CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12633	**Date: May 9, 2024**
	Change Request 13556

SUBJECT: Medical Review Policies for Signature Requirements

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to clarify medical review policies for signature requirements for both prior authorization (PA) and regular medical review processes.

EFFECTIVE DATE: June 10, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 10, 2024

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	3/3.3/3.3.2.4/Signature Requirements
R	3/3.3/3.3.2.5/Amendments, Corrections and Delayed Entries in Medical Documentation

III. FUNDING:
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 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: The purpose of this CR is to clarify medical review policies for signature requirements for both PA and regular medical review processes.

B. Policy: This CR does not involve any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13556.1	Contractors conducting medical review shall review signatures in accordance with revised Publication (Pub.) 100-08 (Program Integrity Manual (PIM)), Chapter 3, Section 3.3.2.4.	X	X	X	X					CERT, RAC, SMRC, UPICs
13556.1.1	Contractors conducting medical review shall note that signatures are required for two distinct purposes-- (i) Based upon specific signature requirements in	X	X	X	X					CERT, RAC, SMRC, UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	statute, regulation, national coverage determination or local coverage determination; and (ii) To resolve authenticity concerns related to legitimacy or falsity of the documentation.									
13556.2	Contractors conducting medical review shall review *Amendments, Corrections and Delayed Entries in Medical Documentation* in accordance with revised Section 3.3.2.5. Note: The following provides a best practice: "*The date and author of any amendment, correction or delayed entry should be identifiable, and the change/addend a should be clearly and permanently denoted"*; however, we note that such recordkeeping	X	X	X	X					CERT, RAC, SMRC, UPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	principles should not be the source of a denial. Rather, signatures in the amendment, correction, and delayed entry are subject to the same signature analysis as provided in Pub. 100-08 (PIM), Chapter 3, Section 3.3.2.4.									
13556.3	Contractors should, at their discretion, add language to their Additional Documentation Requests (ADRs) noting that the provider/supplier is encouraged to review the documentation prior to submission, to ensure that signature requirements in a statute, regulation, national coverage determination, or local coverage determination are met (when applicable) and to ensure that signature information is	X	X		X					CERT, RAC, SMRC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	available when authenticity may be of concern. NOTE: The ADR may inform the provider/supplier that it should submit a signature log or signature attestation as part of the ADR response, when a necessary signature is missing or illegible.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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 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.

ATTACHMENTS: 0

Medicare Program Integrity Manual

Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

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(Rev. 12633; Issued: 05-09-24)

3.3.2.4 - Signature Requirements

(Rev. 12633; Issued: 05-09-24: Effective: 06-10-24; Implementation: 06-10-24)

This section is applicable for Medicare Administrative Contractors (MACs), Unified Program Integrity Contractors (UPICs), Supplemental Medical Review Contractors (SMRCs), Comprehensive Error Rate Testing (CERT), and Recovery Audit Contractors (RACs), as indicated.

For medical review purposes, Medicare requires that the person(s) responsible for the care of the beneficiary*, including providing/ordering/certifying items/services for the beneficiary, be identifiable as such in accordance with Medicare billing and coverage policies, such as the Social Security Act §1815(a) and §1833(e). Medicare contractors shall consider the totality of the medical record when reviewing for compliance with the above.*

Signatures are required upon medical review for two distinct purposes:

1. *To satisfy specific signature requirements in statute, regulation, national coverage determination (NCD) or local coverage determination (LCD); and*
2. *To resolve authenticity concerns related to legitimacy or falsity of the documentation.*

*If a signature **is** required per statute, regulation, NCD or LCD:*

- *Contractors shall use the totality of the record to determine if the signature requirement, as outlined in statute, regulation, NCD, LCD is met.*
- *If the signature requirement is not met, and it is not an instance in which the statute, regulation or NCD/LCD policy indicate that a signature must be in place prior to a given event or a given date, the attestation process may be used to try and resolve the issue. If the attestation process does not resolve the issue, the contractor may pursue a denial and/or any other appropriate corrective actions.*
- *If the signature requirement is not met because the signature is illegible, the signature log process may be used to try and resolve the issue.*

*If signature **is not** required per statute, regulation, NCD, or LCD:*

- *Contractors shall determine if the signature is necessary to identify the author of the record for the purposes of authenticity.*
    - *If not, the contractor shall disregard the missing or illegible signature and continue their review of all medical documentation to determine if the claim meets coverage, coding, and billing requirements.*
    - *If there is not an explicit signature requirement, but in the Contractor's review of the totality of the record they have authenticity concerns related to the legitimacy or falsity of the documentation, they shall pursue the attestation, signature log, denial, and/or fraud referral process, as appropriate.*

NOTE: If review contractors find reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication.

NOTE: When a scribe is used by a provider in documenting medical record entries (e.g., progress notes), CMS does not require the scribe to sign/date the documentation. The treating physician/non-physician practitioner's (NPP's) signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided.

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

A. Handwritten Signature

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

***NOTE**: Stamped signatures are not typically acceptable. CMS permits 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.*

B. Electronic Signatures

Providers using electronic systems shall recognize 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.

C. 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.

D. Signature Attestation Statement

Providers will sometimes include an attestation statement in the documentation they submit. *T*o 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.

In situations where the contractor identifies the need for an attestation (to fulfill a requirement or for authenticity purposes), the contractor shall ask if the billing entity would like to submit an attestation statement or signature log within 20-calendar days. (We note that this timeframe does not apply to the CERT contractor(s)). The 20-calendar 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. Note: if sent via a mail courier without receipt notification, the contractor shall use the sent date plus anticipated mail processing timeframes to calculate. If the biller submits a signature log or attestation that resolves the signature issue, 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-calendar days. (We note that this timeframe does not apply to the CERT contractor(s)). This extension starts upon receipt of the signature attestation or log.

The review contractors shall document all contacts with the provider and/or other efforts to authenticate the signature.

Note: *Contractors* 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 *statute, regulation, NCD or LCD* 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.

E. Signature Dating Requirements

For medical review purposes, if the relevant *statute,* regulation, NCD, *and* LCD are silent on whether the signature must be dated, the *review contractors* 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*th*. The ADR response is one page *in length and comes* from the hospital medical record containing three (3) entries. The first entry is a *physical therapy note* dated October 4*th*. The second entry is a physician visit note that is undated *and t*he third entry is a nursing note dated October 4*th*. The reviewer should conclude that the physician visit was conducted on October 4*th*.

F. Potential Fraud Referrals

At any time, suspected fraud shall result in a referral to the UPIC for development. If MAC, RAC, SMRC or CERT reviewers identify missing/illegible signature*(s) that raise legitimacy or falsity concerns, the reviewer shall consider referring* to the appropriate UPIC for further development *and may consider referring to the Regional Office and State Agency.*

3.3.2.5 - Amendments, Corrections and Delayed Entries in Medical Documentation

(Rev. 12633; Issued: 05-09-24: Effective: 06-10-24; Implementation: 06-10-24)

This section applies to MACs, CERT, *RACs*, SMRC and UPICs, as indicated.

All services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided may not be properly documented. In this scenario, the documentation may need to be amended, corrected, or entered after rendering the service. The date and author of any amendment, correction or delayed entry should be identifiable, and the change/addenda should be clearly and permanently denoted. Contractors shall review any amendment, correction, or delayed entry in accordance with section 3.3.2.4 of this chapter.

If the MACs, CERT, SMRC or *RACs* identify medical documentation with potentially fraudulent entries, the reviewers shall refer the cases to the UPIC and may consider referring to the RO and State Agency.