

**Summit Documentation Article XVI**  
**A COMMON MEDICARE DOCUMENTATION ERROR:**  
**ARE YOU SIGNING YOUR NOTES?**

Part 2 of a series related to Medicare documentation errors

*First convened in September 2007, the Chiropractic Summit represents leadership from some 40 organizations within the profession. The Summit meets regularly to collaborate, seek solutions, and support collective action to address challenges with the common goal of advancing chiropractic.*

*A major focus of the Summit has been to improve practitioner participation, documentation, and compliance within the Medicare system. The article that follows is the fourteenth in a series developed by the Chiropractic Summit Documentation Committee.*

We have all heard that chiropractic documentation is being reviewed by multiple Medicare contractors and that we are failing these reviews at an extremely high rate. So where are we going wrong? Where are our sources of error? The first article in this series addressed treatment plans. This article will address the authentication of your records with a signature.

The Centers for Medicare and Medicaid Services (CMS) reviews fee-for-service claims (Parts A and B), along with their related medical records, for provider compliance with Medicare coverage, payment, coding, and billing rules. The goal is to eliminate improper payments and maintain the Medicare Trust Fund while protecting patients from clinically unnecessary services.

One requirement of Medicare documentation is that services provided be authenticated by the author. Authentication identifies the author of the record, ensures they are who they say they are, allows them to take ownership of the record, and attests that the information contained in the record is correct. The method required by Medicare for authentication is a handwritten or electronic signature. In general, **stamped signatures are not acceptable.**

For a signature to be valid, the following criteria must be met:

- Services provided must be authenticated by the practitioner;
- Signatures must be handwritten, electronic, or stamped (stamped signatures are **only** permitted in the case of an author with a physical disability who can provide proof to a CMS contractor of an inability to sign due to a disability); and
- **Signatures are legible.**

Our source of error related to the authentication of records tends to be either “missing signature” or “illegible signature.” As protection against these types of denials, we recommend you always include a signature log and/or attestation statement when submitting your documentation.

- **Signature Log** – A signature log lists the typed or printed name (first name, last name, credentials) of the author with the handwritten initials or illegible signature contained in the patient record written above, so the author can be identified.
- **Signature Attestation Statement** – An attestation statement may be submitted in cases where the signature is missing (or illegible). It must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. CMS has provided a sample attestation statement, but notes this exact wording is not required:

*“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.”*

Providers using electronic signatures should not need signature logs or attestation statements. However, they need to recognize there is a potential for misuse or abuse with this method. You need a system that is protected against modification and where no one can “sign” your name (authenticate the record) but you (e.g., User ID/Password protection). Remember, **you bear the responsibility for the authenticity of the information** for which an attestation/signature has been provided. You may want to check with your attorney and malpractice carrier for their recommendations concerning the use of electronic signatures.

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*The current members of the Summit Subcommittee on Documentation are Dr. Carl Cleveland III, Dr. Farrel Grossman, Dr. Clyde Jensen, Dr. Steven Kraus, Dr. Salvatore LaRusso, Dr. Peter Martin, Ms. Susan McClelland, Dr. Clay McDonald, Mr. Robert Moberg, Dr. Frank Nicchi, Mr. David O'Bryon, Dr. LeRoy Otto, and Dr. Claire Welsh. **Ms. McClelland served as the principal author of this article.***