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Signature Requirements for Diagnostic Testing

On March 16, 2010, CMS issued a Transmittal 327 Change Request 6698 to Publication 100-08, Medicare Program Integrity, addressing Signature guidelines for Medical Review Purposes. This transmittal Change Request can be found at **http://www.cms.gov/Transmittals/downloads/R327PI.pdf**. This addresses what is now found in the CMS Program Integrity Manual (Internet-Only Manual Publication 100-08, Chapter 3, section 3.3.2.4) and can be found on pages 31-38 at **http://www.cms.gov/manuals/downloads/pim83c03.pdf**

This transmittal and resultant changes to the Program Integrity Manual are of particular importance to otolaryngology practices that order and perform any diagnostic tests, such as CT scans, allergy testing or audiology testing, ordered and performed by the physician.

As of the implementation of these changes, this section is applicable for MACs, Certified Error Rate Testing (CERT) and ZPIC audits. This section does not apply to Recovery Auditors (RAC). Because a practice will never know when they are audited by their MAC (which includes the practice carrier), CERT and ZPIC audits (for Medicaid services), it is critical always to follow these rules as set forth by CMS.

The Program Integrity Manual goes on to state: *"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."*

The important issues brought up in this manual are telling the physician and practice that the report from diagnostic testing that are ordered and performed by the practice need to be signed by the billing physician for medical review purposes.

Exceptions to Signature Requirements

There are three exceptions listed. The first exception is that facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

The first exception is when 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.

This second exception could be applicable to diagnostic testing, which is outlined as intended in the plan of care in the progress note, such as the plan for a CT scan based on the history and exam with a patient with chronic nasal obstruction who is looking for confirmation of chronic or acute sinusitis. Similarly, allergy testing can be outlined in the plan of care in the

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progress test as described in the second exception above. But under the second exception, even with the intent illustrated in the progress note, there must be authentication by the author via handwritten or electronic signature.

The third exception is when CMS has a different regulation about signatures in the CMS Manuals, LCD or NCD. If this is the case, the CMS Manuals, NCD or LCD takes precedence over this rule.

Signature Attestation Statement

However, CMS understands that physicians and practices can make mistakes, and as such, CMS has actually built in a correction mechanism for any physician/practice that mistakenly omits the signature on the report. CMS has a Signature Attestation Statement that may be used after the fact to incorporate reports that were not signed. The Attestation Statement wording can be found in the Program Integrity Manual, 100-08, chapter 3, section 3.3.2.4, page 33 (**http://www.cms.gov/manuals/downloads/pim83c03.pdf**). This attestation can also be included with documents requested for an audit. The regulation actually states the following:

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.*

The CMS signature rule goes on to state that if a signature is illegible, the auditor should be considering information in a signature log or attestation for valid signature. If a signature is missing from an order, the auditor will not count the order when doing the audit, so the service will not be considered ordered. If the signature is missing from any other part of the documentation (other than the order), then the auditor can consider the attestation as a valid signature.

Interestingly, if the practice forgets to include the Signature Attestation with the audit documents when they are requested, the signature rule actually states that the auditor must contact the practice/biller and tell them that the signature is missing and ask them if they would like to submit a Signature Log or a Signature Attestation within 20 days. So, the auditor (MAC, CERT, ZPIC) actually should not be denying services for missing signatures. They should be notifying the practice/biller about the missing signature and asking them if they want to submit an attestation. The 20-day period starts from the date of the phone call requesting the attestation from the MAC, CERT or ZPIC.

CT Scanner Accreditation

When CMS begins to require CT scanner accreditation on Jan. 1, 2012 (for example ICACTL), a signature and signature date will be required on the CT report as part of the multiple elements of the CT report.

According to ICACTL, final reports must contain the following:

- Patient ID
- Date of exam
- Clinical indications
- Description of test performed (name and protocol of exam, quality of study, and non-standard patient prep)
- Dose reduction technique (document "low energy acquisition with pulsed beam and collimated field of view")
- Overview of results including pertinent findings including localization and quantification of abnormal findings
- Appropriate recommendation for follow-up of findings
- Summary of test findings
- Signature with date
- Typewritten

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