CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 248	Date: MARCH 28, 2008
	Change Request 5971

SUBJECT: Signature Requirements Clarification

I. SUMMARY OF CHANGES: Clarification of the instructions on signature requirements for the certification of terminal illness for hospice.

CLARIFICATION
EFFECTIVE DATE: SEPTEMBER 3, 2007
IMPLEMENTATION DATE: April 28, 2008

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:

SECTION A: For Fiscal Intermediaries and 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 248	Date: March 28, 2008	Change Request: 5971

SUBJECT: Signature Requirements Clarification

Effective Date: September 3, 2007

Implementation Date: April 28, 2008

I. GENERAL INFORMATION

A. Background: Change request (CR) 5550, was issued on August 24, 2007, with an effective and implementation date of September 3, 2007. We are clarifying the instructions on signature requirements for the certification of terminal illness for hospice.

B. Policy: Instructions in CR 5550 need to be clarified.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

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	
5971.1	Contractors shall accept hand written and electronic signatures on medical record documentation for medical review purposes.	X	X	X	X	X					

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	
5971.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.	X	X	X	X	X					

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	
	Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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Post-Implementation Contact(s): Nancy Moore, Nancy.moore@cms.hhs.gov, 410-786-6974

VI. FUNDING

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

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. 248; Issued: 03-28-08; Effective Date: 09-03-07; Implementation Date: 04-28-08)

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 other entity when the contractor deems it necessary and in accordance with PIM, chapter 3, §3.4.1.2.

A. 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 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 PIM, chapter 3, §3.5).

B. Signature Requirements

Medicare requires a legible identifier for services provided/ordered. The method used *shall* be hand written or an electronic signature *(stamp signatures are not acceptable)* to sign an order or other medical record documentation for medical review purposes.

NOTED EXCEPTION: *Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice*.

Providers using electronic systems should recognize that there is a potential for misuse or abuse with alternate signature methods. *Fascimile and hard copies of a physician's electronic signature must be in the patient's medical record for the certification of terminal illness for hospice.* 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 should check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.

All State licensure and State practice regulations continue to apply. Where State law is more restrictive than Medicare, the contractor needs to apply the State law standard. The signature requirements described here do not assure compliance with Medicare conditions of participation.

Note that this instruction does not supersede the prohibition for certificates of medical necessity (CMNs) and DME MAC information forms (DIFs). CMNs and DIFs are forms used to determine if the medical necessity and applicable coverage criteria for durable medical equipment, prosthetic, and orthotic supplies (DMEPOS) have been met.

C. 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.

D. 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.

E. 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 MCM §3005.4(p) or MIM §3605.3.

- 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.

F. 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.