

E&M Pitfalls



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E&M Coding Pitfalls

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Disclaimer

This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational a guide and should not be considered a legal/consulting opinion

PitFall

- A hidden or unsuspected danger or difficulty
- Synonyms:
 - Hazard
 - Danger
 - Risk
 - Peril
 - Difficulty



New Patient

- Office
 - Level 4 and Level 5
 - Comprehensive History
 - Comprehensive Exam
- Hospital
 - Level 1 and Level 2 and Level 3
 - Comprehensive History
 - Comprehensive Exam

Medical Decision Making
Determines the
Level of Service

Comprehensive History

- History Of Present Illness (HPI)
 - 4 items
 - Since the onset of symptoms what has been going on
 - What's wrong with the patient
 - How bad?
 - How long?
 - What makes it better/worse?
 - 1 other

Patient #1

- A week ago, pt had a loss of consciousness while at home.
- He was taken to the hospital, diagnosed with a seizure disorder, presumably due to his previous MVA.
- He has been taking seizure medicine twice per day, but does not know the name of the med.
- He has not been driving, he has a follow up with neurology.

Patient #2

- Pt presents for management of chronic/new conditions. She is doing well, denies chest pain shortness of breath, palpitations, dizziness/headaches or syncope. Exercising 3x per week for 30 minutes. Feels she eats healthy.
- In August she had a sore throat for quite a while. When she examined her throat she saw nodules on the tonsils. After a week they were not gone so she saw an ENT.
- ENT did a biopsy that came back lymphangioma. She obtained a second opinion from U of M and pathology came back the same. She needed no further treatment.

Comprehensive History

- Review Of Systems (ROS)
 - 9+ items
- A **complete** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.
 - *!DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.*

Review of Systems (ROS)

- A ***problem pertinent*** ROS inquires about the system directly related to the problem(s) identified in the HPI.
 - *!DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented. (1 system)*
- An ***extended*** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.
 - *!DG: The patient's positive responses and pertinent negatives for **two to nine** systems should be documented.*

Patient #1

- ROS: Neurologic, cardiopulmonary, constitutional, urologic, gastrointestinal, infectious, negative except as in history of present illness.
- What was in the HPI?
- HPI: Patient complains of SOB for 2 days

Patient #2

- ROS: Constitutional, ENT, endocrine cardiac, pulmonary, GI, musculoskeletal, neurologic, hematologic, dermatologic, negative except as in HPI



Comprehensive History

- Past, Family, Social History (PFSH)
 - 1 element of each of 3 areas
 - Family history frequently the one missed
 - Non-~~o~~contributory
 - None ~~o~~n file

Past Family Social History

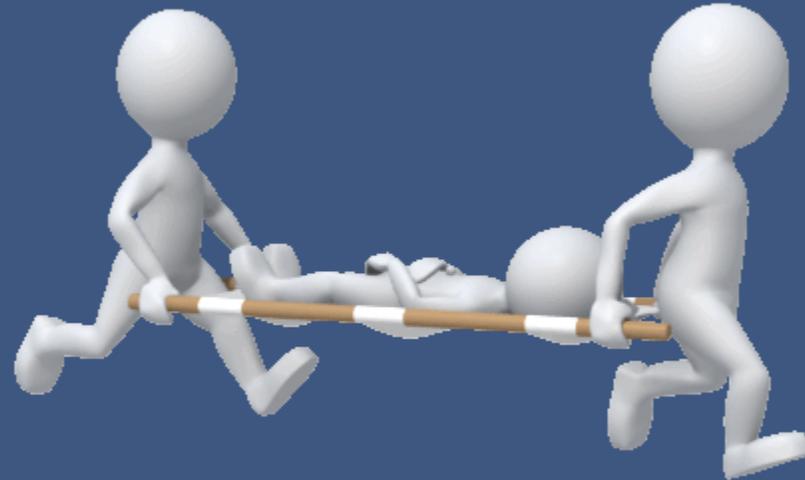
- Don't forget Family History
 - If it is missing, encounter may downcode to subsequent care day.
- Watch the “not” specific phrases – considered unacceptable
 - Non contributory
 - Not on file
 - Mother Alive

History Un-obtainable

What do you document to get credit?

Document your efforts

Maybe, document that without a patient's history, the MDM will be at high level.



History – A Narrative

- When writing a narrative history of the patient to be carried forward for the next physician
- Do NOT put under HPI – make a separate heading
 - May be confused with HPI
 - May appear cloned as an HPI which is problematic

Interval History

- Used for categories of:
 - Subsequent hospital care
 - Follow-up inpatient consultations
 - Subsequent nursing facility
- Not necessary to record information on Past, Family and Social history.

EXAM (1995 E&M Guidelines)

- The extent of examinations performed and documented is dependent upon clinical judgement and the nature of the presenting problem(s).
- They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.
- *!DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented.*
- *A notation of "abnormal" without elaboration is insufficient.*

EXAM (1995 E&M Guidelines)

- *!DG: Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.*
- *!DG: A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*
- *!DG: The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.*

EXAM

Body areas:

- Head, including face Chest, including breasts and axillae Abdomen Neck
- Back, including spine Genitalia, groin, buttocks Each extremity

Organ systems:

- Constitutional (e.g., vitals, gen app) Ears, nose, mouth, throat Resp Musculo Psych
- Eyes Cardiovascular GI Skin Hem/lymph
- GU Neuro

1 body area or system

Up to 7 systems

Up to 7 systems

8 or more systems

(2-4)

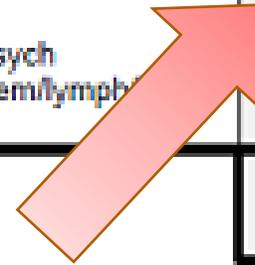
(5-7)

PROBLEM FOCUSED

EXP. PROB. FOCUSED

DETAILED

COMPREHENSIVE



EXAM (1995 E&M Guidelines)

- Detailed -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- 5-7 body areas or organ systems
- Patient #1
 - *RRR, CTA, PERRLA, Throat Clear, No hepatosplenomegaly*

EXAM (1995 E&M Guidelines)

- Comprehensive -- a general multi-system examination or complete examination of a single organ system.
- Patient #2
 - General well developed female, PERRLA, throat clear, cranial nerves intact, heart: RRR; Lungs CTS; Abdomen soft, no hepatosplenomegaly *no edema*

Medical Decision Making (MDM)

Is this a NEW problem??

- Patient here for check of headaches. Several years ago when she was menopausal she had frequent migraines that were treated with Imitrex.
- ROS negative except HPI
- Exam: Well nourished female, in no distress,
- Heart RRR n1, s1,s2, no murmurs, no s3,s4,nl PMI, pulses intact, no thrills, no bruits
- Lungs: Clear to auscultation and percussion
- Skeletal: Normal ROM
- Abdominal: BS soft, non tender, no hepatosplenomegaly, no pulsations, no bruits, no masses, no hernias

Number of Diagnoses or Treatment Options			
A	B	X	C = D
Problem(s) Status	Number	Points	Result
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	Max = 1	3	
New prob. (to examiner); add. workup planned		4	
TOTAL			

Multiply the number in columns B & C and put the product in column D.
Enter a total for column D.



- Is it obvious (stated) that the patient’s problem is new?
- List diagnoses that are diagnosed, treated, addressed or affect the providers medical decision making
- Make note of problems that are not “stable” – i.e. worsening, not responding as expected

DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

Amount and/or Complexity of Data Reviewed	
Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	

Bring total to line C in Final Result for Complexity (table below)

Just because a report has been pulled into your progress note does not mean you get credit for it.

Must be mentioned or addressed in your note

Independent visualization of films can hold extra credit

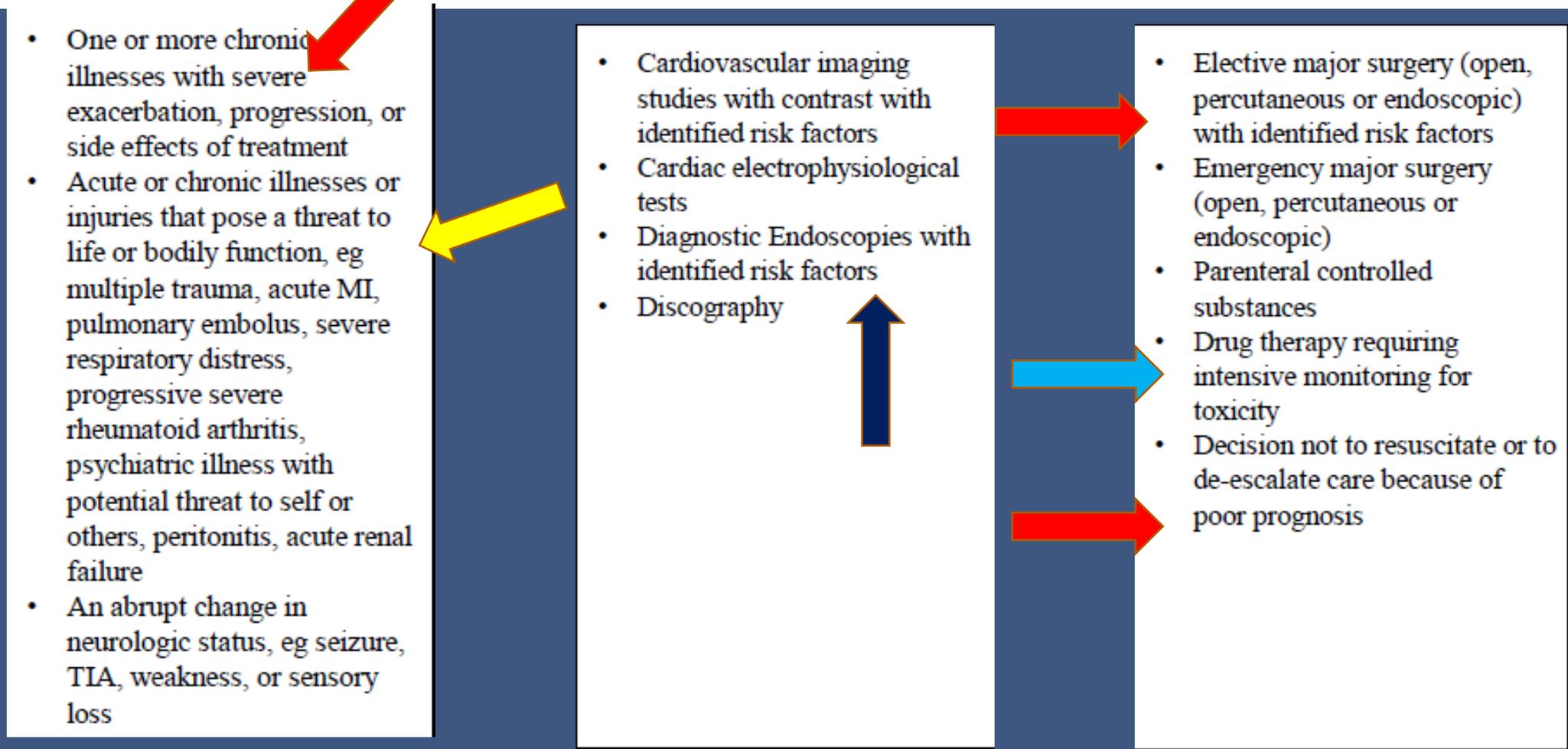
Personally visualized

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	<ul style="list-style-type: none"> One self-limited or minor problem, e.g., cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, e.g., echo KOH prep 	<ul style="list-style-type: none"> First aid Over-the-counter drugs Wound care: bandages Topical dressings
Low	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> Physiologic tests not under stress, e.g., pulmonary function tests Non-cardiovascular imaging studies with contrast, e.g., barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy Wound care without additives
Moderate	<ul style="list-style-type: none"> One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g., lump in breast Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness 	<ul style="list-style-type: none"> Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss 	<ul style="list-style-type: none"> Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography 	<ul style="list-style-type: none"> Elective major surgery (open, percutaneous or endoscopic with identified risk factors) Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

Final Result for Complexity					
A	Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making		STRAIGHT-FORWARD	LOW COMPLEX	MODERATE COMPLEX	HIGH COMPLEX

INPATIENT		Subsequent Inpatient/Follow-up <small>Requires 2 components within shaded area</small>		
History		PF interval	EPF interval	D interval
Examination		PF	EPF	D
Complexity of medical decision		SF/L	M	H
Average time (minutes) <small>(Observation care has no average time)</small>		Subsequent (99231) 15 FU cons (99261)	Subsequent (99232) 25 FU cons (99262)	Subsequent (99233) 35 FU cons (99263)
Level		I	II	III

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
High	<ul style="list-style-type: none"> • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss 	<ul style="list-style-type: none"> • Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography 	<ul style="list-style-type: none"> • Elective major surgery (open, percutaneous or endoscopic with identified risk factors) • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis



With Risk Factors

- Risk above and beyond the normal risk
 - Patient with kidney issues having a CT scan with contrast
- State in the record that the patient is at risk
- Perhaps list why at risk (if not “inherently obvious”)

Drug Therapeutic Requiring Intensive Monitoring for Toxicity

- “Monitor labs”
 - Does not tell the untrained auditor that they are being monitored because of toxicity
- Change to
 - “Monitor Labs for toxicity”

Diagnoses

- Chart documentation
 - In order of severity
- List in chart must match claim form
 - In order
 - In severity
- Don't list the Problem List
- What are YOU taking care of today?

Patient #1

- Patient Active Problem List
 - Pulmonary embolism
 - Colon polyp
 - Nephrolithiasis
 - Erectile dysfunction
 - BPH
 - Closed head injury
 - Essential hypertension
 - Impaired fasting glucose
 - Chronic renal impairment, stage 3
 - Seizure

What are YOU MANAGING today?

Diagnosis

- Why is test being ordered?
 - EHR may require match up
- Signs and Symptoms
 - Negative test

Diagnosis

- Diagnostic Match Up – Ordering Tests or Performing services
 - Match the proper diagnosis to the procedure
 - #1 and #1 or A and A
 - Do not rely on front desk to know
 - They cannot change without specific instruction from the provider
- Encounter that has diagnoses circled
 - Need to also be ordered
 - Not listed alphabetically



Diagnosis

- Pt seen for follow up of Sleep Apnea.
- Pt also complains of asthma flare. SOB, can't sleep
- Doctor prescribes shot of antibiotic and of steroids
- Depo-medrol - Sleep Apnea
- Rocephin – Sleep Apnea
- Office Visit – Sleep apnea
- Asthma
- Patient seen for follow up of dislocated finger
- Patient also has been coughing productively and wheezing
- Chest x-ray was taken in the office
- Chest X-ray – Dislocated Finger
- Office Visit – pneumonia, unsp
- -- dislocated finger

Minor Surgical Procedures - PATH

- Procedures that take only a few minutes (5 minutes or less) to complete (e.g. simple suture)
 - The teaching physician must be present for the entire procedure
 - Teaching physician or resident may document the teaching physician's presence for the entire procedure

ENDOSCOPY - PATH

- Teaching physician must be present during the entire viewing
 - Viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope
 - Viewing the entire procedure through a monitor in another room
 - Does not qualify
- Teaching physician or resident may document the teaching physician's presence for the entire procedure

INTERN & RESIDENT TIME
DOESN'T COUNT
ONLY THE
ATTENDING
PHYSICIAN'S
DOES



Prolonged Care & Counseling and Coordination of Care

- Medical Necessity still must be met
- Documentation of time
 - Start and stop
 - Plus – how much spent in C&C
- Note must reflect discussion for C&C
- Note must reflect why extra time was needed for Prolonged
- Do not put C&C time information at the end of every visit “just in case”

Cloned

- Cloned documentation does not meet medical necessity requirements for coverage of services
 - Lack of specific, individual information
 - Documentation must be specific to the patient and her/his situation at the time of the encounter
- Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services.
 - Falsification of medical record
 - Do not pertain to specific visit to which they are added

Medicare Contractors

- “Cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. Identification of this type of documentation will lead to denial of services.”
- They warned doctors that it would refuse to pay them if they submitted “cloned documentation.”

• NGS

Copy & Paste & Other Shortcuts*

*(AAMC Compliance Officers Forum, EHR Advisory#2, July 11, 2011)

Copy & Paste: selecting data from an original or previous source to reproduce in another location.

Cut & Paste: removing or deleting the original source text or data to place in another location.

Cut and Paste should never be allowed as it alters the original source material.

Copy Forward: a function that copies a significant section or entire prior note.

Automated Change of Note Author: (similar to copy forward) changes authorship of a note written by someone else to current user of the note.

Clinical Plagiarism

- One journal article on EMR cloning went so far as to declare that physicians who copy and paste text from other physicians' notes may be committing "clinical plagiarism" since they are documenting work that they did not perform. The article points out that, "from an auditor's standpoint, you don't know how much work was actually done."
- Reed Gelzer, MD, MPH, co-founder of the Advocates for Documentation Integrity and Compliance
 - "Overwriting (cloning) misrepresents who provided the service, which could alter the amount billed. In addition, by submitting cloned documents for billing you are committing (insurance) fraud."

Provider Attitude Toward Cut & Paste

- Cross sectional survey Resident and faculty physicians at two academic medical centers
 - 90% of physicians who wrote inpatient notes
 - electronically used copy and paste functionality
 - 70% used it almost always
 - Inconsistencies and outdated information were common (71%) in notes containing copy and paste text.
 - 80% wanted to continue to use copy and paste functionality.
- (J. Gen Intern Med. 2009 January; 24(1):63-68)

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3971	Date: February 2, 2018
	Change Request 10412

SUBJECT: E/M Service Documentation Provided by Students (Manual Update)

I. SUMMARY OF CHANGES: This revision to Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 100.1.1, B. E/M Documentation Provided by Students, allows the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. (Manual Update Only)

EFFECTIVE DATE: January 1, 2018

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: March 5, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/101.1.1/Evaluation and Management (E/M) Services

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

CMS Manual System

Department of Health &
Human Services (DHHS)

Pub 100-04 Medicare Claims Processing

Centers for Medicare &
Medicaid Services (CMS)

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Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

100.1.1 - Evaluation and Management (E/M) Services

(Rev. 3971, Issued: 02- 02- 18, Effective: 01-01-18, Implementation: 03- 05-18)

B. E/M Service Documentation Provided By Students

Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the teaching physician *must verify in the medical record all* student documentation *or* findings, *including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.*

Details Questions

- Type of Service
 - Office
 - New patient
 - Established patient
 - Hospital
 - Admissions
 - Initial Encounters
 - Previously called Consults
 - Subsequent care
- Location

100.1.1 - Evaluation and Management (E/M) Services

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Physically Present

- The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

MCM Chapter 12: Sec 100

- Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

MCM Chapter 12: Section 101

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Teaching Physician MUST

- Verify
 - All student documentation or findings
 - Including history, physical exam and/or medical decision making.
- Personally perform (or re-perform)
 - Physical exam
 - Medical decision making activities of the E/M
- May verify student documentation of them rather than re-documenting this work

J8 Part B Provider Outreach and Education Advisory Group (POE AG) Meeting

- All other policies of the Teaching Physicians Section remain in place
- Verified by other POE AG groups, meetings
- CMS –
 - No comment
 - Look to MAC for further comment

100. Teaching Physician Services- MCM Ch 12

- Documentation must be dated and include a legible signature or identity. Pursuant to 42 CFR 415.172 (b), documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.

100. Teaching Physician Services- MCM Ch 12

- In the context of an electronic medical record, the term 'macro' means a command in a computer or dictation application that automatically generates predetermined text that is not edited by the user.
- When using an electronic medical record, it is acceptable for the teaching physician to use a macro as the required personal documentation if the teaching physician adds it personally in a secured (password protected) system.

100. Teaching Physician Services- MCM Ch 12

- In addition to the teaching physician's macro, either the resident or the teaching physician must provide customized information that is sufficient to support a medical necessity determination.
- The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date.
- It is insufficient documentation if both the resident and the teaching physician use macros only.

Scenario 2: The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service

- In this case, the teaching physician must document that he/she was present during the performance of the critical or key portion(s) of the service and that he/she was directly involved in the management of the patient.
- The teaching physician's note should reference the resident's note.
- For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity and the level of the service billed by the teaching physician.

Chapter 12: Sec: 100.1.1

Scenario 2

- Minimally acceptable documentation for scenario:
 - I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note.

- Chapter 12: Sec: 100.1.1

Scenario 4 - Medical resident admits a patient to a hospital late at night and the teaching physician does not see the patient until later, including the next calendar day:

- The teaching physician must document that he/she personally saw the patient and participated in the management of the patient.
- The teaching physician may reference the resident's note in lieu of re-documenting the history of present illness, exam, medical decision-making, review of systems and/or past family/social history provided that the patient's condition has not changed, and the teaching physician agrees with the resident's note.
- The teaching physician's note must reflect changes in the patient's condition and clinical course that require that the resident's note be amended with further information to address the patient's condition and course at the time the patient is seen personally by the teaching physician.

Chapter 12: Sec: 100.1.1

Scenario 4 - Medical resident admits a patient to a hospital late at night and the teaching physician does not see the patient until later, including the next calendar day:

- The teaching physician's bill must reflect the date of service he/she saw the patient and his/her personal work of obtaining a history, performing a physical, and participating in medical decision-making regardless of whether the combination of the teaching physician's and resident's documentation satisfies criteria for a higher level of service.
- For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching

Chapter 12: Sec: 100.1.1

Scenario 4

- Minimally acceptable documentation for the scenario:
 - I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs.
 - I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note.
 - See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written.
 - I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.
- Chapter 12: Sec: 100.1.1

100.1.1 - Evaluation and Management (E/M) Services

- Following are examples of **unacceptable** documentation:
 - “Agree with above.”, followed by legible countersignature or identity;
 - “Rounded, Reviewed, Agree.”, followed by legible countersignature or identity;
 - “Discussed with resident. Agree.”, followed by legible countersignature or identity;
 - “Seen and agree.”, followed by legible countersignature or identity;
 - “Patient seen and evaluated.”, followed by legible countersignature or identity; and
 - A legible countersignature or identity alone.

100.1.1 - Evaluation and Management (E/M) Services

- Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

100.1.1 - Evaluation and Management (E/M) Services

- For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:
 - That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
 - The participation of the teaching physician in the management of the patient.
 - When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician.
- USE OF GC MODIFIER**

