CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 465	**Date: May 17, 2013**
	Change Request 8219

SUBJECT: Use of a Rubber Stamp for Signature

I. SUMMARY OF CHANGES: The purpose of this CR is to clarify the use of a rubber stamp for signature.

EFFECTIVE DATE: June 18, 2013
IMPLEMENTATION DATE: June 18, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.3.2.4/Signature Requirements

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor's activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-08	Transmittal:465	Date: May 17, 2013	Change Request: 8219

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I. GENERAL INFORMATION

A. Background: Medicare claim review contractors (carriers, fiscal intermediaries, Medicare administrative contractors (MACs), the comprehensive error rate testing (CERT) contractor, and recovery audit contractors are tasked with measuring, detecting and correcting improper payments in the fee-for-service (FFS) Medicare program. These contractors review claims and medical documentation submitted by providers.

The purpose of this change request (CR) is to clarify the use of a rubber stamp for signature.

B. Policy: This clarifies and updates the use of a rubber stamp for signature in the Program Integrity Manual.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8219.1	Contractors shall 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.	X	X		X	X	X	X					CERT, RACs, ZPICs

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8219.2	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X		X	X	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Charlene Harven, 410-786-8228 or charlene.harven@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractor's activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

3.3.2.4 - Signature Requirements

(Rev.465, Issued: 05-17-13, Effective: 06-18-13, Implementation: 06-18-13)

This section is applicable for MACs, CERT, and ZPICs. This section does not apply to Recovery Auditors.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

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 some clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and Pub.100-02 chapter 15, §80.6.1 state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation (e.g., a progress note) by the treating physician 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 the CMS' instructions regarding conditions of payment related to 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 needs to be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g., MD, RN, etc.) of the signator. 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.*

NOTE: Conditions of participation (COP) are not conditions of payment.

If MAC and CERT reviewers find reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation that contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead should make use of the signature authentication process. The signature authentication process described below should also be used for illegible signatures.

A. Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

- If the signature is illegible, MACs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

- If the signature is missing from an order, MACs and CERT **shall disregard the order** during the review of the claim (e.g., the reviewer will proceed as if the order was not received).

- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.

B. Signature Log

Providers will sometimes include a signature log in the documentation they submit that lists the typed or printed name of the author associated with initials or illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers should encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials. Reviewers shall consider all submitted signature logs regardless of the date they were created. Reviewers are encouraged to file signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log may be needed again.

C. Signature Attestation Statement

Providers will sometimes include an attestation statement in the documentation they submit. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

Should a provider choose to submit an attestation statement, they may choose to use the following statement:

"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 may subject me to administrative, civil, or criminal liability."

Although this format is acceptable, the CMS currently neither requires nor instructs providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers. However, since no form for signature attestation has been approved by the Office of Management and Budget (OMB), the contractors should not give the providers any standard format on which to submit the attestation. Once the OMB has assigned an OMB Paperwork Reduction Act number to this attestation form, its use will be mandatory.

Note: The MACs and CERT shall NOT consider attestation statements where there is no associated medical record entry. Reviewers shall NOT consider attestation statements from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements). Reviewers shall consider all attestations that meet the above requirements 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. For example, if a policy states the physician must sign the plan of care before therapy begins, an attestation can be used to clarify the identity associated with an illegible signature. However, such attestation cannot be used to "backdate" the plan of care.

D. Signature Guidelines

The guidelines below will assist in determining whether to consider the signature requirements met:

- In the situations where the guidelines indicate **"signature requirements met,"** the reviewer shall consider the entry.

- In situations where the guidelines indicate **"contact billing provider and ask a non-standardized follow up question,"** the reviewer shall contact the person or organization that billed the claim and ask if the billing entity would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins on the date of the telephone contact with the provider or on the date the request letter is received by the provider. If the biller submits a signature log or attestation, the reviewer shall consider the contents of the medical record entry.

- In cases where a reviewer has requested a signature attestation or log, the time for completing the review is extended by 15 days. This extension starts upon receipt of the signature attestation or log.

- The MACs, CERT and ZPICs shall document all contacts with the provider and/or other efforts to authenticate the signature.

  Note: The MACs, CERT and ZPICs shall **NOT** contact the **biller when the claim should be denied for reasons unrelated** to the signature requirement.

		Signature Requirement Met	Contact billing provider and ask a non-standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name Example :  John Whigg, MD	X	
4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity **o**f the signatory. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists (3) physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation **is accompanied** by: a signature log, or an attestation statement	X	
6	Illegible signature NOT over a typed/printed name, NOT on letterhead and the documentation is **UNaccompanied** by: a signature log, or an attestation statement Example: 		X
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but **accompanied** by: a signature log, or an attestation statement	X	
9	Initials NOT over a typed/printed name		X

	UNaccompanied by: a signature log, or an attestation statement		
10	Unsigned typed note with provider's typed name Example: John Whigg, MD		X
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the page		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	"signature on file"		X

E. Electronic Signatures

Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods.

F. Electronic Prescribing

Electronic prescribing (e-prescribing) is the transmission of prescription or prescription-related information through electronic media. E-prescribing takes place between a prescriber and dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-prescribing network. With e-prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. E-prescribing can save time, enhance office and pharmacy productivity, and improve beneficiary safety and quality of care.

A "qualified" e-prescribing system is one that meets the Medicare Part D requirements described in 42 CFR 423.160 (Standards for Electronic Prescribing).

1. E-Prescribing for Part B Medications (Other than Controlled Substances)

The MAC, CERT and ZPIC reviewers shall accept as a valid order any Part B medications, other than controlled substances, ordered through a qualified e-prescribing system. For Medicare Part B medical review purposes, a qualified e-prescribing system is one that meets all 42 CFR §423.160 requirements. When Part B medications have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produce hardcopy pen and ink signatures as evidence of a medication order.

2. E-Prescribing for Part B Controlled Substance Medications

Historically, the Drug Enforcement Agency (DEA) has not permitted the prescribing of controlled substance medications through e-prescribing systems. Therefore, when reviewing claims for controlled substance medications, MAC, CERT and ZPIC reviewers shall only accept hardcopy pen and ink signatures as evidence of a medication order. However, the DEA is in the process of establishing requirements for electronic prescriptions for controlled substances. Refer to 21 CFR§§1300, 1304, 1306 and 1311 for further information.

3. E-Prescribing for Medications Incident to DME

The MAC, CERT and ZPIC reviewers shall accept as valid any e-prescribed order for medications incident to Durable Medical Equipment (DME), other than controlled substances. For the purpose of conducting Medicare medical review of medications incident to DME, a qualified e-prescribing system is one that meets all §42 CFR 423.160 requirements. When medications incident to DME have been ordered through a qualified e-prescribing system, the reviewer shall NOT require the provider to produce hardcopy pen and ink signatures as evidence of a medication order.

G. Additional Signature Requirements for Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS)

Refer to PIM chapter 5 for further details regarding additional signature requirements for DMEPOS.

H. Signature Dating Requirements

For medical review purposes, if the relevant regulation, NCD, LCD and other CMS manuals are silent on whether the signature must be dated, the MACs, CERT and ZPICs shall ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered.

Example: The claim selected for review is for a hospital visit on October 4. The ADR response is one page from the hospital medical record containing three (3) entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer should conclude that the physician visit was conducted on October 4.

I. Additional Documentation Request Language Regarding Signatures

The CERT contractor shall use language in its ADR letters reminding providers that the provider may need to contact another entity to obtain the signed version of a document. For example, a hospital discharge summary in the physician's office files may be unsigned, whereas the version of the discharge summary in the hospital files should be signed and dated. MACs are encouraged to use such language in their letters. In addition, MACs, CERT and ZPICs have the discretion to add language to their ADRs stating that the provider is encouraged to review their documentation prior to submission, to ensure that all services and orders are signed appropriately. In cases where a reviewer finds a note with a missing or illegible signature, the ADR may inform the provider that it should submit a signature log or signature attestation as part of the ADR response.

The following is sample language that reviewers may choose to use in certain ADRs:

> "Medicare requires that medical record entries for services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamp signatures are not acceptable. Beneficiary identification, date of service, and provider of the service should be clearly identified on the submitted documentation.
>
> The documentation you submit in response to this request should comply with these requirements. This may require you to contact the hospital or other facility where you provided the service and obtain your signed progress notes, plan of care, discharge summary, etc.
>
> If you question the legibility of your signature, you may submit an attestation statement in your ADR response.
>
> If the signature requirements are not met, the reviewer will conduct the review without considering the documentation with the missing or illegible signature. This could lead the reviewer to determine that the medical necessity for the service billed has not been substantiated."

J. Potential Fraud Referrals

At any time, suspected fraud shall result in a referral to the ZPIC for development. If MAC, Recovery Auditor or CERT reviewers identify a pattern of missing/illegible signatures, the reviewer shall refer to the appropriate ZPIC for further development.