

# EVALUATION & MANAGEMENT DOCUMENTATION CHECKLIST: 99309

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:

For the subsequent nursing facility care, per day, for the evaluation and management of a patient, 2 of these 3 key components are necessary: <ul style="list-style-type: none"> <li>• A detailed interval history</li> <li>• A detailed examination</li> <li>• Medical decision making of MODERATE complexity</li> </ul>	<input type="checkbox"/>
<b>Usually, the patient has developed a significant complication or a significant new problem.</b> <b>Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.</b>	
<b>Documentation to support this service should include, but is not limited to the following:</b>	
<b>Detailed Interval History Involves:</b> <ul style="list-style-type: none"> <li>• Chief complaint/reason for visit</li> <li>• Extended history of present illness</li> <li>• Extended Review of Systems</li> <li>• A pertinent past, family and/or social history directly related to the patient's problem</li> </ul>	<input type="checkbox"/>
<b>Detailed Physical Exam:</b> <ul style="list-style-type: none"> <li>• An extended examination of the affected body area(s)</li> <li>• Symptomatic/related organ system</li> </ul> <b>Body areas recognized:</b> <ul style="list-style-type: none"> <li>• Head/including face</li> <li>• Neck</li> <li>• Chest, including breasts and axilla</li> <li>• Abdomen</li> <li>• Genitalia, groin, and buttocks</li> <li>• Back</li> <li>• Each extremity</li> </ul> <b>Organ systems recognized:</b> <ul style="list-style-type: none"> <li>• Eyes, ears, nose, mouth, &amp; throat</li> <li>• Cardiovascular</li> <li>• Respiratory</li> <li>• Gastrointestinal</li> <li>• Musculoskeletal</li> <li>• Skin</li> <li>• Neurologic</li> <li>• Psychiatric</li> <li>• Hematologic/Lymphatic/Immunologic</li> </ul>	<input type="checkbox"/>
<b>Low Medical Decision making involves 2 of the 3 below:</b>	
<ul style="list-style-type: none"> <li>• Multiple management options for diagnosis or treatment</li> </ul>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>• Moderate amount of data to be reviewed consisting of: <ul style="list-style-type: none"> <li>- Lab results</li> <li>- Other practitioner's notes/charts e.g. PT, OT, consultants</li> <li>- Diagnostic and imaging results</li> <li>- Labs or diagnostics needing to be performed</li> </ul> </li> </ul>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>• Moderate risk of complications and/or morbidity or mortality <ul style="list-style-type: none"> <li>- Comorbidities associated with the presenting problem</li> <li>- Risk(s) of diagnostic procedure(s) performed</li> <li>- Risk(s) associated with possible management options</li> </ul> </li> </ul>	<input type="checkbox"/>
When choosing 99309 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. <ul style="list-style-type: none"> <li>• 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</li> <li>• 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"> <li>- 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.</li> <li>- 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.</li> <li>- 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.</li> </ul> </li> </ul>	

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:**

[http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval\\_mgmt\\_serv\\_guide-ICN006764.pdf](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.