EVALUATION & MANAGEMENT DOCUMENTATION CHECKLIST: 99306

If you receive a letter from CGS requesting documentation to support a nursing facility visit-initial facility care the following information should be available in the patient records:

For the initial nursing facility care; per day for the evaluation and management of a patient, all 3 of these key components are necessary:

- A comprehensive history
- A comprehensive examination
- Medical decision making of HIGH complexity

Usually the problem(s) requiring admission are of high severity. Physicians typically spend 45 minutes at the bedside and on the patient's facility floor or unit. ☐

When the patient is admitted to the nursing facility in the course of an encounter in another setting such as a physician's office or an emergency room, ALL evaluation and management services provided by that physician in conjunction with the admission are considered part of the initial nursing facility care when performed on the same date of service as the admission or readmission. ☐

Documentation to support this service should include, but is not limited to the following:

Comprehensive History Involves: ☐

- Chief complaint/reason for admission
- Extended history of present illness
- Review of systems directly related to the problem(s) the history of present illness
- A medically necessary review of ALL body systems' history
- A medically necessary complete past, identified in family, and social history

Comprehensive Physical Exam: ☐

- General, multisystem exam -or-
- A complete exam of a single organ system

Body areas recognized:

- Head/including face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, & buttocks
- Back
- Each extremity

Organ systems recognized:

- Eyes, ears, nose, mouth, & throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

Complex Medical Decision making involves 2 of the 3 below:

Extensive management options for diagnosis or treatment

- Extensive amount of data to be reviewed consisting of:
  - Lab results - Other practitioner's notes/charts e.g. PT, OT, Consultants
  - Diagnostic and imaging results - Labs or diagnostics needing to be performed
- High risk of complications and/or morbidity or mortality
  - Comorbidities associated with the presenting problem - Risk(s) associated with possible
  - Risk(s) of diagnostic procedure(s) performed management options

☐

- When choosing 99306 as the appropriate E&M code for the patient's admission; **ALL OF THE ABOVE 3 KEY** components must be met and MEDICALLY NECESSARY for the presenting problem/admission
- Co-morbidities and other underlying diseases in and of themselves are not considered when selecting the E&M codes UNLESS their presence significantly increases the complexity of the medical decision-making
- Time criteria for each E&M are averages/guidelines-and NOT considered determining factors of E&M selection UNLESS counseling and coordination of care consist of GREATER than 50% of the visit-then time may be considered the key or controlling factor when selecting the level of service-if the practitioner chooses to use time as the determining factor:
- If the level of care is being based on time spent with the patient for counseling/coordination of care documentation should support the time for the visit and the documentation must support in sufficient detail the nature of the counseling.
- If the code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.
- Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff may not be considered in selecting the appropriate level of service. *CMS Internet Only Manual; Pub 100-4 30.6.1B and C*

Medicare allows only the medically necessary portion of the visit. Even if a complete note is generated only the necessary services for the condition of the patient at the time of the visit can be considered to determine the level of an Evaluation & Management code.

CMS Pub 100-4 Claims Processing Manual Chapter 13 Sections 20.1, 20.3, 30.1, 40.1

CMS Pub 100-8, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4

Section 1862 (a)(1)(A) of the Social Security Act-Medical Necessity

CMS 1995/1997 Documentation Guidelines for E/M Codes: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html

Always remember when sending **records all entries should be dated and have a legible signature.** If you notice a signature is illegible please provide either a signature log or attestation to support the provider of the services. Failure to provide a legible signature will result in claim delays and possibly service denials.