Documentation Signature Requirements

The treating physician's signature must be present in the documentation associated with all services submitted to Medicare. Medicare requires that the signature be a legible identifier for the provided/ordered services. The physician's signature can be in the form of either a handwritten signature or an electronic signature. Stamped signatures (i.e. rubber stamps) are not acceptable signatures.

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. 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 is 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 following are the signature requirements that claims reviewers will apply, should your claim be subject to medical review from TrailBlazer[SM] or the Comprehensive Error Rate Testing (CERT) contractor. Additional information on the signature guidelines is located within the *Medicare Program Integrity Manual*, Chapter 3, Section 3.4.1.1.B.c.

Handwritten Signatures

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, the contractor shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

- **Signature Log:** Providers will sometimes include 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.
- **Attestation Statement:** For an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the sufficient information to identify the beneficiary.
  - Claims reviewers will not consider attestation statements when there is no associated medical record entry or 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 will consider all attestations that meet the guidelines 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.
- If a signature is missing from an order, claims reviewers will disregard the order during review of the claim.

Below are examples of signature and medical review decision guidelines:

- When the guidelines indicate **signature requirements met,** the reviewer will consider the entry.
- When the guidelines indicate **contact provider and ask a non-standard follow-up question,** the contractor will contact the person or organization that billed the claim and ask if they would like to submit an attestation statement or signature log within 20 calendar days. The 20-day time frame begins once the contractor makes actual phone contact with the provider or on the date the request letter is received at the post office.
- 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.

		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 three 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: a) a signature log, or		X

	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 provider's 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

Electronic Signatures

Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternative signature methods. The individual whose name is on the alternative signature method and the provider bear the responsibility for the authenticity of the information being attested to. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods.

The following are examples of **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 by" with provider's name.
- "Signed before import by" with provider's name.
- "Signed: John Smith, M.D." with provider's name.
- Digitalized signature: Handwritten and scanned into the computer.
- "This is an electronically verified report by John Smith, M.D."
- "Authenticated by John Smith, M.D."
- "Authorized by: John Smith, M.D."
- "Digital Signature: John Smith, M.D."
- "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.

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 for Part B Drugs

- Reviewers will 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.
- Reviewers will accept as a valid order any drugs “incident to” Durable Medical Equipment (DME), other than controlled substances, ordered through a qualified E-prescribing system.
- When Part B drugs and/or drugs “incident to” DME, other than controlled substances, have been ordered through a qualified E-prescribing system, the reviewer will **not** require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.
- When reviewing claims for controlled substance drugs, the reviewer will only accept hardcopy pen and ink signatures as evidence of a drug order.

Ordering Diagnostic Tests

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/ practitioner 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. Tests not ordered by the physician/ practitioner who are treating the beneficiary are not reasonable and necessary.

An “order” is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (e.g., if test X is negative, then perform test Y). An order may be delivered via the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed or faxed to the testing facility. **NOTE:** No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule or for physician pathology services;
- A telephone call by the treating physician/practitioner or his/her office to the testing facility; and
- An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

If the order is communicated via telephone, both the treating physician/practitioner or his/her office and the testing facility must document the telephone call in their respective copies of the beneficiary’s medical records. While a physician order is not required to be signed, the physician must clearly document, in the medical record, his or her intent that the test be performed.

Additional Guidance

Providers should not add late signatures to the medical record, but make use of the signature authentication process. When medical records are requested, you may notice changes within the request letter. To meet the requirements for signatures, additional documentation (attestation statement or signature log) may need to be submitted with your medical records.