DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for
Medicare Fee-For-Service Providers

FACT SHEET

Evaluation and Management (E/M) Services: Complying with Documentation Requirements

This fact sheet describes common Comprehensive Error Rate Testing (CERT) Program errors related to Evaluation and Management (E/M) services and provides information on the documentation needed to support a claim submitted to Medicare for E/M services.

The Centers for Medicare & Medicaid Services (CMS) developed the CERT Program to produce a national Medicare Fee-For-Service (FFS) error rate, as required by the Improper Payments Information Act. CERT randomly selects a small sample of Medicare FFS claims and reviews those claims and medical records from providers/suppliers who submitted them for compliance with Medicare coverage, coding, and billing rules.

In order to accurately measure the performance of the Medicare claims processing contractors and to gain insight into the causes of errors, CMS calculates both a national Medicare FFS paid claims error rate and a provider compliance error rate. The results of the reviews are published in an annual report and semi-annual updates.

CMS strives to eliminate improper payments in the Medicare Program to maintain the Medicare trust funds and protect patients.

E/M services are grouped into several different categories and subcategories of services based on the setting (e.g., hospital or physician's office) and type of service (e.g., initial or subsequent care). Within each category or subcategory of service, there are 3 to 5 levels of services that are specific to the category or subcategory of service. From April 2009 to May 2010, E/M professional services accounted for an estimated $28 billion in Part B payments on a national level. Based on the most recent data from the CERT

Program, 8.4% of those E/M payments were identified as being billed at the wrong code level – either too high or too low. The information contained in this fact sheet is intended to help physicians and other practitioners understand the process required for determining the correct level of code for each E/M service performed and billed.

Components of an E/M Service

- Medical necessity is the overarching criterion for E/M services

- History
- Examination
- Medical decision making

These three **key** components are used to determine the level of service.

- Nature of presenting problem
- Counseling
- Coordination of care

These three are considered **contributory** components.

- Time

Time may be the primary component used to determine the level of service if more than 50% of the E/M encounter includes counseling and/or coordination of care. In these cases, the time must be clearly documented, as well as more than 50% of the time was spent in counseling/coordination of care and a brief summary of counseling and/or coordination of care provided.

Documentation: 'If It Wasn't Documented, It Wasn't Done!'

- Documentation should support the level of service reported. For documentation guidelines pertaining to E/M services, visit http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp on the CMS website. In general, documentation of each patient encounter should include:
  - Reason for encounter and relevant history, physical examination findings, and prior diagnostic test results;
  - Assessment, clinical impressions, or diagnosis;
  - Plan for care; and
  - Date and legible identity of the observer.
- Document the total length of time of the encounter if the level of service is based on counseling and/or coordination of care. Describe the counseling and/or activities to coordinate care.

Determination of the Correct Level of Code

1. Start with the three **key** components identified above: history, examination, and medical decision making.
2. Each **key** component has its own set of levels. The levels for two (history and medical decision making) can be further broken down into elements.

- History: 1) Chief complaint (CC)
  2) History of present illness (HPI)
  3) Review of systems (ROS)
  4) Past, family, and social history (PFSH)
- Medical decision making: 1) Number of diagnoses/management options
  2) Amount/complexity of data
  3) Risk of complications
- Examination: This component has its own set of corresponding levels
  See the E/M guidelines (explained below in the Guidelines section) for qualifications for these separate levels.

3. Determine levels for each of the elements, designating the corresponding **key** components, and then combine these **key** components for final determination of the code.
   - For certain code sets, only two of the three key components are used to determine the level of service. These codes sets include: established patient office visits (Current Procedural Terminology [CPT] codes 99212-99215), subsequent hospital care (CPT codes 99231-99233), and subsequent nursing facility care (CPT codes 99307-99310).

Guidelines

Two sets of official E/M guidelines are available: "1995 Documentation Guidelines for Evaluation and Management Services" and "1997 Documentation Guidelines for Evaluation and Management Services." Use these guidelines to learn more about the specific steps for determining the levels for the **key** components and their respective elements.

- Neither set of guidelines is better. A physician or practitioner may use either set of guidelines to determine the appropriate level of code for the E/M service provided.
- For each separate E/M service, you must use only one set of E/M guidelines throughout the code determination process. Mixing or combining of the two sets of guidelines for a single E/M encounter is not acceptable.
- The "1997 Documentation Guidelines for Evaluation and Management Services" provide more detail on the examination component and the expected/recommended types of examination that should be completed for the respective levels. For example, these guidelines distinguish between a general multi-system exam and a single organ system exam.

Resources

Listed below are resources available from CMS. Please see your Medicare Contractor's website for additional resources.

- CMS Internet-Only Manuals, "Medicare Claims Processing Manual" (Publication 100-04), Chapter 12, Section 30.6 at http://www.cms.gov/manuals/downloads/clm104c12.pdf on the CMS website.
- CMS "Evaluation and Management Services Guide," 1995 Guidelines, and 1997 Guidelines at http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp on the CMS website.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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