



Information for Healthcare Improvement



# Case Review Connection

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## *CMS Signature Guidelines*

The Centers for Medicare & Medicaid Services (CMS) uses transmittals to communicate new or changed policies or procedures that will be incorporated into the CMS Online Manual System. Transmittal 327 outlines signature guidelines contractors need to follow when reviewing medical record documentation and payment of claims. It applies to all Medicare contractors, including Medicare administrative contractors and recovery audit contractors. It also includes useful guidance for providers by specifically outlining what contractors will accept as a signature and when contractors need to query the provider for additional information.

Transmittal 327 also instructs contractors to disregard unsigned orders. When an unsigned order is found during a review, it does not appear that contractors will have the option of requesting additional information from the provider to substantiate the claim, as CMS has indicated that an unsigned order will be considered invalid. CMS permits the following as acceptable means of authentication:

- Electronic signature;
- A legible, handwritten signature, including the author's first and last name; and
- Additional documentation such as a signature key, signature log, or an attestation statement submitted with the medical record to support an illegible or unclear signature. (CMS includes a proposed attestation statement on page 11 of Transmittal 327).

Pages 12 and 13 of Transmittal 327 contain a table that lists the actions contractors will take in response to specific signature situations. For more information, [click here](#).



## *Utilization Reviews*

Connolly Healthcare, the recovery audit contractor (RAC) for Florida, has started to review medical records for utilization. The main utilization category is inpatient admission without a physician's inpatient admit order. The RAC can apply this issue to any and all medical records they are reviewing, including all DRG and other UR reviews. It is an open passage for all utilization review. The supporting CMS regulations and policies can be found in:

- 1) Federal Register 11-27-2006 (42 CFR Part 482) page 2, requires authentication of orders for the care of the patient by a physician/provider
- 2) Benefit Policy Manual Chapter 1, Section 10
- 3) Claims Processing Manual Chapter 3 Section 10 and 40.2.2

### **HAD Reviews—Coding Issue**

When sending in the chart for a higher-adjusted DRG, please send in the complete medical record including the Query/Clarification form, where applicable. When validating the medical record for the requested change, many times, the Query/Clarification form, which is a valuable piece, is missing. This then generates the letter writing process, which adds time to completing the review.

### **Present on Admission Indicator Reporting by Acute IPPS Hospitals**

The Deficit Reduction Act of 2005 requires a quality adjustment in Medicare Severity Diagnosis Related Group (MS-DRG) payments for certain hospital-acquired conditions. The Centers for Medicare & Medicaid Services (CMS) has titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting (HAC & POA). Inpatient Prospective System (IPPS) hospitals are required to submit POA information on diagnosis for inpatient Discharges on or after October 1, 2007.

For more information, visit the HAC & POA web page at [www.cms.gov/HospitalAcqCond](http://www.cms.gov/HospitalAcqCond).

## *FAQs*

**Q.** If a Medicare beneficiary does not have Part A Medicare but has Part B, would the QIO perform an appeal?

**A.** The QIO would not perform this appeal.

**Q.** If a hospital is issuing a preadmission notice of non-coverage for a non-covered inpatient surgical procedure, such as a sleeve gastrectomy, would the QIO perform a review?

**A.** The appropriate notice for this situation is the Advance Beneficiary Notice (ABN). The review would be performed by the Medicare Administrative Contractor.



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