Scribing, Signatures, and Attestations

Medicare auditors investigate instances in which signatures are not in line with Medicare rules.

BY RIVA LEE ASBELL

Medicare's Comprehensive Error Rate Testing (CERT) auditing is conducted by Medicare Administrative Contractors (MACs), the regional subcontractors of the Centers for Medicare and Medicaid Services (CMS), such as WPS Medicare in Wisconsin and Cahaba Government Benefit Administrators LLC in Alabama, Georgia, and Tennessee. Much of this auditing concerns improper chart documentation involving scribing, signatures, and attestation statements. Most practices are not even aware of the regulations, so this review focuses on helping retina specialists get to know these rules and avoid being penalized for minor irregularities in chart documentation.

SCRIBING

Scribes have always been a part of the medical team that promotes office efficiencies, better chart documentation, and improved patient satisfaction. Whether using paper records or electronic health records (EHRs), scribes play an important role in providing thorough and correct medical records. However, most practices are not aware of regulations governing scribes' activities, issued by CMS and incorporated into guidelines issued by the MACs. Most MACs have articles on their websites dedicated to this issue.

A scribe never acts independently but is solely under the jurisdiction of a physician or nonphysician practitioner (NPP) when writing chart notes in any medium and in any setting. The only content of the chart note that is eligible for Medicare payment is that of the physician's dictation based on her or his work. Technicians serving the dual function of intake person (for the Review of Systems and Past, Family and Social history) and scribe must record only what the physician dictates.

The Template

A brief internal review of chart documentation will reveal whether there is documentation of the scribe's presence that meets Medicare requirements. Omission is remedied by incorporating a scribing template into the medical record (Figure 1). On paper, it is quite straightforward; however, in EHRs, a template has to be created that can be signed by both the scribe and the physician and is in addition to the final signature. For paper records, the template must be filled out and scanned into the medical record for that day. The documentation has to be in addition to the final signature at the end of the encounter.

TEMPLATE FOR SCRIBING

Physician or NPP Template

I, _____[add credentials], personally performed the services described in this documentation on this date_____, for_____[patient's name] as scribed by _____in my presence. I have reviewed and verified that all the information is accurate and true.

Additional information:

_____

_____

_____

_____Provider _____Date

Scribe Template

I, _____[add name and credentials], personally scribed the services dictated to me by _____[add physician/NPP name and credentials] in this documentation on this date _____, for_____[patient's name].

Scribe's name:_____(PRINTED)

SCRIBE'S SIGNATURE_____Date_____

Figure 1. Including a scribing template in medical records will reduce the likelihood of omission.

MACs are generally in agreement regarding the various requirements that should be included in the template: name of the scribe and a legible signature, name of the physician and a legible or illegible signature (see section on signatures below), date of service, affirmation that the physician was present during the time the encounter was recorded, and verification that the physician or NPP reviewed the information as to its accuracy and provided supplementary material as pertinent.

Accreditation of Scribes

Whereas scribes do not have to be accredited simply to scribe the physician's or NPP's dictation, they do have to be accredited in order to enter certain types of data into the

Q & A WITH CMS

Q: When meeting the meaningful use measure for computerized provider order entry (CPOE) in the Electronic Health Records (EHR) Incentive Programs, does an individual need to have the job title of medical assistant in order to use the CPOE function of Certified EHR Technology (CEHRT) for the entry to count toward the measure, or can they have other titles as long as their job functions are those of medical assistants?

A: If a staff member of the eligible provider is appropriately credentialed and performs similar assistive services as a medical assistant but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, he or she can use the CPOE function of CEHRT and have it count towards the measure. This determination must be made by the eligible provider based on individual workflow and the duties performed by the staff member in question. Whether a staff member carries the title of medical assistant or another job title, he or she must be credentialed to perform the medical assistant services by an organization other than the employing organization. Also, each provider must evaluate his or her own ordering workflow, including the use of CPOE, to ensure compliance with all applicable federal, state, and local law and professional guidelines.

Note from the author: This applies only to ophthalmic scribes (or technicians) who have been certified and only to scribes in ophthalmology. These CMS rules recently led to a panicked search for associations that certify scribes with the resultant discovery of the American College of Medical Scribe Specialists (ACMSS), an organization that certifies scribes. CMS assented that, as long as scribes were certified and performed functions similar to those of a medical assistant, they could enter CPOE information.

Recently, the Joint Commission of Allied Health Personnel in Ophthalmology (JCAHPO) has launched a program for certifying scribes. If a technician is certified by the JCAHPO, then scribing certification is not required as an additional credential. *The above Q & A can be found on the CMS website at questions.cms.gov/faq.php?faqId=9058.*

EHR system for Meaningful Use. See the box titled *Q & A with CMS* for details on the credentials required for scribes.

SIGNATURES

Medicare has always required a legible identity of the provider. With the intensification of auditing, this requirement has been extended to signature requirements.

Handwritten Signatures

Any Medicare service provided, or any order, must be authenticated (ie, signed) by the provider (ie, the physician or NPP) for office visits, emergency department visits, hospital visits, and diagnostic tests. The one exception that applies to ophthalmology is that orders for clinical diagnostic tests are not required to be signed, per se; however, if the order is unsigned then "there must be medical documentation by the treating physician (eg, a progress note) 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."[1]

Acceptable forms of authentication include a handwritten signature that (yes, you are reading this correctly) may be legible or illegible (with caveats). Most important, the physician must sign his or her own signature; having a scribe or technician sign for the physician is not allowed. Late or added signatures are not acceptable, but attestations may be used. Each encounter must be dated.

Retina & Vitreous Associates, Inc.
Signature Log

Name	Credentials	Signature	Initials
Rachel Wagner	MD, FACS	Rachel Wagner	RW MD
Nathan Asbell	MD, FACS		NA md

Figure 2. A signature log featuring legible and illegible signatures.

Legible Signatures

In order for a signature to be legible, an auditor must be able to read it; whether the physician or staff can read it is irrelevant. Acceptable written signatures include:

- Legible full signature
- Legible first initial and last name
- Initials placed above a typed or printed name
- Initials accompanied by a signature log
- Initials accompanied by an attestation statement

Illegible Signatures

There are acceptable forms of illegible signatures, such as:

- Illegible signature placed above a typed or printed name
- Illegible signature where a letterhead indicates the identity of the individual who signed the entry. The provider's name should be circled to indicate the identity of the individual who signed the entry.
- Illegible signature accompanied by a signature log
- Illegible signature accompanied by an attestation statement

To increase the likelihood that a signature, whether legible or illegible, is valid, offices may have a stamp made for each physician with the printed name and a line above it for the signature. Stamped signatures themselves, however, are not allowable.

Electronic Signatures

An electronic signature is an electronic sound, symbol, or process attached to or logically associated with an EHR to signify knowledge, approval, acceptance, or obligation by the individual who provided or ordered the services.

Electronic signatures must be authenticated and safeguarded against misuse and modification, and they should be easily identifiable as electronic, rather than typewritten or stamped signatures, particularly when the document is printed out for sending to Medicare for audits.

Signature Log

Offices should prepare for the practice (even if the practice is one physician) a signature log that lists the typed or printed name of each physician in the practice and samples of the associated legible or illegible signature(s) and the physician's way of writing his or her initials, and include credentialing initials. This log should be kept current. If the physician or NPP signs his or her name or initials in more than one way, all versions should be included in the log.

TIPS

- Prepare a signature log, and include a copy with every request for medical records from each insurer. Keep it up to date. Even if an office is using EHRs, a physician may have to do an attestation, and the signature log may come in handy.
- Never add a late signature. If no signature was present, then do an attestation.
- A physician cannot sign for another physician.
- Scribes, technicians, and ancillary personnel cannot sign a physician's name.
- All entries must be dated and signed.
- If orders for diagnostic tests are missing (they can be contained within the body of the chart documentation as long as that documentation clearly states the test is to be performed and is signed), then claims will be denied.
- "Signature on file" is not acceptable on a signature line.
- Make sure the office's EMR system has a way of indicating "electronically signed by Dr. So-And-So."
- Make sure billing personnel are aware that they may receive a phone call if a chart is under review and meets criteria except for an acceptable signature. Offices will then have a certain number of days to send in the signature log or an attestation statement, or the claim will be denied.

For each request for medical records from any insurer, this log should be placed as the first page on top of the remainder of the chart documentation. Offices using EHRs may need to include the signature log for use with the signatures on the scribing template and for Interpretation and Reports for diagnostic tests (Figure 2).

Signature attestation statement

An attestation statement may be used for Medicare if the physician has an independent recollection of providing the service and simply did not sign the order, encounter, surgery form, or other document. Each attestation statement may be used only once, and each time a physician uses an attestation statement another one must be prepared. If more than one is needed in a given document, then one must be prepared for each time the physician failed to sign a place in the chart where a signature was required. Each attestation must be signed and dated by the physician.

CMS has provided the following attestation statement for use. It may be used, or the office may have an attorney prepare a suitable one.

> *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.*[1]

SUMMARY

These rules herald a new era in chart documentation requirements and give CMS another tool by which to deny claims. By ensuring that problems with signatures are prevented, the likelihood of claims denial can be reduced. Refer to the Tips sidebar for a list of ways the likelihood of signature errors can be reduced. ■

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1. Centers for Medicare and Medicaid Services. Medical Learning Network. MLN Matters (MM6698). Revised March 16, 2010. www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf. Accessed April 20, 2015.
2. Centers for Medicare and Medicaid Services. Medical Learning Network. MLN Complying with Medicare Signature Requirements. www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf. Accessed April 21, 2015.