Codify
BY AAPC

Internal Medicine Coding Alert

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

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

Caution: Don't let your nurses do the doctor's work, or you could end up with a non-payable visit.

The only parts of the E/M visit that an RN can document independently are the Review of Systems (ROS); Past, Family, and Social History (PFSH); and Vital Signs, according to Palmetto GBA, a Part B carrier. The physician or mid-level provider must review those three areas and write a statement that the nurse's 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 expand on Palmetto's stance, 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 internist won't have to repeat the triage nurse's work. Right now, if the nurse writes "knee pain x 4 days," at the top of the note, some auditors might insist that your doctor needs to write "knee pain x 4 days" in his or her own handwriting underneath. But that requirement is a thing of the past if your carrier echoes Palmetto's requirement.

Bad news: Palmetto guidelines clearly indicate that your doctor can't get credit for HPI unless he or she elaborates on what the triage nurse wrote. In the above case, the doctor needs to note more information about the patient's four-day knee pain 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." Also, Palmetto does not explain how much extra documentation could be required to comply with the guidelines.

For example: An office nurse could document, "Patient comes to follow-up for Type 2 DM, HTN, hypertriglyceridemia, allergic rhinitis, morbid obesity. Pt. reports taking meds consistently, and FBS this AM was 97. Pt. presently has no specific complaints." If all that information is complete and accurate, it's unclear what additional information the physician could add to the note.

What About Scribes?

In many practices, the physician dictates his findings to a non-physician 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," reminds **Suzan Berman, CPC, CEMC, CEDC,** senior manager of coding education and documentation compliance with UPMC in Pittsburgh, Penn. "The scribe is merely documenting the services done by the physician and observed by the scribe," she adds.

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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.

Get to Know Signature Requirements

CMS updated its signature requirements on June 16, outlining the rules that you must follow to meet Medicare's documentation requirements. Among the rules that CMS outlined in MLN Matters article MM6698 is the statement that "in order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary." CMS offers the following example of an attestation statement, but notes that using this format is not specifically 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.

For more on CMS's signature requirements, visit http://www.cms.gov/MLNMattersArticles/downloads/MM6698.pdf.

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