CMS LETTER TO CLINICIANS – E/M DOCUMENTATION UPDATE

On November 8, 2018, CMS released a letter to clinicians regarding E/M documentation and coding reform. This follows the CY 2019 Medicare Physician Fee Schedule Final Rule intentions to reduce burden on clinicians in furtherance of the agency's "Patients Over Paperwork" initiative. Effective January 1, 2019, CMS will:

- Simplify the documentation of history and exam for established patients such that when relevant information is already contained in the medical record, clinicians can focus their documentation on what has changed since the last visit rather than having to re-document information;
- Clarify that for both new and established E/M office visits, a chief complaint or other historical information already entered into the record by ancillary staff or by patients themselves may simply be reviewed and verified rather than re-entered;
- Eliminate the requirement for documenting the medical necessity of furnishing visits in the patient's home versus in an office; and
- Remove potentially duplicative requirements for certain notations in medical records that may have previously been documented by residents or other members of the medical team.

Payment and coding changes for E/M services will be implemented beginning in 2021. The CMS letter can be found here.

If you have any questions, please contact Regan Tankersley at (317) 977-1445 or rtankersley@hallrender.com or your regular Hall Render attorney.