

Ancillary staff: Who can document components of E/M services?

Ancillary staff and/or patient documentation is the process of non-physicians and non-advanced practice providers (APPs) documenting clinical services, including history of present illness (HPI), social history, family history and review of systems in a patient's electronic health record (EHR).

Historically, Medicare required the physician to re-document ancillary staff's entries of the HPI to receive payment for the service. Further, Medicare had not issued guidance on the allowability of patient entries into the medical record.

However, the Centers for Medicare and Medicaid (CMS) addressed these matters in the 2019 Calendar Year Physician Fee Schedule.

The myth

Physicians are required to re-document staff or patient entries in the patient record.*

Debunking the myth

Medicare documentation requirements changed in November 2018 and now allow physicians to "verify" in the medical record staff or patient documentation of components of E/M services, rather than re-documenting the work, if this is consistent with state and institutional policies.

Regulatory clarification

In both the Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2019 (PDF) (CMS, 2018) and an additional FAQ (PDF) (CMS, 2018), CMS expanded current documentation policy applicable to office/outpatient E/M visits. Starting Jan. 1, 2019, any part of the chief complaint (CC) or history that is recorded in the medical record by ancillary staff or the patient does not need to be re-documented by the billing practitioner.

Instead, when the information is already documented, billing practitioners can review the information, update or supplement it as necessary, and indicate in the medical record that they have done so. This is an optional approach for the billing practitioner, and applies to the chief complaint (CC) and any other part of the history (HPI, Past Family Social History (PFSH), or Review of Systems (ROS)) for new and established office/outpatient E/M visits.

CMS notes that it has never addressed who can independently take/perform histories or what part(s) of history they can take, but rather addresses who can document information included in a history and what supplemental documentation should be provided by the billing practitioner if someone else has already recorded the information in the medical record.

The physician must still personally perform the physical exam and medical decision-making activities of the E/M service being billed.

Summary of changes

The Physician Fee Schedule for Calendar Year 2019 (CMS, 2018) allows a physician to verify in the medical record any ancillary staff or patient documentation of components of E/M services, rather than re-documenting the information.

Resources

- | Revisions to Payment Policies Under the Physician Fee Schedule and Other Revision to Part B for CY 2019. 83 FR 59452, *mention at 59635*. Centers for Medicare & Medicaid Services, November 23, 2018
- | Evaluation and Management (E/M) Visit Frequently Asked Questions (FAQs) Physician Fee Schedule (PFS). Centers for Medicare & Medicaid Services, November 26, 2018

Debunking Regulatory Myths overview

Visit the overview page for information on additional myths.

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