

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4068	Date: May 31, 2018
	Change Request 10412

Transmittal 3971, dated February 2, 2018, is being rescinded and replaced by Transmittal 4068, dated, May 31, 2018, to correct typos to section number 100.1.1 on the Transmittal page and business requirement 10412.1, and part of the manual update under section 100.1.1. All other information remains the same.

SUBJECT: E/M Service Documentation Provided by Students (Manual Update)

I. SUMMARY OF CHANGES: This revision to Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 100.1.1 Evaluation and Management (E/M) Services, B. E/M Documentation Provided by Students, allows the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. (Manual Update Only.)

EFFECTIVE DATE: January 1, 2018

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: March 5, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/100.1.1/Evaluation and Management (E/M) Services

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

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IMPLEMENTATION DATE: March 5, 2018

I. GENERAL INFORMATION

A. Background: We are revising Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 100.1.1, to update policy on Evaluation and Management (E/M) documentation provided by students. This policy change was identified by the Documentation Requirement Simplification workgroup. This change is part of a broader goal to reduce administrative burden on practitioners.

B. Policy: This revision to Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 100.1.1, B. E/M Documentation Provided by Students, allows the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E	Shared- System Maintainers				Other	
		A	B	H H H		F M V C	M C S S	V M S S	C W F		
10412.1	Medicare contractors shall be aware of changes to the Medicare Claims Processing Manual, Pub. 100-04, Ch. 12, Section 100.1.1 Evaluation and Management (E/M) Services, B. E/M Service Documentation Provided by Students, contained in this change request.	X	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E D I	C E D I
		A	B	H H H		
10412.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Lindsey Baldwin, 410-786-1694 or lindsey.baldwin@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

100.1.1 - Evaluation and Management (E/M) Services

(Rev.4068, Issued: 05-31-18, Effective: 01-01-18, Implementation: 03-05-18)

A. General Documentation Instructions and Common Scenarios

Evaluation and Management (E/M) Services -- For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association's Current Procedural Terminology (CPT) and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient.

When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician.

Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

Following are four common scenarios for teaching physicians providing E/M services:

Scenario 1:

The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently.

In the absence of a note by a resident, the teaching physician must document as he/she would document an E/M service in a nonteaching setting.

Where a resident has written notes, the teaching physician's note may reference the resident's note. The teaching physician must document that he/she performed the critical or key portion(s) of the service, and that he/she was directly involved in the management of the patient. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 2:

The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he/she was present during the performance of the critical or key portion(s) of the service and that he/she was directly involved in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the

resident's entry together must support the medical necessity and the level of the service billed by the teaching physician.

Scenario 3:

The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he/she personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient. The teaching physician's note should reference the resident's note. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 4:

When a medical resident admits a patient to a hospital late at night and the teaching physician does not see the patient until later, including the next calendar day:

- The teaching physician must document that he/she personally saw the patient and participated in the management of the patient. The teaching physician may reference the resident's note in lieu of re-documenting the history of present illness, exam, medical decision-making, review of systems and/or past family/social history provided that the patient's condition has not changed, and the teaching physician agrees with the resident's note.
- The teaching physician's note must reflect changes in the patient's condition and clinical course that require that the resident's note be amended with further information to address the patient's condition and course at the time the patient is seen personally by the teaching physician.
- The teaching physician's bill must reflect the date of service he/she saw the patient and his/her personal work of obtaining a history, performing a physical, and participating in medical decision-making regardless of whether the combination of the teaching physician's and resident's documentation satisfies criteria for a higher level of service. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Following are examples of minimally acceptable documentation for each of these scenarios:

Scenario 1:

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."

(NOTE: In this scenario if there are no resident notes, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.)

Scenario 2:

Initial or Follow-up Visit: “I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident’s note.”

Follow-up Visit: “I saw the patient with the resident and agree with the resident’s findings and plan.”

Scenarios 3 and 4:

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 NSAIDs.”

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 finding 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.”

Following are examples of unacceptable documentation:

“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.

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.

B. E/M Service Documentation Provided By Students

Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the teaching physician *must verify in the medical record all* student documentation *or* findings, *including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.*

C. Exception for E/M Services Furnished in Certain Primary Care Centers

Teaching physicians providing E/M services with a GME program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. For the E/M codes listed below,

teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

Effective January 1, 2005, the following code is included under the primary care exception: HCPCS code G0402 (Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 12 months of Medicare enrollment).

Effective January 1, 2011, the following codes are included under the primary care exception: HCPCS codes G0438 (Annual wellness visit, including personal preventive plan service, first visit) and G0439 (Annual wellness visit, including personal preventive plan service, subsequent visit).

If a service other than those listed above needs to be furnished, then the general teaching physician policy set forth in §100.1 applies. For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception.

The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's A/B MAC (A). This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a nonhospital entity, verify with the A/B MAC (A) that the entity meets the requirements of a written agreement between the hospital and the entity set forth at 42 CFR 413.78(e)(3)(ii).

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program. Centers must maintain information under the provisions at 42 CFR 413.79(a)(6).

Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. Teaching physicians may include residents with less than 6 months in a GME approved residency program in the mix of four residents under the teaching physician's supervision. However, the teaching physician must be physically present for the critical or key portions of services furnished by the residents with less than 6 months in a GME approved residency program. That is, the primary care exception does not apply in the case of residents with less than 6 months in a GME approved residency program.

Teaching physicians submitting claims under this exception must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident;
- Have the primary medical responsibility for patients cared for by the residents;
- Ensure that the care provided was reasonable and necessary;
- Review the care provided by the resident during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies); and

- Document the extent of his/her own participation in the review and direction of the services furnished to each patient.

Patients under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include:

- Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
- Coordination of care furnished by other physicians and providers; and,
- Comprehensive care not limited by organ system or diagnosis.

Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the range of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.