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Complying with Medicare Signature Requirements

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

What's Changed?

- Added information about signing documentation written by a medical student

You'll find substantive content updates in dark red font.

Introduction

CMS started the Comprehensive Error Rate Testing (CERT) Program to measure improper payments in the Medicare Fee-for-Service (FFS) Program. Under CERT, we review a random sample of all Medicare FFS claims to determine if we paid them properly under Medicare coverage, coding, and billing rules.

Two contractors manage the CERT Program: CERT Statistical Contractor (CERT SC) and CERT Review Contractor (CERT RC).

The CERT SC determines Medicare claims sampling and calculates the improper payment. Visit the CMS CERT webpage to review CERT Improper Payments Reports.

The Medicare Learning Network® (MLN), with the CERT Part A and Part B (A/B) and Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Outreach & Education Task Forces, developed this fact sheet to describe common CERT Program signature requirements errors. It helps providers and their clinical and office staff understand documentation supporting a Medicare claim for medical services and supplies.

Medicare Signature Requirements

Documentation must meet Medicare's signature requirements. Medicare claims reviewers look for signed and dated medical documentation meeting Medicare signature requirements. If entries aren't signed and dated, they may deny the associated claims.

FAQs

How do we define a handwritten signature?

A mark or sign the ordering or prescribing physician or Non-Physician Practitioner (NPP) makes on a document signifies knowledge, approval, acceptance, or obligation.

What if I use a scribe when documenting medical record entries?

Even if a scribe dictates the entry on your behalf, you must sign the entry to effectively authenticate the documents and care you provided or ordered. It's unnecessary to document who transcribed the entry.

What is required for a valid signature?

A valid signature must be:

- For services you provided or ordered
- Handwritten or electronic
  - We allow stamped signatures if you have a physical disability and can prove to a CMS contractor you're unable to sign due to that disability
- Legible or can be confirmed by comparing to a signature log or attestation statement

How do we treat orders differently than other medical documentation?

Orders communicate the need for a patient to get a test, procedure, or piece of equipment. Sign orders promptly, and in some cases, **before starting the service**.

Unsigned orders in those situations aren't subject to signature attestation, and the reviewer will disregard them. You can't create missing orders after the fact to backdate a plan of care or other service. If there's no order in the submitted medical record, Medicare will deny payment.

There are some exceptions—for example, we may accept unsigned orders for clinical diagnostic tests if a signed progress note in the record indicates the practitioner's intent to order the test. Get more information on orders at Medicare Benefit Policy Manual, Chapter 15, Section 80.6.1.

Medical documentation includes notes, lab results, clinical observations, and orders.

What should I do if I didn't sign an order or medical record?

You can't add late signatures to orders or medical records (beyond the short delay that happens during the transcription process). We don't accept retroactive orders.

If your signature is missing from the medical record (other than an order), send an attestation statement. We accept a signature attestation for medical documentation, except orders. The attestation must be associated with a medical record and created by the author. Attestations may be considered, regardless of their creation date, unless the regulation or policy indicates the signature must be in place before a given event or date.

Your MAC may offer specific guidance on signature attestation statements, including whether current laws or regulations allow attestation for missing signatures in certain situations.

Do I need to re-document a medical student's documentation of an Evaluation & Management (E/M) visit before I sign the record?

If you rely on the medical student's documentation, it's unnecessary to re-document the E/M service, but you **must** review and verify (sign and date) the student's medical record entry.

What if I signed the order or progress note but my signature isn't legible?

You or your organization may send a signature log or attestation statement to support the identity of any illegible signatures. A printed signature below the illegible signature in the original record is acceptable.

What is a signature log?

A signature log is a typed listing of physicians and NPPs showing their names with a corresponding handwritten signature. This is an individual log or a group log. A signature log shows signature identity throughout the medical record. We encourage, but don't require, physicians and NPPs to list their credentials in the log.

What if I don't have a signature log in place?

You or your organization may create a signature log at any time. CMS contractors accept all sent signature logs regardless of the date you created them.

Can I avoid delays in claim reviews by sending a signature log or signature attestation with my documentation?

We encourage you to send a complete medical record with proper signature documentation first to avoid medical review delays. This includes a signature log or attestation if needed.

Must I date my signatures?

Documentation must have enough information to show the date you ordered or performed the services. If you dated the entries immediately above and below an undated entry, medical review may reasonably assume the entry date in question.

What are the medical review guidelines for using an electronic signature?

The medical review guidelines for using an electronic signature are:

- Systems and software products must include protections against modification, and you should apply administrative safeguards that meet all standards and laws.
- The individual's name on the alternate signature method and the provider accept responsibility for the authenticity of attested information.
- Order Part B medications, other than controlled substances, through a qualified e-prescribing system.
- Order medications incident to DME, other than controlled substances, through a qualified e-prescribing system. Reviewers shouldn't require the provider produce hardcopy pen and ink signatures as evidence of a medication order.

Check with your attorneys and malpractice insurers before using alternative signature methods.

Resources

- Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4
- MLN Matters® Article SE1419, Medicare Signature Requirements: Educational Resources for Health Care Professionals

The Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) and Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Outreach & Education Task Forces are independent from the Centers for Medicare & Medicaid Services (CMS) CERT team and CERT contractors, which are responsible for calculation of the Medicare Fee-for-Service improper payment rate.