



Physician Signature Requirements for Medical Record Documentation

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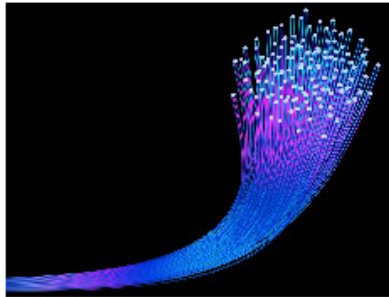


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Authentication Methods

For medical review purposes, Medicare requires that services provided/ordered be authenticated in the medical record. The method used shall be a hand written or an electronic signature. **Stamp signatures are not acceptable.**

John Q. Public



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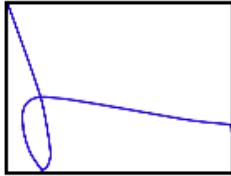
[John Q. Public](#)

Signatures

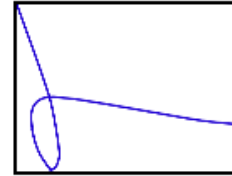
A handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation. Let's review examples of an unacceptable signature and an acceptable signature.

Roll your cursor over the samples for an explanation.

Unacceptable



Acceptable



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A handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation. Let's review examples of an unacceptable signature and an acceptable signature.

John Q Public, MD

If a signature is illegible, as shown in this example, and there is no typed or printed name identifying the author of the signature, then it is unacceptable.





If the signature is illegible, Medicare will consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

If a signature is illegible, it must be accompanied by a legible identifier.

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 can be included on the actual page where the initials or illegible signature are used or might be a separate document.

Sample Signature Log

Name with Credentials	Signature as used in medical records	Alternate forms of signature or initials used in records	Date
John Q. Public, M.D.		JQP	01/10/2015
David Smith, D.O.		D.S.	01/10/2015
Agnes Miller, MA		AM	01/10/2015
Jimmy James, FNP		JJ	01/10/2015

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Signature Attestation Statement

If signatures are missing or illegible, providers may 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."

Note: While this is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.

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Documentation Timeframe

If an attestation statement or a signature log is requested to authenticate a medical record, the organization that billed the claim must submit the documentation to the requestor within **20 calendar days**.

The **20-day** timeframe begins when:

The reviewer makes actual phone contact with the provider, or the reviewer's request letter is received by the U.S. Postal Service (date on the request) Example: request letter is dated 06.01, you have until 06.20 to have the information to us.

First Coast has set up a faxination account for this process and will inform you of the fax number if we need you to submit the attestation statement or signature log for authentication. This faxination is for this purpose only and all other material submitted will not be taken into consideration.

To read more on the 20-day timeframe for additional documentation requests, click this link:
https://medicare.fcso.com/signature_requirements/169692.asp

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Electronic Signatures

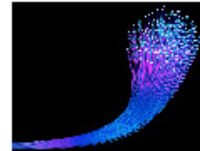
Providers using electronic signatures need to recognize that there is a potential for misuse or abuse.

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.

The following must use a qualified electronic prescribing (e-prescribing) system:

- Part B providers
- Prescriptions for drugs incident to Durable Medical Equipment (DME)



Reference:

Complying with Medicare Signature Requirements Fact Sheet

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

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Signature requirements - exceptions

Exception 1: Facsimiles 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 some clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub.100-02 chapter 15, §80.6.1 state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation (e.g., a progress note) by the treating physician 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.



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Signature requirements - exceptions (cont'd)

Exception 3: Other regulations and the CMS' instructions regarding conditions of payment related to 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 needs to 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, etc.) 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 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.

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e-Prescribing (eRx) signature requirements

Electronic prescribing is the transmission of prescription or prescription-related information through electronic media. Health care professionals can electronically transmit new prescriptions as well as responses to renewal requests directly to a pharmacy through a qualified eRx system, which eliminates the necessity for writing or faxing prescriptions for non-controlled substances.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 423
[CMS-0018-IFC]
RIN 0938-A042

Medicare Program; Identification of Backward Compatible Version of Adopted Standard for E-Prescribing and the Medicare Prescription Drug Program (Version 8.1)

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.
ACTION: Interim final rule with comment period.

Note: CMS defines a “qualified eRx system” as one that meets the Medicare Part D requirements described in Standards for Electronic Prescribing (42 CFR 423.160)

<https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads/cms0018ifc.pdf>

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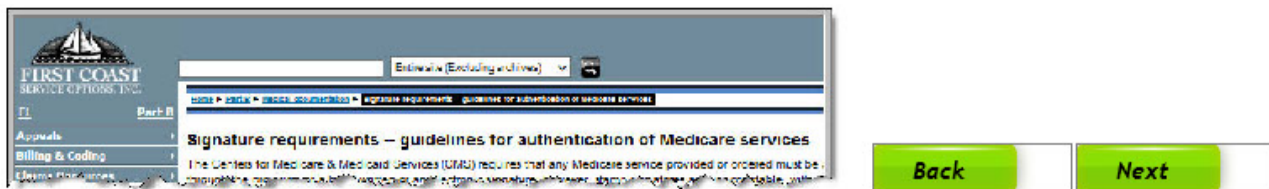
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e-Prescribing (eRx) signature requirements (cont'd)

- e-Prescribing for Part B drugs: Non-controlled substances -- if a provider submits an order for a non-controlled substance through a qualified eRx system, the provider is not required to produce a signed hardcopy as evidence to substantiate the drug order.
- e-Prescribing for Part B drugs: Controlled substances -- the Drug Enforcement Agency (DEA) does not permit the prescribing of controlled substances through e-Prescribing systems; therefore, only a signed (pen and ink) hardcopy of the prescription will be accepted as evidence to substantiate a drug order for controlled substances.

Note: For additional information, please visit *Signature requirements -- guidelines for authentication of Medicare services*: https://medicare.fcso.com/signature_requirements/166303.asp



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References

To find out the critical provider information you need to know regarding the signature requirements, click the following links:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6698.pdf>

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf>

To read the entire CMS manual section addressing the signature requirements including contractor instructions, click on the following link:

[Medicare Program Integrity Manual, Chapter 3, Verifying Potential Errors and Taking Corrective Actions, section 3.3.2.4 Signature requirements](#)

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