Part B Insider (Multispecialty) Coding Alert

Documentation: Prevent Part B Denials with this Signature Primer

Tip: Know the ins-and-outs on incident-to signature rules.

CPT® and ICD-10 codes are essential requirements for Medicare reimbursement. But, you can't stop there if you hope to collect for your services. Moreover, if you forget to sign your records, you could be putting your income at risk.

"Signature issues are among the biggest findings in the comprehensive error rate testing (CERT) and medical error rate programs, said NGS Medicare's **Gail O'Leary** during the MAC's Sept. 19 webinar "Medicare Signature Guidelines."

Here's why: Medicare requires that services provided or ordered be authenticated by the author, and the method used for authenticating would be a handwritten or electronic signature, O'Leary said. "Stamped signatures are not acceptable with the exception of the author having a physical disability that prevents them from signing the record."

Unsigned documentation or a lack of attestation will result in a claim denial, she noted. "Medicare's definition of a handwritten signature is a mark or sign by an individual on a document to signify their knowledge, approval, acceptance or obligation," O'Leary added.

To ensure that you successfully meet CMS signature guidelines and avoid denials, follow these five steps.

Step 1: Know When the Signature Itself Needs Support

In some cases, the provider will sign a document but the signature isn't necessarily one that would appear legible to the average reviewer. In these cases, you have the option of creating, maintaining, and submitting additional documentation, which can include a signature log and/or an attestation, to demonstrate that the signature actually belongs to the provider in question.

"Providers can sometimes include a signature log in the documentation they submit that lists the type or printed name of the author along with credentials associated with initials for an illegible signature," O'Leary said. "A signature log is a typed listing of the providers identifying their names with corresponding handwritten signatures. This may be an individual log or a group log. A signature log may be used to establish signature identity as needed throughout the medical record documentation."

Providers might also include an attestation statement. To be considered valid by Medicare, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.

At any given time, you can submit an attestation statement, signature log, or a document affirming that the signature belongs to the provider if you find the signature to be illegible. "The signature documents can be submitted routinely for all requests for medical records, so in other words, don't wait for us to ask for it - by all means, send it in," O'Leary said.

Step 2: Determine Who Must Sign

In most cases, the provider who performed or ordered the service will sign the record, but there are situations when coders have questions about who needs to sign. For instance, for an incident-to service, it can be confusing to know which provider should enter a signature on the documentation, but the reality is that the record should be signed by the person who performs the service, not the supervising physician.

"The documentation must support evidence that the supervisor was present and available," O'Leary said. "The documentation submitted to support billing incident to services must clearly link the services of the NPP auxiliary staff to the services of the supervising physician. You want to make sure the name and the professional destination of the

person rendering the service is legible in the documentation for the service."

Step 3: Consider the Exceptions

As with most rules, some exceptions do apply to the signature regulations, said NGS Medicare's **Lori Langevin** during the webinar. The first exception, she said, is that facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

In addition, orders for clinical diagnostic tests need not be signed, but the treating physician must have medical documentation indicating that he intended the clinical diagnostic test to be performed, and that documentation must be authenticated by the author via a handwritten or electronic signature.

The third exception involves other regulations and CMS instructions regarding signatures - these can take precedence sometimes over the standard regulations. "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 will follow guidelines to discern the identity and credentials of the signator," Langevin said. "In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence."

The final exception indicates that CMS permits use of a rubber stamp for signatures in accordance with the Rehabilitation Act of 1973, which states that an author with physical disability has to provide proof of their inability to sign due to their disability. In those cases, a rubber stamp would be permitted.

Step 4: Find out Which E-Signatures Work

If you're wondering which types of e-signatures are acceptable from a Medicare standpoint, Langevin answered that by offering a few examples, as follows:

- "Reviewed by" with provider's name
- "Released by" with provider's name
- Chart "Accepted by" with provider's name
- "Electronically signed by" with provider's name
- "Verified by" with provider's name
- "Signed before import by" with provider's name
- Digitized signature: Handwritten and scanned into the computer
- "Authorized by: John Smith, MD"
- "Digital Signature: John Smith, MD"
- "This is an electronically verified report by John Smith, MD"
- "Authenticated by John Smith, MD"
- "Confirmed by" with provider's name
- "Electronically approved by" with provider's name
- "Closed by" with provider's name
- "Finalized by" with provider's name.

Step 5: Get the Rules on Amendments

Medicare requires you to document services in the medical record at the time of rendering, but in some instances, that isn't always possible. If you realize after the fact that the documentation needs to be corrected, amended, or completed, you must ensure that your amendment is in line with Medicare's amendment regulations.

Know the Records that Require Signatures

Figuring out which medical records require a provider's signature can be a daunting task. Moreover, issues with missing signatures bump up the improper payment rate, create headaches for the MACs, and push claims denials through the roof.

There exists much confusion on the issue as evidenced by the most recent comprehensive error rate testing (CERT) report. The research shows that approximately 64 percent of the improper payment rate is due primarily to insufficient data. Signature issues factor greatly into that high amount, suggests NGS Medicare's **Gail O'Leary**.

Check out the following examples offered by O'Leary last month during the MAC's webinar "Medicare Signature Guidelines":

- Inpatient visits
- Office visits
- Lab/diagnostic orders/requisitions
- Certificates of medical necessity
- Treatment plans/plan of care
- Dictated reports
- Treatment log notes
- Initial evaluations or current reevaluations
- Outpatient visits

Documents submitted to MACs containing amendments, corrections, or addenda must meet the following requirements, Langevin said:

1. Clearly and permanently identify any amendment, correction, or delayed entry as such

2. Clearly indicate the date and author of any amendment, correction, or delayed entry, and original date of entry being corrected

3. Clearly identify all original content, without deletion.

"We're not going to consider undated or unsigned entries handwritten in the margin of a document," she said.

In addition, if there is a correction to make, it should never be erased; a neat cross out can be added if the date and initials of the person making the change is clear; but added information should make clear there was inaccurate information being corrected and indicate what the new information is.