Who can document what for E/M?

The latest from CMS on ancillary staff, resident and student documentation

By Shea Lunt, RHIA, CPC, CPMA, PMP

Documentation requirements for an evaluation and management (E/M) service are clearly outlined in the 1995[1] and 1997[2] Documentation Guidelines for Evaluation and Management, published by the Centers for Medicare & Medicaid Services (CMS). However, in many situations, E/M services are provided under the direction of a physician with ancillary staff, residents and students involved in the visit.

This may lead to misunderstanding of who can document certain parts of the E/M service, including the three key components of history, exam and medical decision-making.

Adding to the confusion is a Change Request[3] (CR) released Feb. 5 that revised the CMS *Medicare Claims Processing Manual*[4] regarding medical student documentation. It was published with a Jan. 1, 2018 effective date and an implementation date of March 5.

Providers must understand and follow CMS guidelines to ensure proper documentation and payment for E/M services when documentation is performed by someone other than the billing provider to support E/M services.

Ancillary staff documentation

The history component of the E/M service is where allowance is made for the provider to review and reference information recorded by ancillary staff or to review and reference previously recorded information. Guidelines limit this to occur in the areas of the review of systems (ROS) and past, family and/or social history (PFSH).

Take note of the following points:

- If a common record is used (e.g., an EHR), an ROS and/or PFSH obtained during an earlier encounter does not need to be re-recorded if the provider reviews and updates the information by:
  - Noting any new ROS and/or PFSH information, or remarking no change; and
  - Documenting the date and location of the previous ROS and/or PFSH.

Example: "No changes noted from the last XYZ clinic visit ROS and PFSH on 3/4/18."

Ancillary staff may record the ROS and/or PFSH or a form may be completed by the patient obtaining this information. The provider must document in the record a statement that either gives more information or confirms the data recorded by others.

Although these guidelines may offer efficiencies, the other two areas of history — the chief complaint (CC) and history of present illness (HPI) — are left up to the provider to document. As shown in the chart below, all four parts of history are considered to qualify for a given type.

Unlike history, the exam and all medical decision-making (MDM) should be performed and documented by the provider. The only exception is defined within the constitutional system of the exam in which guidelines state that vital signs may be measured and recorded by ancillary staff.

CC*	HPI*	ROS	PFSH	Type of history
Required	Brief	N/A	N/A	Problem focused
Required	Brief	Problem Pertinent	N/A	Expanded problem focused
Required	Extended	Extended	Pertinent	Detailed
Required	Extended	Complete	Complete	Comprehensive

**Documentation by the provider is required except in the constitutional system*

Exam (per 1995/1997 guidelines)

Description of examination*	Type of exam
A limited examination of the affected body area or organ system	Problem focused
A limited examination of the affected body area or organ system and other symptomatic or related organ system(s)	Expanded problem focused
An extended examination of the affected body area(s) and other symptomatic or related organ system(s)	Detailed
A general multi-system examination or complete examination of a single organ system	Comprehensive

**Documentation by the provider is required except in the constitutional system*

Resident documentation

In teaching settings, services are payable if they are furnished by a resident when a teaching physician is physically present during the critical or key portions of the service. Both the teaching physician and residents may document physician services in the patient's medical record.

For E/M services, the combination of resident and teaching physician documentation in the medical record must support medical necessity and the level of service. The teaching physician must personally document both:

- Performance of the service or physical presence during the critical or key portions of the service furnished by a resident
- Participation in the management of the patient

Example: "I saw and evaluated the patient. I discussed with resident and agree with resident's findings and plan as documented in the resident's note."

Student documentation

CMS CR 10412 revises the *Medicare Claims Processing Manual* to allow the teaching physician to verify any student documentation of E/M services, rather than redocumenting the work. Before this change, student documentation was treated in the same manner as ancillary staff, in which only documentation of the ROS and PFSH parts of the history component could be referenced.

The policy on E/M documentation will be updated to allow the teaching physician to verify in the medical record, rather than redocument, all student documentation of findings, including history, physical exam and/or medical decision-making. Per CMS, "[t]he teaching physician must personally perform (or reperform) the physical exam and medical decision-making activities of the E/M service being billed." Although the teaching physician must continue to perform the work as before, the new requirement offers significant reduction in the duplication of documentation.

MDM (per 1995/1997 guidelines)

Presenting problems*	Diagnostic procedures*	Risk*	Overall MDM
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low
Multiple	Moderate	Moderate	Moderate
Extensive	Extensive	High	High

**Documentation by the provider is required except in the constitutional system*

Keeping E/M documentation in perspective

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be appropriate to bill a higher level of E/M service when a lower level of service is warranted and the higher level is not medically necessary.

The volume of documentation should not be the primary influence upon which a specific level of service is billed. To maintain a balance between patient care and documentation requirements, proper utilization of ancillary staff, residents and medical students can offer great efficiencies. When doing so, it is crucial for providers to be aware of the latest CMS guidelines and ensure that they are followed.

Contact Shea Lunt at slunt@thehaugengroup.com.

Notes:

1. "1995 documentation guidelines for Evaluation and Management services." Medicare Learning Network. Available from: go.cms.gov/1LjiQwx.
2. "1997 documentation guidelines for Evaluation and Management services." Medicare Learning Network. Available from: go.cms.gov/2sy2Q4f.
3. "E/M service documentation provided by students (Manual update)." MLN Matters. May 31, 2018. Available from: go.cms.gov/2oiYpr8.
4. Centers for Medicare & Medicaid Services. *Medicare Claims Processing Manual*. Chapter 12, Rev. 3971, June 13, 2018. Available from: go.cms.gov/2IaoaGh.