Electronic Health Record Documentation FAQs

These FAQs provide guidance under relevant federal laws for the Medicare program1. Additional state or local requirements may apply.

# Q: Under Medicare payment rules, can non-physician staff, such as a registered nurse (RN), licensed practical nurse (LPN) or medical assistant (MA), enter elements of an evaluation and management (E/M) visit without the physician present?

**A: Yes, certain elements, like the Review of Systems (ROS) and Past, Family, and/or Social History (PFSH), may be recorded in the EHR by non-physician staff.**

Medicare guidance specifically allows ancillary staff to enter information derived from the patient for the ROS and/or PFSH. However, the physician must provide a notation in the medical record supplementing or confirming the information recorded by others to document that the physician reviewed the information.

For other elements of a visit, like the History of Present Illness (HPI) or Chief Complaint (CC), Medicare rules do not explicitly indicate who may enter documentation. However, several Medicare Administrative Contractors (MACs) currently interpret Center for Medicare & Medicaid Services (CMS) regulations to prohibit the physician (or non-physician practitioner (NPP), if billing for the service) from delegating these elements of the service. Practitioners should check with their respective MACs before allowing individuals other than the treating physician to document an HPI or CC.

If the non-physician is entering information about an HPI or CC on behalf of the physician while the physician is present in the room with the patient, some MAC guidance suggests that this practice is allowable as long as the physician actually performed the E/M service billed, the scribe simply served to transcribe the service provided by the physician, and the scribe's entry is authenticated by the physician. Other MACs, however, restrict this practice. Providers should consult with their MAC before using a scribe to complete entry of an HPI or CC.

# Q: Under Medicare payment rules, can an RN document a patient's medication list in the EHR as part of medication reconciliation (MR) during E/M visit?

**A: Yes, where MR is part of the ROS or PFSH for the E/M service, under Medicare payment rules, the medication list may be recorded by any ancillary staff, and then signed by the physician.**

MR is included in the Advancing Care Information performance category in the Merit-Based Incentive Payment System (MIPS) as well as the Meaningful Use (MU) program.

# Q: Can licensed staff enter electronic orders, such as laboratory or x-ray requests?

**A: Yes, certain credentialed individuals may enter orders for diagnostic tests in an office (non- facility) setting.**

Medicare generally requires that services provided/ordered be authenticated by the author. A physician's failure to properly authenticate an order could lead to denial of payment by a MAC. However, there are circumstances where Medicare does not require a physician signature, such as for diagnostic tests (e.g., clinical diagnostic laboratory tests and diagnostic x-rays), when ordered in an office setting. While these orders need not be signed by the physician, he or she must clearly document in the medical record his or her intent that the test be performed. Providers should also check state, local, and professional guidelines.

[1] Source: Legal Memorandum Guidelines for Entering Patient Data into an Electronic Health Record. Akin Gump Strauss Hauer & Feld LLP. March 29, 2016