Part B Insider (Multispecialty) Coding Alert

Reader Questions: CMS Spells Out MD's Role in E/M

Question: I've heard that for an E/M visit, the physician is responsible for certain parts of that visit. Does Medicare state this explicitly?

Answer: In the E/M service documentation guidelines, CMS states that ancillary staff or even the patient (via questionnaire) may record the review of systems (ROS) and past, family, and/or social history (PFSH) portions of the history component.

Be careful: To receive credit for these history elements, the doctor should date and sign the patient's chart to indicate he reviewed the entire history note.

Straight from the source: The 1995 E/M guidelines state, "The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others."

The 1997 guidelines include the exact same wording as above. In addition, the 1997 guidelines refer to documentation by ancillary staff in another section, which describes requirements for the "constitutional" element of the exam: "Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)."

You can download the documentation guidelines from www.cms.gov/MLNEdWebGuide/25_EMDOC.asp

Watch out: Check your state requirements. For instance, some states require the physician to sign off on any incidentto services, such as 99211 (Office or other outpatient visit for the evaluation and management of an established patient ...), as well as higher-level E/M services, such as 99212-99215, provided by mid-level providers (for instance, an NP). Other states do not require the physician to sign off on incident-to services, but the physician does have to create the plan of care.