CMS Minimally Acceptable E/M Scenarios and Language

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 findings and plan of care.”

Follow-up Visit: “Hospital Day #5. I saw and evaluated the patient. I agree with the findings and plan as documented in the resident’s note.”

Initial or Follow-up Visit: “I saw and evaluated the patient. I reviewed the resident’s note and agree with the resident’s findings and plan as written.”

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

Scenarios 3 and 4 language examples:

Initial 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 NSAIIDS.”

Initial or 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,
- “Seen and agree.” followed by legible countersignature or identity,
- “Patient seen and evaluated; followed by legible countersignature or identity; and A legible countersignature or identity alone.

IMPORTANT CONTACT INFORMATION

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

**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.

<table>
<thead>
<tr>
<th>Points</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self-limited or minor (maximum of 2)</td>
</tr>
<tr>
<td>1</td>
<td>Established problem, stable or improving</td>
</tr>
<tr>
<td>2</td>
<td>Established problem, worsening</td>
</tr>
<tr>
<td>3</td>
<td>New problem, with no additional work-up planned (maximum of 1)</td>
</tr>
<tr>
<td>4</td>
<td>New problem, with additional work-up planned</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Points</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Review or order clinical lab tests</td>
</tr>
<tr>
<td>1</td>
<td>Review or order radiology test (except heart catheterization or echo)</td>
</tr>
<tr>
<td>1</td>
<td>Review or order medicine test (PFTs, EKG, cardiac echo or catheterization)</td>
</tr>
<tr>
<td>1</td>
<td>Discuss test with performing physician</td>
</tr>
<tr>
<td>2</td>
<td>Independent review of image, tracing, or specimen</td>
</tr>
<tr>
<td>1</td>
<td>Decision to obtain old records</td>
</tr>
<tr>
<td>2</td>
<td>Review and summation of old records</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Decision to obtain old records</td>
</tr>
<tr>
<td>Moderate</td>
<td>Review and summation of old records</td>
</tr>
<tr>
<td>Low</td>
<td>Review or order clinical lab tests</td>
</tr>
</tbody>
</table>

**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 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 are coded to 99234-99236.

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