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Top Medicare Claim Denials... And How to Avoid Them

March 2013

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The slide features a woman in a white lab coat on the right side, smiling. The background is light gray with decorative wavy lines in teal, pink, and white at the bottom. Logos for 'HEALTHCARE first' and 'HAYDEL Consulting Services, LLC' are in the top left.

Home Care Claim Denials

Home Health industry has never under more scrutiny since the 1990's

- MACs (FIs)**
- RACs**
- Zone Contractor (ZPIC)**

State agencies have been tasked with higher survey standards.

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The slide has a teal header bar with the title 'Home Care Claim Denials'. The main content is in bold black text. The 'HEALTHCARE first' logo and 'patients before paperwork' tagline are at the bottom left. There are decorative wavy lines on the left side.

Home Care Claim Denials

OIG Study

- Highlighted OASIS transmission errors
- Improbably low LUPA rates
- In 2010, Medicare paid \$19.5 billion to 11,203 home health agencies for services provided to 3.4 million beneficiaries.
- HHAs with questionable billing mostly located in TX, FL, CA and MI.

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Home Care Claim Denials

OIG Study

- Home health agencies submitted 22% of claims in error in 2008, resulting in \$432 million in improper payment.
- \$328M for claims that did not meet Medical Necessity
HHAs with questionable billing mostly located in TX, FL, CA and MI.
- OASIS data for 392,180 (6%) of claims in 2009 was not submitted (over \$1 billion in Medicare payments).
- Only 199 HHAs were penalized by CMS with the 2% payment reduction from 2007 through 2010.

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Home Care Claim Denials

What are the top reasons for denials?

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Top Home Care Claim Denial Reasons

5CHG1 – Medical Review HIPPS Code Change/Doc Contradicts MO/M Item(s)

- OASIS data conflicts with what was billed

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Top Home Care Claim Denial Reasons

5AMVN/5FMVN – More Visits than Reasonable and Necessary

- Skilled nurse visits not covered because documentation indicated more visits were provided than were reasonable and necessary
- Visits may be denied that do not affect payment but will affect the overall charge denial rate.
- Example: A patient receives 9 SNVs and 12 therapy visits. 7 SNVs are denied. Payment is the same because the LUPA threshold was exceeded and therapy was paid but the charge denial rate will include the payment for the 7 SNVs.

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Top Home Care Claim Denial Reasons

5F023/5T023 – No Plan of Care or Certification

- No plan of care established and approved by a physician
- All pages MUST be included
- This reason for denial is often cited when there is a care plan. Always use page numbers on your documentation.
- Example: a patient has a 485 which is paginated (1/2, 2/4. etc.) Pages 3 and 4 are absent. Regardless that all elements of the POC were on pages 1 and 2, a denial will result because your documentation reflects that an incomplete document was submitted.
- Care plans are omitted from ADRs and/or the wrong POC may be submitted because agencies are working against a deadline.

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Top Home Care Claim Denial Reasons

5ANOA/5FNOA – Unable to Determine Medical Necessity of HIPPS Code Billed as Appropriate OASIS Not Submitted

- HHA did not submit the OASIS for the HIPPS code billed on the claim
- Be aware of inappropriate RAC denials based on OASIS submission

Top Home Care Claim Denial Reasons

5ANOA/5FNOA – Unable to Determine Medical Necessity of HIPPS Code Billed as Appropriate OASIS Not Submitted

- From PPS Revisions for 2010:

We are implementing the provision to require the submission of OASIS, for final claims, as a condition of payment, and revising § 484.210.

“Data used for the calculation of the national prospective 60-day episode payment” to reflect this requirement.

Top Home Care Claim Denial Reasons

5F012/5T012 – Physician’s Plan of Care and/or Certification Present – Signed but not Dated

- Documentation submitted did not include the physician's signed certification or recertification
- Electronic signatures ensure compliance with this standard
- See signature transmittal document

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Top Home Care Claim Denial Reasons

5A301/5F301 – Info Provided Does Not Support the M/N for Therapy Services

- Clinical documentation did not support the medical necessity of the skilled services from start of care
- Therapy evaluation MUST be complete
- Ensure that therapy complies to Coverage determination. Palmetto GBA LCD is based on National Coverage guidelines and is included in your handouts.
- Documentation requirements are near the end of the 37 page document.

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Top Home Care Claim Denial Reasons

5ADSD – Dependent Services Denied (Qualifying Service Denied Medically)

- Non-skilled services denied because skilled services were not provided or denied
- Includes home health aide and social work services

Top Home Care Claim Denial Reasons

5T009 – Claim Level Denial for Multiple Line Denials

- According to the documentation in the medical record, the agency made a billing error
- Multiple reasons for denial within the claim

Top Home Care Claim Denial Reasons

5FF2F/5TF2F – Face to Face Encounter Requirements Not Met

- No Face to Face encounter documented
- Physician who signed the certification is not the physician they have on record being the patient's physician
- Integrated databases are revealing no claim from MD for date of service
- Even though it is not requested, multiple agencies have received denials for not sending a face to face encounter document for ADRs for second or later episodes. Always send your face to face regardless of what is requested.

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Top Home Care Claim Denial Reasons

5A041/5F041 – Info Provided Does Not Support the Medical Necessity (M/N) for this Service

- Clinical documentation submitted for review did not support the medical necessity of the skilled services billed
- See Medicare Benefits Manual - Chapter 7
- The ability to appeal these denials is directly related to the contents of the clinical record.
- Appealing a denial for failing to document Medical Necessity is like trying to shoot a target with an unloaded gun. It simply cannot be done.

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Top Home Care Claim Denial Reasons

56900 – Auto Deny – Requested Records Not Submitted

- Medical records were not received in response to an ADR in the required time frame; therefore, unable to determine medical necessity.
- 21.5% of claims denied
- They was an issue with Palmetto last year that has been resolved. Numerous denials were received for sending records later when they were not late.

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Strategies for Denials

1. Review your claims through DDE or other revenue management tool to make sure they are not in ADR.
2. Have a process in place to review End of Episodes so they will be clean for billing
3. Provide education during orientation and annually on coverage guidelines
4. Integrity of data should be measured on an ongoing basis

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Use Your Tools

- Even the most basic software for home health has tools that are useful.
- Look for late paperwork. Notes that are completed long after the visit are rarely accurate.
- Review medications in the computer to look for clues for incorrect or incomplete diagnosis coding.

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Raising the Bar

- Every agency has documentation issues.
- Give information in bite size pieces. Field nurses are busy people with short attention spans.
- Recognize superior documentation as well as problematic documentation.
- Provide multiple ways to present information.
- You will never save money by skimping on QA.

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For More Information

Haydel Consulting Services

225-253-4876

www.haydelconsultingservices.com

julianne@haydelcs.com

HEALTHCARE*first*

800-841-6095

www.healthcarefirst.com

sales@healthcarefirst.com

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CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 327	Date: March 16, 2010
	Change Request 6698

SUBJECT: Signature Guidelines for Medical Review Purposes

I. SUMMARY OF CHANGES: Medicare claim review contractors (carriers, fiscal intermediaries (called affiliated contractors, or ACs), Medicare administrative contractors, the comprehensive error rate testing contractor, and recovery audit contractors) are tasked with measuring, detecting and correcting improper payments in the fee for service Medicare program. These contractors review claims and medical documentation submitted by providers.

The previous language of the Program Integrity Manual required a legible identifier in the form of a handwritten or electronic signature for every service provided or ordered. This CR updates these requirements and adds e-prescribing language.

EFFECTIVE DATE: MARCH 1, 2010

IMPLEMENTATION DATE: April 16, 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:

Funding for implementation activities will be provided to contractors through the regular budget process.

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: 327	Date: March 16, 2010	Change Request: 6698
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SUBJECT: Signature Guidelines for Medical Review Purposes

EFFECTIVE DATE: MARCH 1, 2010

IMPLEMENTATION DATE: April 16, 2010

I. GENERAL INFORMATION

A. Background: Medicare claim review contractors (carriers, fiscal intermediaries (called affiliated contractors, or ACs), Medicare administrative contractors (MACs), the comprehensive error rate testing (CERT) contractor, and recovery audit contractors) are tasked with measuring, detecting and correcting improper payments in the fee for service (FFS) Medicare program. These contractors review claims and medical documentation submitted by providers.

The previous language in the PIM required a “legible identifier” in the form of a handwritten or electronic signature for every service provided or ordered. This CR updates these requirements and adds e-prescribing language.

B. Policy: Clarifies and updates various sections of the Program Integrity Manual.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an “X” in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
6698.1	All signature requirements in this CR are effective retroactively for CERT for the November 2010 report period.										CERT
6698.2	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.	x	x	x	x	x					CERT, PSC, ZPIC
6698.3	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.	x	x	x	x	x					CERT, PSC, ZPIC
6698.4	Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, (e.g. signatures on plans of care must be signed prior to services being rendered), those signature requirements take precedence.	x	x	x	x	x					CERT, PSC, ZPIC
6698.5	For medical review purposes, <u>if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the</u>	x	x	x	x	x					CERT, PSC,

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	<u>signature be legible or present</u> and the signature is illegible/missing, the reviewer shall follow the guidelines listed in the PIM to discern the identity and credentials (e.g. MD, RN) of the signator.									ZPIC	
6698.6	If there are reasons for denial unrelated to signature requirements the reviewer shall not proceed to signature authentication. If the criteria in the relevant Medicare policy <u>cannot be met but for a key piece of medical documentation which contains a missing or illegible signature</u> , the reviewer shall proceed to the signature assessment.	x	x	x	x	x				CERT, PSC, ZPIC	
6698.7	If the signature is <u>illegible</u> , 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.	x	x	x	x	x				CERT, PSC, ZPIC	
6698.8	If the signature is <u>missing from an order</u> , ACs, MACs, PSCs, ZPICs and CERT shall disregard the order during the review of the claim.	x	x	x	x	x				CERT, PSC, ZPIC	
6698.9	If the signature is <u>missing from any other medical documentation</u> , ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.	x	x	x	x	x				CERT, PSC, ZPIC	
6698.10	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.	x	x	x	x	x				CERT, PSC, ZPIC	
6698.11	Reviewers shall consider all submitted signature logs regardless of the date they were created.	x	x	x	x	x				CERT, PSC, ZPIC	
6698.12	Reviewers shall NOT consider attestation statements where there is NO associated medical record entry.	x	x	x	x	x				CERT, PSC, ZPIC	
6698.13	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).	x	x	x	x	x				CERT, PSC, ZPIC	
6698.14	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.	x	x	x	x	x				CERT, PSC, ZPIC	
6698.15	In the situations where the guidelines in the PIM indicate "signature requirements met," the reviewer shall consider the entry.	x	x	x	x	x				CERT, PSC, ZPIC	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6698.16	In situations where the guidelines in the PIM 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.	x	x	x	x	x					CERT, PSC, ZPIC
6698.17	If the biller submits a signature log or attestation, the reviewer shall consider the contents of the medical record entry. In cases where the reviewer contacts the provider, the time frame for completing the review is extended for an additional 15 days.	x	x	x	x	x					CERT, PSC, ZPIC
6698.18	Reviewers shall NOT contact the biller when the claim should be denied for reasons unrelated to the signature requirement.	x	x	x	x	x					CERT, PSC, ZPIC
6698.19	Contractors shall document their contact with the provider and/or other efforts to authenticate the signature.	x	x	x	x	x					CERT, PSC, ZPIC
6698.20	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.	x	x	x	x	x					CERT, PSC, ZPIC
6698.21	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.	x	x	x	x	x					CERT, PSC, ZPIC
6698.22	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	x	x	x	x	x					CERT, PSC, ZPIC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	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.										
6698.23	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.	x	x	x	x	x				CERT, PSC, ZPIC	
6698.24	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.									CERT	
6698.25	ACs and MACs are encouraged to 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.	x	x	x	x	x					
6698.26	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.	x	x	x	x	x				CERT	
6698.27	At any time, evidence of fraud shall result in referral to the PSC/ZPIC for development.	x	x	x	x	x				CERT, PSC, ZPIC	
6698.28	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.	x	x	x	x	x				CERT, PSC, ZPIC	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6698.29	<p>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.</p> <p>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.</p>	X	X	X	X	X					

Each contractor is encouraged to develop and post to their Web sites provider education language explaining the new signature guidelines.

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):

Melanie Combs-Dyer (Melanie.Combs-Dyer@cms.hhs.gov)

Post-Implementation Contact(s):

Melanie Combs-Dyer (Melanie.Combs-Dyer@cms.hhs.gov)

Marissa Malcolm (Marissa.Malcolm@cms.hhs.gov)

VI. FUNDING

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

Funding for implementation activities will be provided to contractors through the regular budget process.

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.327, Issued: 03-16-10, Effective: 03-01-10, Implementation: 04-16-10)

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. 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).

B. 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 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.”

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

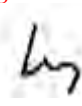
The guidelines below will assist reviewers in determining whether to consider the signature requirements met.


- 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 signature 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 of 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: 1) a signature log, or 2) an attestation statement	X	
6	Illegible Signature NOT over a typed/printed name, NOT on letterhead and the documentation is UNaccompanied by:		X

	a) a signature log, or b) an attestation statement Example: 		
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but accompanied by: a) a signature log, or b) an attestation statement	X	
9	Initials NOT over a typed/printed name UNaccompanied by: a) a signature log, or b) 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.

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 *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.

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.

G. Additional Signature Requirements for DMEPOS

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

H. 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.*

I. 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.”

J. 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.

Local Coverage Determination (LCD): Home Health-Physical Therapy (L31542)

http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=31542&ContrId=227&ver=28&ContrVer=1&CtrctrSelected=227*1&Ctrctr=227&name=Palmetto+GBA+%2811004%2c+RHHI%29&DocType=Active&s=48&bc=BBAAAAIAAAAAAA%3d%3d&

Documentation Requirements

1. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to the A/B MAC upon request.
2. The plan of treatment written by the patient's physician after any needed consultation with the qualified physical therapist and signed by the physician. This must be in the patient's medical record and made available to the A/B MAC upon request.
3. When documenting family member/caregiver training and education, the documentation should include the person(s) being trained and the effectiveness of the training and education. The training and education should be an adjunct to the active therapy with the patient.
4. OASIS data should support the medical necessity of the services documented in the medical records. For therapy services the OASIS MO2200 should be filled out completely and filed with the State Repository. An updated and completed OASIS for the billing period should be on file with the State Repository and in the patient's medical records to be made available to the A/B MAC upon request.
5. The progress note for services should reflect:
 - a. An ongoing reassessment of the patient's response to treatment,
 - b. Progress toward predicted goals,
 - c. Clinical rationale for continued skilled treatment,
 - d. Recommended changes to the plan of treatment,
 - e. Services provided at the time of treatment

Evaluation/Reevaluations

The physician and/or physical therapist's evaluation/re-evaluation assess the area for which physical therapy treatment is being planned. It must be completed prior to beginning therapy. Evaluations must contain the following information:

1. Reason for referral
2. Diagnosis/condition being treated

3. Past level of function (be specific)
4. Evaluations must contain physical and cognitive baseline data necessary for assessing rehabilitation potential and measuring progress.
5. Current level of function
6. Objective measurements such as strength, ROM, pain, ADL level, or edema
7. Treatment techniques/modalities selected for treating current illness or injury
8. Limitations which may influence the length of treatment
9. Short and long term goals stated in objective measurable terms, and their expected date of accomplishment
10. Frequency and duration of therapy
11. Re-assessments must be performed at least every 30 days by a qualified physical therapist. The 30 day clock begins with the first therapy's visit/assessment/measurement/documentation (of the physical therapy).

Plan of Treatment

Services are to be furnished according to a written plan of treatment determined by the physician after any needed consultations with the qualified physical therapist and signed and dated by the physician after an appropriate assessment (evaluation) of the condition (illness or injury) is completed. The plan of treatment must be completed before active therapy begins. The plan of treatment must be signed by the referring or attending physician prior to billing the service to Medicare. The written plan of treatment may not be altered by an physical therapist. *Electronic signatures are acceptable if the proper documentation is submitted to the J11 MAC. However, stamped dates are not allowed.

1. The written plan of care must contain the following elements:
 - a. Diagnosis being treated and the specific problems identified that are to be addressed
 - b. Treatment techniques/modalities or procedures being used for specific problem to attain the stated goals
 - c. Specific functional goals for therapy in objective measurable terms (patient/caregiver maybe included or taken into consideration)
 - d. Amount, frequency, and duration of therapeutic services

e. Rehabilitation potential - therapists/physician's expectation of the patient's ability to meet the goals at initiation of treatment (patient and, when appropriate, caregiver goals may be incorporated)

Treatment Note/Progress Notes

1. A treatment note should be written for each visit using objective measurements and functional accomplishments. It should contain the objective status of the patient, a description of the services performed, the patient's response to the services and the relation toward the treatment goals.

2. The treatment note should document any treatment variations with the associated rationale.

3. The treatment notes should be written using objective measurements and functional accomplishments. Use statements which demonstrate the patient's response to the therapy such as:

a. "Able to perform exercises as prescribed for 15 reps"

b. "Able to safely transfer from bed to toilet with standby assistance"

c. "Can now abduct shoulder 120 degrees"

d. "Able to don a pull over shirt with minimal assistance"

4. Avoid terms such as:

a. "Doing well"

b. "Improving"

c. "Less pain"

d. "Increased range of motion"

e. "Increased strength"

f. "Tolerated treatment well"

Certification/Re-certification

1. The certifying physician must document that he or she had a face-to-face encounter with the patient. The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.

2. Certifications and re-certifications by the physician, must be on file and available to the J11 MAC when the request for payment is forwarded.

3. Certifications are required upon initiation of therapy and at least every 60 days thereafter for Home Health.

4.The referring/attending physician establishes or reviews the plan of treatment and makes the necessary certifications. must sign and date all certifications/re-certifications.

5.Documentation should indicate the prognosis for potential restoration of function in a reasonable and generally predictable period of time, or the need to establish a safe and effective maintenance program.

**My Favorite Patient
123 Happy Street
HealthcareFirst, USA 00000**

**Name of RAC (Connolly, Integrigard, etc.)
RAC Address**

Request Number 00000000000000

Request Date 0000000000

Claim Reference 000000000000LAR

Dates of Service 01.01.2013 through 03.01.2013

Patient Date of Birth 01.01.2013

December 18, 2012

APPEAL FOR DENIAL RELATED TO AUTOMATIC DATA

The claim referenced on the cover of this appeal has been found to be questionable according to a "Semi-Automated" review by Connolly Healthcare. The assumption that the agency billed inappropriately and is subject to an overpayment assessment is incorrect.

The Federal Regulations regarding home health care mandate that agencies complete and submit OASIS documentation within specific time frames depending on the kind of assessment completed. In this case, the recertification assessment was missed. This oversight is isolated and we relied on guidance from CMS to address it.

The OASIS Questions and Answers published the following information on January 12 of this year. It was originally offered to agencies in 2006 and revised in 2009 to the information below which remains current as of January of 2012.

A11. When an agency does not complete a recertification assessment within the required 5 day window at the end of the certification period, the agency should not discharge and readmit the patient. Rather, the agency should send a clinician to perform the recertification assessment as soon as the oversight is identified. The date assessment completed (M0090) should be reported as the actual date the assessment is completed, with documentation in the clinical record of the circumstances surrounding the late completion. A warning message will result from the non-compliant assessment date, but this will not prevent assessment transmission. No time frame has been set after which it would be too late to complete this late assessment, but the agency is encouraged to make a correction or complete a missed assessment as soon as possible after the oversight is identified. Obviously, this situation should be avoided, as it does demonstrate non-compliance with the comprehensive assessment update standard (of the Conditions of Participation). For the Medicare PPS patient, payment implications may arise from this missed assessment. Any payment implications must be discussed with the agency's Medicare Administrative Coordinator (MAC).

We are in complete agreement that this situation should be avoided. We readily admit that we erred in performing this assessment late. It is an isolated incident and we have implemented processes to reduce the likelihood of a repeat occurrence. However, the only Condition for **Payment** related to OASIS is that the data be submitted prior to billing the final episode.

In this instance, when the patient was noted to be without an assessment, the agency turned to CMS regulations for guidance. As noted above the guidance clearly instructs the agency to not discharge the patient. The remedial efforts that we preferred would have included discharging and readmitting the patient but that course of action is clearly prohibited.

We take the Conditions of Participation very seriously. However, on other occasions when Conditions of Participation are violated, the agency or facility is given a chance to submit a plan of corrections. It is not until there are repeated violations that any sanctions are leveled.

It is further noted that in this case, the OASIS was submitted timely and that no billing occurred prior to OASIS submission which is a condition for payment.

We draw your attention to the OIG Report dated February 2012 which identified the role of CMS, the state agencies and the home health agencies in ensuring that the CoP's regarding OASIS data were met.

CMS does not penalize HHAs for late submissions. In 2009, HHAs submitted 15 percent of OASIS datasets after the required 30-day timeframe (see Table 3).²⁴ HHAs submitted almost a million OASIS (962,646) datasets late; about a third of those (342,936) were more than 21 days late.

Because the Office of the Inspector General CMS did penalize agencies for late submissions, we dispute the authority of a Recovery Audit Contractor to deny a claim three years after an isolated late submission.

Attached please find the February 2012 report and accept this document as our formal request to appeal this decision.

**My Favorite Patient
123 Happy Street
HealthcareFirst, USA 00000**

**Name of RAC (Connolly, Integrigard, etc.)
RAC Address**

Request Number 00000000000000

Request Date 0000000000

Claim Reference 00000000000000LAR

Dates of Service 01.01.2013 through 03.01.2013

Patient Date of Birth 01.01.2013

PUT YOUR DATE HERE

APPEAL FOR DENIAL RELATED TO AUTOMATIC DATA

The claim referenced on the cover of this appeal has been found to be questionable according to a “Semi-Automated” review by Connolly Healthcare. The assumption that the agency billed inappropriately and is subject to an overpayment assessment is incorrect.

The Federal Conditions of Participation mandate that home health agencies complete and submit OASIS data to the state repository according to well defined timeframes. On January 1, 2010, the Prospective Payment System for home health was updated to include a provision that required the submission of OASIS, for final claims, as a condition of payment, and revising § 484.210.

Please note that the final claim for the episode in question was not submitted until the OASIS data used in the calculation of the final HIPPS code was transmitted.

We are in complete agreement that OASIS should be submitted timely and according to the conditions of participation. We readily admit that we erred in submitting this assessment late. It is not our policy to disregard the OASIS submission requirements but these isolated incidents do not warrant a denial of a claim. The only Condition for **Payment** related to OASIS is that the data used in the calculation for final claims be submitted prior to billing the final episode.

We take the Conditions of Participation very seriously. However, on other occasions when Conditions of Participation are violated, the agency or facility is given a chance to submit a plan of corrections. It is not until there are repeated violations that any sanctions are leveled.

We draw your attention to the OIG Report dated February 2012 which identified the role of CMS, the state agencies and the home health agencies in ensuring that the CoP’s regarding OASIS data were met.

CMS does not penalize HHAs for late submissions. In 2009, HHAs submitted 15 percent of OASIS datasets after the required 30-day timeframe (see Table 3).²⁴ HHAs submitted almost a million OASIS (962,646) datasets late; about a third of those (342,936) were more than 21 days late.

Because the Office of the Inspector General CMS did penalize agencies for late submissions, we dispute the authority of a Recovery Audit Contractor to deny a claim for late submission of OASIS data.

Attached please find the February 2012 report and accept this document as our formal request to appeal this decision.