Optometry Coding & Billing Alert

Documentation: Avoid Faltering on Signature Rules & Exceptions With These 3

Useful Tips

Analyze CMS's requirements or you risk the wrong use of signatures.

If you are not aware of CMS documentation guidelines for signatures, you are unnecessarily risking the chances of denial of your claims. Here are some tips that will help you become proficient with the signature requirements.

Tip 1: Know the Signature Rules

You may already know that CMS signature requirements can be found in section 3.3.2.4 of chapter 3 of the Medicare Program Integrity Manual.

According to the policy, Medicare requires that services provided/ordered be authenticated by the billing physician for medical review purposes. The method used must be a legible hand written or an electronic signature with the provider's credentials, and Medicare will not accept stamp signatures. However, you may use a stamp to provide a legible interpretation of the provider's signature, which is still required, notes **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE**, AHIMA-approved ICD-10 CM/PCS trainer and president of Maggie Mac-Medical Practice Consulting in Clearwater, Fla.

Application: The policy is of particular importance to practices that order and perform any diagnostic tests, such as CT scans or imaging studies.

Tip 2: Where There Is A Rule, There Are Exceptions

These signature regulations may be in place, but you can still override them based on the following 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 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.

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 is legible or present and the signature is illegible/ missing, the reviewer shall follow the guidelines in the Change Request to discern the identity and credentials (e.g. MD, RN) of the signature. 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.

The second exception could be applicable to diagnostic testing outlined as intended in the plan of care in the progress note for example, if your FP orders imaging studies based on the history and exam of a patient with dyspnea and chest pain, looking for complications. But under the second exception, even with the intent illustrated in the progress note, there must be authentication by the author via handwritten or electronic signature.

Drawing the line: The CMS Program Integrity Manual specifically considers a handwritten signature to be a mark or a sign by an individual that signifies knowledge, approval, acceptance or obligation. If the signature is illegible, the reviewer should consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

Tip 3: Bear In Mind The Timeliness Of Signatures

Remember, the billing physician should not add late signatures to the medical record beyond the short delay that occurs during the transcription process. Instead, he could make use of the signature authentication process if necessary.

As a correction mechanism for missing signature on the medical report, CMS created the signature attestation statement procedure. You may use this to incorporate reports that were not signed, for instance, and include it with documents requested for an audit.

The instructions for signature attestation statement mechanism include:

- An attestation statement must be signed and dated by the author of the medical record entry.
- An attestation statement must contain sufficient information to identify the beneficiary.
- An attestation statement must be associated with a medical record entry and must be by the author of the medical record entry in question.
- 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 will consider all attestations that meet the guidelines 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.

Important: If someone other than the author of the medical record entry in question signs the attestation statement, Medicare claims reviewers cannot accept them. "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," CMS says.

For more information on these guidelines, check the link at:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf.