

EVALUATION & MANAGEMENT DOCUMENTATION CHECKLIST: 99308

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

<p>For subsequent nursing facility care, per day, for the evaluation and management of a patient, 2 of these 3 of these key components are necessary:</p> <ul style="list-style-type: none"> • An expanded problem focused interval history • An expanded problem focused examination • Medical decision making of Low complexity 	<input type="checkbox"/>
<p>Usually the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.</p>	
<p>Documentation to support this service should include, but is not limited to the following:</p>	
<p>Expanded Problem focused History Involves:</p> <ul style="list-style-type: none"> • Chief complaint/reason for visit • Brief history of present illness • Problem pertinent system review 	<input type="checkbox"/>
<p>Expanded Problem focused Exam:</p> <ul style="list-style-type: none"> • A limited exam of the affected body area or organ system and • Other symptomatic or related organ system(s) <p>Body areas recognized:</p> <ul style="list-style-type: none"> • Head/including face • Neck • Chest; including breasts and axilla <p>Organ systems recognized:</p> <ul style="list-style-type: none"> • Eyes, ears, nose ,mouth and throat • Cardiovascular • Respiratory • Hematologic/Lymphatic/Immunologic 	<input type="checkbox"/>
<p>Low Medical Decision making involves 2 of the 3 below:</p>	
<ul style="list-style-type: none"> • Limited management options for diagnosis or treatment 	<input type="checkbox"/>
<ul style="list-style-type: none"> • Limited amount of data to be reviewed consisting of: <ul style="list-style-type: none"> - Lab results - Diagnostic and imaging results 	<input type="checkbox"/>
<ul style="list-style-type: none"> • Low risk of complications and/or morbidity or mortality <ul style="list-style-type: none"> - Comorbidities associated with the presenting problem - Risk(s) of diagnostic procedure(s) performed 	<input type="checkbox"/>
<p>When choosing 99308 as the appropriate E/M code for the patient's visit; 2 OF THE ABOVE 3 key components must be met and MEDICALLY NECESSARY for the presenting problem/visit.</p> <ul style="list-style-type: none"> • 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: DOCUMENTATION OF TIME MUST BE PRESENT <ul style="list-style-type: none"> - 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. 	

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

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

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.

CMS Internet Only Manual; Pub 100-4 30.6.1B and C