheelchairs, hospital beds, prosthetic devices, etc. Be sure to personally complete all medical information on such forms. Demographic information, such as patient name and address should be fully completed by the supplier or physician.
- Medical services, supplies, and devices are sometimes aggressively marketed to beneficiaries, with little regard for the medical condition, examples include: transcutaneous electrical nerve stimulator devices and power operated scooters. While these devices are helpful for some beneficiaries, physicians should use extreme caution when prescribing or ordering them, due to the creative ways they are sometimes marketed.

- Medicare can pay for items or services that are reasonable and medically necessary.

- Certification forms include helpful information about eligibility for the service or product being prescribed.

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Signature Guidelines for Medicare Review Purposes

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.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written 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, section 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, NCD, LCD and CMS manuals are silent on whether the signature be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below 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 AC, MAC and CERT reviewers shall apply the following signature requirements:

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, ACs, MACs, PSCs, 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, ACs, MACs, PSCs, ZPICs and CERT shall disregard the order during the review of the claim.
- If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.



The following are the signature requirements that the ACs, MACs, RACs, PSCs, ZPICs, and CERT contractors 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.
- For medical review purposes, if the relevant regulation, NCD, LCD, and other CMS manuals are silent on whether the signature must be dated, the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered.
- Definition of a Signature Log: 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.
- Definition of an Attestation Statement: The statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- 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.
- 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.



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- 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.



**Thank you for viewing this month's
LGT Physician's View Point Newsletter**

**If you have any questions concerning topics covered in
this issue please contact you LGT Professional today.**

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