Scenario 1: Teaching Physician: personally performs all required E/M elements without the Resident. Resident: may or may not have performed an independent E/M service.

Documentation
- Teaching physician writes independent note addressing all E/M components in absence of resident note.

OR
- Teaching physician may reference resident documentation if present.

Teaching physician documents personal performance of critical/key portion(s) of the service and direct involvement in the management of the patient.

NOTE: Level of service is determined by the composite of resident/teaching physician documentation when appropriate reference is made by the teaching physician to resident documentation.

Scenario 1 language examples:

Admitting Note: "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

Follow-up Visit: "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."

Follow-up Visit: "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."

Scenario 2: Resident: performs required elements in the presence of or jointly with the teaching physician.

Documentation
- The resident documents the E/M service.
- Teaching physician documents personal performance of critical/key portion(s) of the service and direct involvement in the management of the patient.

NOTE: Level of service is determined by the composite of resident/teaching physician documentation when appropriate reference is made by the teaching physician to resident documentation.

Scenario 2 language examples:

Initial or Follow-up Visit: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

Follow-up Visit: "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

Follow-up Visit: "See resident's note for details. I saw and evaluated the patient and agree with the resident's findings and plans as written."

Follow-up Visit: "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

CMS Examples of Unacceptable Documentation:

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

- "Agree with above." followed by legible countersignature or identity;
- "Rounded, Reviewed, Agree." followed by legible countersignature or identity;
- "Discussed with resident. Agree." followed by legible countersignature or identity;
- "Patient seen and evaluated." followed by legible countersignature or identity; and
- A legible countersignature or identity alone.

Preventive Medicine Guidelines

If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine service, and if the problem is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate office visit (99201-99215) should also be reported with the modifier -25.

If an insignificant problem is encountered and does not require any additional work, then an additional E/M should not be reported.

Preventive Medicine Services

New Patient Established Patient
- 99381 < 1 year 99391 < 1 year
- 99382 1 - 4 years 99392 1 - 4 years
- 99383 5 - 11 years 99393 5 - 11 years
- 99384 12 - 17 years 99394 12 - 17 years
- 99385 18 - 39 years 99395 18 - 39 years
- 99386 40 - 64 years 99396 40 - 64 years
- 99387 ≥ 65 years 99397 ≥ 65 years

IMPORTANT CONTACT INFORMATION

Chief Institutional Integrity Officer: 744-5200
Associate Director of Compliance Billing: 744-3388
University Attorney’s Office for Health Sciences: 744-3013
ECU Office of Internal Audit Hotline: 328-9025

Compliance Hotline (toll free): (866) 515-4587 (No Caller ID)
Website address: http://www.ecu.edu/cs-dhs/institutionalintegrity/

e-mail: dhscpliance@ecu.edu

There will be no repercussions for inquiries or good faith reporting of actual or possible violations of the BSOM Code of Conduct or the Compliance Program. It is a serious violation of BSOM’s policy to retaliate or attempt to retaliate against anyone who makes a good faith report of a suspected violation.

IF IT CONCERNS YOU, IT CONCERNS US!
Documenting E/M Components

**History Elements:**
- HPI: chronological description of illness/ailment
  - Location: site
  - Duration: onset
  - Context: setting
  - Timing: interval
  - Quality: descriptive
  - Assoc. Signs & Sx.: concurrent
  - Severity: intensity
  - Modifying Factors

**Organ System:**
- Const.
- Eyes
- ENMT
- Cardio
- Resp
- GI
- GU
- Musc
- Integ
- Psych
- Neuro
- Endocr.
- Hem/Lymph
- All/Imm
- All others neg.
- Unable to obtain: history unobtainable from the patient/other source should describe the patient's condition/circumstances that precludes obtaining a history.
- Complete ROS: 10 or more organ systems must be reviewed. Systems with pertinent +/- must be individually documented.
- Documentation of pertinent +/- inclusive of terminology "all other systems reviewed and negative" is acceptable as a complete ROS.

**PFSh: past events**
- Past
- Family
- Social

**Medical Decision Making:**
Definition: The complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering a, b, and c.

a. **Problems:** The # of possible diagnoses and/or the management options that must be considered.

```
Self-limited or minor (maximum of 2)  1
Established problem, stable or improving  1
Established problem, worsening  2
New problem, no additional work-up planned (maximum of 1)  3
New problem, with additional work-up planned  4
```

b. **Data Review/Ordered:** The amount and/or complexity of medical records, diagnostic test, and/or other information that must be obtained, reviewed and analyzed.

```
Review or order clinical lab tests  1
Review or order radiology test (except heart catheterization or echo)  1
Review or order medicine test (PFTs, EKG, cardiac echo or catheterization)  1
Discuss test with performing physician  1
Independent review of image, tracing, or specimen  2
Decision to obtain old records  1
Review and summation of old records  2
```

c. **Risk:** Risk is defined as significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

Guidelines for Observation Care

1. Observation care includes all services performed by the supervising provider per day regardless of location when provided in conjunction with initiating observation status. This would include, but is not limited to, emergency department, provider office, and nursing home.
2. Admission to inpatient hospital services on same date as observation care, code to initial hospital care (99221-99223).
3. Admission to inpatient hospital service on date subsequent to date of observation care: code observation date to category (99218-99220) and code subsequent date to initial hospital care (99221-99223).
4. Observation service extending beyond the date of initial observation care should be coded utilizing subsequent observation care (99224-99226).
5. These codes may not be utilized for post-operative recovery if the procedure is considered part of the surgical "package."
6. Patients admitted and discharged on the same date from observation status or inpatient hospital care to 99234-99236.

Inpatient Evaluation and Management Services

Critical Care Guidelines

1. Critical care codes (99291-99292) are used to report the total duration of time spent by a provider providing critical care services.
2. A critical illness or injury acutely impairs one or more vital organ systems such as there is a high probability of imminent or life threatening deterioration in the patient's condition.
3. The following services are included in critical care: interpretation of cardiac output smarts, CXR's, pulse oximetry, blood gases, information/data stored in computers, gastric intubation, temp. transcutaneous pacing, ventilatory management, vascular access procedures.
4. Time spent with the individual patient must be recorded in the record. Do not include time spent performing bedside procedures that are separately reported services.
5. Time spent with family members or surrogate decision makers may be included if the patient is unable to participate and the conversation bears directly on the management of the patient.