Authentication of Medical Record Documentation

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Authentication is a generic term that includes any method of establishing the authorship of a record entry, such as a handwritten or electronic signature. The Centers for Medicare & Medicaid Services (CMS), as outlined in the *Medicare Program Integrity Manual*, chapter 3, "requires that services provided/ordered be authenticated by the author."[1] Any practitioner providing services to patients (Medicare and non-Medicare) must be aware of the requirements for authenticating the documentation maintained in the medical record. Signatures are the culmination of the procedures and services provided and identify the billing practitioner and owner of the work provided. Failure to provide and validate appropriate signature authentication in the documentation makes it very difficult to support the fact that the service was provided. Neglecting to follow authentication requirements can result in the denial or recoupment of payments.

Handwritten Signatures

There are still instances in which handwritten signatures may be appropriate or applicable. When handwritten signatures are used, they must meet basic requirements, such as legibility, to be accepted. The *Medicare Program Integrity Manual* defines a handwritten signature as "a mark or sign by an individual on a document signifying knowledge, approval, acceptance, or obligation."[1] CMS has provided directions to the Medicare Administrative Contractors (MACs) about how to determine whether a signature is acceptable.

If a signature is missing or illegible, the provider may be allowed to submit a signature log or signature attestation statement. A signature log shows the signatures of the group or department's staff and providers, identifying each by name. A signature attestation statement, on the other hand, is a statement signed and dated by the author of the medical record entry in which they take responsibility for the entry. These methods are not a substitute for appropriate documentation practices, and they may be difficult to implement when the practice is being audited and, subsequently, has limited time to respond.

If MACs, Supplemental Medical Review Contractors, and Comprehensive Error Rate Testing auditors encounter unsigned orders during claims review, CMS has instructed them to disregard the order and treat the service as unordered.

Electronic Signatures

An electronic signature is authentication using a system and software that are protected against modification and apply administrative procedures that correspond to recognized standards and laws. Many states have published regulations on the implementation and use of electronic signatures.

According to the *Code of Federal Regulations, Title 21*, Part 11, electronic signatures require the full name of the provider, credentials, date and time stamp, and a lead-in statement to support the type of signature.[2] These regulations define signature manifestations as "signed electronic records [that] shall contain information associated with the signing that clearly indicates all of the following: the printed name of the signer, the date and time when the signature was executed, and the meaning (such as review, approval, responsibility, or authorship) associated with the signature."[2]

The *Code of Federal Regulations* also outlines that electronic and handwritten signatures executed to electronic records must be linked to the specific electronic record. This practice is to ensure the signature cannot be removed, copied, or transferred in some way to falsify the electronic record or documentation.

With the prevalence of electronic health records (EHRs), this requirement is not new. Considering ongoing cyberattacks, a refresher about the general requirements of electronic signatures is offered below:

- Each electronic signature shall be unique to 1 individual and shall not be reused by, or reassigned to, anyone else.
- Before an organization establishes, assigns, certifies, or otherwise sanctions an individual's electronic signature, or any element of such electronic signature, the organization shall verify the identity of the individual.
- Individuals using electronic signatures shall, prior to or at the time of such use, certify to the agency that the electronic signatures in their system, used on or after August 20, 1997, are intended to be the legally binding equivalent of traditional handwritten signatures.

Palmetto GBA, a MAC, lists several examples of acceptable written and electronic signatures vs unacceptable signatures on its website.[3] Acceptable signature examples include the following:[3]

- Illegible signature over a typed or printed name
- "Electronically signed by" with provider's name

- "This is an electronically verified report by John Smith, MD."

Unacceptable signatures include the following:[3]

- Dictated and/or transcribed notes missing valid signatures
- "Finalizing and approving" the notes
- Unsigned typed note with provider's typed name
- Initials not over a typed or printed name, with neither a signature log nor an attestation statement.

Timeliness of Documentation

Once providers understand and have in place appropriate signature processes, they must also consider the timing of authentication. In oncology, if signatures are applied late or if they are lacking, auxiliary staff cannot move forward with the plan of care; it also creates issues with billing for the various oncology services.

When signatures are lacking or submitted late for services such as dosimetry planning in radiation oncology, the treatment delivery cannot commence and may delay necessary care. Lack of orders may delay the drug regimen from beginning or necessary changes due to how the patient is or is not tolerating the originally ordered drugs.

Although CMS does not quantify the date or timeline by which a signature must be applied to the medical record, the expectation is that the signature is applied at the time the service is rendered. This practice supports the evidence that any required physician supervision was provided, as well as the physician work attributed to that service.

CMS addresses the timeliness of signatures in 2 different manuals. First, within the *Medicare Claims Processing Manual*, chapter 12, regarding signatures on evaluation and management documentation: "The service should be documented during, or as soon as practicable after, [provision of the service] in order to maintain an accurate medical record."[4] Second, within the *Medicare Program Integrity Manual*, chapter 3: "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."[1]

Another MAC, WPS Government Health Administrators, has outlined a reasonable time frame of 24 to 48 hours in which documentation must be completed: "A provider must complete the documentation before submitting a claim to Medicare. Medicare does not provide reimbursement for services without supporting documentation. Some providers choose a date once a month or once a quarter to document the services. This decision delays Medicare payments and can affect patient care."[5]

"Remember: Accurate and timely completion of medical records is part of the provider's responsibility to the patient and Medicare. Ask yourself, 'How can I remember seeing all my patients and what happened during that visit if more than 24 to 48 hours have passed?'"[5]

There is always the possibility that unforeseen circumstances will happen, preventing timely documentation. In these instances, it is important that the medical record tells the story. Explain what happened and know how to work through those scenarios as part of your compliance plan. For example, the EHR is down and cannot be accessed by anyone. How are things documented? Do you have supplies to allow for handwritten documentation? What is the process for getting this documentation into the EHR when it is back online?

On its website, WPS offers other scenarios and guidance for practitioners when these situations happen and provides examples that would not support a delay:[5]

1. When providers cannot document at the time of service, add a note to the record explaining the delay. Below we provide examples. This is not an all-inclusive list:
   - Acceptable circumstances:
     - A provider went into labor and has not returned to work yet.
     - A provider was in a car accident and unable to return to work before they dictated the record.
   - Unacceptable circumstances:
     - The provider went on vacation and did not complete dictation.
     - The provider forgot to complete the record.
2. Add an addendum stating the errors or the missing information. We recognize late entries to clarify the original written explanations. Never alter an original record. The addition should not:
   - Prove the medical necessity.
   - Prove the fact the provider performed a service.
3. Include the following information in the addendum:
   - The date the provider added it (not the original date of the record).
   - Legible signature of the person making the entry.
   - Legible provider initials and credentials.
4. A best practice is to also include the time of the entry.

Although many providers believe that every new day brings new hoops to jump through to be paid, it is important to understand and address some of the basics, including the authentication of medical record documentation. To avoid unnecessary delays or denials, providers should perform an annual review of compliance plans, documentation systems, and basic processes.

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