Dermatology Coding Alert

Documentation: Watch Out: Nurse's History Note Might Be Audit Bait

The physician must indicate that he reviewed any nurse's notes.

Warning: Don't let your nurses do the doctor's work, or you could wind up with a non-payable visit. The only parts of the E/M visit that an RN can document independently are the Review of ystems (ROS), Past, Family, and Social History (PFSH) and Vital Signs, according to Frequently Asked Questions (FAQ) answer from Palmetto GBA, a Part B carrier. The physician or mid-level provider must review those three areas and write a statement that the documentation is correct or add to it.

Only the physician or non-physician practitioner who conducts the E/M service can perform the History of Present Illness (HPI), Palmetto adds.

Exception: In some cases, an office or Emergency Department triage nurse can document "pertinent information" regarding the Chief Complaint or HPI, Palmetto says. But you should treat those notes as "preliminary information." The doctor providing the E/M service must "document that he or she explored the HPI in more detail," Palmetto explains. Other payers have expanded on Palmetto's announcement, letting physicians know that they cannot simply initial the nurse's documentation. For example, Noridian Medicare publishes a policy that states, "Reviewing information obtained by ancillary staff and writing a declarative sentence does not suffice for the history of present illness (HPI). An example of unacceptable HPI documentation would be 'I have reviewed the HPI and agree with above.'"

Good news: Thanks to this clarification, your dermatologist won't have to repeat the triage nurse's work. Right now, if the nurse writes "skin rash x 4 days," at the top of the note, some auditors might insist that your doctor needs to write "skin rash x 4 days" in his own handwriting underneath. But that requirement is a thing of the past if your carrier echoes Palmetto's requirement.

Bad news: Now this carrier has made it clear that your doctor can't get credit for HPI unless he elaborates on what the triage nurse wrote. In the above case, the doctor needs to note more information about the patient's four-day skin rash for the entry to count in the HPI.

Not everybody greets the Palmetto FAQ with open arms. This clarification may cause more confusion, because there's no definition of the word "preliminary." Palmetto does not explain how much extra documentation could be required to comply with the guidelines.

What About Scribes?

In many practices, the physician dictates his findings to a mid-level provider who acts as a "scribe," documenting the information as the physician says it. Medicare payers also maintain specific rules for this type of arrangement. "When using a scribe, it's important to keep in mind that the scribe cannot interject any personal observations," notes **Suzan Berman, CPC, CEMC, CEDC,** senior manager of coding education and documentation compliance with UPMC in Pittsburgh. "The scribe is merely documenting the services done by the physician and observed by the scribe." In addition, the physician must review the scribe's documentation, and then sign the note "indicating that it has been reviewed and he/she is in agreement," Berman says. "This authenticates the note and is a requirement for billing purposes." Palmetto and many other Medicare payers require that the scribe's name must be identified in the medical records, confirms Berman.