CHART TALK ~ ANESTHESIA CODING CONVERSATIONS

DOCUMENTATION & COMPLIANCE TIP SHEET

Signatures, Authentication & Late Entries

A complete service still needs a record that can be attributed to the person who documented or performed it.

WHY THIS MATTERS

Anesthesia records contain time-sensitive clinical and billing information. Signatures and electronic authentication establish authorship and accountability, while late entries, addenda, and corrections must preserve the integrity of the original record. A missing signature or improperly altered entry can create audit risk even when the underlying service was clinically appropriate.

THE CODING TIP

Authenticate - do not recreate. Correct - do not conceal. When documentation needs completion or correction, follow the applicable Medicare, payer, facility, and organizational rules. The record should make clear who entered the information, when it was entered, and what was added or corrected.

THE 6-POINT AUTHENTICATION CHECK

01	WHO?	Can the author or responsible practitioner be identified?
02	WHAT?	Is the relevant anesthesia record, procedure note, evaluation, or other service documentation authenticated as required?
03	WHEN?	Does the record contain the applicable date/time information for the entry and service?
04	HOW?	Is the signature/electronic authentication method acceptable under the payer and organization's policy?
05	CHANGES?	If information was added or corrected later, is the amendment clearly identified without obscuring the original entry?
06	CONSISTENCY?	Do the signature, credentials, timestamps, and documented role make sense with the service being billed?

SIGNATURE VS DOCUMENTATION

A signature authenticates documentation. It does not supply missing clinical content.

For example, a physician signature on an anesthesia record does not by itself establish the seven medical-direction requirements, the anatomical target of a nerve block, or the elements of a separately reportable ultrasound-guidance service. The underlying documentation must still support the billed service.

WHAT MAY COUNT AS AUTHENTICATION?

- Handwritten signatures when accepted under the applicable rules.
- Electronic signatures or authenticated electronic entries that identify the author.
- Other electronic authentication methods permitted by the payer, facility, and organizational policy.
- Signature logs or attestations in circumstances where the applicable payer permits them.
- Credentials and identifying information sufficient to establish the practitioner's identity when required.

LATE ENTRY, ADDENDUM, OR CORRECTION?

TYPE	GENERAL PURPOSE	DOCUMENTATION PRINCIPLE

Late entry	Adds information that was omitted from the original record	Identify it as a late entry and use the current date/time according to policy.
Addendum	Adds information or clarification to an existing entry	Clearly link the addendum to the original documentation and authenticate it.
Correction	Corrects inaccurate information in the existing record	Preserve the original information/audit trail and clearly identify the correction.

NEVER MAKE THE RECORD LOOK AS IF IT WAS DOCUMENTED EARLIER

A late entry or correction should not be backdated or entered in a way that makes it appear contemporaneous when it was not. Electronic health record audit trails and metadata may reveal when an entry was actually created or changed. Corrections should increase transparency, not create a misleading chronology.

ANESTHESIA-SPECIFIC AREAS TO CHECK

- Pre-anesthesia evaluation authentication.
- Anesthesia record authentication by the applicable anesthesia professional(s).
- Medical-direction documentation attributable to the physician when medical direction is reported.
- Regional block and invasive-line procedure notes.
- TEE and other separately reported diagnostic/procedural documentation.
- Post-anesthesia evaluation or care documentation when required.
- Relief/handoff documentation when provider participation changes.
- Any late correction to anesthesia start/stop times or other claim-defining information.

COMMON DOCUMENTATION MISTAKES

- Unsigned procedure note used to support a separately billed service.
- A signature added without clarifying who actually performed or documented the service.
- Backdating an addendum to the date of service.
- Deleting or overwriting original information rather than preserving an audit trail.
- Using a late entry to introduce information that cannot be reliably supported as having occurred.
- Assuming a co-signature automatically proves medical direction, supervision, or personal performance.
- Correcting anesthesia time after billing without following the organization's correction and rebilling process.
- Using a signature attestation when the applicable payer does not permit it for that circumstance.

CODER'S TIP

Separate two questions: “Is the record authenticated?” and “Does the record contain the documentation required for the code?” A yes to one does not automatically mean yes to the other.

QUICK EXAMPLE

Scenario: A nerve-block procedure note contains detailed anatomy, laterality, medication, and ultrasound information, but the note is not authenticated by the practitioner.

Coding point: The clinical detail may support the procedure concept, but authentication must still satisfy the applicable payer and organizational requirements before relying on the note for billing.

WHEN TO STOP AND REVIEW

- A claim-defining note is unsigned or the author cannot be identified.
- The signature date/time is substantially later than the service and the record does not explain the entry.
- Anesthesia start or stop time was changed after the original record was completed.
- A late entry adds medical-direction steps, postoperative-pain intent, or other facts that materially affect billing.
- The original documentation has been overwritten or cannot be reconstructed.
- The EHR shows conflicting authorship or timestamps.
- A signature log, attestation, or co-signature is being used and payer acceptance has not been verified.

AUDITOR'S RED FLAGS

- Large numbers of records signed long after the date of service.

- Identical late-entry language across multiple audited records.
- Corrections made only after a payer audit request.
- Authentication by someone whose documented role does not match the service.
- Late additions that consistently create support for previously missing billable elements.
- Records whose visible documentation conflicts with the EHR audit trail.

AUTHORITATIVE RESOURCES

- CMS Medicare Program Integrity Manual, Chapter 3 - current medical-record documentation and signature requirements.
- CMS MLN guidance on medical record documentation and signature requirements.
- Current Medicare Administrative Contractor guidance applicable to signature logs, attestations, amendments, and corrections.
- Current payer policy/contract and organizational EHR, authentication, amendment, correction, and compliance policies.

BOTTOM LINE

A late entry can clarify the record. It should never rewrite history.

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