Medical Records

In the event of a claim review, information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to treating physician/practitioner's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for determining that an item is reasonable and necessary. DMEPOS suppliers are reminded that:

- Supplier-produced records, even if signed by the prescribing physician/practitioner, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS CMNs, are subject to corroboration with information in the medical record.
- A prescription is not considered to be part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.

In addition to the general requirements discussed above, certain DMEPOS items may have specific documentation requirements. Details regarding these policy specific requirements are contained in the applicable LCD-related Policy Article.

Reminders

CMS Medicare Learning Network (MLN) Matters (MM) Special Edition 1022 indicates, "The Medicare program does not have requirements for the media formats for medical records. However, the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities. Providers must have a medical record system that insures that the record may be accessed and retrieved promptly."

Resource

- CMS Internet Only Manual (IOM) Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.7 - 5.9

Last Updated Jan 28, 2020

Orders

The supplier for all durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) is required to keep on file a physician prescription (order). A supplier must have an order from the treating physician before dispensing any DMEPOS item to a beneficiary. The treating physician must sign and date the detailed written order.

Physician means any of the following entities legally authorized to practice by a State in which he/she provides their services. The services performed by a physician within these definitions are subject to any limitations posed by the State on the scope of practice.

- Doctor of medicine;
- Doctor of osteopathy (including osteopathic practitioner) - must be licensed to practice medicine and surgery;
- Doctor of dental surgery or dental medicine;
- Chiropractor (see below);
- Doctor of podiatric medicine; and
- Doctor of optometry.

The term physician does not include practitioners such as a Christian Science practitioner or naturopath. There is no Medicare benefit for DMEPOS items ordered by these entities.

Medicare coverage for all items and services furnished or ordered by chiropractors, with the exception of treatment by means of manual manipulation of the spine to correct a subluxation, is statutorily excluded. Therefore, all DMEPOS items ordered by chiropractors are denied.

Medicare coverage for all items and services furnished or ordered by podiatrists is limited by State statutes governing the scope of practice for podiatry. DMEPOS suppliers should be familiar with the limitations imposed by the statutes of the state(s) in which they operate and dispense DMEPOS items. Claims submitted to the DME MAC, when furnished or ordered by podiatrists practicing outside the limits of their licensures, will be denied as statutorily noncovered. Podiatrists are excluded by statute from ordering a power operated vehicle (POV) or power wheelchair.

Physician assistants, nurse practitioners and clinical nurse specialists may also order DMEPOS (see below for more information).

Last Updated Aug 10, 2018

Requirement of New Orders

A new order is required:

- For all claims for purchases or initial rentals
- If there is a change in the order for the accessory, supply, drug, etc.
- On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy
- When an item is replaced
- When there is a change in the supplier, and the new supplier is unable to obtain a copy of a valid order and documentation from the original supplier.

A new order is required when an item is being replaced because the item is worn or the beneficiary's condition has changed. The supplier's records should also include beneficiary-specific information regarding the need for the replacement item. This information should be maintained in the supplier's files and be available to the DME MAC, and Zone Program Integrity Contractor (ZPIC) on request. Failure to provide the appropriate documentation or providing documentation that contains broad, nonspecific explanations will result in a claim(s) denial.

A new order is required before replacing lost, stolen, or irreparably damaged items to reaffirm the medical necessity of the item. Proof of loss or damage through documentation such as a police report, picture, or corroborating statement should be submitted with the claim.

For items that require a Certificate of Medical Necessity (CMN), the CMN may serve as the written order **if** the narrative description in Section C is sufficiently detailed. If the item requires a written order prior to delivery and the supplier uses the CMN as the written order, the supplier must have received the fully completed CMN (original "pen and ink," electronically maintained, photocopy, or facsimile image) **before** dispensing the item. For accessories, supplies, and drugs related to an item requiring a CMN, the CMN may serve as the written order **if** the narrative description in Section C is sufficiently detailed.

Affordable Care Act and New Orders

The Affordable Care Act (ACA) Section 6407 requires a face-to-face encounter to occur within 6 months prior to the written order prior to delivery (WOPD) for certain DME items listed within it. This requirement applies any time a new order has been obtained for the purposes of Medicare payment. The only exception to the requirement for a face-to-face encounter within 6 months is when a new order is obtained due to state law, and the order is **not** being used as documentation to support a claim for Medicare payment. If the order is being used to meet a Medicare requirement, a new face-to-face must be conducted.

If a new order is being used as documentation to support continued medical need or to fulfill any other documentation requirement for Medicare payment, then a face-to-face encounter within 6 months prior would be required.

Resource

- CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual (PIM), Chapter 5, Section 5.2.4

Last Updated Dec 19, 2019

Medical Documentation Signature Requirements

CMS provides signature requirements guidance via CMS Change Request (CR)9225, CR9332, CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4.

In order for a signature to be valid, the following criteria are used:

- Services that are provided/ordered must be authenticated by the author
- Signatures shall be handwritten or an electronic signature.
- Signatures are legible
- Rubber Stamps for signatures are allowed in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that he/she has reviewed the document.
- Medical record entries completed by a scribe must be authenticated by the treating physician's/non-physician's (NPP's) signature and date.

Dated Signature

To be in compliance with conditions of participation and receive accreditation, all signatures need to be dated and timed; however, Medical Review (MR) must be able to determine on which date the service was performed or ordered. If the entry immediately above or below the entry is dated, MR may reasonably assume the date of the entry in question. Specific signature requirements found in NCDs, LCDs or other CMS manuals supersede the instructions in CR9225.

Missing Signature

Providers should not add late signatures to the medical record, other than those that result from the short delay that occurs during the transcription process. Providers should use the signature attestation process. Medicare does not accept retrospective orders.

If a clinical diagnostic test order does not require a signature, regulations state 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 must also be authenticated by the author via a handwritten or electronic signature.

Illegible Signature

Providers may submit a signature log or attestation to support the identity of the signer. Contractors will be looking for some indication in other documentation to support the identity of the signer.

Signature Log

A signature log is a typed listing of provider names followed by a handwritten signature. A signature log can be used to establish signature legibility as needed throughout the medical record documentation. MR encourages providers to include their professional credentials/titles as well on the signature log.

If your facility doesn't have a signature log currently in place, MR will accept all submitted signature logs regardless of the date they were created. While the creation of the log may be a time consuming process, the end result will be that claims with illegible signatures will be processed more quickly than those that do not have a signature log.

Signature Attestation

It is acceptable to attest your signature. CMS has provided a guide for a signature attestation in CR9225 and in the IOM, Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4 . Noridian has adopted this guide and formatted it to this interactive Signature Attestation Statement form. The attestation must be signed and dated by the author of the medical record entry and contain sufficient information to identify the beneficiary.

Signature Log vs Attestation - Speed of Completion

The Additional Documentation Request (ADR) will request a signature log/attestation for claims selected for medical review. MR encourages all providers to carefully review all documentation that is submitted for an ADR to ensure that all orders and services are signed appropriately.

Initial ADR submissions that include a signature log or attestation for claims with illegible signatures will expedite claim processing. When an attestation request is necessary, the time frame for Noridian to complete the review is changed to 45 days rather than 30 days.

Signature for Amendments, Corrections, and Delayed Entries

All services provided to beneficiaries are expected to be documented in the medical records at the time they are rendered. Occasionally certain entries are not properly documented and will need to be amended, corrected, or entered after rendering the service. Health record documents submitted containing amendments, corrections, or addenda must clearly and permanently be identified as such, clearly indicate the date and author of the entry, and clearly identify all original content without deletion. When correcting a paper medical record, amendments or delayed entries may be initialed and dated if the medical record contains evidence associating the provider's initials with his/her name. When correcting electronic health records, entries must provide a reliable means to identify the original content, the modified content, and the date and authorship of each modification of the record.

Scribe Services

To reduce the amount of documentation overload, many physicians are looking to Medical Scribe services.

Per CMS Change Request (CR)10076, Scribes are not providers of items or services. When a scribe is used by a provider in documenting medical record entries (e.g. progress notes), CMS does not require the scribe to sign/date the documentation. The treating physician's/non-physician practitioner's (NPP's) signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided. Reviewers are only required to look for the signature (and date) of the treating physician/non-physician practitioner on the note. Reviewers shall not deny claims for items or services because a scribe has not signed/dated a note.

Questions Regarding the Signature Requirements

Questions may be directed to the Provider Contact Center. If your facility is currently under medical review, contact the Medical Review Examiner assigned to your file.

The guidelines below will assist in determining whether the signature requirements have been met.

		Signature Requirement Met	Contact billing provider and ask a non-standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name Example :  John Whigg, MD	X	
4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity **o**f the signatory. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists (3) physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation **is accompanied** by: a signature log, or an attestation statement	X	
6	Illegible signature NOT over a typed/printed name, NOT on letterhead and the documentation is **UNaccompanied** by: a signature log, or an attestation statement Example: 		X
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but **accompanied** by: a signature log, or an attestation statement	X	
9	Initials NOT over a typed/printed name **UNaccompanied** by: a signature log, or an attestation statement		X
10	Unsigned typed note with provider's typed name Example: John Whigg, MD		X
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the page		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	"signature on file"		X

Acceptable Electronic Signatures (Examples; Not Limited To)

- ‘Approved by' with provider's name
- ‘Authorized by' with provider's name
- Chart 'Accepted By' with provider's name
- ‘Closed by - with date/time' with provider's name
- ‘Completed by' with provider's name
- ‘Confirmed by' with provider's name
- ‘Data entered by' with provider's name
- Digitalized signature: Handwritten and scanned into computer
- 'Electronically signed by' with provider's name
- ‘Electronically verified by' with provider's name
- ‘Finalized by' with provider's name
- ‘Generated by' followed by a signature and treating physician credentials
- 'Released by' with provider's name
- 'Reviewed by' with provider's name
- ‘Sealed by' with provider's name
- ‘Seized by' with provider's name
- ‘Signed before import by' with provider's name
- 'Signed by' with provider's name
- 'Signed: John Smith, M.D.' with provider's name
- 'This is an electronically verified report by John Smith, M.D.'
- ‘Validated by' with provider's name
- 'Verified by' with provider's name

Note: 'Signed but not read' is not acceptable

Resources

- CMS IOM, Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4
- CMS Medicare Learning Network (MLN) Matters (MM)6698

Last Updated Jan 14, 2020

Copied from Noridian Website 2/13/2020

https://med.noridianmedicare.com/web/jadme/topics/documentation

Proof of Delivery

42 CFR 424.57(c)(12) requires suppliers to maintain proof of delivery (POD) documentation in their files.

POD documentation, as well as claims documentation, must be maintained in the supplier's files for 7 years (starting from the DOS).

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item(s) are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The relationship of the designee to the beneficiary should be noted on the delivery slip obtained by the supplier (i.e., spouse, neighbor). The signature of the designee should be legible. If the signature of the designee is not legible, the supplier/shipping service should note the name of the designee on the delivery slip.

For the purpose of the delivery methods noted below, designee is defined as any person who can sign and accept the delivery of DMEPOS on behalf of the beneficiary.

The supplier should also have on file any documentation containing a description of the item delivered to the beneficiary to determine the accuracy of claims coding including, but not limited to, a voucher, invoice or statement in the supplier records. A description of the items(s) delivered must be noted on the POD. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number.

POD documentation must be available to the Medicare contractor on request. All services that do not have appropriate POD from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the Office of Inspector General (OIG) or the National Supplier Clearinghouse for investigation and/or imposition of sanctions.

As a general Medicare rule, the date of service shall be the date of delivery. There are three methods of delivery. Regardless of the method of delivery, the contractor must be able to determine that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) were received by a specific beneficiary:

- Delivery directly to the beneficiary or authorized representative
- Delivery via shipping or delivery service
- Delivery of items to a nursing facility on behalf of the beneficiary

Delivery via Shipping or Delivery Service Directly to a Beneficiary

If the supplier uses a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable POD would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD document must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number, or alternative method that links supplier's delivery documents with delivery service's records

- A description of item(s) being delivered. Description can be a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number
- Quantity delivered
- Date delivered
- Evidence of delivery
  If a supplier utilizes a shipping service or mail order, suppliers have two options for the DOS to use on the claim.

1. Suppliers may use shipping date as DOS. Shipping date is defined as date delivery/shipping service label is created or date item is retrieved by shipping service for delivery; however, such dates should not demonstrate significant variation
2. Suppliers may use date of delivery as DOS on claim
   Suppliers may also use a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD document must contain the information specified above.

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