Evaluation & Management Provider Compliance Summary

Documentation Compliance Criteria for Evaluation & Management (E&M) Services

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Source Information: Medicare Policy

Purpose

The United Mine Workers of America Health and Retirement Funds (the Funds) processes and pays Medicare claims as a Health Care Prepayment Plan contracted through the Centers for Medicare and Medicaid Services (CMS). The purpose of this summary is to provide education about Medicare documentation guidelines to improve the quality of records needed to support the payment of Medicare claims paid by the Funds on behalf of CMS.

Requirement & Retrospective Audits

Medicare requires documentation which is legible, complete, appropriately authenticated and supports medical necessity for services reported on the insurance claim form. You may be audited retrospectively by the Funds or CMS to ensure that you have complied with all Medicare payment policies.

Legibility of the Record

- Upon a request for records or for authorization purposes, if hand-written records are not legible, please also submit a typed or printed version of the record reflecting its contents word-for-word.
- All notes, orders and entries made in the patient's record should be dated, time stamped and signed by the author.
- Each note stands alone and should include sufficient information to support the level of service, medical necessity and codes reported on the claim form.
- Generally, the medical record should not be altered. However, errors should be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions should be dated, timed, and legibly signed or initialed. You should not add signatures at a later date or alter the record in any way not permitted by applicable Medicare requirements. Delayed entries within a reasonable time frame (24-48 hrs.) may be acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
- Medicare generally requires that services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature (stamp signatures are not acceptable). Please see additional directives provided below under "Authentication of Records, Orders, and Notes."
- To avoid an error for signature reasons, we recommend that you make certain your documentation contains a LEGIBLE IDENTIFIER (signature) or valid electronic signature of the

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person performing the service and include a signature sample when responding to a request for records.
- The authentication requirement (i.e., legible signature, signature log or signature attestation statement) applies to various documents for many Medicare-covered services. The Funds follows applicable Medicare authentication guidelines.

Authentication of Records, Orders, and Notes

The Funds recommends the following to properly authenticate your documents related to Medicare claims:

- ALWAYS sign your notes and document and sign all orders. Notes and/or orders submitted with just a typed signature/signature line with no handwritten or electronic signature may not be acceptable.
- Notes that have been transcribed should always be reviewed and signed – either electronically or with a hand-written signature - by the author of the note.
- Do not sign a typed note without proof reading and making corrections to the note prior to signing.
- You should print your name along with your written signature for clarification.
- Initials should also have a printed name for clarification. When a note is from an inpatient setting, a full signature is preferred along with a printed name.
- Signatures should be legible. A signature for which no letters can be established or that does not contain a typed/printed name for clarification may not be acceptable. Signature logs should be submitted when the signature is not legible. Signature logs should contain a sample signature with a typed or printed name, credentials, and when employment began and terminated (if applicable). Please use the sample signature log accompanying this summary.
- When a signature is not present and the record has been requested for review or audit by the Funds, please use the attached Medicare attestation statement. Provide the appropriate information on the attestation statement, sign it legibly, and submit the attestation statement with the unsigned records to the Funds.

The following are acceptable forms of signature for Medicare claims:

- Legible handwritten signatures
- Illegible signatures over a typed/printed name
- Illegible signatures where the letterhead, addressograph or other information on the page indicates the identity of the individual signing the document
- Illegible signatures accompanied by a signature log or an attestation statement
- A legible first initial and last name
- Initials over a typed/printed name or accompanied by a signature log or an attestation statement

Coding Guidelines

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Claims should be coded using data sets in accordance with the applicable Administrative Simplification Rules of the Health Insurance Portability & Accountability Act of 1996, as amended (HIPAA). The current year Current Procedural Terminology (CPT), HCPCS level 1 and ICD-9-CM codes are to be used when coding Medicare claims sent to the Funds.

Applicable regulations, Medicare manuals, coding guidelines and Medicare medical necessity policies found in your Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) should also be followed. Applicable Medicare National Correct Coding Initiative (NCCI) bundling guidelines, applicable Medically Unlikely Edits (MUEs) as well as applicable 1995 or 1997 E&M documentation guidelines should be followed by your office.

Evaluation & Management (E&M) Services

Expenses paid by Medicare, including expenses for Evaluation and Management (E/M) services, must be "medically reasonable and necessary." The level of service should be determined by the ***medical complexity of the visit*** with supporting documentation according to the CPT Book and the 1995 and 1997 Documentation Guidelines. Auditors will likely review the complexity and risk associated with the patient's condition (i.e., the medical decision-making component) for a particular visit and then audit the history and exam to ensure that the appropriate levels of key criteria have been met to support the code assignment submitted on the claim form.

Information used by Medicare is contained within the medical record documentation of history, examination and medical decision-making. Medical necessity of E/M services is based on the following attributes of the service that affected the physician's documented work:

- Number, acuity and severity/duration of problems addressed through history, physical and medical decision-making.
- The context of the encounter among all other services previously rendered for the same problem.
- Complexity of documented comorbidities that clearly influenced physician work.
- Physical scope encompassed by the problems (number of physical systems affected by the problems).

Documentation of the E&M Visit

Identify all the presenting complaint(s) and/or reason(s) for the visit for which physician work occurred:

- Demonstrate clearly the history, physical and extent of medical decision-making associated with each problem.
- Demonstrate clearly how physician work (expressed in terms of mental effort, physical effort, time spent and risk to the patient) was affected by comorbidities or chronic problems listed.

Ensure the nature of the patient's presentation corresponds to CPT's contributory factors of the nature of the presenting problem and/or patient's status descriptions for the code reported. For instance:

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- 99231 – “Usually the patient is stable, recovering or improving.”
- 99232 – “Usually the patient is responding inadequately to therapy or has developed a minor complication.”
- 99233 – “Usually the patient is unstable or has developed a significant complication or a significant new problem.”

Utilize clinical examples in CPT Appendix C. The clinical examples are believed by CPT to represent the physician work that is medically necessary to provide appropriate patient care in the specified clinical circumstances of the example.

Understand that Medicare expects actual documentation of services similar to the ones in the examples to also satisfy CMS documentation requirements to demonstrate the service billed was provided.

Documentation of Procedures Performed During the Office Visit

Injections

- There must be a signed order for the injection in addition to the reason (diagnosis) for the injection to support medical necessity. Orders should contain the following elements:
  - Patient's name;
  - Date and time of when the order was written; and
  - Signature of the ordering clinician.
- A complete record of the administration of the injection is required. Whether the provider is administering a more invasive injection, such as a joint or trigger point injection, or the injection is delegated to ancillary staff in the office, the following elements must be present in the record for the date of service filed on the claim:
  - Verification of the order and a clearly stated reason for the injection;
  - Documentation of the diagnosis or condition being treated - there must be a specific reason for the administration and it should match the provider's written order;
  - Date and time of the injection;
  - Route of administration (e.g., IM, SQ, IV)
  - Location of injection (e.g., deltoid)
  - Dosage administered;
  - Amount administered and any discarded (if applicable);
  - Appropriate authentication (e.g., legible signature, which includes credentials such as MD, PA, NP, LPN, RN, CMA, etc.).
- Medical necessity requirements must be met. Please reference Local and/or National Coverage Determinations to determine if a specific drug is covered under Medicare rules as prescribed by the physician.

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Injections Billed with Nurse Visits (99211)

Coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary (e.g., nursing) personnel. The physician must be present in the office suite for services to be covered by Medicare as incident to a physician's professional service. If this condition is met, the following documentation is required to support both 99211 and the injection administration as well as the charge for the drug administered:

- 99211 Description: "*Office or other outpatient visits for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.*"
- Append modifier "-25" to "99211" and report "99211-25" as the first line item on the claim if it is necessary to indicate that on the day a procedure or service identified by a CPT code was performed (in this instance, an injection), the patient's condition required a significant, separately identifiable evaluation and management service, which is above and beyond the other service provided (i.e., the injection). Ensure that documentation supports the use of modifier 25.
- Documentation for code 99211 should support key E&M components, such as a review of the patient's history (why the patient is there for the nurse visit), an exam (i.e., vital signs) and/or the medical decision-making component. Two of the three components need to be evident in the record and go beyond the reason for the injection. An example might be the nurse checking the patient for side effects from current medications, which might contraindicate giving the injection that day, or checking other complaints the patient may have to determine whether the physician should be called into the exam room.
- ***NOTE:*** If the RN, LPN or other auxiliary personnel furnishes the injection in the office and the physician is ***not present in the office*** to meet the supervision requirement, then both the injection and *99211 are not covered* because they do not meet Medicare's incident-to guidelines.

Phlebotomy (Blood collection)

Venipuncture is the blood collection procedure from a vein, usually for laboratory testing. Code 36415 is typically reported for this procedure and is a high-volume service billed by many clinical diagnostic labs, physician offices and other facilities.

Double billing situations may occur when the reference lab and the physician's office both bill code 36415 for the same patient and the same laboratory tests. To avoid an overpayment situation due to duplicate billing, please be advised of the following documentation requirements:

- Your office may bill for venipuncture only when the procedure has been performed by you or under delegation to one of your ancillary staff members in the office and the procedure is appropriately documented in the patient's record.

- The following should be documented by the person performing the phlebotomy to support billing and reimbursement under your provider number as follows:

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- ❖ Reason for the specimen draw;
- ❖ Date, time and location of the needle-stick;
- ❖ Name of phlebotomist and appropriate authentication of the medical record entry; and
- ❖ Physician presence in the office suite to satisfy the incident-to requirement for this service.

- ➢ An order for the lab test should be evident in the progress note along with the reason for the order.
- ➢ When the record lacks a definitive diagnosis, ICD9 guidelines permit symptoms or signs to be coded.
- ➢ Check with your reference laboratories to ensure that they are NOT filing claims for code 36415 when your office has performed the service and should be reimbursed. It is YOUR responsibility to ensure that duplicate billing has not occurred, to maintain billing compliance and to avoid overpayments.

Minor Procedures

Minor procedures, such as ECGs or laceration repairs, are examples of procedures typically performed in the office setting. Services must be medically necessary and separately identifiable when billed with an E&M code.

- ➢ When an E&M code is reported in addition to the minor procedure performed on the same day on the same patient by the same provider, modifier 25 may be required. The E&M service is sequenced first on the claim form with modifier 25, the minor procedure is sequenced subsequent to the E&M service.
- ➢ Ensure that documentation in the record supports the use of modifier 25 by indicating that the patient's condition required a significant, separately identifiable evaluation and management service, which is above and beyond the other service (e.g., a laceration repair).

Non-Physician Practitioners (NPPs)

Non-physician practitioners or NPPs include Physician Assistants, Nurse Practitioners, Certified Nurse Midwives or other health care professionals set forth in Medicare rules. NPP office visits for services rendered to new patients, new problems or where procedures are performed should be billed using the NPP's NPI billing number on the claim form and NOT billed as incident-to.

NPP as Incident-to (Billing the NPP using the Physician's NPI number on the claim)

For hospital patients and Skilled Nursing Facility (SNF) patients who are in a Medicare covered stay, there is no Medicare part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under §1861(s)(2)(A) of the Social Security Act.

Follow Medicare guidelines for ***Shared Visits*** when applicable (see guidelines below).

A non-physician practitioner such as a physician assistant or a nurse practitioner may be licensed under State law to perform a specific medical procedure and may be able to perform the procedure without

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physician supervision and have the service separately covered and paid for by Medicare as a physician assistant's or nurse practitioner's service. However, in order to have that same service covered as *incident to the services of a physician*, it must be performed under the ***direct supervision*** of the physician as an integral part of the physician's personal in-office service.

Use the following criteria to verify that your billing procedures are in compliance:

- The physician sees the patient (at a previous visit) and initiates the plan of care that the NPP is carrying out. For example, the physician sees a patient with hypertension and asks the patient to follow up with the NPP.
- The physician remains involved in the patient's care and documents this involvement in the patient's chart. For example, the physician's review of the NPP's note or discussions between the NPP and the physician may be documented, as well as periodic face-to-face time between the physician and the patient.
- The NPP must be an employee, leased employee or independent contractor of the physician or the group that employs the physician.
- The patient's physician (or another employed physician) must be in the office and immediately available. Medicare has made it clear that you may not bill the NPP service under the physician's provider number unless the physician is in the office suite and immediately available to provide backup. Telephone availability is not sufficient.
- The service must be provided in the office. Incident-to services may not be billed in the emergency department, hospital or nursing home. Incident-to services are meant to cover usual and typical services provided in the office.
- Unless the provider is a nurse practitioner, physician assistant, certified nurse midwife or clinical nurse specialist, the service can only be billed as 99211.

Please reference the Medicare policy manuals for more information regarding Medicare incident to rules.

<u>Shared Visits (Physician and NPP)</u>

In general, incident-to services are for office-based services, and ***shared visits are for hospital services***. Shared visits are E&M services provided to inpatients in a hospital or outpatients in the emergency department.

These services are literally "shared" between the physician and NPP.

If both the physician and the NPP have a face-to-face encounter with the patient, the key elements of both notes may be combined and one E&M service may be billed under the physician's provider number.

- The physician must have a face-to-face encounter with the patient.
- It is not sufficient to simply note, "Seen and agree," nor is it sufficient to simply countersign the note when billing a shared visit.

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- The physician may see the patient before, after or at the same time the NPP sees the patient.
- Evidence must be present in the record that both the physician and NPP have personally performed a portion of the visit. Progress notes of both providers must be authenticated by the author of the note.
- Elements of both notes are combined to select the appropriate level of hospital E&M service to report on the claim. The service is then filed under the physician's provider number.

Recommended Medicare Resources & References (not all inclusive)

Authentication: Program Integrity Manual, Publication 100-08 Chapter 3, Section 3.4.1.1

E&M: 1995 and 1997 Documentation Guidelines found at www.cms.gov

Medicare Claims Processing Manual, Publication 100-4 Chapter 12, Section 30.6.1 and 30.6.13

Medicare Benefit Policy Manual, Publication 100-2 Chapter 15, Sections 30, 50 and 60

Current Procedural Terminology (CPT) Book, Evaluation & Management Section, Appendix C

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