Providers Should be Aware of New Signature Requirements in Effect

By Amy K. Fehn, Esq. and Jennifer Colagiovanni, Esq.
Wachler & Associates, P.C.

One way providers can avoid Medicare audit denials is to be aware of and comply with CMS's recently updated signature guidelines. Contractors engaged in medical review activities are instructed to apply the new signature requirements for reviews occurring on or after April 16, 2010.

The new guidelines clarify the signature requirements set forth in the Medicare Program Integrity Manual. Previously, the manual language required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. The new requirements expand on the existing guidelines, requiring that services provided/ordered be authenticated by the author. Handwritten or electronic signatures are listed as acceptable methods of authenticating documentation, whereas stamp signatures are expressly excluded.

With respect to handwritten signatures, the revised manual sections include a table that provides examples of when the signature requirements have and have not been meet. In cases where the requirements have not been met, such as if the signature is found to be illegible, the contractor is instructed to consider a signature log or signature attestation statement to determine the identity of the author. A signature log lists the typed or printed name of the provider associated with initials or an illegible signature. It may also be helpful for providers to list their credentials on the signature log as well. The guidelines require contractors to consider signature logs regardless of the date they were created.

Signature attestation statements are another way for providers to authenticate medical documentation. The attestation must be signed and dated by the author of the medical record entry at issue and must sufficiently identify the beneficiary who was provided or ordered services. It is important for providers to recognize that an attestation cannot take the place of a medical record entry, that is, an attestation statement may not be considered when there is no associated medical record to authenticate.

A signature attestation statement from the author of a medical record will also be considered if the provider's signature is missing from the documentation at issue. This requirement applies to all medical documentation missing a signature *other than an order*. In cases where the provider's signature is missing from an order, contractors are instructed to disregard the order in the review of the claim. The claim is then reviewed as if the order was not included in the medical records submitted. As providers might expect, the absence of an order will almost certainly increase the likelihood of claim denials for most Medicare covered services.

When the signature is illegible or missing, the guidelines require the contractor to contact the billing provider or organization to request that an attestation statement or signature log be submitted. Providers are given 20 calendar days to submit the requested log or attestation, with the timeframe starting on the date the contractor made contact with the provider or the postmark date on a written request letter. If the provider submits the requested information, the contractor

is afforded an additional 15 days to review the claim, thereby extending the timeframe for review from 60 to 75 days.

The signature authentication process is intended to provide a signature assessment in situations where the Medicare criteria is met except for a key piece of documentation which is missing a signature or contains an illegible signature. It is in this case that the contractor is required to initiate the signature authentication process. Contractors are not required to proceed with signature authentication if the claim can be denied for reasons unrelated to the signature requirements. In the context of audit activities, the failure to comply with the signature guidelines essentially creates a denial rationale for what may otherwise be a covered Medicare claim. Providers can prevent unnecessary claim denials by understanding and implementing practices that satisfy the signature guidelines.

One practical measure providers may want to consider is creating signature logs as part of their compliance program before being subject to an audit. This will be particularly important in instances where the person who created the medical record at issue in the audit is no longer employed by the provider or organization. If the signature on the record is illegible, an existing signature log listing the employee's initials or illegible signature could be submitted and considered by the contractor. If a signature log was not created during that individual's employment, it may be difficult or impossible to locate the person for purposes of creating a log to submit. Further, as previously discussed, providers are only given a 20 day timeframe to comply with a request for a signature log or attestation. Also, if the signature log is readily available it can be given to the reviewers at the beginning of an audit.

In the context of prepayment medical reviews and additional documentation request (ADR) letters, contractors may advise providers that in order to comply with the signature requirements, they may need to contact the hospital or other facility where the services were provided in order to obtain a *signed* copy of the medical records. For instance, the copy of a hospital discharge summary kept in the physician's office file may be unsigned, while the copy in the hospital chart is signed and dated. Providers who are billing for services provided in a hospital or other facility may want to proactively have a system for obtaining copies of the signed documentation in the other entity's possession. It may be difficult to quickly obtain copies of the signed documentation needed when trying to timely respond to multiple ADR requests or a post-payment review.