Myth or fact? Ancillary staff can't document parts of E/M services

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The Centers for Medicare & Medicaid Services (CMS) does not require physicians to redocument information in a patient’s record that has already been documented by practice staff or by patients themselves.

The AMA is spreading that message, in addition to clarifying other regulations, to reduce the administrative burdens that physicians encounter every day and can impact the delivery of care. This series of articles, “Debunking Regulatory Myths,” seeks to provide clarification to physicians and their care teams in an effort to aid physicians in their day-to-day practice environment.

“Our primary focus is to clarify confusion around what regulations require,” said Christine Sinsky, MD, AMA vice president of professional satisfaction.

The AMA’s debunking regulatory myths series is part of the AMA’s practice transformation efforts and provides physicians and their care teams with resources to reduce guesswork and administrative burdens so their focus can be on streamlining clinical workflow processes, improving patient outcomes and increasing physician satisfaction.

The series includes a webpage devoted to each regulatory myth, such as the one that physicians must redocument information that has already been documented in the patient record. In these articles, the myth is stated and debunked, and resources are provided to remove any lingering doubt that the myth isn’t true. More articles are being added regularly.

“This misinterpretation of regulations is happening all over the place,” said Kevin Taylor, MD, the AMA’s director of organizational transformation, regarding nonexistent or misinterpreted regulatory and administrative rules that drain the time and energy of physicians and staff.
Redocumentation requirement repealed

Historically, physicians had been required by CMS to redocument staff entries to a patient’s history of present illness, social history, family history and review of systems in order to receive payment for the service as part of an evaluation and management (E/M) visit.

But CMS eliminated this requirement as of Jan. 1, 2019.

CMS addressed the matter in the 2019 Medicare physician fee schedule and in an E/M frequently asked questions document related to the fee schedule that were both released in November 2018. Both the final rule and the FAQ document plainly states that “any part of the chief complaint or history that is recorded in the medical record by ancillary staff or the beneficiary does not need to be redocumented by the billing practitioner.”

“Everything has been migrating to that approach,” said Dr. Taylor, citing CMS Administrator Seema Verma’s Patients over Paperwork initiative.

A 2017 JAMA Viewpoint column notes an analysis finding that nearly 80% of 342 wasteful rules identified at 24 health care organizations could be changed without government regulatory or legislative action.

“Unintended burden” lifted

In the case of the redocumentation rule, CMS acknowledged the unnecessary burden that had been created.

“Our current regulations present an unintended burden for billing practitioners, unnecessarily requiring them to redocument information entered into the medical record by physicians, residents, nurses, students, and other members of the medical team when it would be sufficient for them to simply review and verify it,” CMS said in the 2019 Medicare physician fee schedule.

Physicians must still personally perform the physical exam and medical decision-making activities of the E/M service being billed, notes the AMA article on debunking the redocumentation myth.

Send in your questions


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Physicians and members of their care team are invited to submit their queries about misinterpreted regulations that might be diverting their time from patients. Email the practice transformation team directly at Practice.Transformation@ama-assn.org.