

# Medicare Signature and Medical Record Authentication

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Medicare has revised their rules regarding medical record authentication and signature requirements as of November 10, 2021. This revision contained some minor but important points of which providers need to be aware.

Medicare requires that services provided and/or ordered be authenticated by original author who is responsible for the care of that specific patient for that specific encounter. The medical record authentication requirement is the same regardless of how the claim was submitted (by provider's office or billing service). The use of paper records, electronic health records, paper claims or electronic claims submission has no impact on the requirement for record authentication by the provider.

When a provider signs a medical record for a specific service, that provider is also attesting that any entries into that record by staff are being corroborated. Although a good practice, staff or scribes entering medical record information are not required to sign and date their own entries. Medicare considers only the provider of a service as responsible for authenticating the medical record. For any record review, the medical record reviewers have been instructed that the signature requirements are met when the responsible provider has authenticated any particular record.

Medical record signatures must be clearly visible after each entry. The method of signature can be either handwritten or electronic. Each method has some specific guidance. Keep in mind that with very few exceptions, signature stamps are not allowed or an acceptable form of signature. Any illegible signature without a typed or printed name identifying author, accompanied by a signature log or signature attestation is unacceptable. Medicare carriers indicate that late signatures should not be added to any medical record to ensure accuracy of the record. (Palmetto)

**Handwritten Signature:** A handwritten signature is defined as a mark or sign on document indicating that the provider is attesting to, has knowledge of, is approving of, and accepting obligation of and for any documentation in that particular record. All handwritten signatures should be legible and clearly indicate who signed along with the date of signature.

In the event of an illegible signature that is not identified with the printed name, the provider can use a Signature Log, an Attestation Statement or other documentation to identify the signature. Keep in mind that if a record or an order are not signed, a medical reviewer can disregard and disallow order and not allow claim for said ordered procedure, test, or service. (See example below)

**Signature Log:** A signature log is a list containing the typed or printed name of provider with their initials and handwritten signature and provider credentials (although the credentials are not mandatory). While a signature log can be on the actual page of the documentation where the illegible signature or initials are used, typically a signature log is on a separate page. The date a signature log is created is not considered and could be after a request has been made for medical records during a review. One suggested "best practice" would be to keep a signature log of current and past providers on file and accessible in the event it is necessary. (See example below)

**Signature Attestation:** An attestation is a statement signed and dated by the provider responsible for a particular medical record entry and contain information to identify the patient. An attestation form has yet to be standardized although the Office of Management and Budget (OMB) is working on a standardized form as a part of the Paperwork Reduction Act. When OMB issues said form, its use will become mandatory. The date of the creation of a signature attestation is not considered in the event of a medical record review with few exceptions when an attestation cannot be used to backdate a record (e.g.: plan of care signed prior to beginning of therapy). (See example below)

During a medical record review, if the reviewer finds an instance where the signature guidelines are not met and there is no other reason to deny the claim(s), they are instructed to "contact billing provider and ask a non-standardized follow up question" such as "Does the provider wish to submit a signature log or attestation. Providers would be given 20 calendar days for such submission.

**Electronic and digitized signature:** These types of signatures are affixed to an electronic medical record (EHR). All EHR systems and software should protect against any record modifications once the record is signed to prevent any abuse or misuse. Once an electronic or digitized signature has been affixed and time stamped and dated, the record should only be able to be changed via a chart addendum or amendment which is also electronically signed, time stamped and dated. Providers should check with their attorneys to ensure they have adequate administrative procedures in place and all laws and malpractice insurer rules are being followed.

E-signatures must be time stamped, dated, contain the provider's name and professional designation along with a printed statement that indicates acknowledgement of their responsibility for the authenticity of the medical record. (See examples below)

A digitalized signature is an electronic image or a handwritten signature reproduced in its identical form using a pen tablet. This is an "actual" real time signature done electronically (think digital sign-out with a credit card transaction). Digitalized signatures typically use special encrypted software that allows for sole usage, if submitting medical records for a review to Medicare that has a digitized signature, be sure to submit your protocols followed fir digitized signature affixation.

As well, it is important to understand that electronic and digital signatures are not the same as 'auto-authentication' or 'auto-signature' systems when the provider cannot review the medical record prior to signing. As well, statements like 'Signed but not read' are unacceptable. Happy Coding.....

**Attachment 1: Examples of Printed Statements for Electronic Signatures:**

- Electronically signed by
- Signed by
- Authenticated by
- Approved by
- Completed by
- Verified by
- Finalized by
- Confirmed by

**Attachment 2: Examples when Signature Requirements NOT met:**

- Illegible signature NOT over a typed/printed name, NOT on letterhead and documentation is unaccompanied by signature log or attestation statement
- Initials NOT over typed/printed name & unaccompanied by signature log or attestation statement
- Unsigned typed note with provider's typed name
- Unsigned typed note without providers typed/printed name
- Unsigned handwritten note and only entry on page
- "Signature on file"

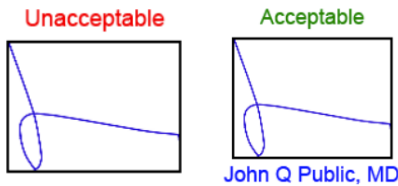
**Attachment 3: Documentation for Completed Medical Record Patient Encounter (Legible):**

- Encounter reason
- Relevant patient history
- Physical examination findings
- Prior diagnostic test results
- Assessment - clinical impression & diagnoses
- Plan of care – including orders for testing or other procedures
- Date and legible provider signature
- Signatures within a day or two OR claim could be denied
- Filing ANY CLAIM prior to record completion is risky, at best

**Attachment 4: Cases Specific Signature Guidance Does Not Apply**

1. Facsimiles of original written/electronic signatures are acceptable for certifications of terminal illness for hospice
2. There are a few cases when an order does not need to be signed if there is signed medical documentation by that provider that they intended to order a specific special service such as a diagnostic test - a test listed in a patient’s Plan of Care, for instance. (42 CFR 410 and Pub.100-02 chapter 15, Section 80.6.1)
3. If there are other CMS’ instructions or signature regulations that exist (regulation, NCD, LCD, or CMS manual) with specific signature instructions, then the other guidance take precedence over instructions in 3.3.2.4 - Signature Requirements.
4. Rubber stamp signature would be permitted only if a provider has a physical disability that prevents them from signing and has provide proof of the disability to their CMS contractor (Rehabilitation Act of 1973).

**Attachment 5: Unacceptable Handwritten Signature**



**Attachment 6: Example of Signature Log**

Family Medical Center Signature Log

Printed Name	Title	Signature	Signature Variations
Larry J. Russell	M.D.	<i>[Handwritten Signature]</i>	<i>[Handwritten Variations]</i>
Deborah Pittillo	F.N.P.-C.	<i>[Handwritten Signature]</i>	<i>[Handwritten Variations]</i>
Joy Ciaccio	F.N.P.-C.	<i>[Handwritten Signature]</i>	<i>[Handwritten Variations]</i>
Linda Brooks	F.N.P.-C.	<i>[Handwritten Signature]</i>	<i>[Handwritten Variations]</i>
Denise Hunt	F.N.P.-C.	<i>[Handwritten Signature]</i>	<i>[Handwritten Variations]</i>

**Attachment 7: Example of Signature Attestation**

"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 hereby 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

**Attachment 8: References:**

- CMS Medicare [Program Integrity Manual \(Pub. 100-08\), chapter 3, section 3.3.2.4](#) [PDF](#)
- CMS [MLN Matters article MM6698](#) [PDF](#) , "Signature Requirements for Medical Review Purposes"
- [Signature Attestation Statement](#) [PDF](#)
- [Acceptable Attestations and Signatures](#)
- Novitas Signature FAQ: <https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00005015>