



Derm Coding Consult

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CMS Releases Third Quarterly CCI Edit Updates, Effective October 1, 2017

In a continuous effort to promote national correct coding methodologies, and to control improper coding that can lead to inappropriate payments in Part B claims, the Centers for Medicare and Medicaid Services (CMS) develops, updates and maintains the National Correct Coding Initiative (NCCI) Edits.

The NCCI edits are based on CMS coding policies and use coding conventions defined in the American Medical Association's CPT Manual (AMA CPT), national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, as well as a review of the current coding practices.

These edits are utilized by Medicare claims processing contractors to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services. They are not, however, applied to facility claims for inpatient services.

CPT codes representing services denied based on NCCI edits cannot be billed to Medicare beneficiaries. Because these denials are based on incorrect coding or medically unlikely edit (MUE) value(s), rather than medical necessity, the provider cannot utilize an "Advanced Beneficiary Notice" (ABN) form to seek payment from a Medicare beneficiary. Furthermore, because the denials are based on incorrect coding or MUEs, rather than a legislated Medicare benefit exclusion, the provider cannot seek payment from the beneficiary with or without a "Notice of Exclusions from Medicare Benefits" (NEMB) form.

As such, healthcare providers are discouraged from incorrectly interpreting Medically Unlikely Edit (MUE) values as utilization guidelines. MUE values do **NOT** represent units of service that may be reported without concern about medical review. Providers **MUST** continue to only report services that are medically reasonable and necessary.

The NCCI is a CMS program, therefore, its policies and edits represent CMS national policy. However, NCCI policies and edits do not supersede any other CMS national coding, coverage, or payment policies.

Sometimes, other payers may utilize the NCCI edits as they deem necessary. It is important for dermatology practices to check other payer contracts to determine if the NCCI policies are used to allow for correct coding and claim processing.

2017 Third Quarter Updates

The latest package of Procedure to Procedure (PTP) CCI edits, Version 23.3, effective October 1, 2017, is now available via the CMS Data Center (CDC) at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>

Choose the Practitioner PTP Edits v23.3 effective October 1, 2017

NCCI Procedure-to-Procedure (PTP) Edits

Developed to prevent improper payment when incorrect code combinations are reported, the NCCI PTP edits allow for non-payment of healthcare insurance claims of services that should not be reported together. Each edit has a column one and a column two HCPCS/CPT code. If a healthcare provider reports a combination of the two codes in an edit pair for the same beneficiary on the same date of service (DOS), the column one code is eligible for payment but the column two code is denied unless a clinically appropriate NCCI-associated modifier is also reported.

— see **CMS THIRD QUARTER** on page 2

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IMPORTANT Please Route to:

Dermatologist Office Mgr Coding Staff Billing Staff

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Column 1/Column 2 Edits		
Column 1	Column 2	Modifier 0=not allowed 1=allowed 9=not applicable
11602	11100	1
11602	17250	1
17000	11100	1
17004	11100	1
17004	11423	1
17004	17110	1
17110	11100	1
17110	17000	1
17110	17262	1
17262	11622	1
11442	11900	1
11442	17250	1
17110	11443	1
17110	11642	1
17110	17261	1
17311	17262	1

Examples of Appropriate Use of Modifier 59

Modifier 59 – *Distinct Procedural Service* – is used to identify procedures/services, other than evaluation and management services (E/M) that are normally not reported together, but are appropriate under the circumstances.

Documentation must support a different session, different procedure or surgery, different site or organ system,

separate incision/excision, or separate lesion not ordinarily encountered or performed on the same day by the same provider to the same patient.

For example:

17000 -59	OR	11301	OR	11603 - 59
+17003		11100 -59		11100 - 59
17110		+11101		11101
				17110

It is not appropriate to use modifier 59 where another established modifier more descriptive of the circumstances is available to be used. Modifier 59 should only be used as a modifier of last resort

It is important to know the appropriate use of modifier 59 to avoid unwarranted claim audits. Appending modifier 59 – or any modifier on an add-on code is inappropriate unless your payer specifically requests you to do so.

Medically Unlikely Edits (MUE)

Developed to reduce the paid claims error rate for Part B claims, an MUE for a HCPCS/CPT code is the maximum units of service that a healthcare provider can report under most circumstances for a single beneficiary on a single date of service (DOS).

MUEs prevent payment for an inappropriate number/quantity of the same service on a single day. These edits are based on:

- ✓ Anatomic considerations;
- ✓ HCPCS/CPT code descriptors;
- ✓ CPT instructions, CMS policies;
- ✓ Nature of service/procedure
- ✓ Nature of analyte;
- ✓ Nature of equipment; and
- ✓ Clinical judgment

For example, complex repair code 13121 - scalp, arms, and/or legs; 2.6cm to 7.5cm has an MUE of 1 due to CPT instructions and based on anatomical considerations. If

— see **CMS THIRD QUARTER** on page 3

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Contributing Writer

Nicole Torling, Lead Designer

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Editor's Notes:

The material presented herein is, to the best of our knowledge accurate and factual to date. The information and suggestions are provided as guidelines for coding and reimbursement and should not be construed as organizational policy. The American Academy of Dermatology/Association disclaims any responsibility for the consequences of actions taken, based on the information presented in this newsletter.

Mission Statement:

Derm Coding Consult is published quarterly (March, June, September and December) to provide up-to-date information on coding and reimbursement issues pertinent to dermatology practice.

Address Correspondence to:

Mollie MacCormack, MD, FAAD
Editorial Board Derm Coding Consult
American Academy of Dermatology Association
P.O. Box 4014 Schaumburg, IL 60168-4014

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complex repair code 13121 is performed more than once, on two separate defects, of the same CPT anatomic grouping, the two defect sizes should be added and the total length of the two repairs is reported using a single appropriate code.

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
13121	1	2 Date of Service Edit: Policy	Anatomic Consideration

Note: Not all HCPCS/CPT codes have an MUE

MUE Adjudication Indicators (MAI) and Rationales

MAI 1 is a claim line edit and indicates the units of service value applied at the line level. This MUE is based on the nature of the service or analyte expressed by the CPT code

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
88341	9	1 Line Edit	Nature of Service/ Procedure

In this case, the maximum units on the claim line must not exceed 9. If clinically appropriate, excess units can be dropped to the next line and appended with Modifier 76, Repeat procedure or service by same physician. Should the claim be denied, it can be appealed with clinical data to justify medical necessity of the additional units of service.

MAI 2 is a date of service edit and indicates the units of service value is determined based on policy or anatomic considerations. In this context, policy can be interpreted as an intrinsic definition of the CPT code or published CMS policy.

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
11100	1	2 Date of Service Edit: Policy	Code Descriptor/ CPT Instruction
11450	1	2 Date of Service Edit: Policy	CMS Policy
15780	1	2 Date of Service Edit: Policy	Anatomic Consideration

When denied due to an MAI 2, the claim is not appealable as limitations are created by coding or CMS policy. For example, it would be contrary to correct coding policy to report more than one unit of service for CPT code 11100 – “skin biopsy, first lesion” because one would not realistically biopsy two ‘first lesions’ on the same DOS as indicated within the code descriptor.

MAI 3 indicates a value that indicates the typical maximum unit of service to appear on a correctly coded claim but could, in unusual circumstances be payable. MAI 3 are “per day edits based on clinical benchmarks” or anatomic considerations.

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
17311	4	3 Date of Service Edit: Clinical	Clinical Data
17313	3	3 Date of Service Edit: Clinical	Clinical: CMS Workgroup
11770	1	3 Date of Service Edit: Clinical	Anatomic Consideration

If claim denials based MAI 3 edits are appealed, MACs may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. e.g., 17311 - *Mohs micrographic technique... first stage* when reported with more than 4 units on the same date of service can be appealed with medical records.

Add-on Code Edits

Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if, and only if, one of its primary codes is also eligible for payment.

For example, additional destruction of premalignant lesion(s) (actinic keratosis), second to fourteen lesions, cannot be reported without the primary destruction code 17000 on the same DOS as follows:

17000
+17003

For more information, please see:

Overview and Background:

<https://www.cms.gov/Medicare/Coding/NationalCorrect-CodInitEd/MUE.html>

Frequently Asked Questions: <https://questions.cms.gov/faq.php?id=5005&rtopic=1867&rsubtopic=7005> ❖

United Healthcare Delays Consultation Codes Payment Policy

On October 1, 2017, United Healthcare (UHC) announced that it would delay execution of eliminating payment for consultations to allow physicians more time to adjust to changes in how these services will be reported. It is unclear as of right now when this will take effect, but what does seem clear is that UHC may require physicians and other qualified healthcare providers (QHP) to report consultation services with a different Evaluation and Management (E/M) code based on the setting in which the encounter takes place.

— see **UNITED ELIMINATES PAYMENT** on page 4

United Healthcare Eliminates Payment for Consultation Codes

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Consultations performed in the office should be reported with the appropriate level of Office E/M. CPT code 99201 – 99215. The E/M code selected for these encounters should be based on the patient’s status as either a new or established patient and the complexity of the encounter provided and documented. Consultations provided in an inpatient setting should be reported with either an Initial Hospital Care code 99221 – 99223 or Subsequent Hospital Care code 99231 – 99223. Initial Hospital Care codes are used to report a first face-to-face encounter during the patient’s stay in the hospital. Additional encounters during the same admission should be reported with the Subsequent Hospital Care codes.

To understand the use of consultation service codes as reported in the treatment of its members, UHC utilized claims data to analyze the use of these codes. According to their findings, the data revealed misuse by providers when reporting consultation services. If this policy is implemented and in addition to aligning with the Centers for Medicare & Medicaid Services (CMS) policy regarding consultation codes, this strategic change would be a part of UHC’s Triple Aim program, which is committed to improving health care services, health outcomes and overall cost of care.

OFFICE/OUTPATIENT SETTING BILLING GUIDELINES

In the office or outpatient setting, physicians and other QHPs will use the new or established patient encounter CPT codes (99201-99215) in place of office CPT consultation codes (99241 – 99245). The level of E/M reported remains dependent on the complexity of the visit. All providers should follow the evaluation and management (E/M) documentation guidelines when reporting all E/M services.

It is important to note that a direct correlation between levels of E/M and the various categories of codes (i.e. consultations, outpatient, inpatient, new, or established patient codes) does not exist. For example, a level 2 office consultation may equate to either a level 2 or 3 established patient Office or Other Outpatient CPT code (99212 or 99213).

The E/M code should be selected based on the content of the service. The volume of documentation should not be the primary influence upon which the level of service is billed. Documentation should support the medical necessity of the encounter and the level of service reported. The duration of the visit is an ancillary factor and does not dictate the level of service billed unless more than 50 percent of the face-to-face time (for office or outpatient encounters) or floor time (for inpatient encounters) is spent providing counseling or coordination of care.

INPATIENT SETTING BILLING GUIDELINES

In a hospital (inpatient) setting and nursing facility setting, physicians who perform an initial evaluation may bill an Initial Hospital Care code 99221 – 99223 or Initial Nursing

Facility Care code 99304 – 99306. Follow-up visits in the facility setting should be billed as Subsequent Hospital Care encounters 99231 – 99233 or Subsequent Nursing Facility Care visits 99307 – 99310. As with Medicare patients, these facility setting codes should be used in place of inpatient consultation codes, 99251-99255.

The two lowest level Inpatient Consultation codes (99251 and 99252) do not have correlating initial inpatient E/M codes (see Hospital/Inpatient comparison table below). While the Centers for Medicare and Medicaid Services (CMS) recommends the use of the Subsequent Inpatient E/M codes 99231 and 99232 when the work, documentation and medical necessity do not support the services of 99221, it is not known at this time if United Healthcare will follow Medicare’s lead in this practice.

COMPARING E/M LEVELS – OFFICE/OUTPATIENT

Consult Code	New Patient Code	Established Patient Code	History	Exam	MDM
99241 15 min	99201 10 mins	99212 10 mins	Problem Focus	Problem Focus	Straightfwd
99242 30 mins	99202 20 mins	99212/ 99213 10/15 mins	Exp Problem Focus	Exp Problem Focus	Straightfwd
99243 40 min	99203 30 mins	99213/ 99214 15/25 mins	Detailed	Detailed	Low
99244 60 mins	99204 45 mins	99214/ 99215 25/40	Comprehensive	Comprehensive	Moderate
99245 80 mins	99205 60 mins	99215 40 mins	Comprehensive	Comprehensive	High

COMPARING E/M LEVELS – HOSPITAL/INPATIENT

Old Consult Code	New Patient Code	History	Exam	MDM
99251 20 mins	99499 99231 15 mins	Problem Focus	Problem Focus	99231: Straightfwd or low
99252 30 mins	99499 99232 25 mins	Exp Problem Focus	Exp Problem Focus	99232: Straightfwd
99253 55 mins	99221 30 mins	Detailed	Detailed	Low
99254 80 mins	99222 50 mins	Comprehensive	Comprehensive	Moderate
99255 110 mins	99223 70 mins	Comprehensive	Comprehensive	High

UHC stated in its October 2017 Network Bulletin, that additional updates to this policy will be available in future Network Bulletins. For more information, go to: UHCprovider.com ❖

Insurance Company Reimbursement Threats

In an attempt to reduce medical spending, several insurance companies have implemented reimbursement policies that run contradictory to well-accepted coding conventions and guidelines.

Modifier 25

Since 2012, some insurance companies have imposed a 50% reduction on the Evaluation and Management (E/M) procedure when modifier 25 is appropriately appended. The policy runs counter to current guidelines where payers typically recognize the services being provided as separate and distinct with full reimbursement for the E/M. During the rigorous valuation process at the RUC, both work RVUs and practice expense inputs for procedures typically provided with an E/M are appropriately reduced to account for any overlap between the services making additional restrictions challenging to justify.

Multiple Procedure Payment Reduction

In 2017, two insurers imposed a Multiple Procedure Payment Reduction (MPPR) of 100/50/25/25/25 which runs contrary to the industry standard set by Medicare, which reduces payment to 50% for procedures two through five. Additionally, when the insurers are implementing this policy it is stated that any procedure beyond five will be denied. Again, this runs counter to CMS policy which provides an opportunity for appeal and justification in order to receive appropriate reimbursement.

How to Respond

In both instances insurance companies indicate that these policies bring them into alignment with industry standard, a premise with which the American Academy of Dermatology Association disagrees with.

If a practice is contracted with an insurer that has adopted either of these policies, or if the practice is unsure, it is important to review the Evidence of Benefit (EOB) alongside the fee schedule. In some instances, physicians have reported insurers are improperly selecting which code should be reduced, cutting reimbursement even more egregiously.

If it is discovered an insurer is imposing these, or similar payment reductions, contact David Brewster at DBrewster@aad.org. ❖

To Bill or Not to Bill? Reporting Suture Removal After a Biopsy

A biopsy has been performed and sutures were required to close the defect. The patient returned to the office for suture removal at a later time. How

should the return visit be reported? The answer to this clinical scenario is not quite as simple or straightforward as it appears.

Biopsies, similar to shave removals and Mohs surgery, have zero global days. Procedures that lack global days have no post-operative values included in the value of the code. Therefore, according to CPT guidelines, a follow-up encounter is reportable after one of these procedures.

However, is it always appropriate to bill for suture removal after a biopsy? What is the most appropriate method to report suture removal after a biopsy?

While suture removal is not included in the value of the biopsy code itself, depending on what additional work is provided and documented, it may or may not be appropriate to report the suture removal as a separate encounter.

Typically, the work portion of the suture removal is captured within a post-biopsy Evaluation and Management (E/M) service. As with any E/M service (excluding those based on time), the level of the encounter should be selected based on the complexity of the encounter. For example, a post biopsy visit or encounter in which sutures are removed, the wound is assessed, pathology results are reviewed and a discussion of the diagnosis and treatment options takes place would support the use of an E/M code as long as it is appropriately documented. Documentation in the medical record that simply states "suture removal" is insufficient and will not provide the information necessary to support the billing of any E/M level of service.

The ICD-10-CM diagnosis codes used to report post-biopsy encounters that include the removal of sutures should identify the medically necessary reason for the encounter. In this case, the first diagnosis code should reflect the reason for the previous biopsy. An additional ICD-10-code to report the need for suture removal during the encounter may also be reported, for example code Z48.02 - Encounter for removal of sutures. CPT code 15850 may be used to report suture removal under anesthesia. However, there is not a specific CPT code that can only be used to report suture removal when not performed under anesthesia. ❖

New 2018 Coding Resource from the AAD

The AAD is happy to introduce a new educational resource for our members! In late 2017, the Academy will be launching *Principles of Documentation for Dermatology*, a book that takes a very close look at the very fine aspects of appropriate documentation and captures the key elements and key concepts necessary to support CPT and ICD-10-CM code selection. Additionally, this book touches upon coding guidelines that need to be considered in order to submit claims for reimbursement.

— see **CODING RESOURCE** on page 6

New 2018 Coding Resource from the AAD

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Given the very distinct nature of claims submission, this book is intended for dermatologists to learn how to properly support code selection by appropriately documenting the patient-physician encounter.

The main goal of the *Principles of Documentation for Dermatology* is to help dermatologists and other qualified healthcare professionals streamline medical record documentation to meet coding compliance, support the level of service(s) rendered and ultimately ensure accurate reimbursement.

Ideally, the *Principles of Documentation for Dermatology* book is meant to be used in conjunction with the Academy's Dermatology Coding and Billing Manual, which is updated annually to capture dermatology coding changes and is a long-standing and trusted annual AAD publication. The Coding and Billing Manual provides members with the latest coding updates within the CPT and ICD-10-CM coding systems. The 2018 edition has all the CPT updates that will affect Dermatology as well as hundreds of changes to the ICD-10-CM code system. ❖

FAQs

This month we are highlighting interesting questions and direct answers from some Medicare Administrator Contractors (MACs). These questions are a good educational resource for staff members. The main topic for these questions is material for a claim appeal.

These coding questions were answered by Noridian Solution MAC: JE and JF Provider Outreach Department

Q) When is modifier 25 appropriate on a visit the same day as a minor surgical procedure for the same condition?

A) The initial evaluation is always included in the allowance for a minor surgical procedure.

A modifier 25 can be appended to a visit on the same day as a minor surgical procedure when the visit is unrelated to the diagnosis for which the surgical procedure is performed, unless the visit occurs due to complications of the surgery.

Q) If a CPT code has a Medically Unlikely Edit (MUE) of 2, should we bill it on two separate line with no modifier?

A) No, line two (2) will deny if there is no modifier appended. Bill for both procedures on one line with number of units two (2).

Q) If performing CPT code 17261 on two lesions, how should those be billed?

A) For this code, multiple surgery rules applies, so you can bill it on one line with the number of units 2 or bill on separate line with modifier 76 appended on the code on line 2.

Q) A dermatologist sees an established patient with a history of skin cancer for a six months follow-up screening consisting of a full skin exam. The physician did a minor procedure for actinic and seborrheic keratosis. Is an E/M visit also billable?

A) The E/M can be billed and a modifier 25 appended for the follow up visit for an established patient that had a history of skin cancer.

Q) Are the X modifiers no longer valid?

A) The X modifiers are still valid but the Centers for Medicare & Medicaid Services (CMS) issued instructions to not use them until they publish instructions and examples on how to use them.

Q) Should a provider continue to use the X subset modifiers?

A) Effective January 2015, CMS has indicated that providers can continue to use modifier 59 and additional guidance and education for the appropriate use of the subset modifiers is forthcoming as CMS continues to introduce the modifiers in a gradual and controlled fashion.

Q) Have the modifier 59 subset modifier instructions been released yet?

A) No. CMS has not published instructions or examples yet.

Q) If a surgeon finds that a minor procedure is listed in column I and the major procedure is in column II of NCCI, how should the codes be indicated on a claim?

A) When billing the claim, the code order is not important, as long as modifier 59 is appended to the column II code.

Q) What is the difference between modifier 59 and modifier 91?

A) Modifier 59 is used when trying to unbundle an NCCI edit. Modifier 91 is used when laboratory test(s) are performed more than once on the same day for the same patient.

Additional questions for this MAC can be found by visiting the following link <https://med.noridian-medicare.com/web/jeb/education/event-materials/modifiers-qaQ10>.

— see **FAQ** on page 7

FAQs

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The following questions and answers are from Novitas MAC JH and JL

Q) How do we bill if both a physician and non-physician practitioner sees the patient in the office during the same encounter?

A) When an evaluation and management service is a shared/split encounter between a physician and a non-physician practitioner (nurse practitioner, PA, clinical nurse specialist, or clinical nurse midwife, the service is considered to have been performed “incident to” if the requirements for “incident to” are met and the patient is an established patient. If “incident to” requirements are not met for the shared/split E/M service, the service must be billed under the non-physician’s national provider identifier (NPI), and payment will be made at the appropriate physician fee schedule payment.”

Q) What must be included in my medical record documentation when administering medication(s)?

A) Medical record documentation should include the name of the medication, the dosage and the route of administration. The site of the injection should also be documented as well as any patient reactions to the medication and signature of the person administering the medication. Documentation must be maintained in the patient’s chart to support the medical necessity of the injection given. When a portion of the drug is discarded, the medical record must clearly document the amount administered and the amount wasted.

Q) What code should physicians report if a HCPCS code couldn’t be found for the medication being administered?

A) Providers should report charges for all drugs and biologicals using the correct HCPCS codes for the items rendered. It is also important that providers make certain the reported units of service for the specific HCPCS code are consistent with the quantity of the drug and/or biological.

In the situation where there is no code to accurately describe the medication being administered providers should use a “not otherwise classified (NOC)” code based on the HCPCS descriptor. You should only use NOC codes if there is no HCPCS or Current Procedural Terminology code available that describes the service performed. These codes should only be used if a more specific code is unavailable. Depending on the medication provided, report J3490 (unclassified drugs), J3590 (unclassified biologics), or J9999 (not otherwise classified, antineoplastic drugs).

You can find additional questions for this MAC by visiting https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00005049&_afrLoop=1027151696184050#!%40%40%3F_afrLoop%3D1027151696184050%26contentId%3D00005049%26_afrLoop%3D923p0aitv_117 ❖

In the Know...

Medicare Signature Requirements

So many times you hear the adage: if it wasn’t documented, it wasn’t done. This reflection of conventional wisdom is so widespread and so frequently repeated that it is often assumed to be Medicare law. However, what is Medicare “law” is if it is not signed, it is not complete, an actual Centers for Medicare and Medicaid Services (CMS) requirement (see MLN Matters® Number: SE1419 - Medicare Signature Requirements).

In this MLN, Medicare states that all services provided and/or ordered must be authenticated by the author. The method of authentication can be a handwritten or electronic signature.

Further, in MLN Matters® Number: MM6698, Medicare outlines the Signature Guidelines for Medical Review Purposes. In this document, Medicare discusses the signature rules, signature logs and attestation statements as they pertain to medical record review.

Medicare: If you do not have an acceptable signature on services provided/ordered, your Medicare payment may be impacted

Rubber stamped signatures are not acceptable. However, there are some exceptions, for example:

- facsimiles of original written or electronic signatures are acceptable for the certification of terminal illness for hospice.
- orders for clinical diagnostic tests do not require a signature because 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 and will suffice for a signed diagnostic test order.
- when relevant regulation, National Coverage Determination (NCD), Local Coverage Determination (LCD) and CMS manuals are silent on whether the signature be legible or present and the signature is illegible/missing, the reviewer will follow the guidelines listed in MLN Matters® Number: MM6698 to discern the identity and credentials (e.g. MD, RN) of the signatory.

❖ *In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, the signature requirements therein will take precedence.*

— see **IN THE KNOW** on page 8

In the Know...

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How does this affect you and your practice?

Before submitting medical records to Medicare for review purposes, healthcare providers must ensure that the medical record is accurate and signed. There are several variations of acceptable handwritten and electronic signatures that are available to providers.

Sign your medical record documentation in a timely manner, Be ready for a medical record review.

Healthcare providers should not add late signatures to the medical record, beyond the short delay that occurs during the transcription process. Instead make use of the signature authentication process. It is important to note that appending a handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation, says Medicare.

Remember the rule, ***if it is not signed, it is not complete.***

For more information on Medicare Signature Guidelines, please review the following educational resources:

MLN Matters: MM6698 - Signature Guidelines for Medical Review Purposes: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf>

MLN Matters@Number: SE1419 - Medicare Signature Requirements: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf>

Medicare Program Integrity Manual Chapter 3 - Verifying Potential Errors and Taking Corrective Actions: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>

Now You Are In The Know!



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930 East Woodfield Road, Schaumburg, Illinois 60173-4729