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Documentation Guide LL Prosthesis.

January 2023.

Lower Limb Prosthesis
Prosthetist Documentation Packet.

January 2023.

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If you need help:

Contact the Ottobock Reimbursement Team

- Call 800-328-4058 and ask for reimbursement, or
- Email your request to Reimbursement911@Ottobock.com

Ottobock Reimbursement North America
P 800 328 4058 F 800 230 3962
US: shop.ottobock.us.com
CA: shop.ottobock.ca.com
reimbursement911@ottobock.com

Prosthetist's Documentation.

a. **Functional Evaluation** (K-level should match physician's evaluation

Activities prior to amputation

- Activities that patient did in the past and would like to get back to using a new device (e.g., home, work, therapeutic, exercise).
- Current activities.
- Focus on activities that the new prosthesis will allow that the current prosthesis does not.
- Describe difficulties, such as falls, stumbles, not making it across street before light changes, inability to change speed when needed, etc.
- How will patient be able to do it better with the new prosthesis?

Future/potential future activities.

- If these vary from prior activities, an explanation will be required)

Testing to corroborate K-Level evaluation

- This could be a walking speed test, timed walking test, Timed Up and Go (TUG), Prosthetic Evaluation Questionnaire (PEQ), Amputee Mobility Predictor (AMP), or other.

*Additional (If ordering a MP knee for a K2 patient that does not have potential for K3):

- Include history of falls and stumbles (if applicable).
- State why improved stability in stance will allow increased independence for your patient.
- State why you believe your patient has the potential for use a less restrictive walking device (if applicable).

**Allowed by some private insurance payers. Not allowed for Medicare plans.*

Functional Levels (K-Levels) for Lower Limb

K-0: Does not have the ability or potential to ambulate (or transfer safely) with or without assistance and a prosthesis does not enhance their quality of life or mobility

K-1: Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. **K-2:** Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces.

K-3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

K-4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

b. **History of Prosthetic Use**

Your records should have a history of each prosthesis patient has used/trialed in the past.

- Brand of component
- How long did patient use it?
- What was the result?

c. **Current Prosthesis**

History of each component being replaced

- Age, condition, how did it work out?

Description of the labor involved

- Casting, modification, time, tools used, materials used, where material was applied, etc.

Reason for replacement

- Change in patient's condition
- Item no longer fits
- Does not meet functional needs
- Worn (cannot be repaired)
- (Medicare) Cost to repair will be greater than 60% of the Medicare allowable for a new device
- (Medicare) item is lost or damaged beyond
- Repair in an incident (e.g., accident, natural disaster)

d. **Recommendation for the type and brand of the new prosthesis/components:**

- Must be based on physician's recommendation
- Include rationale for your decision
- Include medical necessity and justification for each HCPCS code, including addition codes.

e. **Patient's motivation and desire to ambulate.**

f. **Documentation of the Refill Request**

- Items such as socks and liners are considered non consumable and may be treated as a refill item.
- If the SWO identifies them with quantity and frequency, they may be dispensed as needed without obtaining a new order.
- In this situation, there must be documentation of the request for the refill, SWO, and proof of delivery.
- The following elements should be included when documenting the request.
    - Patient's name (or authorized representative and relationship)
    - Date of request (must be no sooner than 4 days prior to delivery/shipping)
    - Description of each item requested
    - RT/LT
    - Quantity
    - Condition of items being replaced
- Note: Shipment/delivery may not occur sooner than 10 calendar days prior to current supply exhausting.

g. **Fitting, Adjustment, and Delivery note(s) for all** items delivered.

h. **Chart note for each visit** with patient with printed name, credential, signature and date on each
note.

i. **Patient's name on each page and pages organized and numbered** in a manner to avoid mix up during an audit/medical review.

Prosthetist's Documentation Checklist.

Patient Name: Date: Completed by:

FROM THE PHYSICIAN (within 6 mo. for prior auth)

History of Amputation

- ❑ Date and Cause of amputation(s)
- ❑ Affected side(s) and level(s) of amputation
- ❑ Clinical course, interventions & results, prognosis

Physical Examination

- ❑ Height, weight, recent loss/gain
- ❑ Cognitive ability to use & care for new prosthesis
- ❑ Condition of residual limb
- ❑ Cardiopulmonary, Musculoskeletal, Neurological
- ❑ Strength, ROM, gait, balance, coordination

Functional Limitations

- ❑ Limitations caused by current condition/comorbidities
- ❑ Diagnoses causing the symptoms.

Ambulatory assistance

- ❑ Used currently/prior to amputation
- ❑ Situational/temporary?
- ❑ Plan to be free of assistive devices (if applicable).

Functional Level

- ❑ Patient's activities prior to amputation
- ❑ Patient's current activities & impact of the limitations identified above.
- ❑ Desired & potential activities using new prosthesis

Prosthetic Use

- ❑ Past: components tried & result
- ❑ Current: History and condition of each component
- ❑ Reason for replacement

For Repair, Replacement, or Refill

- ❑ Patient continues to use a prosthesis
- ❑ The prosthesis is medically necessary

Desire and Motivation

- ❑ To ambulate

Functional State

- ❑ K-Level (based on prior activities, current condition, and motivation to ambulate).
- ❑ Recommendation for new prosthetic components
- ❑ For potential K-level, include explanation & plan to reach desired K-Level & approx. how long it will take

STANDARD WRITTEN ORDER (SWO)

(supplier generated)

- ❑ Date of Order: on/prior to the delivery date
- ❑ Narrative description, HCPCS code, HCPCS code narrative, or Brand Name/Model Number.
- ❑ Physician demographics/NPI ok for Medicare
- ❑ Physician's handwritten signature, date
- ❑ Quantity & RT/LT
- ❑ Meets your state's requirement for orders
- ❑ Patient name on each page/MBI ok for Medicare

PROSTHETIST'S DOCUMENTATION

Functional Level – should match physician's determination

- ❑ Testing
- ❑ Activities prior to amputation
- ❑ Current Activities
- ❑ Future activities
- ❑ For potential K-Level: explanation for the difference

History of Prosthetic Use Over Time

- ❑ Brand, how long used, result

History of Current Components

- ❑ History of components being replaced (age, condition, result)
- ❑ Description of Labor (casting, modification, time, tools, materials & where applied
- ❑ Reason for Replacement

Recommendation for Type and Brand of Prosthesis

- ❑ Based on physician's recommendation
- ❑ Medical Necessity and Justification for each component

Desire and Motivation

- ❑ To ambulate and use new prosthesis

Additional

- ❑ Fitting, Adjustment, & Delivery note(s)
- ❑ Chart note for each visit
- ❑ Signature of signee

For Refills (liners, socks, etc.)

- ❑ Continued Need: MD note within 12 mo. (or substitute new verbal/written order).
- ❑ Continued Use: Document the refill request and condition of the item being replaced.

PROOF OF DELIVERY

- ❑ Delivery Date
- ❑ Patient's Name
- ❑ Delivery Address
- ❑ Narrative description, HCPCS code, HCPCS code narrative, or Brand Name/Model Number.
- ❑ Signature and Printed name of signee
- ❑ Relationship to patient and reason why patient cannot sign
- ❑ Signature time, if signed on same day as SWO obtained.

❑ BENEFICIARY AUTHORIZATION

❑ ABN IF REQUIRED

Fax to:		Fax from:	
Company:		Company:	
Phone:	Fax:	Phone:	Fax:
Patient Name:		Date of Birth:	No. Pages:

FAX: Documentation Request for a Lower Limb Prosthesis

This is a request for medical records on the above patient relative to his/her prosthesis.

- ❑ **History of Amputation:** Cause, date & side of amputation(s); clinical course, therapeutic interventions & results, prognosis
- ❑ **Physical Examination**
  1. Weight, Height, Weight Loss/Gain.
  2. Cognitive ability to use the use and care for the new prosthesis
  3. Condition of residual limb
  4. Cardiopulmonary, musculoskeletal, neurological, strength, ROM, gait, balance, coordination
- ❑ **Functional Limitations** Describe nature and extent of any functional limitations, whether from current prosthesis, current condition, or comorbidities (e.g., decreased pulmonary reserve, disabling cardiovascular, neuromuscular, peripheral vascular or musculoskeletal conditions).
- ❑ **Ambulatory Assistance Used** prior to the amputation and/or current. Is it routine, situational, temporary? Explain
- ❑ **Document Medical Necessity in K-Level Terms:** (see descriptions below)
  1. Patient's activities prior to amputation
  2. Patient's current activities along with any functional limitations as identified above
  3. Activities that patient desires to get back to (and has the potential for) using the new prosthesis.
  4. Describe patient's desire and motivation to ambulate with the new prosthesis
- ❑ **Document the condition/status of current prosthesis and reason for replacement of each component.** If worn/broken, describe the condition of each component that needs to be replaced. If patient's physical condition or functional needs have changed, describe why prosthesis/component no longer meets his/her needs.
- ❑ **Describe Past Experience with Prostheses/Components** Describe what has been tried in the past and the results.
- ❑ **For continuing care (e.g. replacement, repair, or refill)** Document continued medical necessity and continued use.
- ❑ **Recommendation for the new components.** Include medical reason for your decision.
- ❑ **K-Level.** State the patient's current K-Level. If the patient has potential to reach a higher K-level designation in the future, include an explanation and treatment plan that will achieve this increase in functional level, and what it will take to get there (e.g. physical therapy, gait training, etc.). The plan should specify in your opinion approximately how long _____ it will take the patient to be functioning at the potential K-Level and address use of the mobility aid if pertinent.

  Functional Capabilities for Lower Extremity [K-Levels]

  Level K-0: Does not have the ability/potential to ambulate or transfer safely with/without assistance

  Level K-1: Home Ambulator with ability/potential for transfers or ambulation on level surfaces at fixed cadence.

  Level K-2: Limited Community Ambulator with ability/potential for ambulation and to traverse low level environmental barriers

  Level K-3: Full Community Ambulator with ability/potential for ambulation with variable cadence and to traverse higher level barriers

  Level K-4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

Please FAX the signed and dated Medical Necessity documents to:

_____ at (_____)_____

Justifying Functional Level.

Following is Medicare's coverage criteria for a lower limb prosthesis, which is also found in many private and commercial insurance policies. For Medicare **all** criteria must be documented!

COVERAGE

A lower limb prosthesis is covered when the beneficiary:

1. Will reach or maintain a defined functional state within a reasonable period of time; and
2. Is motivated to ambulate.

FUNCTIONAL LEVELS:

A determination of the medical necessity for certain components/additions to the prosthesis is based on the beneficiary's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist and treating physician, considering factors including, but not limited to:

- The beneficiary's past history (including prior prosthetic use if applicable); and
- The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and
- The beneficiary's desire to ambulate.

CLASSIFICATION LEVELS:

Clinical assessments of beneficiary rehabilitation potential must be based on the following classification levels:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.

Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulatory who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

Actual versus Potential K-Level

If replacing a prosthesis and patient is currently ambulating at the desired K-Level required for the componentry being ordered, there should be a statement that "patient will maintain the K-Level."

If patient has the "potential" to reach a higher K-level designation within a reasonable time, an explanation for the difference is required. The physician's order should include a treatment plan that will achieve this increase in functional level, (e.g. physical therapy, strength/ gait training, etc.). For Medicare, the plan must estimate how long it will take the patient to function at the potential K-Level. Once the "potential" K-Level is defined, the patient may be designated as that K-Level for billing purposes.

Bilateral Amputees

Medicare states that bilateral amputees cannot be strictly bound by functional level classifications; however, the records must still document the beneficiary's past history, current condition, desire, motivation and designate actual/expected functional potential. If you are putting higher-level componentry on the patient than their K-Level designation, the initial claim will be denied, and you will need to appeal to get reimbursed. Medical documentation should include rationale for the higher-level componentry.

For devices with K2 criteria requirements:

Use "K-Level" language in your documentation. Describe "real life" daily activities detailing the terrain encountered, including low-level environmental barriers that the patient encounters, such as a curb, minimal stairs, or slightly uneven surface. Describe why patient has potential or ability to perform these activities. If patient has other functional limitations (e.g. vascular/cardiovascular disease, cognitive issues, osteoarthritis, etc.), explain why these issues will not limit the patient's ability to use the new prosthesis to perform the activities.

Per the Medicare LCD for LL Prosthetics, the following codes are covered for K2 and above:

Feet			
L5972	Flexible keel Foot	L5878	Multi-axial ankle/foot
Axial Rotation			
L5984	Axial rotation unit, w/ without adjustability	L5985	Dynamic prosthetic pylon
L5986	Multi-axial rotation unit (MCP or equal)		

For devices with K3 criteria requirements:

Use “K-Level” language in your documentation. Include “real life” daily activities that require ambulation with variable cadence, and describe with great detail the terrain encountered. Include vocational, therapeutic, and exercise activities that demand prosthetic utilization beyond simple (K2 level) locomotion. Describe why patient has the potential or ability to perform each activity and what is involved, such as how far will the patient walk, when will he/she need to change cadence, and types of barriers encountered. If the patient has other functional limitations (e.g. vascular/ cardiovascular disease, cognitive issues, osteoarthritis, etc.), explain why these issues will not limit the patient’s ability to use the device to perform the activities.

Per the Medicare LCD for LL Prosthetics, the following codes are covered for K3 and above:

Feet			
L5973	MP Controlled ankle foot system, dorsiflex and/or plantarflex control	L5976	Energy storing foot (Seattle Carbon Copy II or equal)
L5979	Dynamic response foot with multi-axial ankle	L5980	Flex foot system
L5981	Flex-walk system or equal	L5987	Shank foot system with vertical loading pylon
Knees	**(Endoskeletal Knee Shin System)**		
L5610	Hydracadence system	L5613	Knee disarticulation, 4-bar linkage with hyd swing phase control
L5814	Polycentric, hydraulic swing phase control, mechanical stance phase lock.	L5822	Pneumatic swing, friction stance phase control
L5824	Fluid swing phase control	L5826	Hydraulic swing phase control, with miniature high activity knee frame
L5828	Fluid swing and stance phase control	L5830	Pneumatic/swing phase control
L5840	4-bar linkage or multiaxial, pneumatic swing phase control	L5848	Fluid stance extension, dampening feature
L5856	MP control feature, swing and stance phase	L5857	MP control feature, swing phase only
L5858	MP control feature, stance phase only	L5859	Powered programmable flexion/extension assist control (see LCD for additional criteria)
Hips			
L5961	Polycentric hip joint, pneumatic/hydraulic control, rotation control w/w out flexion and/or extension		

Example – Changing from a Mechanical knee to a C-Leg

Daily Activities	Current Prosthesis/ Component	Replacement Prosthesis/ Component
List daily activities with great detail, including those that require traversing environmental barriers, changes in gait speed, and prosthetic utilization beyond simple locomotion when applicable.	Describe current prosthesis (e.g. technologic design & features).	Describe replacement prosthesis (E.g. technologic design & features).
Activities (e.g. home maintenance, work, therapeutic, exercise). • Describe setting • Current Responsibilities • Problems with prosthesis • Goals	How does the current prosthesis work for this activity? • Can patient successfully execute the activity? • Any falls or stumbles? • Strain to sound side? • Other issues?	How will the replacement prosthesis solve the problem? • What feature will allow patient to execute the activity? • Or do it better? • Explain why

Documenting the Reason for Replacement.

(Medicare documentation requirements)

Correct Prosthesis: The supplier (prosthetist) is responsible to provide the correct prosthesis for the patient. If an incorrect prosthesis is supplied the supplier is obligated to make the situation right (take back the incorrect prosthesis, provide the correct one, and adjust the billing). There is no time limit for this.

Repairs and Adjustments: Repairs and adjustments are covered when necessary to make the prosthesis functional. Repairs and adjustments are covered under the initial order. Note: manufacturer-required repairs and service/maintenance are covered as a repair after the warranty expires.

What about the 5-year Useful Lifetime Rule? This rule does not apply to prosthetics. The Social Security Act was amended in 2001 to exclude Prosthetics from the Useful Lifetime Rule, so amputees could get replacements when needed.

What is a Replacement? A replacement is the provision of an identical or nearly identical item. If the item is different from what you originally provided (e.g. different HCPCS code) the item is not considered a replacement.

Rules for Replacement

1. **Replacement** is covered if the treating physician orders a replacement of the entire prosthesis or a major component (foot, ankle, knee, hip, socket) and the replacement falls under one of the following Reasons for Replacement (see examples starting on page 2).

   a) There is a change in the physiological condition of the patient; or

   b) There is irreparable wear of the prosthesis/component; or

   c) The condition of the prosthesis/component requires repairs, and your estimated cost of such repairs is greater than 60% of the cost [Medicare allowable] of the replacement prosthesis/component.

2. **Loss or Irreparable damage (from accident/natural disaster)** is covered without a new physician's order.

3. ***Identical or Nearly Identical:** To qualify as a replacement, the new prosthesis must be identical or nearly identical (e.g. different HCPCS code) to the prosthesis/component being replaced. If not, it is considered a NEW prosthesis/component and new documentation & evaluations will be required. See the Documentation Guide in this packet.

Tips:

- Take care when describing the current prosthesis in the medical record, so it does not sound like an incorrect prosthesis was provided.
- Choose one reason (see examples below) for replacing the prosthesis and carefully build a case to support this in the patient's medical record. Explain with great detail why the prosthesis is being replaced. While it is required that the status of the current prosthesis be documented, if the patient's functional need or physiological condition has changed and a different prosthesis is needed, this should be the main focus of the documentation.

Documentation Requirements

Reason for Replacement	Documentation Requirement
CHANGE IN PATIENT'S CONDITION: PHYSIOLOGICAL OR FUNCTIONAL *Replace with Identical or Nearly Identical Device	**Reason for Replacement:** The reason for replacement in this case would be a change that has occurred in the patient's physiological condition or a change in the patient's functional need. Documentation should include evidence to support that change (e.g. limb measurements, recorded weight changes, changes in activities, results from gait testing performed & how it has changed from previous results, etc.) **Physician:** New Standard Written Order (SWO) is required. Medical necessity and the reason for replacement can be located either on the order (SWO) or in the physician's medical record. **Prosthetist:** Document condition of the item(s) being replaced, reason for replacement, and description of labor involved. Proof of delivery & signed SWO must be on file.

Reason for Replacement	Documentation Requirement
IRREPARABLE WEAR/TEAR OF THE DEVICE (REPAIR NOT POSSIBLE). *Replace with Identical or Nearly Identical Device	**Reason for Replacement:** The reason for the replacement would be wear/tear of an item that cannot be repaired and what caused the wear and tear. Documentation should include information to support that item is worn/torn and why it cannot be repaired. If patient is very active, record daily activities. If patient is overweight, record the weight. If the componentry is worn due to age, include original date of service for the worn component. There may be other reasons. **Physician:** New Standard Written Order (SWO) is required. Medical necessity and the reason for replacement can be located either on the order (SWO) or in the physician's medical record. **Prosthetist:** Document condition of the item(s) being replaced, reason for replacement, and description of labor involved. Proof of delivery & signed SWO must be on file.
WEAR/TEAR OF THE DEVICE WHEN COST OF THE REPAIR IS GREATER THAN 60% OF THE COST OF A REPLACEMENT. *Replace with Identical or Nearly Identical Device	**Reason for Replacement:** The reason for replacement would be "the cost of repair is greater than 60% of the cost to replace the item (i.e. 60% of the total allowable for the new codes being billed)." If replacing an MPK, we suggest having on file a quotation to support this. **Physician:** New Standard Written Order (SWO) is required. Medical necessity and the reason for replacement can be located either on the order (SWO) or in the physician's medical record. **Prosthetist:** Document condition of the item(s) being replaced, reason for replacement, and description of labor involved. Proof of delivery & signed SWO must be on file.

Reason for Replacement	Documentation Requirement
Irreparable damage due to specific Accident or Natural Disaster (e.g. fire or flood) **or** **Device is lost or stolen** Replace with exact same device as originally ordered.	**Physician:** Item may be replaced under the original order. **Prosthetist:** Proof of loss or damage through documentation such as a police report, photograph, or corroborating statement should be submitted with the claim. Describe in medical record that the prosthesis, as originally ordered, still meets the beneficiary's medical needs. Retain documentation of item(s) being replaced, reason for replacement, and description of labor involved. Compliant original order, and proof of delivery must be on file.

Reference: LCA. Standard Documentation for All Claims Submitted to the DME MACs (A55426). [Revised January 1, 2023]

Signature Requirements for Documentation.

What is Allowed?

Handwritten and electronic only. (stamped signatures are allowed if signee cannot sign due to a disability)

Handwritten Signatures

- A handwritten signature is a mark or sign for services provided/ordered.
- An illegible signature should be accompanied by a signature log or attestation statement.
- Orders (e.g., SWO, prescriptions, plans of care) must be validated with a timely signature. Without a signature, they will be considered invalid.
- Documentation (other than orders) lacking a signature requires an attestation in order to be valid.
- It is not allowed to add late signatures to a medical record (beyond the short delay that occurs during the transcription process). In this situation, an attestation must be used instead of the signature.

Signature Dates

Even though it is best practice to include the date and time with the author's signature, for auditing purposes, a signature does not need to be dated if there is enough information to determine the date of when the service was performed or ordered. Example: dated entries immediately above or below the signature.

Signature Log/Key

- A signature log accompanies one set of medical records.
- Lists the printed name (and credentials) associated with initials or an illegible signature.
- The signature log can be a separate document (or it can be on the actual page where the initials or illegible signature are used).
- A signature log may be created at any time.
- Illegible signatures of yourself or your office staff should have an attestation.

Examples:

Name	Signature & Credential/Title	Initial	Date of Signature
John Doe, MD	*John Doe, MD*	JD	03/15/23
Jane Doe, CPO	*Jane Doe, CPO*	JD	03/15/23
John Roe, Office Manager	*John Roe, Office Manager*	JR	03/15/23

"Signature Attestation Statement

Name of Patient:	
Medicare Number:	

I, _____ , hereby attest that the
Print full name of the physician/practitioner.

medical record entry for _____ accurately reflects signatures/
Date of medical record entry.

notations that I made in my capacity as a(n) _____ when
Insert credentials, e.g. M.D.

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.

_____
Signature of Author of the Medical Record

_____
Date

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. Reviewers will not consider attestation statements where there is no associated medical record entry or someone other than the author (even a partner in the same group practice) of the medical record entry in question signs this statement." (DME MAC Jurisdictions B & C)

Electronic Signature

“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” (DME JD)

References

DME MAC Jurisdictions B & C. CMS Signature Requirements. Revised 10-19-2020.

DME Jurisdiction D. Signature Guidelines for Medical Review. Revised 11-25-2019

CMS Complying with Medicare Signature Requirements Fact Sheet

CMS IOM, Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4

CMS Medicare Learning Network (MLN) Matters (MM)6698

Changes to the Medical Record: Amendments, Corrections and Delayed/Late Entries.

The CMS Program Integrity Manual instructs the Medicare Auditors to consider all properly written amendments, corrections, and late/delayed entries in patient medical records. This means that the physician can add clarification to the medical record after-the-fact if something was missed when the patient was there; however, there are specific record keeping principles that need to be followed.

“All services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. When making review determinations the MACs, CERT, Recovery Auditors, SMRC, and UPICs shall consider all submitted entries that comply with the widely accepted Recordkeeping Principles” (CMS Program Integrity Manual)

What are Recordkeeping Principles?

“Regardless of whether a documentation submission originates from a paper record or an electronic health record, documents submitted to MA, CERT, Recovery Auditors, and UPICs containing amendments, corrections or addenda must:

- Clearly and permanently identify any amendment, correction, or delayed entry as such, and
- Clearly indicate the date and author of any amendment, correction, or delayed entry, and
- Clearly identify all original content, without deletion” (CGS JC)

Specific Rules for Amendments, Corrections and Late Entries

Late Entries

“A late entry supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry.” (Noridian JE)

Addendums

"An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum." (Noridian JE)

[An example would be a lab test not yet available at the time of the exam.]

Corrections

"Paper Medical Record

- Use a single line strike through so the original content is still readable, and
- The author of the alteration must sign and date the revision.

Electronic Health Records (EHR):

- Distinctly identify any amendment, correction, or delayed entry, and
- Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record." (CGS JC)

What is Considered Falsified Documentation?

"Examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over, or
- Adding to existing documentation (except as described in late entries, addendums and corrections)" (Noridian JE)

References

CMS Program Integrity Manual. 3.3.2.5 Amendments, Corrections and Delayed Entries in Medical Documentation. (Rev. 10365; Issued: 10-02-20; Effective: 08-27-20; Implementation: 08-27-20)

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