Part B Insider (Multispecialty) Coding Alert

Part B Documentation: New MAC Tip Reminds Practices What the Nurse Can--and Cannot--Document

Hint: Documenting HPI is the job of the doctor or NPP.

Your nurse might be quite adept at recording your documentation but if she documents too much, your notes might not be applicable to your coding choices. That's the word from a new E/M Tip that Part B MAC Palmetto GBA issued last week, reminding doctors what ancillary staff members can document in your Medicare records.

"Ancillay staff may only document the Review of Systems (ROS), Past, Family, and Social History (PFSH) and Vital Signs," the latest tip, published Sept. 23, indicates.

As for the history of present illness, leave that to the physician or NPP, Palmetto says. "Only the physician or NPP that is conducting the E/M service can perform the history of present illness (HPI). This is considered physician work and not relegated to ancillary staff. The exam and medical decision making are also considered physician work and not relegated to ancillary staff."

Exception: "In certain instances, an office or emergency room triage nurse may document pertinent information regarding the chief complaint (CC)/HPI, but this information should be treated as preliminary information," Palmetto continues. "The physician providing this E/M service must consider this information preliminary and needs to document that he or she explored the HPI in more detail."

Reality: This clarification makes it obvious that your doctor can't get credit for HPI unless he elaborates on what the triage nurse wrote.

Other payers have expanded on Palmetto's announcement, letting physicians know that they cannot simply initial the nurse's documentation. For example, Noridian Medicare published 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.'"

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.

"In E/M services, surgical, and other such encounters, the 'scribe' does not act independently, but simply documents the physician's dictation and/or other activities during the visit," says Part B MAC WPS Medicare in its Guidelines for the Use of Scribes in Medical Record Documentation. "The physician who receives the payment for the services is expected to be the person delivering the services and creating the record, which is simply 'scribed' by another person."

Key difference: The main difference between a scribe and an ancillary staff member recording the documentation is the source of where the person is getting the information. If the doctor or NPP is speaking and someone is writing it down word-for-word, that's a scribe. If, however, the patient is speaking and someone is writing that down, that's record documentation, not a scribe situation.

In addition, if an NPP performs the whole visit for an inpatient and the doctor later makes rounds and signs the note, that's not a "scribe" situation either, and cannot be billed under the physician's NPI (since incident to is not applicable in the facility setting). A situation like this would have to be billed using the NPP's name and NPI, WPS Medicare says.