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Are physicians required to re-document staff or patient entries in the patient record?

DEBUNKING THE MYTH

The Centers for Medicare and Medicaid Services (CMS) allows physicians to verify staff or patient documentation of components of E/M services, rather than re-documenting the work, if this is consistent with state policies and regulations.[1,2]

BACKGROUND

Ancillary staff and/or patient documentation is the process of non-physicians and non-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, CMS required the physician to re-document ancillary staff entries of the HPI and histories to receive payment for the service. Further, CMS had not issued guidance on the allowability of patient entries into the medical record.

However, CMS addressed these matters in the 2019 Calendar Year Physician Fee Schedule. There are no restrictions as to who can input this information into the patient's visit note. Thus, elements could be entered by the patient through portal questionnaires, etc., and by clinical and ancillary staff.

In January 2021 Medicare documentation requirements were further simplified: when billing by content (as opposed to time) medical decision making is the only component that drives the level of service determination--the level of service is not determined by the history of present illness, social history, family history, review of systems or physical exam.[3]

However, it is important to note that the documentation elements, although not required for LOS code selection, must still be present to support the LOS selected. As an example, if a level 4 EM code is selected for an asthma exacerbation, the H&P and physical exam sections must contain the information that supports a level 4 code: description of respiratory symptoms or distress, elevated respiration rate, and auscultation findings, etc.

KEY TAKEAWAY

Collaborating with ancillary staff—and even patients—to document in the medical record, as opposed to re-documenting this information, can reduce burnout by increasing the time physicians spend caring for patients and decreasing the time they spend on documentation.

The 2019 CMS changes allow physicians to verify patient and staff supplied information for ambulatory visit documentation; there is no longer the requirement that physicians re-document these types of information.

In 2021 CMS changes allow physicians to determine the level of service based on either medical decision making (when billing by content) or by time. The bulk of the note (H&P, Histories, PE) must still be present, and the content must support the severity of the EM code that is selected based on medical decision making.

References

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3. Office of the Federal Register. Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2021. Vol CMS-1734-F.; 2020. Accessed September 9, 2025. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f