Medicare Signature Guidelines

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Today's Presenters

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Objectives

- To assist the Medicare Part B provider community with understanding the Medicare signature guidelines

Agenda

- Test Your Knowledge
- Signature Requirements
- Exceptions
- How to Determine Signature Requirements are Met
- Amendments, Corrections and Delayed Entries in Medical Documentation
- E-Prescribing
- FAQs
- References

Test Your Knowledge

Test Your Knowledge

- Send your answers for the “Test Your Knowledge” questions in the question box

Test

- A Medicare provider can not make amendments to a medical record
  - True
  - False

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Test

- A signature log is not acceptable for Medicare
  - True
  - False

Test

- A stamped signature is never acceptable for Medicare
  - True
  - False

Test

- There are many acceptable electronic signatures allowed by Medicare
  - True
  - False

Test

- Medicare will accept a valid order for any Part B medications, other than controlled substances, ordered through a qualified e-prescribing system
  - True
  - False

Signature Requirements

Handwritten Signature

- This is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation

Signature Log

- Identifies the author associated with initials or an illegible signature
- Credentials encouraged
- Must be a part of the patient's medical record
- Claim reviewers will consider submitted signature logs, regardless of the date created

Attestation 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.”

Examples of Medical Records Requiring a Signature

- Dictated reports
- Outpatient visits
- Lab/diagnostic orders/requisitions
- Certificates of medical necessity
- Treatment plans/plan of care
- Treatment log notes
- Initial evaluations or current reevaluations
- Inpatient visits
- Office visits

Exceptions

Exception #1

- Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice

Exception #2

- Orders for clinical diagnostic tests are not required to be signed
  - There must be medical documentation by the treating physician that they intended the clinical diagnostic test be performed
  - Must be authenticated by the author via a handwritten/electronic signature
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 80.6.1

Exception #3

- Other regulations and CMS instructions regarding signatures take precedence
  - For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the signature is legible or present and the signature is illegible/missing, the reviewer will follow guidelines to discern the identity and credentials of the signator
  - In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence

Exception #4

- CMS would permit use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973
  - Author with physical disability has to provide proof of their inability to sign due to their disability

How to Determine if Signature Requirements are Met

Determining Signature Requirements

Signature	Sig. Req. Met	Contact Provider
Legible full signature	X	
Legible first initial and last name	X	
Illegible signature over a typed/printed name	X	
Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signatory (e.g., An illegible signature appears on a prescription. The letterhead of the prescription lists (3) physician's names. One of the names is circled.)	X	
Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by a signature log/attestation statement	X	

Determining Signature Requirements

Signature	Sig. Req. Met	Contact Provider
Illegible signature NOT over a typed/printed name, NOT on letterhead and the documentation is unaccompanied by a signature log/attestation statement		X
Initials over a typed or printed name	X	
Initials NOT over a typed/printed name but accompanied by a signature log/attestation statement	X	
Initials NOT over a typed/printed name unaccompanied by a signature log/attestation statement		X
Unsigned typed note with provider's typed name		X

Determining Signature Requirements

Signature	Sig. Req. Met	Contact Provider
Unsigned typed note without providers typed/printed name		X
Unsigned handwritten note, the only entry on the page		X
Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
"Signature on File"		X

Acceptable Electronic Signatures

- Chart "Accepted by" with provider's name
- "Electronically signed by" with provider's name
- "Verified by" with provider's name
- "Reviewed by" with provider's name
- "Released by" with provider's name
- "Signed before import by" with provider's name
- Digitalized signature: Handwritten and scanned into the computer

Acceptable Electronic Signatures

- "This is an electronically verified report by John Smith, MD"
- "Authenticated by John Smith, MD"
- "Authorized by: John Smith, MD"
- "Digital Signature: John Smith, MD"
- "Confirmed by" with provider's name
- "Closed by" with provider's name
- "Finalized by" with provider's name
- "Electronically approved by" with provider's name

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Amendments, Corrections and Delayed Entries in Medical Documentation

Amendments

- Occasionally certain entries related to services provided are not properly documented
- Documentation will need to be amended, corrected, or entered after reviewing the service
  - The MAC will consider submitted entries that comply with the recordkeeping principles

Recordkeeping Principles

- Documents submitted to MACs containing amendments, corrections or addenda must
  1. Clearly and permanently identify any amendment, correction or delayed entry as such, and
  2. Clearly indicate the date and author of any amendment, correction or delayed entry and original date of entry being corrected
  3. Clearly identify all original content, without deletion

Recordkeeping Principles

- Paper medical records
  - When correcting, these principles are generally accomplished by
    - A single line strike through so original content can still be read, and
    - Author of the alteration must sign and date revision
  - Must be clearly signed/dated upon entry

Recordkeeping Principles

- Electronic health records
  - Principles specified previously remain necessary
  - EHRs containing amendments, corrections or delayed entries must
    - Distinctly identify amendment(s), correction(s) or delayed entry, and
    - Provide reliable means to clearly identify the original content, altered content, as well as date and authorship of each modification of the record

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Electronic Prescribing (E-Prescribing)

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E-Prescribing for Part B Medications (Other than Controlled Substances)

- MAC reviewers will accept as a valid order any Part B medications, other than controlled substances, ordered through a qualified e-prescribing system
  - For medical review purposes, e-prescribing system must meet all 42 CFR Section 423.160 requirements
  - [Standards for Electronic Prescribing, 42 CFR 423.160]

E-Prescribing for Part B Controlled Substance Medications

- MAC reviewers will only accept hardcopy pen and ink signatures as evidence of a medication order
  - The DEA is in the process of establishing requirements for electronic prescriptions

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FAQs

FAQ

- What is required for a valid signature?
  - The following criteria must be met
    - Services provided/ordered must be authenticated by the ordering practitioner
    - Signatures are handwritten, electronic, or stamped (stamped signatures are only permitted in the case of an author with a physical disability who can provide proof of an inability to sign due to a disability); and
    - Signatures are legible
  - CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3, Section 3.3.2.4 - Signature Requirements

FAQ

- What should I do if I have not signed an order/medical record?
  - Retroactive signatures are not acceptable
  - Submit an attestation statement
  - If an order for tests is unsigned, you may submit progress notes showing intent to order the tests
  - Progress note must specify what tests were ordered
  - CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3, Section 3.3.2.4 - Signature Requirements

FAQ

- What do I do if the signature is not legible?
  - Submit a signature log or attestation
  - If original record contains a printed signature below illegible signature, this is acceptable
  - CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3, Section 3.3.2.4 - A Handwritten Signature

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FAQ

- What if there is no signature log currently in place?
  - A signature log can be created at any time

FAQ

- Can I attest to my signature?
  - Yes, you can attest that a signature is your own
  - [CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3, Section 3.3.2.4.C – Signature Attestation Statement]

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FAQ

- Can I automatically send a signature log/attestation with the medical documentation?
  - Yes. This will help avoid delays in the review process

FAQ

- Do signatures need to be dated?
  - Documentation must contain enough information to determine the date the service was performed/ordered
  - CMS IOM Publication 100-08, *Medicare Program Integrity Manual,* Chapter 3, Section 3.3.2.4.H – Signature Dating Requirements

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FAQ

- What are the guidelines for electronic signatures?
  - Systems/software must include protections against modification
  - Apply administrative safeguards
  - Part B providers must use a qualified electronic prescribing system
  - CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3, Section 3.3.2.4.E-F – Electronic Signatures and Electronic Prescribing

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FAQ

- Who needs to sign the medical record for incident to services?
  - The supervising physician does not need to sign
    - He/she must be present in the office
    - It has to be a follow-up visit to a care plan already in place

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FAQ

- Can someone from the same medical practice sign a record in the absence of the ordering physician's signature?
  - **No.** Even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements.

References

References

- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3
- MLN® Fact Sheet: *Complying with Medicare Signature Requirements*
- MLN Matters® *MM6698 Revised: Signature Guidelines for Medical Review Purposes*
- NGS YouTube Video: Medicare Signature Guidelines
- Change Request 8219: Use of a Rubber Stamp for Signature

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Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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