If a contractor chooses to allow supporting paper documentation to be submitted with the claim for medical review purposes the contractor shall inform providers in their jurisdiction of that fact (see Pub. 100-08, PIM, chapter 3, §3.5).

D. Signature Requirements

All signature requirements in this CR are effective for CERT reviews retroactively for the November 2010 report period. All signature requirements for ACs, MACs, PSCs and ZPICs are applicable for reviews conducted on or after 30 days after the issuance of this CR.

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

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. This 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 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) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

The AC, MAC and CERT reviewers shall apply the following signature requirements:

If there are reasons for denial unrelated to signature requirements the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation which contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process.

1. Handwritten Signature

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, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

- If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT **shall disregard the order** during the review of the claim.

- If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.

a. 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 might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers may encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials. Reviewers shall consider all submitted signature logs regardless of the date they were created. Reviewers are encouraged to file signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log may be needed again.

b. Signature Attestation Statement

Providers will sometimes include in the documentation they 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 hearby 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."

While this is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.

NOTE: Reviewers shall NOT consider attestation statements where there is NO associated medical record entry. 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). Reviewers shall consider all attestations that meet the above requirements 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. For example, if a policy states the physician must sign the plan of care before therapy begins, an attestation can be used to clarify the identity associated with an illegible signature but cannot be used to "backdate" the plan of care.

c. Signature Guidelines

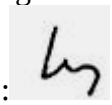
The guidelines below will assist reviewers in determining whether to consider the signature requirements met.

- In the situations where the guidelines indicate "**signature requirements met**," the reviewer shall consider the entry.

In situations where the guidelines indicate "**contact billing provider and ask a non-standardized follow up question"** the reviewer shall contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins once 1) the contractor makes an actual phone contact with the provider or 2) the date the request letter is received by the post office. If the biller submits a signature log or attestation, the reviewer shall consider the contents of the medical record entry. In cases where the provider submits an attestation, the time frame for completing the review is 75 days rather than 60 days.

NOTE: Reviewers shall **NOT** contact the **biller when the claim should be denied for reasons unrelated to the si**gnature requirement.

- Contractors shall document their contact with the provider and/or other efforts to authenticate the signature.

		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 **o**f the signator. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists 3 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: a signature log, or an attestation statement	X	
6	Illegible Signature NOT over a typed/printed name, NOT on letterhead and the documentation is **UNaccompanied** by: a signature log, or an attestation statement Example: 		X
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but **accompanied** by: a signature log, or an attestation statement	X	
9	Initials NOT over a typed/printed name **UNaccompanied** by: a signature log, or an attestation statement		X
10	Unsigned typed note with provider's typed name		X

	Example: John Whigg, MD		
11	Unsigned typed note without providers 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

2. Electronic Signatures

Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For 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.

3. 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 can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care.

A "qualified" e-prescribing system is one that meets the Medicare Part D requirements described in 42 CFR 423.160 (Standards for Electronic Prescribing)

a. E-Prescribing for Part B Drugs (Other than Controlled Substances)

The AC, MAC, CERT, PSC and ZPIC reviewers shall 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. When Part B drugs have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.

b. E-Prescribing for Part B Controlled Substance Drugs

Currently, the Drug Enforcement Agency does not permit the prescribing of controlled substance drugs through e-prescribing systems. Therefore, AC, MAC, CERT, PSC, and ZPIC reviewers shall NOT accept as a valid order any controlled substance drugs that are ordered through any e-prescribing system, even one which is qualified under Medicare Part D. When reviewing claims for controlled substance drugs, the reviewer shall only accept hardcopy pen and ink signatures as evidence of a drug order.

c. E-Prescribing for Drugs Incident to DME

The AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified e-prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified e-prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produced hardcopy pen and ink signatures as evidence of a drug order.

E. Review of Documentation Solicited After Claim Receipt

The process whereby a contractor requests additional documentation after claim receipt is known as "development." Providers selected for review are responsible for submitting medical records requested of them by the contractor within established timeframes. Development requirements are listed below in section 3.4.2.1.

F. Requirements That Certain Tests Must Be Ordered By The Treating Physician

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 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.

G. Diagnosis Requirements

Section 1833(e) of the Act provides that no payment may be made "under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person . . ."Contractors may require information, in accordance with the requirements below whenever they deem necessary to make a determination listed in section 3.4.1 and thus to determine appropriate payment.

Some provider types are required to submit diagnosis codes on all claims while other provider types are required to submit diagnosis codes only if such information is required by an LCD.