November 26, 2018

**Evaluation and Management (E/M) Visit Frequently Asked Questions (FAQs)**
**Physician Fee Schedule (PFS)**

This document addresses Frequently Asked Questions (FAQs) regarding documentation and payment for evaluation and management (E/M) visits under the Medicare Physician Fee Schedule (PFS).

**1. What parts of the history can be documented by ancillary staff or the beneficiary starting in CY 2019?**

The CY 2019 PFS final rule expanded current policy for office/outpatient E/M visits starting January 1, 2019 to provide that any part of the chief complaint (CC) or history that is recorded in the medical record by ancillary staff or the beneficiary does not need to be re-documented by the billing practitioner. Instead, when the information is already documented, the billing practitioner can review the information, update or supplement it as necessary, and indicate in the medical record that she or she has done so. This is an optional approach for the billing practitioner, and applies to the chief complaint (CC) and any other part of the history (History of Present Illness (HPI), Past Family Social History (PFSH), or Review of Systems (ROS)) for new and established office/outpatient E/M visits. To clarify terminology, we are using the term "history" broadly in the same way that the 1995 and 1997 E/M documentation guidelines use this term in describing the CC, ROS and PFSH as "components of history that can be listed separately or included in the description of HPI." This policy does not address (and we believe never has addressed) who can independently take/perform histories or what part(s) of history they can take, but rather addresses who can document information included in a history and what supplemental documentation should be provided by the billing practitioner if someone else has already recorded the information in the medical record.