Guidelines for Documentation: Provider Signatures and Credentials

One of the most common reasons that physician medical records fail an audit is because the documentation does not meet basic guidelines. For diagnosis documentation and coding, you should meet the following guidelines: 1) based on a face-to-face visit; 2) includes patient name and date of birth or ID; 3) includes the date of visit; 4) legible, organized note; 5) clearly states the patient’s diagnoses and their status; 5) includes the signature and credentials of the provider.

Recently, the Centers for Medicare and Medicaid Services (CMS) have clarified the requirements for what constitutes a valid provider signature. Specifically, the provider's name and credential must be clearly stated. Examples of acceptable physician signatures are: handwritten signature or initials; signature stamp that complies with state regulations; and electronic signature with authentication by the respective provider.

The credentials for the provider of services must be somewhere on the medical records - either next to the provider's signature or pre-printed with the provider's name on the practice's stationery.

In addition to the name, it must be clear what type of provider has documented the note in the medical record – for example: MD, NP, RN, RD, MA, etc. CMS does not accept all provider types as valid sources of diagnosis data for severity adjustment. If the provider credential cannot be determined, then that medical record is not considered a valid source and will not pass an audit.

If you have the physician’s name and credential printed on your stationery, you must still make sure it is clear who is signing the note.

Other important examples:

- If you use transcribed notes with a typed provider signature and credential, they must be signed by the provider on a timely basis (definitely not more than one year later). The signature shows that the provider has reviewed and approved the content.
- If you use an electronic medical record, you must have an electronic signature with authentication. Again the purpose is to make sure it is clear which provider has reviewed and approved the medical record documentation.
- For signature stamps without a hand-written signature, CMS accepts the guidelines set by the state in which you are practicing – know your state’s rules.

Basic principles of diagnosis coding:

Every patient should be seen at least once each year with all significant medical diagnoses reviewed and documented in the medical record which is dated and signed by a physician. A claim or encounter for each physician visit should be submitted that includes specific codes for all diagnoses that are documented in the medical record.

The information and examples provided above are minimal documentation to support diagnosis coding as only one part of a complete progress note. Final decisions about diagnosis coding should be based on review of standard reference materials.

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