CMS Manual System

Pub. 100-08 Medicare Program Integrity

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 59 **Date: NOVEMBER 28, 2003**

CHANGE REQUEST 2937

I. SUMMARY OF CHANGES:

NEW/REVISED MATERIAL - EFFECTIVE DATE: 1/1/2004
***IMPLEMENTATION DATE: 1/5/2004**

Disclaimer: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. SCHEDULE OF CHANGES (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	3/ 4.1.1/B-F/ Documentation Specifications for Areas Selected for Prepayment or Postpayment MR
R	5/1.1.2/ Written Orders

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

Business Requirements

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I. GENERAL INFORMATION

A. Background: N/A

B. Policy: N/A

C. Provider Education:

Contractors shall inform affected provider communities by posting either a summary or relevant portions of this instruction on their websites within two weeks of the issuance date of this instruction. In addition, this same information shall be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected provider communities, you must use it to notify subscribers that information about signature requirements is available on your Web Site.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
2937.1	**The contractor shall not deny claims on the basis of type of signature type submitted, with an exception for Durable Medical Equipment Certificates of Medical Necessity.**	**Contractor**

II. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations:

IV. OTHER CHANGES

Citation	Change
N/A	

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: 1/1/2004 **Implementation Date: 1/5/2004** **Pre-Implementation Contact(s): Dan Schwartz** **Post-Implementation Contact(s): Regional Offices**	**These instructions should be implemented within your current operating budget**

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Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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

(Rev. 59, 11-28-03)

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, Section 4.1.2.

A -- Review of Documentation Submitted with the Claim

If a claim targeted for prepayment or postpayment review (including automated, routine, or complex) contains a modifier indicating that additional documentation is attached or was submitted simultaneously with an electronic claim, the contractor must review the documentation before denying the claim. 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, §5.1).

NOTE: The term "clear policy" means a statute, regulation, NCD, coverage provision in an interpretive manual, or LMRP 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.

B -- Signature Requirements

Medicare requires a legible identity for services provided/ordered. The method used (e.g. hand written, electronic, or signature stamp) to sign an order or other medical record documentation for medical review purposes in determining coverage is not a relevant factor. Rather, an indication of a signature in some form needs to be present. Do not deny a claim on the sole basis of type of signature submitted.

Providers using alternative signature methods (e.g. a signature stamp) should recognize that there is a potential for misuse or abuse with a signature stamp or other alternate signature methods. For example, a rubber stamped signature is much less secure than other modes of signature identification. The individual whose name is on the alternate signature method 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 (CMN). CMNs are a term of art specifically describing particular Durable Medical Equipment forms. As stated on CMN forms, "Signature and date stamps are not acceptable" for use on CMNs. No other forms or documents are subject to this exclusion.

***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 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 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 LMRP.

- **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 s*ervices 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 LMRP (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 LMRP for that service. Contractors must educate providers about this requirement beginning no later than January 1, 2002. This outreach should occur via website 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 LMRP 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 LMRP 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.

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Chapter 5 – Items and Services Having Special DMERC Review Considerations

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1.1.2 -Written Orders

(Rev. 59, 11-28-03)

Written orders are acceptable for all transactions involving DMEPOS. Written orders may take the form of a photocopy, facsimile image, electronically maintained, or original "pen-and-ink" document *(See Chapter 3, Section 4.1.1 B.)*

All orders must clearly specify the start date of the order.

For items that are dispensed based on a verbal order, the supplier must obtain a written order that meets the requirements of this section.

If the written order is for supplies that will be provided on a periodic basis, the written order should include appropriate information on the quantity used, frequency of change, and duration of need. (For example, an order for surgical dressings might specify one 4 x 4 hydrocolloid dressing that is changed 1-2 times per week for 1 month or until the ulcer heals.)

The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number.

If the order is for a rented item or if the coverage criteria in a policy specify length of need, the order must include the length of need.

If the supply is a drug, the order must specify the name of the drug, concentration (if applicable), dosage, frequency of administration, and duration of infusion (if applicable).

Someone other than the physician may complete the detailed description of the item. However, the treating physician must review the detailed description and personally sign and date the order to indicate agreement.

If a supplier does not have a faxed, photocopied, electronic or pen & ink signed order in their records before they can submit a claim to Medicare (i.e., if there is no order or only a verbal order), the claim will be denied. If the item is one that requires a written order prior to delivery (see Section 1.1.2.1), the claim will be denied as not meeting the benefit category. If the claim is for an item for which an order is required by statute (e.g., therapeutic shoes for diabetics, oral anticancer drugs, oral antiemetic drugs which are a replacement for intravenous antiemetic drugs), the claim will be denied as not meeting the benefit category and is therefore not appealable by the supplier (see MCM Section 12000 for more information on appeals). For all other items, if the supplier does not have an order that has been both signed and dated by the treating physician before billing the Medicare program, the item will be denied as not reasonable and necessary

If an item requires a CMN and the supplier does not have a faxed, photocopied, electronic, or pen & ink signed CMN in their records before they submit a claim to Medicare, the claim will be denied. If the CMN is used to verify that statutory benefit requirements have been met, then the claim will be denied as not meeting the benefit category. If the CMN is used to verify that medical necessity criteria have been met, the claim will be denied as not reasonable and necessary.

Medical necessity information (e.g., an ICD-9-CM diagnosis code, narrative description of the patient's condition, abilities, limitations, etc.) is NOT in itself considered to be part of the order although it may be put on the same document as the order.