You can easily avoid an omnipresent problem that emanates from non-compliance with CERT signature requirements:

You’ll want to do that because the risk for noncompliance is not being down-coded, but having your claims denied. Here is a brief guide.

Who May Sign for the Physician

The physician must sign his/her own signature. It is not acceptable for scribes or technicians to sign for the physician. Late or added signatures are not acceptable. Each encounter must be dated. Stamped signatures are not allowed.

What Requires a Signature

Any Medicare service provided or ordered must be authenticated by the provider (physician). This includes office visits, emergency department visits, hospital visits, and diagnostic tests. In other words—everything!

Acceptable Forms of Authentication

An illegible or legible handwritten signature (yes, you are reading this correctly) is acceptable (with caveats). Once again, stamped signatures are not allowed.

Legible signatures. This means an auditor can read it—not that the physician, administrator, or technician can read the handwriting. Acceptable legible signature formats include

- Legible full signature
- Legible first initial and last name

Illegible signatures. This probably means your practice. Actually, there are acceptable forms of illegible signatures:

- Illegible signature placed above a typed or printed name
- Illegible signature accompanied by a signature log (more on this later)
- Illegible signature accompanied by an attestation statement (more on this later, too)

Electronic signatures. CMS is working on guidelines for electronic medical records and has provided the following guidance.

By CMS definition the electronic signature is an electronic sound, symbol, or process attached to or logically associated with an electronic medical record to signify knowledge, approval, acceptance, or obligation by the individual who provided or ordered the services.

Electronic signatures must be authenticated, safeguarded against misuse and modification, and be easily identifiable as electronic, rather than typewritten, signatures.

CMS cautions, “As the individual represented by the electronic signature bears responsibility for the authenticity of the information, physicians are strongly encouraged to check with their attorneys and malpractice insurers regarding the use of alternative signature methods.”

Signature Log

My recommendation is that each practice (even if it is one physician) prepare a signature log in a three-column format that lists

- the typed or printed name of each physician in the practice
- the associated legible or illegible signature sample
- a sample of initials.

If the physician signs in more than one way, add those samples to the log. Include credentialing initials (e.g., MD or DO) after the name. Keep this current. For each request for medical records (from any insurer) this should automatically be placed as the first page.

Signature Attestation Statement

CMS has provided the following attestation statement for current use. This is a one-time use. Each time you use an attestation statement you must prepare another one. It must

continued on page 58
be signed and dated by the physician. You can use this one prepared by Medicare or have your attorney prepare a suitable one.

I, [print full name of the physician/practitioner], hereby attest that the medical record entry for [insert date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., MD] 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 may subject me to administrative, civil, or criminal liability.

Practical Tips
• Prepare a signature log as soon as you read this and include a copy with each request for medical records from each insurer. Keep it up-to-date.
• Never add a late signature. If no signature was originally present, do an attestation.
• A physician cannot sign for another physician.
• Scribes/technicians/ancillary personnel cannot sign the physician’s name.
• All entries must be dated as well as signed.
• If orders for diagnostic tests are missing (they can be contained within the body of the chart documentation as long as that documentation is signed) claims will be denied.
• “Signature on file” is not acceptable.
• For practices using paper, consider revising your examination forms by pre-printing the physicians’ names across the bottom of the last page with a line above each as the place for that person’s signature.
• Make sure your EMR has a way of indicating “electronically signed by [physician’s name]” and prepare a statement outlining your security/methodology for providing access to the medical records.
• Make sure your billing personnel are aware that they may receive a phone call if a chart is under review and meets all criteria except acceptable signature. You then have 20 days to send in either the signature log or an attestation statement—or the claim will be denied.

Note

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