CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 343	Date: June 18, 2010
	Change Request 6982

SUBJECT: Medical Review Resolutions in the Absence of a Plan of Care (POC) and the Outcome Assessment Information Set (OASIS)

I. SUMMARY OF CHANGES: The CR provide instructions pertaining to the review and payment of home health claims when a provider fails to submit an OASIS and requirements governing the absence of the POC for home health Part A/B services, inpatient rehabilitation and hospice services.

EFFECTIVE DATE: July 19, 2010
IMPLEMENTATION DATE: July 19, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.4.1.1/Documentation Specifications for Areas Selected for Prepayment or Postpayment MR

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 343	Date: June 18, 2010	Change Request: 6982

SUBJECT: Medical Review Resolutions in the Absence of a Plan of Care (POC) and the Outcome Assessment Information Set (OASIS)

EFFECTIVE DATE: July 19, 2010
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I. GENERAL INFORMATION

The CR provide instructions pertaining to the review and payment of home health claims when a provider fails to submit an OASIS and requirements governing the absence of the POC for home health Part A/B services, inpatient rehabilitation and hospice services.

A. Background:

Outcome Assessment Information Set (OASIS)

In 2000, CMS implemented the Home Health Prospective Payment Systems (HHPPS) to reconcile Medicare payment for home health claims. Under the HHPPS, the Home Health Resource Group (HHRG), patient classification system is used to assign each patient to a HHRG. The HHRG case-mix classification is based on the data elements selected from the OASIS assessment required at 42 CFR Section 484.55. The assessment must be patient specific, accurate and reflect the current health status of the patient. This status includes certain OASIS elements used for calculation of payment, including documentation of clinical needs, functional status, and service utilization

Plan of Care (POC)

Comprehensive care planning is an essential element of good patient care under the Medicare program and, in fact, is specifically written into the coverage and/or certification requirements for a number of settings. The Social Security Act describes for purposes of the Part A benefit for home health, inpatient rehabilitation facility, and hospice criteria and standards used for covering these services which includes establishing an individualized written POC. The POC, which must be established by a physician(s), and in the case of hospice, an interdisciplinary group, identifies treatment goals and coordination of services to meet patient needs. In situations where the provider of services fails to comply with the POC requirements, contractors may deny the claim as not meeting statutory requirements under the Social Security Act. Pursuant to 42 C.F.R, section 489.21, a provider of services may not charge a beneficiary for services that have been denied for the reasons stated in both sections of this memorandum.

B. Policy: Section 1814 of the SSA and CFR Section 418.200 require that a plan of care must be established and periodically reviewed by the attending physician/medical director and interdisciplinary group for the hospice program.

Medicare's HH PPS Rate Update for CY 2010 final rule, published in the November 10, 2009, Federal Register, included a provision to require the submission of the OASIS as a condition of payment, which was codified in our regulations at 42 CFR 484.210(e). As such, beginning January 1, 2010, home health agencies (HHAs) were required to submit an OASIS as a condition for payment. Contractors may deny the claim as a result of not meeting this regulatory requirement.

The CFR 412 describes the criteria and standards for establishing the written POC.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6982.1	Contractor shall not authorize payment if the provider fails to submit an OASIS.	X		X		X					RAC CERT ZPIC
6982.2	Contractors shall not authorize payment if a POC is not established AND is not in the medical records.	X		X		X					RAC CERT ZPIC
6982.3	When reviewing home health claims, contractors shall ensure that services provided were related to the individual illness and stipulated in the POC.	X		X		X					RAC CERT ZPIC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Nancy More, Nancy.moore@cms.hhs.gov, 410-786-6974
Post-Implementation Contact(s): Regional office business function lead

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

3.4.1.1 - Documentation Specifications for Areas Selected for Prepayment or Postpayment MR

(Rev.343, Issued: 06-18-10, Effective: 07-19-10, Implementation: 07-19-10)

The contractor may use any information they deem necessary to make a prepayment or postpayment claim review determination. This includes reviewing any documentation submitted with the claim as well as soliciting documentation from the provider or third party providers when the contractor deems it necessary and in accordance with Pub. 100-08, PIM, chapter 3, §3.4.1.2.

A. Outcome Assessment Information Set (OASIS)

Medicare's HH PPS Rate Update for CY 2010 final rule, published in the November 10, 2009 Federal Register, included a provision to require the submission of the OASIS as a condition of payment, which was codified in our regulations at 42 CFR 484.210(e). As such, beginning January 1, 2010, home health agencies (HHAs) were required to submit an OASIS as a condition for payment. Contractors may deny the claim as a result of not meeting this regulatory requirement. The assessment must be patient specific, accurate and reflect the current health status of the patient. This status includes certain OASIS elements used for calculation of payment, including documentation of clinical needs, functional status, and service utilization.

B. Plan of Care (POC)

Comprehensive care planning is an essential element of good patient care under the Medicare program and, in fact, is specifically written into the coverage and/or certification requirements for a number of settings. The Social Security Act describes for purposes of the Part A benefit for home health, inpatient rehabilitation facility, and hospice criteria and standards used for covering these services which includes establishing an individualized written POC.

The POC, which must be established by a physician(s), and in the case of hospice, an interdisciplinary group, identifies treatment goals and coordination of services to meet patient needs is set forth in §418.200 requirement for coverage.

Section 1814(a)(2)(C) and Part B 1835(a)(2)(A) and CFR 409.43 state that a POC established by a physician (treating physician) must contain all pertinent information (e.g. history, initial status, goals, procedures/services duration, progress notes etc).

Section 412.622 require an individualized plan of care by a rehabilitation physician that meets the requirements listed the regulation.

In situations where the provider of services fails to comply with the POC requirements, contractors may deny the claim as not meeting statutory requirements under the Social Security Act.

Pursuant to 42 C.F.R, section 489.21, a provider of services may not charge a beneficiary for services that have been denied for the reasons stated in both sections of this memorandum.

C. Review of Documentation Submitted with the Claim

If a claim is targeted based on data for prepayment or postpayment medical review (including automated, routine, or complex) contractors may review unsolicited supporting documentation accompanying the claim, but are not required to do so.

There are two exceptions to this rule. Contractors may deny without reviewing attached or simultaneously submitted documentation (1) when clear policy serves as the basis for denial, and (2) in instances of medical impossibility (see Pub. 100-08, PIM, chapter 3, §3.5.1).

NOTE: The term "clear policy" means a statute, regulation, NCD, coverage provision in an interpretive manual, or LCD that specifies the circumstances under which a service will always be considered non-covered or incorrectly coded. Clear policy that will be used as the basis for frequency denials must contain utilization guidelines that the contractor considers acceptable for coverage.

If a contractor chooses to allow supporting paper documentation to be submitted with the claim for medical review purposes the contractor shall inform providers in their jurisdiction of that fact (see Pub. 100-08, PIM, chapter 3, §3.5).

D. Signature Requirements

All signature requirements in this CR are effective for CERT reviews retroactively for the November 2010 report period. All signature requirements for ACs, MACs, PSCs and ZPICs are applicable for reviews conducted on or after 30 days after the issuance of this CR.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature. Stamp signatures are not acceptable.

EXCEPTION 1: Facsimile 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 Pub. 100-02, 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.

1. Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.

- 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.

a. Signature Log

Providers will sometimes include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature. 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 may encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials. Reviewers shall consider all submitted signature logs regardless of the date they were created. Reviewers are encouraged to file signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log may be needed again.

b. Signature Attestation Statement

Providers will sometimes include in the documentation they submit an attestation statement. 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 hearby 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 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. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.

NOTE: Reviewers shall NOT consider attestation statements where there is NO associated medical record entry. Reviewers shall NOT consider attestation statements 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). Reviewers shall consider all attestations that meet the above requirements 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. For example, if a policy states the physician must sign the plan of care before therapy begins, an attestation can be used to clarify the identity associated with an illegible signature but cannot be used to "backdate" the plan of care.

c. Signature Guidelines

The guidelines below will assist reviewers in determining whether to consider the signature requirements met.

- In the situations where the guidelines indicate "**signature requirements met**," the reviewer shall consider the entry.

In situations where the guidelines indicate "**contact billing provider and ask a non-standardized follow up question"** the reviewer shall 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 1) the contractor makes an actual phone contact with the provider or 2) the date the request letter is received by the post office. If the biller submits a signature log or attestation, the reviewer shall consider the contents of the medical record entry. In cases where the provider submits an attestation, the time frame for completing the review is 75 days rather than 60 days.

NOTE: Reviewers shall **NOT** contact the **biller when the claim should be denied for reasons unrelated to the si**gnature requirement.

- Contractors shall document their contact with the provider and/or other efforts to authenticate the signature.

		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 signator. 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		X

	Example: 		
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

2. Electronic Signatures

Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products which are protected against modification, etc., and should apply administrative procedures which are adequate and correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bears the responsibility for the authenticity of the information being attested to. Physicians are encouraged to check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.

3. Electronic Prescribing

Electronic prescribing (e-prescribing) is the transmission of prescription or prescription-related information through electronic media. E-prescribing takes place between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-prescribing network. With e-prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. E-prescribing can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care.

A "qualified" e-prescribing system is one that meets the Medicare Part D requirements described in 42 CFR 423.160 (Standards for Electronic Prescribing)

a. E-Prescribing for Part B Drugs (Other than Controlled Substances)

The AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any Part B drugs, other than controlled substances, ordered through a qualified e-prescribing system. For Medicare Part B medical review purposes, a qualified e-prescribing system is one that meets all 42 CFR 423.160 requirements. When Part B drugs have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.

b. E-Prescribing for Part B Controlled Substance Drugs

Currently, the Drug Enforcement Agency does not permit the prescribing of controlled substance drugs through e-prescribing systems. Therefore, AC, MAC, CERT, PSC, and ZPIC reviewers shall NOT accept as a valid order any controlled substance drugs that are ordered through any e-prescribing system, even one which is qualified under Medicare Part D. When reviewing claims for controlled substance drugs, the reviewer shall only accept hardcopy pen and ink signatures as evidence of a drug order.

c. E-Prescribing for Drugs Incident to DME

The AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified e-prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified e-prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produced hardcopy pen and ink signatures as evidence of a drug order.

E. Review of Documentation Solicited After Claim Receipt

The process whereby a contractor requests additional documentation after claim receipt is known as "development." Providers selected for review are responsible for submitting medical records requested of them by the contractor within established timeframes. Development requirements are listed below in section 3.4.2.1.

F. Requirements That Certain Tests Must Be Ordered By The Treating Physician

Effective November 25, 2002, 42 CFR 410.32(a) requires that when billed to any contractor, all diagnostic x-ray services, diagnostic laboratory services, and other diagnostic services must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.

G. Diagnosis Requirements

Section 1833(e) of the Act provides that no payment may be made "under this part unless there has been furnished such information as may be necessary in order to determine the amounts due

such provider or other person . . ."Contractors may require information, in accordance with the requirements below whenever they deem necessary to make a determination listed in section 3.4.1 and thus to determine appropriate payment.

Some provider types are required to submit diagnosis codes on all claims while other provider types are required to submit diagnosis codes only if such information is required by an LCD.

- Claims Submitted by Physicians or **§1842(b)(18)(C) of the Act** Practitioners Must Contain Diagnosis Codes.

Section 1842 (p)(1) of the Act states that each claim submitted by a physician or §1842(b)(18)(C) of the Act practitioner "shall include the appropriate diagnosis code (or codes)…". For services from physicians and §1842(b)(18)(C) of the Act practitioners submitted with an ICD-9 code that is missing, invalid, or truncated, contractors must return the billed service to the provider as unprocessable in accordance with Pub. 100-04, chapter 1, section 80.3.2.1.2.

- Claims Submitted By All Other Provider Types Must Contain Diagnosis Codes If Such Codes Are Required By An LCD (effective 7/1/02).

In order to address potential abuse or overutilization, contractors can require that ICD-9 diagnosis codes be submitted with each claim for the targeted service. This information is used in determining whether the services are covered and correctly coded. Effective April 1, 2002, contractors may require ICD-9 diagnosis codes to be submitted by all non-physician billers with every claim for a targeted service only if such a requirement appears in an LCD for that service. Contractors must educate providers about this requirement beginning no later than January 1, 2002. This outreach should occur via Web site bulletin articles, etc.

For individual non-physician providers who are identified due to unusual billing practices, fraud referrals, etc., contractors may also require ICD-9 diagnosis codes to support the medical necessity of all or some claims submitted by the targeted entities, even if no LCD exists requiring such codes.

For services submitted with an ICD-9 diagnosis code that is missing, incorrect or truncated as indicated above, contractors must return the billed service to the provider as unprocessable.

H. Requirements for Lab Claims

The American Medical Association's (AMA) 1998 edition of the Current Procedural Terminology (CPT) established three new and one revised Organ or Disease Oriented laboratory panels. Since these panels are composed of clinically relevant groupings of automated multichannel tests there is a general presumption of medical necessity. If there is data or reason to suspect abuse of the new panel codes, contractors may review these claims. Should contractors determine the need to develop a LCD for laboratory panel codes, develop these policies at the panel code level. In some instances of perceived abuse of the new panel codes, you may review the panel and deny component tests on a case-by-case basis or evaluate the need for the component level test.

I. Additional Signature Requirements for DMEPOS

See Pub. 100-08, PIM, chapter 5, for further details regarding additional signature requirements for DMEPOS.

J. Signature Dating Requirements

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.

EXAMPLE: The claim selected for review is for a hospital visit on October 4. The ADR response is one page from the hospital medical record containing three entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer may conclude that the physician visit was conducted on October 4.

K. ADR Language Regarding Signatures

The CERT contractor shall use language in their ADR letters reminding providers that the provider may need to contact another entity to obtain the signed version of a document. For example, a hospital discharge summary in the physician office files may be unsigned while the version of the discharge summary in the hospital files may be signed and dated. ACs and MACs are encouraged to use such language in their letters. In addition, all reviewers have the discretion to add language to their ADRs stating that the provider is encouraged to review their documentation prior to submission, to ensure that all services and orders are signed appropriately. In cases where a reviewer notices a note with a missing or illegible signature, the ADR may inform the provider they may submit a signature log or signature attestation as part of the ADR response.

The following is sample language that reviewers may choose to use in certain ADRs:

> "Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature. Stamp signatures are not acceptable. Patient identification, date of service, and provider of the service should be clearly identified on the submitted documentation.
>
> The documentation you submit in response to this request should comply with these requirements. This may require you to contact the hospital or other facility where you provided the service and obtain your signed progress notes, plan of care, discharge summary, etc.
>
> If you question the legibility of your signature, you may submit an attestation statement in your ADR response.

If the signature requirements are not met, the reviewer will conduct the review without considering the documentation with the missing or illegible signature. This could lead the reviewer to determine that the medical necessity for the service billed has not been substantiated."

L. Fraud Referrals

At any time, evidence of fraud shall result in referral to the PSC/ZPIC for development. If AC, MAC or CERT reviewers identify a pattern of missing/illegible signatures it shall be referred to the appropriate PSC/ZPIC for further development.