Frequently Asked Questions: Signature Requirements

Change Request (CR) 6698 - Signature Guidelines for Medical Review Purposes
http://www.cms.gov/Transmittals/downloads/R327PI.pdf

In addition to the Centers for Medicare & Medicaid Services (CMS) regulations and guidance, providers are encouraged to refer to federal, state and their office/facility internal documentation compliance guidelines.

In our multispecialty group, we do several ancillaries – CT, Echocardiography, ECG, Pulmonary Function testing, lab and x-ray. Are we required to have a signed order?

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 the Medicare Benefit Policy Manual, 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. The progress notes must specify what tests are being ordered.

Refer to the CMS CERT Signature FACT sheet and CR 6698 in the direct link:
http://www.CMS.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

March 2011

The practitioner must separately date and time his/her signature authenticating an entry, even though there may already be a date and time on the document, since the latter may not reflect when the entry was authenticated. Does this mean that even if the physician writes the order with a date and time that he must also authenticate his signing the order with the date and time?

Yes. Excerpt from The State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals states:
http://cms.gov/manuals/Downloads/som107ap_a_hospitals.pdf

The practitioner must separately date and time his/her signature authenticating an entry, even though there may already be a date and time on the document, since the latter may not reflect when the entry was authenticated. For certain electronically-generated documents, where the date and time that the physician reviewed the electronic transcription is automatically printed on the document, the requirements of this section would be satisfied. However, if the electronically-generated document only prints the date and time that an event occurred (e.g., EKG printouts, lab results, etc.) and does not print

the date and time that the practitioner actually reviewed the document, then the practitioner must either authenticate, date, and time this document itself or incorporate an acknowledgment that the document was reviewed into another document (such as the H&P, a progress note, etc.), which would then be authenticated, dated, and timed by the practitioner.

According to the information that I have from the 2009 State Interpretive guideline, the date and time requirement does not apply to these types of orders. It states: The requirements for dating and timing <u>do not apply</u> to orders or prescriptions that are generated outside of the hospital until they are presented to the hospital at the time of service. Once the hospital begins processing such an order or prescription, it is responsible for ensuring that the implementation of the order or prescription by the hospital is promptly dated, and timed in the patient's medical record. Does this mean that the hospital is responsible for signing off orders with the date and time once the patient presents for the procedure or service?

Yes.

March 2011

Is the signature attestation valid for use if an *order* is present but is not signed? Is the signature attestation valid ONLY for use on OTHER medical record entries?

No, the signature attestation is not valid for an unsigned order. If an order is unsigned, providers may submit signed progress notes for the service(s) ordered. If the order was for diagnostic tests, the progress notes must document intent to order the tests and specify what tests are being ordered. A note stating "Ordering Lab" is not sufficient.

If the practitioner's signature is missing from the medical record, an attestation statement from the author of the medical record can be submitted for authentication.

Refer to the CMS CERT Signature FACT sheet for signature education:
http://www.CMS.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

March 2011

Is there a distinction made for orders to "admit to inpatient"?

No. Inpatient status begins at the time the inpatient order is written by the physician.

March 2011

Is a superbill acceptable as an order?

No, Cahaba GBA does not accept a superbill as an order.

March 2011

What is required in a "signature log"? Is this narrowly defined as a log of typed names with corresponding formal and informal signatures? Or can it be any method of identifying the author of an entry, e.g., the signature on the back of the medical staff membership application that corresponds with the legible name on the application, or alternatively, the 4-digit identifier that correlates to the physician name?

A signature log 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 may be a separate document.

Cahaba GBA reviewers may encourage providers to list their credentials in the signature log. However, reviewers shall not deny a claim for a signature log that is missing credentials. All submitted signature logs are considered regardless of the date they were created.

Refer to Change Request (CR) 6698 - Signature Guidelines for Medical Review Purposes
http://www.cms.gov/Transmittals/downloads/R327PI.pdf

What are the signature requirements for physician orders?

Hospitals must ensure that all orders, including verbal orders, are dated, timed, and authenticated promptly. For further education on physician orders, refer to the State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals § 482.24 c (1)(i)&(ii): http://cms.gov/manuals/Downloads/som107ap_a_hospitals.pdf.

March 2011

Would a supervising physician have to sign behind a non-physician professional, e.g., NP, PA, if that person has his/her own NPI (provider number)?

There are specific Medicare regulations and guidelines for the non-physician practitioners. The non-physician practitioner must be a licensed professional in their specialty authorized by the state in which services are furnished within the scope of practice in accordance with state laws. Because state laws and regulations differ for each state, non-physician practitioners are encouraged to review their state laws governing their specialty, as well as state and national professional association regulations.

A supervising physician counter signature is required after a nurse practitioner documentation/signature that work **incident to** a supervising physician. Refer to incident to guidelines in the Medicare Benefit Policy Manual - Chapter 15; section 60 - Incident To:
http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

A supervising physician counter signature is not required for a nurse practitioner that has his/her own NPI (provider number) working within the scope of their practice under state laws as an independent nurse practitioner.

Most states require a counter signature by a supervising physician for physician assistant services. Physician assistants are encouraged to refer to state laws and regulations governing the scope of practice

for their specialty. The American Academy of Physician Assistants (AAPA) web site lists a summary of state laws and regulations that address physicians review or co-sign of the physician assistant medical record entries at:

AAPA website: Federal and State Advocacy – Laws and Regulations:
http://www.aapa.org/the_pa_profession/federal_and_state_affairs/resources/item.aspx?id=755

Additional Medicare references for non-physician practitioners are below:

- The Medicare Learning Network® (MLN) Products Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants (APRN/AA/PA) page provides Medicare information and resources for APRN/AA/PAs.
- Medicare Claims Processing Manual - Chapter 12; section 120 - Physician/Practitioner Billing
- Medicare Benefit Policy Manual - Chapter 15: PA and CRNP in sections 190 and 200

March 2011; revised August 2011; revised January 2012

Our out of town physician orders are usually faxed or brought in with the patient, usually signed, but should they come to us not signed, how do we handle?

If an order is unsigned, providers may submit signed progress notes for the service(s) ordered. If the order was for diagnostic tests, the progress notes must document intent to order the tests and specify what tests are being ordered. A note stating "Ordering Lab" is not sufficient.

If the practitioner's signature is missing from the medical record, an attestation statement from the author of the medical record may be submitted for authentication.

Refer to the CMS CERT Signature FACT sheet guidelines:
http://www.CMS.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

Should these reports have physician's signature, date and time when signed?

The State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Interpretive Guidelines §482.24(c)(1) states: All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

Reference: The State Operations Manual Appendix A
http://cms.gov/manuals/Downloads/som107ap_a_hospitals.pdf

March 2011

When you fax a report back and forth trying to obtain a signature, you will lose the quality of the report. Are Dr's, NP, PA required to sign their credentials after their names when signing orders?

Cahaba GBA encourages providers to include credentials with signatures in the medical record to identify the practitioner performing the service. If the signature and credentials are illegible, a signature log is acceptable. However, reviewers shall not deny a claim for a signature log that is missing credentials.

March 2011

Can doctors working in the same practice sign orders for each other? One doctor has ordered but another signs the order.

CMS Transmittal 327 CR 6698, states physicians cannot sign for the other physicians.
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).

However, an exception for verbal orders is located in the CMS IOM 100-07 Interpretive Hospital Guidelines in §482.24(c) (1) (i) and §482.24(c) (1) (ii):

482.24(c)(1)(i) - All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted in paragraph (c)(1)(ii) of this section.

482.24(c)(1)(ii) - For the 5 year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to write orders by hospital policy in accordance with State law.

In some instances, the ordering practitioner may not be able to authenticate his or her verbal order (e.g., the ordering practitioner gives a verbal order which is written and transcribed, and then is "off duty" for the weekend or an extended period of time). In such cases, for a temporary period expiring on January 26, 2012, it is acceptable for another practitioner who is responsible for the patient's care to authenticate the verbal order of the ordering practitioner. CMS provided this temporary exception in order to take account of differences among hospitals in their rate of adoption of electronic medical record systems that would permit the ordering practitioner to easily and efficiently authenticate an order in all circumstances.

March 2011

We are an independent Radiology practice and billing service. One of the expectations mentioned is a clinical diagnostic test does not have to be signed as long as the medical record shows intent for the service to be performed. We do not always have access to the patient's medical records from the referring physician. Your recommendation?

Providers that bill Medicare services are responsible for submitting supporting medical record documentation, if requested for review of services.

The Medicare Claims Processing Manual, PUB 100-04, Chapter 34, section 10.3 states:
If a claim is suspended for medical review, an Additional Documentation Request (ADR) may be issued to obtain information needed to make a determination. Providers, physicians, and suppliers are responsible for providing the information needed to adjudicate their claims. If no response is received to the ADR within the specified timeframes, the medical review department will likely deny the service as not reasonable and necessary based on a lack of documentation.

March 2011

If you use Electronic PCR's for an ambulance service. If the computer does not capture the signatures, can a back-up signature form be used along with the EPCR?

Cahaba GBA encourages providers to complete medical records with appropriate signature documentation initially to avoid delays in the completion of a review, if applicable. This would include a signature log or attestation, if needed. The appropriate signature method is a handwritten or electronic signature. Providers are encouraged to contact their electronic medical record vendor for guidelines on printing electronic medical records with signatures.

March 2011

Would it be acceptable if you have a stamped signature, can you have the provider go back and sign next to the stamp?

No. Stamped signatures and backdated medical records are not acceptable. The appropriate signature method is a handwritten or electronic signature. Refer to CR 6698:
http://www.cms.gov/Transmittals/downloads/R327PI.pdf

March 2011

In nursing homes, are primary care physicians the only ones who can sign orders for residents or can physician assistants, nurse practitioners, advanced practice nurses, etc., sign orders?

The Code of Federal Regulations (CFR) addresses the delegation of tasks in Skilled Nursing Facilities (SNFs) and nursing facilities. Refer to 42 CFR Public Health § 483.40 Physician Services:

4 (e) *Physician delegation of tasks in SNFs.* (1) Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who;

(i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State;

(ii) Is acting within the scope of practice as defined by State law; and

(iii) Is under the supervision of the physician.

(2) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.

(f) *Performance of physician tasks in NFs.* At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.

Medicare Information for Advanced Practice Nurses and Physician Assistants:
http://www.cms.gov/MLNProducts/downloads/Medicare_Information_for_APNs_and_PAs_Booklet_ICN901623.pdf

March 2011

What should I do if I haven't signed an order or medical record?

Medicare does not accept retroactive orders. Late signatures may not be added to the medical records (beyond the short delay that occurs during the transcription process). If an order is unsigned, providers may submit signed progress notes for the service(s) ordered. If the order was for diagnostic tests, the progress notes must document intent to order the tests and specify what tests are being ordered. A note stating "Ordering Lab" is not sufficient.

If the practitioner's signature is missing from the medical record, providers can submit an attestation statement from the author of the medical record.

Refer to the CMS CERT Signature FACT sheet guidelines:
http://www.CMS.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

March 2011

If my practice has a documented standing order policy that a urinalysis be performed for specific conditions/diagnoses, will this suffice for intent on patients with those diagnoses?

A standing order would not satisfy documentation of intent. While CMS does not require an order for a clinical diagnostic test, the physician must document the intent for each test performed and specify the type of test. The progress notes must contain a handwritten or electronic signature.

Refer to the CMS CERT Signature FACT sheet:
http://www.CMS.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

May 2011

Does the electronic signature have to be a perfect match to the physician medical license or the provider enrollment forms or can it be the name that everyone knows the doctor by and the name

that he goes by? For example, if the doctor's name is "William Doe" on his medical license and provider enrollment forms, can his electronic signature on the EMR be "Bill Doe, MD"?

Or if the provider's name is "June Nancy Doe", can the electronic signature be written with "Nancy Doe, NP?

The physician's printed name should be the same as the name on the license and provider enrollment form. If the group practice supplies a list of illegible signatures in column 1, followed by a list of printed names in column 2; the list of printed names should be the same as the name on the medical license and provider enrollment form. The provider may print his name and alternate forms of his signature or initials used in the medical records directly under his signature.

May 2011

Our physicians are based at a teaching hospital. Sometimes they have their residents dictate operative notes. I have some questions regarding making corrections to medical records. If something is missing from an op note, and the resident or attending physicians does an addendum to medical record, will the physician electronic signature suffice, or must the date of the signature be on or after the date of the addendum? What things need to be addened? If the diagnosis is missing or operation performed, name of doctor, these things...do they require an addendum if they are missing?

If an addendum is added to the medical record to indicate correct information, the addendum must include the date it was created, the time and signature of the physician. The physician creating the addendum should determine what missing documentation is needed in the medical record. The appropriate signature method is a handwritten or electronic signature.
Medicare does not accept retroactive orders. Late signatures may not be added to the medical records (beyond the short delay that occurs during the transcription process). If an order is unsigned, providers may submit signed progress notes for the service(s) ordered. If the order was for diagnostic tests, the progress notes must document intent to order the tests and specify what tests are being ordered.

If the practitioner's signature is missing from the medical record, an attestation statement from the author of the medical record may be created. 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.

In addition to office and or hospital compliance guidelines, refer to the following CMS references for additional signature and medical record documentation information:

Guidelines for Teaching Physicians, Interns, and Residents:
http://www.cms.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf

Publication 100-07 - The State Operations Manual Appendix A - Interpretive Guidelines for Hospitals - §482.24(c) Content of Record: http://cms.gov/manuals/Downloads/som107ap_a_hospitals.pdf

CMS CERT Signature FACT sheet:
http://www.CMS.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

June 2011