



E/M Question and Answer

Billing

- 1) If a provider performs a procedure and also examines the patient for other circumstances unrelated to the procedure, would it be appropriate to bill an Evaluation and Management (E & M) service for the additional examination?**

If the patient presents for a procedure and the provider needs to perform a separately identifiable exam, it would be appropriate for the provider to bill an E&M for this service. Remember to apply the 25 modifier with the E&M to indicate that a separately identifiable service was performed.

- 2) What is the appropriate way to bill for a physician's services with a routine physical/visit in conjunction with a medically necessary visit (i.e. follow-up visit to monitor use of medications for chronic illnesses)? What is the appropriate way to determine the amount to charge the beneficiary for the non-covered portion of a preventive visit with a covered medical visit: (1) should our established charge for the covered medical visit be subtracted from our established charge for the preventive visit; or (2) the Medicare allowed amount for the covered medical visit?**

If the physician performs the preventive/annual exam etc., and also performs a medically necessary E/M service at the same encounter, the physician would report the medically necessary E/M (e.g., 99213) and Medicare will pay for that service. The physician, in turn, is supposed to subtract the 99213 visit payment (Medicare Allowed Amount) from their preventive medicine charge. We call this a "carve out."

Medicare allows carve outs to give providers an incentive to address both the preventive and covered issues in one visit. Medicare understands that there is a need to address a patient's other concerns related to chronic illnesses during a preventive visit. Allowing carve outs reimburses the physician for those components performed in a preventive visit that would normally be covered by Medicare if done independent of that visit, while still allowing the physician to be compensated for the remaining preventive services at their normal standard fee. In addition, this benefits the beneficiary as some of their expenses for that visit were covered and they need only come in once.

Due to the number of questions we receive regarding the amount to charge for carve out services, WPS staff sought and received clarification from CMS.

First, select the most appropriate code for the preventative (routine/physical visit) visit (codes 99381-99387 or 99391-99397).

Next, select the most appropriate Evaluation and Management (E&M) code for the medically necessary portion of the visit.

Subtract the appropriate Medicare Allowed Amount for the medically necessary E&M visit from your charge for the preventive exam.

The remaining balance is what you will charge for this portion of the exam. This portion will be a "non-covered" service.



3) How is a "significant issue" determined when performing a Preventive Medicine Service (Routine Annual Check-up) that would then warrant a split billing of a covered Evaluation and Management (E & M) and the Preventive service, in the office setting for an established patient?

It would be considered a "significant issue" when a new or different abnormality/medical problem or a change or exacerbation of a pre-existing condition is revealed in the process of examining the patient and the physician determines it is significant enough to require additional work to perform the key components of the appropriate level office E & M.

4) What is the appropriate way to submit a claim with two billable services, such as an Evaluation and Management (E & M) code and a procedure code? Would the use of a modifier be necessary?

The appropriate way to bill this example would be to include the appropriate procedure code and the appropriate level of E & M. In addition, all services performed on the same day should be billed on the same claim. The necessity of a modifier will depend on the service/procedure performed. For example:

1. If the service is a minor surgery or endoscopy (000/010 postoperative days), a 25 modifier would be reported when a significant evaluation above and beyond the usual pre-operative/post-operative care associated with the minor surgery/endoscopy is performed.
2. If the service is a major surgery (090 postoperative days) and the need is an emergency or urgent, you would report a 57 modifier with the appropriate E & M service.
3. When performing a radiology, laboratory, or medicine service, a modifier applied to the E & M service is not needed.

Please Note: Generally when billing a surgical procedure, an E & M service is included in the procedure. By applying the 25 modifier, the provider is indicating that a significant separately identifiable service was performed above and beyond the procedure code billed. By applying the 57 modifier the provider is indicating the surgery was not pre-planned or scheduled. As always, the provider's documentation must support all services billed.

REFERENCES:

Internet-Only Manual (IOM) Claims Processing Manual (Pub. 100-04), Chapter 12, Section 40. (<http://cms.hhs.gov/manuals/downloads/clm104c12.pdf>) (pdf - 171 pages; 886KB)

5) If a physician sees a family member of a patient to discuss a patient's condition, can the provider bill for an evaluation and management service?

No. In order for the physician to bill there must be a face to face with the patient and the key components of the appropriate E & M procedure code must be met.

6) Can I bill a hospital visit on the same day as another physician?

Yes, when the physicians are each responsible for a different aspect of the patient's care, both visits may be billed if the physicians are in different specialties and the visits are billed with different diagnoses. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician unless the evaluation and management services are for unrelated problems.



- 7) **We have several patients who fail to keep their annual appointment. What is the soonest an established patient is considered a 'new patient' for billing an Evaluation and Management (E & M) visit?**

New Patient Visits

1. "New patient" is defined as a patient who has not received any professional services from the physician within the previous 3 years.
2. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.
3. If no face to face encounter has previously occurred between the physician and the patient, then the patient may be coded as a new patient the first time a face to face encounter does occur.

For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed but a face to face encounter does not take place, then this patient remains a new patient for whenever the initial evaluation and management service occurs.

- 8) **When billing for non-renal episodic visits (e.g. sore throat, cold, etc.) in a dialysis facility during a dialysis visit, is it appropriate to bill for the non-related Evaluation and Management (E& M) codes outside of the G-code visit? If so, would we append a -25 modifier (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E& M visit?**

The answer to both questions, as qualified below, is yes. The MCP (monthly capitation physician) may bill for non-related E & M services on the same day as dialysis, using a -25 modifier with one of the E & M codes as listed and described below.

This answer is based on the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Pub. 100-4, Ch. 8, Section 170 (<http://cms.hhs.gov/manuals/downloads/clm104c08.pdf>), (pdf - 112 pages; 548KB) and is quoted for your reference:

Therefore, payment for all evaluation and management services is bundled into the payment for 90935, 90937, 90945 and 90947, except for the following evaluation and management services which may be reported on the same date as dialysis service with the use of the -25 modifier and they are separately identifiable and met any medical necessity requirements:

99201-99205 Other or other outpatient visits for a new patient

99291-99215 Office or other outpatient visit for an established patient

99221-99223 Initial hospital care for a new or established patient

99238-99239 Hospital discharge day management services

99241-99245 Office or other outpatient consultations, new or established patient

99251-99255 Initial inpatient consultations, new or established patient

*99291-99292 Critical care services*

In the absence of one of these codes being reported with the -25 modifier and meeting other requirements listed above, pay only the dialysis service and deny the evaluation and management service. Furthermore, payment is not allowed for more than one dialysis service per day.

9) A patient is discharged from an inpatient hospital and then admitted to a Nursing Facility (NF) on the same day by the same physician. Would the discharge from the hospital and admission to the NF be separately payable to Medicare?

Yes, Medicare allows a hospital discharge and Nursing Facility admission on the same day by the same Physician with the exception of the patient in a global period following a surgery.

Nursing Facility evaluation and management services performed by the operating surgeon for the post-operative care related to the recovery of the surgery and not requiring a return to the operating room are included in the global surgery fee and are not paid separately.

If the operating surgeon is admitting the patient to the nursing facility during the post operative period for a condition unrelated to the surgery, the surgeon should report the service with a 24 modifier. Documentation that the admission is unrelated to the surgery must be available to the Carrier on request.

REF:

IOM 100-04, Ch 12, Section 30.6.9.2

IOM 100-04, Ch 12, Section 30.6.9.2 (B)

IOM 100-04, Ch. 12, Section 40-40.9

Consultations

1. The physician has admitted the patient to a palliative care unit in the hospital or nursing facility. Can the palliative care physician, responsible for the care in that unit, bill for a consultation?

No. The admitting physician is not requesting the advice, opinion, suggestions etc. from the palliative care physician. The palliative care physician could bill for a new or subsequent patient visit code as appropriate. In addition, depending on how the facility classifies the patient, the billing would reflect the place of service.

The Centers for Medicare and Medicaid Services (CMS) has published information on the rules for consultation services. You can find this information in the Internet Only Manual (IOM) 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.10. Please see the reference below.

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> 

2. A patient has made an appointment with a specialist's office. The patient's attending physician suggested that the patient make the appointment with the specialist. The attending physician and the specialist have not had any contact, either verbal or written, concerning this patient's care. The specialist will send a written report to the attending physician. Is this a consultation?



No. The attending physician is not requesting the advice, opinion, suggestion etc from the specialist. The specialist does not have any documentation indicating a request from the attending physician. While it is good medical practice for the specialist to share his/her findings with the attending physician, this does not make the service a consultation. The specialist could bill for an initial or subsequent care visit as appropriate.

The Centers for Medicare and Medicaid Services (CMS) has published information on the rules for consultation services. You can find this information in the Internet Only Manual (IOM) 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.10.

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> 

3. What is Medicare's definition of a specific problem?

Medicare does not have a single definition for the term "specific problem." As the term relates to consultation services, "specific problem" should address the services provided.

4. Can a consult for preoperative clearance be billed when the patient does not have a diagnosis other than needing clearance for surgery?

Preoperative consultations are payable for new or established patients performed by any physician or qualified Non-Physician Practitioner (NPP) at the request of the surgeon, as long as all of the requirements for performing and reporting consultation codes are met and the service is medically necessary and not routine screening.

If the services provided are clearance for surgery, then the findings of the evaluation and management examination should be documented in the patient's medical record. As directed by CMS, Carriers pay for a reasonable and medically necessary consultation. According to Pub 100-4, Ch. 12, Section 30.6.10: *The surgeon must request opinion or advice of the physician regarding evaluation and/or management of a specific problem.*

In the scenario outlined in the question above, the diagnosis should be the reason for the surgical procedure. The appropriate office consultation codes (CPT 99241-99245) or initial inpatient consultation codes (CPT 99251-99255) should be used. The reason for the consultation must be evident in the consulting physician's written report or in the request from the referring physician.

REFERENCE:

Pub 100-4, Ch. 12, Section 30.6.10 (<http://cms.hhs.gov/manuals/downloads/clm104c12.pdf>) (pdf - 171 pages; 886KB)

5. When providing telemedicine services, what place of service (POS) should the provider use for the "distant site"?

Per the Internet Only Manual (IOM), "distant site" is defined as *the site where the physician, providing the professional service, is located at the time the service is provided via a telecommunications system.* Therefore, the POS code matching the physical location of the provider, should be used.

REFERENCE: Pub 100-4, Ch. 12, (<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>) (pdf - 171 pages; 886KB)

6. Does a Consulting provider need to have written documentation requesting the consult in order to qualify the visit as a consult?



The initial request may be a verbal interaction between the requesting physician and the consulting physician; however, the verbal conversation shall be documented in the patient's medical record, indicating a request for a consultation service was made by the requesting physician or qualified NPP. A *written* request for a consultation from an appropriate source and the need for a consultation must be documented in the patient's medical record. A written report *shall* be furnished to the requesting physician or qualified NPP. In an office setting, the documentation requirement may be met either by a specific written request for the consultation from the requesting physician or qualified NPP or by a specific reference to the request in the consultant's records. In this setting, the consultation report is a separate document communicated to the requesting physician or qualified NPP.

7. Can physicians and nurse practitioners combine documentation to bill a higher level of service for a consultation?

No. According to the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Pub. 100-4, Chapter 12, Section 30.6.10, a consultation shall not be performed as a split/shared E/M visit.

8. A patient is referred to a physician for consultation regarding back pain. The consultant sees, examines the patient, and then determines that this is a trigger point. He then injects the patient. Can the physician bill separately for the consultation or does it get bundled into the trigger point injection?

Yes, the physician can bill separately for the consultation. Even if the procedure had a global period, the appropriate level of consultation can still be billed as long as the decision to perform the minor or major procedure resulted from the findings of the consultation.

If it was known before the visit took place that the procedure was going to be performed (e.g. the visit was for a repeat injection or was set up for an initial injection), the visit would be bundled into the treatment. This is because the findings of the E/M did not result in the determination to do the procedure.

9. Is only one initial consult code per provider/specialty allowed per hospitalization? In the case of a trauma patient who is hospitalized for an extended period of time, is it appropriate (for a provider who bills an initial consultation then does not follow the patient, but is consulted again at a later date) to bill a subsequent initial consultation?

The Initial Inpatient Consultation may be reported only **once** per consultant per patient per facility admission. The follow-up care shall be reported using the Subsequent Hospital Care codes. Effective January 1, 2006, the follow-up Inpatient Consultation codes (99261-99263) are deleted. In the hospital setting, following the initial consultation service, the Subsequent Hospital Care codes (99231-99233) shall be reported for additional follow-up visits. In the nursing facility setting, following the initial consultation service, the Subsequent Nursing Facility (NF) Care codes (new CPT codes 99307-99310) shall be reported for additional follow-up visits. Effective January 1, 2006, CPT codes 99311-99313 are deleted and not valid for Subsequent NF visits. Also, effective January 1, 2006, the Confirmatory Consultation codes (99271-99275) are deleted.

10. Where in Medicare policy or in the CMS Internet-Only Manual is the definition of "appropriate source"?

Upon further research, there is not a definition of "appropriate source" in the manual or policy; but, it would appear any Medicare qualified provider acting within his scope of practice involved in



the care and treatment of patients within that scope, seeking advice from a specialist or expert in the care and treatment of that patient, would be an appropriate source.

11. In regards to consults, is a copy of the consulting physician's note sent to the requesting physician, sufficient documentation for the guideline in PHYS-006 on consult criteria that states "a written report from consulting physician to the referring physician?"

After a consultation has been completed, provision of a copy of the consulting physician's note to the referring physician can satisfy the Medicare requirement of a written report from the consulting physician to the referring physician. The consulting physician's note, however, must contain the referring physician's name, plus evidence that the referring physician requested both the consultation and the consulting physician's opinion. A telephone communication, alone, from the consulting physician will **not** satisfy the requirement. There must be a **written** report from the consultant. (In addition, all the additional criteria for a consultation that have been set forth in IOM 100-4 Chapter 12 A must have been met.)

12. What are the requirements for consults in a hospital setting?

The Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual (Publication 100-4), Chapter 12, Section 30.6.10 (F) states: *Documentation for Consultations: A written request for a consultation from an appropriate source and the need for a consultation must be documented in the patient's medical record. The initial request may be a verbal interaction between the requesting physician and the consulting physician; however, the verbal conversation shall be documented in the patient's medical record, indicating a request for a consultation service was made by the requesting physician or qualified NPP. The reason for the consultation service shall be documented by the consultant (physician or qualified NPP) in the patient's medical record and included in the requesting physician or qualified NPP's plan of care. The consultation service request may be written on a physician order form by the requestor in a shared medical record. A written report shall be furnished to the requesting physician or qualified NPP. In an emergency department or an inpatient or outpatient setting in which the medical record is shared between the referring physician or qualified NPP and the consultant, the request may be documented as part of a plan written in the requesting physician or qualified NPP's progress note. An order in the medical record may consist of an appropriate entry in the common medical record.*

REFERENCE: Publication 100-4, Chapter 12

<http://cms.hhs.gov/manuals/downloads/clm104c12.pdf> (pdf - 171 pages; 886KB)

13. A physician sends a patient to your pain management office because of chronic back pain. A physician at the pain management office examines the patient, and discusses possible treatment with the patient. The patient declines to have a joint injection and decides to continue with physical therapy and chiropractic manipulations. The examining physician from the pain management office prepares and sends a report of his/her findings to the patient's primary care physician (PCP). You also state that it appears to you that an opinion of a specific problem is being requested from an employee of the pain management office. He/she renders services to the patient, and his/her opinion/report is then sent back to the PCP. Would the above scenario qualify as a Consultation?

Based on the expertise of Medicare Medical Review and Medical Policy staff, and the information provided above, it appears the situation may qualify as a "Consultation" service. IOM 100-4 Chapter 12 B, Consultations, states *Medicare Carriers can consider payment for a Consultation*



when all of the criteria for the use of a Consultation code are met. The policy specifically mentions the following; however, this listing is not "all inclusive," as there are other guidelines that also apply to Consultation services.

A Consultation is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

The request for the Consultation comes from an appropriate source and the need for the Consultation must be documented in the patient's medical record.

After the Consultation is provided, the consultant prepares a written report of his/her findings, which he/she then provides to the referring physician.

In the scenario, it is not clear who "sent" the patient for the consultation. In order for an Evaluation and Management (E/M) visit to qualify as a consultation, a **request** from an appropriate source and the need for a consultation **must be documented in the patient's record**.

It is important to remember that, while your inquiry provides a short/brief description of the scenario, WPS Medicare cannot instruct providers on specific coding issues. In "scenario situations," there are often underlying circumstances and/or unknown elements of the case that can affect the outcome of our response. The provider of service can refer to the IOM 100-4 Chapter 12 B to assist in determining whether the service provided meets the current coverage criteria and guidelines for a Consultation service.

14. If a patient is not homebound, can a low-level office visit be billed for an Evaluation and Management home visit. The provider understands the higher level of an E & M service may not be billed if not medically necessary.

Per Internet Only Manual (IOM) Section 30.6.14 (B)

*Under the home health benefit, the beneficiary must be confined to the home for services to be covered. For home services by a physician using these codes (99341-99350), the beneficiary does not need to be confined to the home. **The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.***

The place of service for an office visit is (11) and the POS for a home visit is (12). The CPT codes for these POS are different for each type of service and they must match the code billed, or the service will be denied.

15. Clarification from CMS regarding Consultation documentation: must there be documentation by both the referring physician and the consultation in the patient's medical record?

A request for a consultation from an appropriate source and the need for consultation (i.e. the reason for a consultation service) shall be documented by the consultant in the patient's medical record and included in the requesting physician or qualified NPP's plan of care in the patient's medical record; and

After the consultation is provided, the consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician.



REFERENCE: IOM Publication 100-4, Chapter 12, Section 30.6.10 (A)
(<http://cms.hhs.gov/manuals/downloads/clm104c12.pdf>) (pdf - 171 pages; 886KB)

Documentation

1. What information, in a physicians' note for a clinic/office visit, would constitute as a "Plan of Care"?

For a physician's note to qualify as a plan of care, it would need to contain at least:

- the patient's diagnosis,
- long term treatment goals,
- and the type, amount, duration and frequency of services.

It must be established before treatment has begun and may be adjusted by the appropriate practitioner.

REFERENCE: Medicare Resident & New Physician Guide, Chapter 5, "Evaluation and Management Documentation."
(<http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf>)

2. If the past medical section states a chronic or current illness (that the provider is not treating), can it be used in the Review of Systems (ROS)? If the past medical section lists several conditions and there is no mention of controlled or uncontrolled, could this be used in the ROS?

No, per both the 1995 and 1997 Evaluation and Management (E & M) Documentation Guidelines, "a Review of Systems is an inventory of body systems obtained through a series of questions seeking to identify signs or symptoms that the patient may be experiencing or has experienced."

A past medical history would not contain a patient's pertinent positive and/or negative responses as related to the problems identified in the patient's history of the present illness.

REFERENCES: 1995 Documentation Guidelines for Evaluation and Management Services
(<http://www.cms.hhs.gov/MLNProducts/downloads/referencel.pdf>)

1997 Documentation Guidelines for Evaluation and Management Services
(<http://www.cms.hhs.gov/MLNProducts/downloads/referencell.pdf>)

3. Can the provider switch between the 1995 and the 1997 Evaluation and Management (E & M) Guidelines within the body of the note? For example, could there be a '97 history with a '95 exam for the same service on the same note?

The 1995 and 1997 E & M documentation guidelines cannot be mixed and matched on the same E & M service. Wisconsin Physicians Services (WPS) uses both the 1995 and the 1997 guidelines when reviewing a service, and applies the guidelines that are most advantageous to the provider of the service.



REFERENCES: 1995 Documentation Guidelines for Evaluation and Management Services
(<http://www.cms.hhs.gov/MLNProducts/downloads/referencel.pdf>)

1997 Documentation Guidelines for Evaluation and Management Services
(<http://www.cms.hhs.gov/MLNProducts/downloads/referencell.pdf>)

4. **When vitals are recorded in the chart on a flow sheet by a medical assistant (MA), does the physician need to re-dictate them in his note or reference them in his note to count for credit under the "constitutional section" for evaluation and management coding?**

Yes. The vitals need to be referenced. If the MA wrote them in the flow chart, it would not be apparent that the physician saw the vitals unless the physician actually referenced or re-dictated them in his/her note.

In a physician's handwritten note for a visit, the medical assistant will usually write the vitals at the beginning. In that case, it would be a fair assumption that the physician saw and was aware of the vitals and agreed with the findings. In the case of a dictated note, it is assumed that the physician saw the vitals taken by the MA before he dictated them. In both of those scenarios, as long as it could be easily inferred from the physician's notes that the physician was aware of the vitals, nothing further would be necessary.

5. **What is the correct way to document counseling/coordination of care when it dominates more than 50% of the encounter for the Evaluation and Management (E&M) service?**

According to the Medicare Resident and New Physician Guide, 7th Edition, Chapter 6, (<http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf>), in the case where counseling and/or coordination of care **dominates** (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), the time is considered the key or controlling factor to qualify for a particular level of E&M service.

If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of the time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.

This documentation should be available to the carrier upon request.

6. **Who can perform the History of Present Illness (HPI) portion of the patient's history?**

The history portion refers to the subjective information obtained by the provider or ancillary staff. Although ancillary staff can perform the other parts of the history, that staff cannot perform the history of present illness (HPI) portion of the patient's history. Only the provider can perform the HPI.

Emergency Care

1. **A patient presents to the Emergency Department (ED) for care. The ED Physician treats the patient's signs and symptoms then makes the determination for the patient to be admitted as an inpatient. The patient is getting ready to be transferred to the inpatient floor, and then suddenly becomes critically ill. The same ED Physician then**



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performs critical care services. Can the ED Physician bill both ED services and Critical Care services on the same date of service?

No. Since the patient is described as being "ready to be admitted to an inpatient status", he/she has not yet been discharged from the ED. Any services provided to the patient while on ED status are considered to be part of the same ED session, and should be factored into the overall billing of the appropriate level of ED visit. Therefore, in this instance, the critical care that had been provided may be factored into either the overall level of ED service billed, or the critical care service may be billed with the correct codes to reflect the total time spent on critical care. However, both critical care and ED services cannot be billed for the same session.

2. If an Emergency Room (ER) physician contacts another provider for assistance, would it be appropriate for both of the physicians to bill separately for their services?

If the documentation **clearly** indicates that each physician performed separately identifiable services, it **may be** appropriate for them to bill for the services they performed.

HPI

1. Can the status of a chronic or inactive disease be used in the HPI (History of Present Illness) in lieu of a new problem or illness?

As stated in the 1997 Evaluation and Management Guidelines, under HPI, chronic or inactive conditions may be used when applying these guidelines. In both the 1995 and 1997 Documentation Guidelines for E/M Services, the history is a required part of the E/M. The HPI is a part of the history. The level of documentation for the HPI is based on how many of the following elements, as detailed in the 1995 and 1997 Documentation Guidelines for E/M Services, are recorded:

1. Location
2. Quality
3. Severity
4. Duration
5. Timing
6. Context
7. Modifying factors
8. Associated symptoms

REFERENCES: 1995 Documentation Guidelines for Evaluation and Management Services (<http://www.cms.hhs.gov/MLNProducts/downloads/referencel.pdf>)
1997 Documentation Guidelines for Evaluation and Management Services (<http://www.cms.hhs.gov/MLNProducts/downloads/referencell.pdf>)

2. If the nurse takes the History of Present Illness (HPI), can the physician then state "HPI as above by the nurse" or just "HPI as above" in the documentation?



No, the physician needs to fully document the HPI.

- 3. Can History of Present Illness (HPI) elements be counted for both the Chief Complaint (CC) and the associated signs/symptoms? For instance, a patient presents with chest (location) pain (CC) that she has had for 3 days (duration). She also experiences shortness of breath (associated signs/symptoms) when walking up stairs (context).**

No. According to the Evaluation and Management 1995 and 1997 documentation guidelines, "The CC, ROS [Review of Symptoms] and PFSH [Past Family, and/or Social History] may be listed as separate elements of history, or they may be included in the description of the history of the present illness."

The Chief Complaint (CC) is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return or other factor that is the reason for the encounter. In the above scenario, the pain is the reason for the encounter and the patient's history of present illness is chronologically described by the additional elements. The location is the site of the symptom. The duration is the length of time of existence of the sign/symptom. The context is the circumstance or factor that surrounds a particular event, including what precedes or follows the symptom. The associated symptoms are factors or symptoms that accompany the main symptoms.

REFERENCES: 1995 Documentation Guidelines for Evaluation and Management Services (<http://www.cms.hhs.gov/MLNProducts/downloads/referencel.pdf>)
1997 Documentation Guidelines for Evaluation and Management Services (<http://www.cms.hhs.gov/MLNProducts/downloads/referencell.pdf>)

- 4. How is context for History of Present Illness (HPI) elements defined?**

Context is the circumstances or factors that surround a particular event, including what precedes or follows a symptom.

For example, a provider may see a patient who experiences esophageal reflux that occurs most nights approximately 2 hours after he goes to bed and if he has had supper after 8 p.m. If the patient sleeps with his head elevated, he has symptoms on fewer nights. In this scenario, when the esophageal reflux happens (at night), the circumstances under which the esophageal reflux happens (eating after 8p.m.), and what makes the esophageal reflux better (head elevated) would constitute "context."

Miscellaneous

- 1. Is there an audit sheet for Evaluation and Management on the Medicare website?**

WPS has no audit tool for Evaluation and Management Services which is available to the general public. Evaluation and Management Services should be coded using the information found in Chapter 12 of the Claims Processing manual.

REFERENCE: Claims Processing Manual, Chapter 12.
<http://cms.hhs.gov/manuals/downloads/clm104c12.pdf> (pdf - 171 pages; 886KB)



2. **If documentation is requested for review and the provider's documentation is illegible, would it be appropriate for another staff member (i.e., coder, nurse) to interpret the documentation and submit the more "legible" form of documentation?**

Yes, that is acceptable; however, remember to submit the actual illegible documentation initially requested with the more legible form of documentation.

REFERENCE: Program Integrity Manual, Chapter 3
(<http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf>)

3. **Is it appropriate to infer location for a psychological or psychiatric chief complaint?**

Yes. The location (of brain) can be inferred from a psychological chief complaint. Location is the site of symptoms or where the problem is located.

4. **Can a radiologist at a radiology IDTF (Independent Diagnostic Testing Facility) change the treating physician's order for a MRI or CT Scan from without contrast to with contrast? What Place of Service (POS) code should I use for Evaluation and Management (E&M) services provided in a convent or monastery?**

The treating physician must order all diagnostic tests furnished to a beneficiary who is not an institutional inpatient or outpatient. A testing facility that furnishes a diagnostic test ordered by the treating physician must not change the diagnostic test or perform additional diagnostic tests without a new order.

However, if the testing facility cannot reach the treating physician/practitioner to change the order or obtain a new order and documents this in the medical record, then the facility may furnish the additional diagnostic test if **all** of the following criteria apply:

1. The testing center performs the diagnostic test ordered by the treating physician/practitioner;
2. The interpreting physician at the testing facility determines and documents that, because of the abnormal test result of the diagnostic test performed; an additional diagnostic test is medically necessary;
3. Delaying the performance of the additional diagnostic test would have an adverse effect on the care of the beneficiary;
4. The result of the test is communicated to and used by the treating physician/practitioner in the treatment of the beneficiary; and
5. The interpreting physician at the testing facility documents in his/her report why additional testing was done.

REFERENCE: Medicare Carriers Manual (MCM) - Part 3 - Claims Process, Chapter 15, §15021
(<http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021921>)

5. **What differences are there between the 1995 and the 1997 Medicare E/M Guidelines when it pertains to the different exam levels?**



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Providers will have to review each living situation according to the definitions in the Currently Procedural Terminology (CPT) book and the Centers for Medicare & Medicaid Services (CMS) Place of Service (POS) Code definitions (<http://cms.hhs.gov/PlaceofServiceCodes/Downloads/POSDataBase.pdf>) and then decide which POS code is appropriate. Depending upon the convent or monastery, some will be domiciliary codes, and some will be a private residence.