ED Documentation
• Teaching Physicians
• Shared Services
• Scribes

CMS Policy Change  April 26, 2019

CMS Transmittal 4283 changes policy regarding teaching physicians providing evaluation and management services.

Represents a significant change in policy for documentation of E&M services by teaching physicians involving residents.
Old Policy

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.

Old Policy

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.**

The old policy went on to give 3 pages of E&M clinical examples and documentation requirements.
For purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate:

- That the teaching physician performed the service or was 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.

The presence of the teaching physician during E/M services may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

CMS Transmittal 4283

- With the new policy all that is necessary is that someone (could be the nurse, resident or physician) documents that the attending physician was present during the key or critical portions of the service and participated in the management of the patient.

- If TP presence has been documented, all that is needed from the attending physician is a signature.
Problems with CMS Transmittal 4283

Only addressed changes to the documentation requirements for E&M services.

There have not been any published updates to the documentation requirement for procedures, interpretations or critical care.

Problems with CMS Transmittal 4283

May be difficult to train physicians that an E&M only encounter can be signed (provided the resident has documented their presence and participation) but must do the usual attestations for charts that have procedures, interpretations or critical care.
Problems with CMS Transmittal 4283

If the facility opts to let the attending physicians only sign the charts, the residents will have to be trained to document the attending’s presence and participation in the E&M service.

• This is contradictory to how they have been trained up until now.
• The prior policy prohibited this practice.

Problems with CMS Transmittal 4283

While the CMS policy has changed, hospital policies and corporate compliance standards are still based on the old policy.

Before we can make the decision to follow the new policy, both of those issues will have to be addressed.
In an effort to reduce mandatory and duplicative medical record evaluation and management (E/M) documentation requirements, we finalized an amended regulatory provision:

... as a condition of payment under the PFS that the teaching physician must be present during certain portions of services that are furnished with the involvement of residents (individuals who are training in a graduate medical education program).

Sections 415.172(b) and 415.174(a)(6), respectively require that the teaching physician’s presence and participation in services involving residents must be documented in the medical record.

We amended these regulations to provide that a physician, resident, or nurse may document in the patient’s medical record that the teaching physician presence and participation requirements were met.

As a result, for E/M visits furnished beginning January 1, 2019, the extent of the teaching physician’s participation in services involving residents may be demonstrated by notes in the medical records made by a physician, resident, or nurse.

Comment: Several commenters encouraged CMS to re-examine the current requirements regarding documentation of the billing practitioner’s physical presence and participation in certain E/M services and procedures. The commenters stated that this physical presence and participation requirement results in significant burden for teaching physicians and PA and APRN preceptors when their students are participating in patient care. These commenters stated that while physical presence and participation of physicians and practitioners in the clinic is critical for safe patient care, presence in the examination room is onerous and unnecessary. The commenters also noted that this requirement greatly diminishes the learning experience for students, as they do not develop the ability to think or operate independently, formulate diagnoses, and generate treatment plans, producing less experienced graduate clinicians who are not as prepared as they could be to provide care on their own.
• Response: We did not propose any changes to requirements pertaining to the documentation of physical presence and participation for certain E/M services and procedures at §§ 415.172 and 415.174, and we are not addressing these requirements in this final rule.
Final Rule 11/15/19

- Comment: One commenter questioned whether their assumption is correct that this proposal applies to all types of services (that is, procedures, E/M services, and diagnostic services).

- Response: The commenter’s assumption is accurate; our proposed medical record documentation policy would apply broadly to all services of physicians, PAs and APRNs, regardless of the type of service (E/M, procedure, diagnostic test) or the setting in which the service is furnished.

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E&M Services

Per CMS Transmittal 4283 – April 26, 2019

The medical records must demonstrate:

- That the teaching physician performed the service or was 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.
E&M Services following new policy.
The presence of the teaching physician during E/M services may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

EDMD – “I was physically present during critical and key points of the service and participated in the management of the patient.” + EDMD signature
Or
Resident, nurse or other - “Dr. Xxx was physically present during critical and key points of the service and participated in the management of the patient.” + EDMD signature

Surgical Procedures – no official policy change yet.
For minor procedures which take only a few minutes to complete, such as a simple suture, and involve relatively little decision making once the need for the operation is determined, the TP must be present for the entire procedure in order to bill for the procedure.

“Procedure performed by the resident under my direct supervision.”
Surgical Procedures – no official policy change yet.

For major procedures (lasting more than five minutes), the TP must be physically present during the "key portion(s)" of the service and must be immediately available to furnish service during the entire procedure. The TP must document the extent of his/her participation.

“I was present for the key portions of the procedure performed by the resident”

Interpretations – no policy change yet.

If a resident documents an interpretation, the TP must indicate that they personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings.
Interpretations

Attending documentation of “present during procedure” does not allow billing EKG or US interpretations.

Attending must review and agree with resident interp.

Critical Care – no policy change yet.

The TP documentation must provide substantive information including:
• TP critical care time,
• Patient was critically ill while the TP saw the patient,
• What made the patient critically ill,
• Treatment / management provided by the TP.
Critical Care

CMS example of acceptable TP documentation for E&M involving resident.

“I saw the patient with the resident and agree with the resident’s findings and plan.”

CMS example of unacceptable TP documentation for critical care involving Resident.
“‘I came and saw (the patient) and agree with (the resident)”.

Critical Care

CMS example of acceptable TP documentation for critical care involving Resident.

"Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."
Medical Students

Medicare does not pay for any service furnished by a student.

Any contribution and participation of a student to the performance of a billable 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.

These requirements have not changed.

Medical Students – Old Policy

The teaching physician may not refer to a student’s documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision-making activities of the service.

This has changed.
The teaching physician must verify 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.

Medical Students

Procedures performed by students are still not billable.
• For the same burden reduction purposes, we … revised a paragraph in our manual instructions on “Teaching Physician Services” at Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 100.1.1B., to reduce duplicative documentation requirements by allowing a teaching physician to review and verify (sign/date) notes made by a student in a patient’s medical record for E/M services, rather than having to redocument the information, largely duplicating the student’s notes.

• Comment: Several commenters suggested that CMS specifically name the types of students that it intends to include as those who are eligible to make notes in the medical record documentation in order to avoid unnecessary confusion by obscuring the intended scope of students as “other members of the medical team.”

• These commenters stated that explicitly naming the types of clinicians and students for which the documentation they add can be reviewed and verified by the billing professional would eliminate misinterpretation on the part of health systems, care providers, and educators, and would improve both clinical training opportunities and, ultimately, patient care.
Response: We acknowledge that uncertainty in the healthcare industry and for MACs about the specific types of students who were allowed to make notes in the medical record which teaching physicians could review and verify without re-documenting was a factor we considered in proposing to revise the documentation requirements in the CY 2020 PFS proposed rule. We find the comment to be persuasive regarding the need for us to be more explicit regarding the flexibility we intend to establish for other physicians, PAs and APRNs and their students.

After considering the comments, we are finalizing our proposal with a couple of modifications. We are explicitly naming PA and NP, CNS, CNM and CRNA students as APRN students, along with medical students, as the types of students who may document notes in a patient’s medical record that may be reviewed and verified rather than re-documented by the billing professional;
Medical Students
Summary

- Attending physician or resident must be at the bedside while the student performs any of the E&M elements.

- Attending physician must personally perform (or re-perform) the physical exam and medical decision-making activities of the E&M service being billed. **This cannot be done by the resident!**

- The attending physician may verify student documentation, rather than re-documenting information that has already been documented.

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Medical Students - Documentation Sample

Attestations for Student Encounter w/o Resident Involvement

Teaching Physician – I was present with the medical student during the visit. I personally performed an exam, made the assessment and developed the care plan, as documented above. I have verified student’s documentation and agree with the student’s findings.
Medical Students - Documentation Sample

TP Attestation for Student Encounter w/ Resident Involvement

Resident – I was present with the medical student during the history and exam.

Teaching Physician – I personally performed an exam, made the assessment and developed the care plan (e.g. medical decision making), as documented above. I have verified and agree with the student and resident’s documentation.

Shared Services

Physician Assistants (PA) and Nurse Practitioners (NP), are referred to as Non-Physician Practitioners (NPP) by Medicare

Any services for which Medicare will pay a physician are also covered when performed by a NPP.

However, the services of the NPP are reimbursed at 85% of the Medicare allowable.
Shared Services

When the NPP and the MD share in the performance of the E&M service, the claim can be filed under the attending physician’s ID number and the service will be reimbursed at 100% of Medicare allowable.

The physician must have contact with the patient and not simply review and/or co-sign the patient's medical record.

The MD must perform and document some portion of the elements of the E&M service (history, physical exam, or medical decision making) in whole or part.

Shared Services

A generic attestation will not suffice as documentation to support a shared service.

Unacceptable documentation: "I have personally seen and examined the patient independently, reviewed the PA's Hx, exam and MDM and agree with the assessment and plan as written"

To qualify as a shared visit, both the physician and the PA must each personally perform part of the visit, and both the physician and the PA must document the part(s) that he or she personally performed.
Shared Services

The physician documentation should be linked to the NPP documentation of the shared/split service, and affirmatively state one (or more) element(s) of the encounter.

This one (or more) element(s) may be an element of history, physical examination, or medical decision-making.

The physician does not have to repeat and redocument the entire E&M service.

Final Rule 11/15/19

• Seems to muddy the waters re: Shared Services.
  • We proposed to establish a general principle to allow the physician, the PA, or the APRN who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students or other members of the medical team.
  • …this principle would apply across the spectrum of all Medicare-covered services paid under the PFS. We noted that because the proposal is intended to apply broadly, we proposed to amend regulations for teaching physicians, physicians, PAs, and APRNs to add this new flexibility for medical record documentation requirements for professional services furnished by physicians, PAs and APRNs in all settings.
• We did not make any proposals specific to split/shared services in the CY 2020 PFS proposed rule. We thank the public commenters for raising these issues. We will review and take into account the public comments received on this topic and will consider the issues raised in the comments for possible future rulemaking.

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Shared Services

Shared Service Template

Patient presents with (insert injury) to (insert location). My exam shows (insert relevant exam of affected system or area). I reviewed the PA's note and agree with PA's findings and plan.

For example: Patient presents with laceration to left hand. My exam shows a 3cm laceration on the palm of the left hand, distal neurovascular function and ROM are normal. I reviewed the PA's note and agree with PA's findings and plan.
Shared Services

• Shared service policy only applies to E&M services.
• Critical care cannot be reported as a shared service.
• Procedures cannot be reported as a shared service.
• Interpretations cannot be reported as a shared service.

Medical Decision Making

Medical decision making is measured by:
• the number of possible diagnoses and/or the number of management options
• the amount and/or complexity of medical records, diagnostic tests, and/or other information reviewed
• the risk of complications, morbidity and/or mortality
Marshfield Clinic Scoring

- Marshfield Clinic – 32 site and 600 physician multispecialty clinic based in Marshfield, WI

- The E&M documentation guidelines were beta-tested at Marshfield Clinic before HCFA released them in 1994

- As part of that process, clinic staff helped their regional Medicare carrier to develop an audit worksheet that included a scoring system for the MDM

Marshfield Clinic Scoring

- The score sheets never made it into the documentation guidelines

- Used by physicians, professional coders and payers to evaluate documentation

- CMS acknowledges that its reviewers use score sheets but says their use is neither encouraged nor prohibited.
MDM variables

• Marshfield MDM scoring

<table>
<thead>
<tr>
<th>Problems to Exam Physician</th>
<th>Number</th>
<th>Points</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max = 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); stable, improved</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); worsening</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max = 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New prob. (to examiner); add. workup planned</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total

Bring total to line A in Final Result for Complexity

New Problem to the Examiner

What is a "New Problem"

• In the Marshfield Clinic's audit worksheets, a "new problem" is defined as new to the examining physician.

• According to Bart McCann, MD, former Executive Medical Director of HCFA "The decision making guidelines were designed to give physicians credit for the complexity of their thought processes. Giving a physician more credit for handling a problem he or she is seeing for the first time, even when that problem has been previously identified or diagnosed, is within the spirit of the guidelines".
New Problem to the Examiner

- In emergency medicine, most patients are new patients who present to the ED with complaints that are new problems to the emergency clinician who must evaluate these issues and determine if any investigative studies or therapeutic interventions are medically necessary.

Marshfield Scoring - Number of Diagnoses / Treatment Options

New Problem, no add’l work-up planned 3 points

New Problem, add’l work-up planned 4 points

2 common definitions

A. Additional diagnostic work-up after the current E&M service is completed.

B. Diagnostic work-up during the current E&M service.
Additional work-up planned

• **Answer:** The MDM Problem Points lists “new problem, additional workup planned”: workup that is accomplished during an office visit is not “planned”, since it’s already been performed. The concept of “additional workup planned” applies to diagnostic testing or consultative opinion(s) planned beyond the office visit. An exception to this rule applies to emergency room (ER) visits; diagnostic studies which are ordered and completed during an ER visit, and included in medical decision making, may be credited as additional workup. *Updated 6/9/2017*

Additional work-up planned

Per Noridian:
• Q3. Please clarify if "new problem to provider, additional workup" means that the additional workup must be done beyond that encounter at that time.

• For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision making. Or, does additional work-up consist of any diagnostic testing, laboratory testing, etc. that can be performed during the visit.

• A3. There is no specific indication that "further workup needed" must be completed at a future date.
Additional work-up planned

**Definitions**

| Additional Work-up Planned | Any testing/consultation/referral that is being done beyond that Encounter to assist the provider in medical decision making. |

• An example of Additional Work-up Planned, is if the physician schedules testing him/herself or communicates directly with the patient’s primary physician or representative the need for testing *which is to be done after discharge from the ED*, and the appropriate documentation has been recorded. Credit for “Additional Work-up” Planned is granted (4 points assigned).

• Credit is not given for the work up if it occurs during the ER Encounter.

• Patients admitted to the hospital under the care of a physician other than the ER physician may have testing done as part of the admitting physician’s care for that patient. The ER physician will not receive credit for the Additional Work-up Planned done under the care of the admitting physician.
Novitas Add’l W/U

• What constitutes additional workup in the Amount and Complexity of Data grid for Medical Decision Making?

• Additional workup is anything done beyond that encounter at that time. For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision-making.

Novitas Add’l W/U

• Is the physician doing additional workup?

• Additional workup will require the physician to review the results/make decisions on a day other than the day of the patient encounter.
Q6. My question centers on the number of diagnosis or management options in the MDM of the E/M service. When coding an Emergency department encounter, would all presenting problems fall under the "new problem" category (either with or without additional workup)?

The 1995 and the 1997 DGs have a table the provider can use in determining the level of MDM. There is no specific "new problem" category.

The number of possible diagnosis and/or the number of management options your provider considers is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician. The highest level of risk in any one category determines the overall risk.
WPS MDM

- Q2. Define self-limited or minor problem in the medical decision making grid under minimal level of risk. At times, it is difficult to determine whether a problem is self-limited or minor or whether it is a new problem with no additional work-up planned.

- A2. The 1995 and 1997 DGs indicate the determination of risk is complex and not readily quantifiable and includes some examples in each of the categories. The DGs do not address a new problem with no additional work up planned. Therefore, you can use the examples provided in the DGs to determine the level of the presenting problem.

Noridian MDM

Medical necessity cannot be quantified using a points system. Determining the medically necessary level of service (LOS) involves many factors and is not the same from patient to patient and day to day. Medical necessity is determined through a culmination of vital factors, including, but not limited to:

- Clinical judgment
- Standards of practice
- Why the patient needs to be seen (chief complaint),
- Any acute exacerbations/onsets of medical conditions or injuries,
- The stability/acute of the patient,
- Multiple medical co-morbidities,
- And the management of the patient for that specific DOS.
What is “additional work up planned”? 

- Historically ERcoder has used interpretation A when scoring MDM.

- We have resisted interpretation B and the concept that any ancillary study ordered following a history and physical exam of the patient should be considered “additional work-up”.

- Interpretation B may cause charts to be coded at a higher level that what seems appropriate for the patients presenting problem.

What is “additional work up planned”? 

<table>
<thead>
<tr>
<th>Final Result for Complexity</th>
<th>A Number diagnoses or management options</th>
<th>≤1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>≥4 Extensive</th>
</tr>
</thead>
</table>

- It is important to remember that the points assigned by the Marshfield scoring are translated back in to CMS/CPT language in the next step of the scoring tool.

- It is unreasonable to make the argument that a patient that had a strep test or simple ankle x-ray had an extensive diagnoses or management options.
What is “additional work up planned”?

• But as the practice of emergency medicine has advanced, the complexity of the evaluations and diagnostic workups that are performed in the ED have become much more complicated.

• The unrelenting stance that “additional work up planned” is only admits, transfers, etc. may result in assigning an E&M code that does not accurately reflect the complexity of medical decision making that was necessary to appropriately evaluate the patient.

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Marshfield- Amount and/or Complexity of Data to be Reviewed

<table>
<thead>
<tr>
<th>Amount and/or Complexity of Data to Be Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another healthcare provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
</tr>
</tbody>
</table>
**CMS “unofficial” Response**

- **Question:** What constitutes review of old records for the medical decision making component of an E/M?

  **Answer:** “Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement information obtained from the patient should be documented. If there is no relevant information beyond that already obtained, this fact should be documented. A notation of "old records reviewed" or "additional history obtained from family" without elaboration is not sufficient.”

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**EKG Pay vs Points**

- The ordering of the EKG would be part of the Medical Decision Making (MDM) under the Risk category under Diagnostic Procedures Ordered.

- The interpretation of the ordered EKG is considered part of the EKG reimbursement, and as such is not part of the Amount and/or Complexity of Data to be Reviewed category under the MDM portion of the E/M service.

- Counting both a review of the ordered EKG and billing for the interpretation and report of the same EKG is incorrect.
Independent visualization of image, tracing or specimen itself

• If I personally review a film, e.g. x-ray, electrocardiogram (EKG) in my office, will I receive 2 points on the E/M score sheet?

• Yes, you may get two points for independent visualization of an image, tracing or specimen on the E/M score sheet in the Amount and/or Complexity of Data Reviewed section under the Medical Decision Making key component.

• The medical record documentation must clearly indicate that the physician/qualified NPP personally (independently) visualized and performed the interpretation of the image; tracing or specimen and that he/she did not simply read/review a report from another physician/qualified NPP.

MDM Controversies
Rx Mgmt

When can prescription drug management be credited in the MDM Risk of Complications chart?

- Credit is given for prescription drug management when documentation indicates medical management of the prescription drug by the physician who is rendering the service.
- Medical management includes:
  - a new drug being prescribed,
  - a change to an existing prescription
  - or simply refilling a current medication.
- The drug and dosage should be documented as well as the drug management.

EMR MDM

Medical Decision Making

- Discussion of test results with the performing providers: yes
- Decide to obtain previous medical records: yes
- Obtain history from someone other than the patient: no
- Review and summarize previous medical records: yes
- Discuss the patient with another provider: yes
- Independent visualization of image, tracing, or specimen: yes
Auditor response

• “These statements provide no clinical insight as to what happened in the ED or how these steps impacted the diagnosis or treatment of the patient. Documentation that is aimed to meet the guidelines for payment but is clinically irrelevant to the patient presenting problem will not increase the level assigned to that visit.”

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