Eli's Hospice Insider

DOCUMENTATION: Find Out What it Takes to Write a Good Physician Narrative

Specificity wins over length.

Hospices looking for guidance on how physicians should write their attestations of hospice patients' terminal illnesses aren't getting much help from a recent CMS Q&A on the matter.

"We have not mandated that specific language be included in the physician's attestation," CMS says of the new requirement that took effect on Oct. 1. "Any language under the physician's signature which attests that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient meets the attestation regulatory requirement," CMS says.

Good and bad news: The physician narrative isn't tricky, but it can be hard to get physician paperwork, and this is one more thing you've got to do, says attorney **Marie Berliner** with Lambeth & Berliner in Austin, Texas.

Try this: Have a system in place where you track down the doctor to get the signed and dated certification paper work before you bill or you may wind up having to pay, says attorney **Connie Raffa** with Arent Fox in New York, NY.

Some agencies send clerks to wait in the doctor's office and actually find it saves money in the long run, Raffa says. If, instead, you were caught up in a fraud edit, you would have to pull records, make copies and scans, pay for an attorney, and conduct an appeals process, all of which can add up to great expense, she says.

Performing internal compliance audits, with the help of a qualified attorney, can be cheaper in the long run, Raffa says. Anything found would be covered under attorney client privilege and you can fix what you found before it gets you in hot water with the government.

Get to the Heart of the Matter

The narrative can be a short, one to two sentence summary, Berliner says. Simply stating, "Based on [the patient's diagnosis] I certify that this patient has a prognosis of six months or less," will do the trick.

Caveat: Surveyors can cite failure to have this documentation on file. The fact that you're missing a record can bring unwanted attention. In its December newsletter for providers RHHI Cahaba stressed that the narrative must be specific and unique to the patient and shouldn't contain check boxes or boilerplate text. Other than advising that the physician's signature confirms that he composed the narrative, the RHHI said, "There is no prescribed length. There are no examples."