



Basic E and M Avoiding Common Errors

Presented by Medicare Part B
Provider Outreach and Education
March 2016

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Objectives

- To increase your knowledge of proper billing practices for Evaluation & Management (E&M) Services
- To decrease National Paid Claims Error Rate
- Ensure the delivery of quality care to our Medicare beneficiaries

Acronyms

CERT	Comprehensive Error Rate Testing
CID	Claim Identification #
E/M	Evaluation and Management Services
MAC	Medicare Administrative Contractor
MDM	Medical Decision Making
IOM	Internet Only Manual
MLN	Medicare Learning Network
MR	Medical Review
RA	Recovery Auditor

Agenda

- Evaluation & Management Services
 - E/M basics
 - Medical Necessity
 - Documentation Guidelines
 - Common E/M coding errors
 - Resources

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E and M Visits - Initial and Subsequent

Billing/Coding Guidelines

- Familiarize with two parts of AMA CPTs
 - E/M codes used frequently
 - Clinical examples appendix
- Determine nature of presenting problem
 - Is it self-limited or minor, low severity, moderate severity or high severity
- Determine if more appropriate
 - 3 key components or
 - Counseling and coordination of care

Billing/Coding Guidelines ₂

- Remember any physician can use any exam
 - 1995, 1997 General, or 1997 Single Organ
- Learn one exam and learn it well
- Determine if decision making
 - Straightforward or high complexity
 - Neither? Determine complexity
 - Low or moderate
- Make simple code selection table codes frequently used

E/M Basics

- Every E/M must contain correct levels:
 - History
 - Exam
 - Medical Decision Making

History Elements

History Type	Chief Complaint	History of Present Illness	Review of Systems (ROS)	Past, Family and/or Social History
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

Chief Complaint

- All levels require a chief complaint
 - Should correlate with primary diagnosis (DX)
 - Follow up (F/U) as chief complaint should indicate what F/U was for
 - Primary DX should indicate what visit was for

Key Components for E/M

CPT	History	Exam	MDM
99204	Comprehensive	Comprehensive	Moderate
99205	Comprehensive	Comprehensive	High
99214	Detailed	Detailed	Moderate
99221	Detailed	Detailed	Straightforward or Low
99232	Expanded Problem	Expanded Problem	Moderate
99233	Detailed	Detailed	High

Exam Elements

Type of Exam	Description
Problem Focused	Limited examination of affected body area or organ system
Expanded Problem Focused	Limited exam of affected body area or organ system
Detailed	Extended exam of affected body area(s) or organ system(s)
Comprehensive	General multi-system exam or complete exam of a single organ system

Medical Decision Making Elements

Type of Decision Making	Number of Diagnoses or Management Options	Complexity Amount of Review Data	Risk of Complications, Morbidity and/or Mortality
Straight-forward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Code Component	1995 Guideline Requirements	1997 Guideline Requirements
Hx – History of Present Illness	Specific Requirements	Specific Requirements
Hx – Review of Systems	Specific body area or organ system requirements	Specific body area or organ system requirements
Hx – Past, Family, Social History	Brief information required	Brief information required
Physical Examination	General multi-system exam <ul style="list-style-type: none"> • 8 or more organ systems • 4 levels • Single level more extensive • Description of single system exams inadequate • Requirements not clear 	General multi-system exam and 10 single system exams <ul style="list-style-type: none"> • 4 levels • Very descriptive • Requirements often not relevant • Confusing shading & bullets format
Medical Decision Making	<ul style="list-style-type: none"> • 4 levels • Laundry list of examples <u>not reflective</u> of clinical assessments & plans 	<ul style="list-style-type: none"> • 4 levels • Laundry list of examples <u>not reflective</u> of clinical assessments & plans

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Medical Necessity

Medical Necessity

“Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”

Per Internet Only Manual (IOM) *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, section 30.6.1

Medical Necessity

- **Level of E/M Services:** The most common error found for E/Ms is the lack of documentation to support the level of E/M Services billed. The most common documentation lacks key components including Extent of History, Extent of Examination, and Complexity of Medical Decision Making (MDM).

Medical Necessity ²

Medical necessity cannot be quantified using a points system. Determining the medically necessary LOS is multi-factorial and is not the same from patient to patient and day to day. Medical necessity is determined through a culmination of factors, including, but not limited to:

Clinical judgment

Standards of practice

Why patient needs to be seen (chief complaint)

Any acute exacerbations/onsets of medical conditions or injuries

Stability/acuteity of patient

Multiple medical co-morbidities

Management of patient for that specific DOS

Medical Necessity Criteria

- Consistent with the symptoms and diagnoses or treatment of the patient's condition, illness, disease or injury
- In accordance with accepted professional medical standards
- Not primarily for the convenience of the patient or provider
- Furnished at the most appropriate level that can be safely provided to the patient

Keep Exam in Perspective

- Examination is only one of three components to determine level of service and may be least important
- History of Present Illness (HPI); only performed by physician
- Review of Systems (ROS) & Past Family Social History (PFSH) must be reviewed and notated by physician; ancillary staff may only record
- Comprehensive exam occurs in only a few encounters (99215)

New Patient Definition

- No services received from physician of same specialty who belongs to same group practice for three years
- Internal Medicine and Family Practice considered different specialty
- Patient seen by same doctor, but not since a three year interval considered new patient
- Patient seen by physician covering or on-call physician considered patient of usual doctor and is not a new patient

Established Patient 99212-99215

- Office or other outpatient visit for E/M of an established patient, which requires at least two of these three key components
 - History
 - Exam
 - Decision making
 - Levels depend on problem/problems presented

Element of Time

- Time is defined as face to face time
- Cannot round up to next level based on time
- All components of code must be met

Counseling and/or Coordination of Care

- Dominates more than 50% of encounter
- Total length of time of encounter must be documented
- Record should describe counseling and/or activities to coordinate care and patient's response

99211

- Established patient with minimal problem
- Typically five minutes or less spent on services
- Medical necessity for visit
- Documentation of clinical history, exam, decision level, and physician supervision
 - Blood pressure monitoring
 - Anticoagulation monitoring visits
 - Immunizations/administering injection medications

99211 Payable Examples

Established patient office visit for patient on regular immunotherapy who developed wheezing, rash, and swollen arm after last injection-possible dose adjustments discussed and injection is given

Office visit for an established patient for blood pressure check and medication monitoring and advice

Office visit with new or concerning bruise checked by the nurse (whether or not the patient is taking anticoagulants); patient advised on care, what to be concerned about and continuing/changing current dosage advised (if on anticoagulants)

99211 Non Payable Examples

Established patient office visit with long standing allergic rhinitis receiving monthly maintenance allergy injection

Office visit for an established patient with a previous stroke coming to a coagulation clinic staffed by a lab technician or pharmacist. There is no physician in facility at time that blood is drawn

If sole purpose of a visit to physician's office is to draw blood or receive an injection, then do not bill 99211, but only the appropriate injection or blood drawing code

Office visit for an established patient with Pernicious Anemia who has no complaints and is given a monthly Vitamin B-12 injection

Inpatient Initial Hospital Care

- 99221-99223 (Initial Care)
 - Admitted to hospital less than eight hours - same date
 - Do not bill hospital discharge 99238/99239
 - Bill initial care codes and discharge codes if patient is admitted and discharged on different dates
- 99234-99236 (Observation/Inpatient)
 - Admitted to hospital more than eight and less than 24 hours and discharged on same date
 - Codes include admit and discharge services

Initial Hospital Visit by Two Providers Involved in Same Admission

- Only one provider may be Principal Physician of Record
- Principal physician appends AI modifier
- Provider who performs an initial evaluation may bill initial hospital codes
 - Medicare does not accept consultation codes

Inpatient Subsequent Hospital Care

- 99231-99233 (Subsequent care)
 - These codes may only be reported once per day by same physician or by physicians of same specialty and same group
 - Payment for these codes represent all services given during a day whether or not related
 - Bedside and patient's floor/unit counseling/coordination care
 - Timed 15 minutes to 35 minutes

Hospital Discharge

- 99238-99239 (Discharge)
 - Face to face service between attending physician and patient
 - Other physicians shall use subsequent hospital care
 - Report discharge code for actual date of visit by physician
 - Even if patient is discharged from facility on a different date
- IOM *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.9.2

Prolonged Services

- 99354-99357 prolonged services involving direct (face-to-face) patient contact
 - Inpatient or outpatient setting beyond usual service
 - In addition to E/M – once per day
 - Without face-to-face, bundled into other services

99214 with direct face-to-face services (including visit) = 95 minutes

99214 x 1 (E/M)

99354 x 1 (Prolonged 1hr)

99355 x 1 (Prolonged additional 30 minutes)

Prolonged Services

- Prolonged services are intended to be used for unusual circumstances requiring additional time beyond the typical/average time of the visit code billed.
- Prolonged Services is an example of a time-based service that requires time be documented in the medical record.

99499 – Unlisted E/M Service

- In rare circumstance when physician (or NPP) provides a service not reflecting a CPT code description, service must be reported as unlisted service
- 99499 must be used when visit does not reflect even the lowest level E/M service (in an applicable CPT code family) yet still evidences medical necessity

99499 – Unlisted E/M Service ²

- Documentation should include type of service, place of service, and brief statement why another E/M code does not apply
- Claims individually reviewed
- Concise narrative/description in Item 19 or electronic equivalent
- Do not send documentation with claim

Other E/M Services – Same Day

- Hospital care service provided earlier in day; later patient's condition radically changed, may be appropriate to bill critical care on same day
 - Emergency department services are not payable on same calendar date as critical care when provided by same physician to same patient
 - Careful documentation required to support both services

E/M Modifiers

Modifier	Description
24	Unrelated E/M service by same physician during a post op period
25	Significant separately identifiable E/M service
57	Decision for surgery

Modifier 24

- Unrelated E/M service by same physician during postoperative period
- Provided during postoperative period by same physician who performed procedure
- Documentation supports service is not related to postoperative care of procedure

Modifier 25

- Significant evaluation and management service by same physician on date of global procedure
- If physician indicates service is a significant, separately identifiable E/M service, above and beyond usual pre-op and post-operative work of procedure
- Usually has a different diagnosis

Modifier 57

- Decision for surgery made within global surgery period
- E/M on day of or day before a surgical procedure with 90-day global surgical period
- Decision for surgery already included in the 0 or 10 day global procedures



Documentation Guidelines

Documentation – Why Important?

- Required to record facts, findings, and observations
- Chronologically documents care of patient
- Facilitates health care professionals evaluation, treatment, planning, and progress
- Validates the service and provider of service with signatures

Documentation Provides

- Communication and continuity of care among health care professionals
- Claims review and payment
- Utilization review and quality of care
- Required documentation list on Noridian's website:
 - <https://www.noridianmedicare.com>

Complete/Accurate Documentation

- Assess condition
- Progress & treatment results
- Plan of care
- Medical rationale
- Reason for encounter
- Other ancillary services where appropriate
- Document all services
- Why services provided
- Support treatment
- Records complete and legible
- Review laboratory results
- X-ray results

Reports and Records

- Physician orders
- Medication records
- Lab Reports
- Verbal orders
- Hospice records
- Nurses notes
- Progress notes
- Ambulance notes
- Progress notes
- Diagnostic test results
- H/P
- Operative reports
- SNF records
- Path reports
- PT orders/notes

Dispensing Order

- May be verbal or written
- Must contain:
 - Description of the item
 - Beneficiary's name
 - Prescribing physician's name
 - Date of the order and the start date if different
 - Physician signature if written or suppliers signature if verbal

Items Provided on a Periodic Basis

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

New Order Requirements

- There is a change of supplier
- There is a change in the item(s), frequency of use, or amount prescribed
- There is a change in the length of need or a previously established length of need expires
- State law requires a prescription renewal
- The policy requires a prescription renewal
 - i.e. Surgical Dressing policy requires a new order every 3 months

Physician Intent Lab/Diagnostic Tests

- CERT looking for
 - Order or requisition signed by physician
 - Notation in patient's record
- Verbal/telephone order documented at treating physician's office or
 - E-mail from physician to be verified
 - Medical records contain a valid diagnosis
- May need physician signature attestation
 - Physician signature must be legible and completely filled out (include credentials)

Amended Medical Records

- Addendum
 - Used to provide information that was not available at time of original entry
 - Should be timely and bear current date and reason for addition or clarification of information being added to medical record

Amended Medical Records ²

- Correction
 - Never write over, or otherwise obliterate passage when an entry is made in error
 - Draw a single line through erroneous information
 - Sign and date deletion, stating reason for correction above or in margin
 - Document correct information on next line or space with current date and time, making reference back to original entry

Amended Medical Records ³

- Late entry
 - Supplies additional information that was omitted from original entry
 - Entry bears current date, is added as soon as possible, and is written only if person documenting has total recall of omitted information, and is signed by person making the change

Medical Record Cloning

- Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.

Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Record Maintenance

- Providers required to maintain ordering and referring documentation for seven years from date of service
 - Codification of existing requirements
 - Record retention is considered part of normal business practice
 - 42 Code of Federal Regulations (CFR) Section 424.516 (d)



COMMON E/M ERRORS

“Pay it right the first time”

What Medical Review has been looking at for JE and JF

- JF
- 99214 for Family Practice
- 99233 Internal Medicine (current)
- JE
- 99285 Emergency Department Visit,
(current)
- 99233 Hematology and Oncology
- 99205 Cardiology and Pulmonology

JF – Medical Review Specific

Articles, Billing... Coverage Articles... Recovery Auditor... Materials, A042... Rehabilitation... and Links...

JF Part B / CERT & Reviews / Medical Review (Noridian) / Review Notifications and Findings

CERT & REVIEWS

- ▶ Comprehensive Error Rate Testing (CERT)
- ▼ Medical Review (Noridian)
 - Review Notifications and Findings**
 - Non-complex Review
 - Notifications and Findings
 - Probe Reviews
 - Targeted Reviews
 - Documentation of Medical Necessity
 - Automated Development System (ADS) Submissions
 - Office of Inspector General (OIG)
 - Quality Improvement Organization (QIO)
 - Recovery Auditor
 - Zone Program Integrity Contractor (ZPIC)

Review Notifications and Findings

Noridian performs pre-payment review in accordance with the [CMS Progressive Corrective Action \(PCA\) Plan](#). The Noridian Part B Medical Review (MR) team is responsible for conducting these audits to ensure that Medicare claims have been billed and paid appropriately.

Current Noridian Service-Specific Reviews

- Air Ambulance Fixed Wing
- Air Ambulance Rotary Wing
- Ambulance Service, A0427: ALS, Emergency Transport
- Annual Wellness Visit, G0439
- Chiropractic Manipulative Treatment, 98941
- Drug Screen, G0431
- Ground Ambulance, A0428, BLS, Nonemergency Transport
- Hematology/Oncology Office Visit, Established Patient, 99214
- Infliximab Injection, 10mg, J1745
- Internal Medicine Subsequent Hospital Care, 99233
- Office/Other Outpatient Visit, 99214: Established Patient [E/M](#) Provided by Family Practice
- Ranibizumab Injection, 0.1mg, J2778
- Subsequent Hospital Care, 99233: [E/M](#) Provided by Nephrology
- Total Hip Arthroplasty, 27130
- Total Knee Arthroplasty

Questions or concerns, contact [MR](#) at medicalreviewpartB@noridian.com

JE – Medicare Review – Specific

Browse by Topic

Browse by Specialty

Fees & News
Fee Schedules, Articles, Bulletins ...

Policies
LCDs, NCDs, MoIDX, Coverage Articles...

CERT & Reviews
Medical Review, Recovery Auditor...

Education & Outreach
Training Events, Materials, ACTS...

Enrollment
Enroll, Opt Out, Make Changes, Revalidate...

Forms
Downloadable Forms and Links...

JE Part B / CERT & Reviews / Medical Review (Noridian) / Review Notifications and Findings

CERT & REVIEWS

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- Ambulance Service, A0427: ALS, Emergency Transport
- Ambulance Service, A0428: BLS, Non-Emergency Transport
- Ambulance Service, A0429: BLS, Emergency Transport
- Annual Wellness Visit, G0439
- Chiropractic Manipulative Treatment, 98942
- Colonoscopy, 45378
- Computed Tomography Angiography, Chest, 71275
- Destruction of Premalignant Lesions - Actinic Keratosis 17004, Dermatology
- Drug Screen, G0431
- Emergency Department Visit, 99285
- Extracapsular Cataract Removal with Insertion of Intraocular Lens Prosthesis, 66984
- Ground Ambulance A0428 BLS, Nonemergency Transport
- Hematology/Oncology Subsequent Hospital Care, 99233
- Initial Nursing Facility Care, 99306
- Internal Medicine Subsequent Hospital Care, 99233
- Magnetic Resonance Imaging, Brain, 70553
- Myocardial Perfusion Imaging, Tomographic (SPECT), 78452
- Office or Other Outpatient New Patient Visit, 99205, Provided by Cardiology
- Office or Other Outpatient New Patient Visit, 99205, Provided by Pulmonary Disease
- Prolonged Service in the Office or Other Outpatient Setting, 99354
- Subsequent Nursing Facility Care, 99309
- Total Knee Arthroplasty, 27447
- Ultrasound, Abdominal, 76700

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Common Errors

- Insufficient Documentation
- Incorrect Coding
- Medical Necessity Not Supported
- Documentation Doesn't Support Level Billed
- Prolonged Services
- Time-based Services
- Duplicate submissions
- Other Issues

When Documentation is Requested

- Timely response is critical
- Provide all requested records
- Records must be legible
- Include appropriate signatures and credentials
- Check right beneficiary, right service, right date of service
- Clear copies of documentation

Documentation Doesn't Support Level Billed

- Each encounter must tell a complete story
- Prior encounters cannot be considered unless referenced by date in the encounter being audited
- All three components (history, exam and medical decision making) must be present when billing initial/new patient visits

Documentation Doesn't Support Level Billed

- Should be able to find a correlation between chief complaint/HPI/exam findings and what is documented for medical decision making
- It would not be medically necessary or appropriate to bill a higher level E/M when a lower level of service is warranted.

Documentation Doesn't Support Level Billed

- Requires all 3 key components at levels indicated
- Lowest key component determines the level of service
 - Initial visits (office, hospital, home)
- Requires only two 2 of 3 key components at levels indicated
 - Subsequent visits

CERT Findings Improper Payments

Part B Service	\$ Amounts	No Doc	Insufficient Doc	Medical Necessity	Incorrect coding
Office visits - new	\$490,841,942	0.7%	18.2%	0.9%	77.1%
Office visits - established	\$1,141,913,178	4.8%	4.8%	0.0%	59.7%
Hospital visit - initial	\$888,882,432	3.7%	29.1%	0.0%	66.2%
Hospital visit - subsequent	1,048,419,405	4.3%	55.9%	0.4%	38.3%

CERT Findings Improper Payments

Part B Service	\$ Amounts	No Doc	Insufficient Doc	Medical Necessity	Incorrect coding
Emergency room visit	\$292,397,866	0.0%	9.7%	0.6%	89.7%
Nursing home visit	\$362,260,716	9.9%	40.8%	0.0%	49.3%

CERT Findings

- In Review of E/M services by the CERT contractor of all our states has revealed a lack of documentation to support
- The leading cause of down coding is incomplete documentation
- Not meeting the levels basic requirements
- Lack of documentation for levels billed
- Not all components of codes are being fulfilled

CERT Findings cont..

- Down coding by two levels
- No exam completed
- Three out of three not completed

CERT Example 1

- Billed 99223
- Down coded to 99499
- Rationale:
 - History is comprehensive, MDM is high, no exam documented

CERT Example 2

- Billed 99223
- Down coded to 99221
- Rationale:
 - Level of exam and history was detailed, MDM was moderate

Other Issues

- Legibility
- Date of service billed does not match date of service documented in the patient's chart
- Signature

Signature Requirements

- Signatures:
 - Services provided/ordered must be authenticated by the author
 - Must be legible
 - Should include the practitioner's first and last name
 - Handwritten or Electronic
- No stamped signatures (CR 8219)
 - Example: “unacceptable” signature




For an attestation statement to be valid, it must be signed by the performing provider

Location of Attestation Form

JE – <https://med.noridianmedicare.com/documents/10525/78978/Signature+Attestation+Statement/>

JF- https://www.noridianmedicare.com/partb/claims/cert/docs/signature_attestation_statement.pdf


Medicare Part B

SIGNATURE ATTESTATION STATEMENT

Today's Date: _____

Provider Information

Billing Provider's Name: _____

Billing Provider's NPI: _____

Performing Provider's Name: _____

Performing Provider's NPI: _____

State in which the Provider's health care business is located: _____

Beneficiary Information

First and Last Name: _____

Date of Birth: _____

Date of Service: _____

Attestation Statement:

I, _____, hereby attest that the medical record entry for
(Provider Name)
 _____ accurately reflects signatures/notations that I made in my
(Date of Service)
 capacity as _____ when I diagnosed/treated
(Provider's Credentials, e.g. M.D. etc.)
 the Medicare beneficiary listed above.

I do hereby further attest that this information is true, accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to administrative, civil or criminal liability.

Signature and credentials: _____

Provider Initials: _____

Note: For an attestation statement to be valid it must be signed by the performing provider.



Resources and Reminders

Evaluation and Management Web Page

Browse by Topic

Browse by Specialty

Fees & News
Fee Schedules, Articles, Bulletins ...

Policies
LCDS, NCDs, MoIDX, Coverage Articles...

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JF Part B / Browse by Specialty / Evaluation and Management (E/M)

BROWSE BY SPECIALTY

- Ambulance
- Ambulatory Surgical Center (ASC)
- Anesthesia & Pain Management
- Cardiology
- Chiropractic
- Diabetic, Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) Services
- End Stage Renal Disease (ESRD)
- Evaluation and Management (E/M)**
- Independent Diagnostic Testing Facility (IDTF)
- Laboratory
- Locum Tenens and Reciprocal Billing
- Mental Health
- Nephrology
- Nonphysician Practitioners
- Oncology / Hematology
- Optometry / Ophthalmology
- Outpatient Therapy
- Podiatry
- Radiology and Radiation Oncology Services
- Surgery
- Telehealth

Evaluation and Management (E/M)

- Documentation and Level of Service
- Evaluation and Management Clarification

Guideline Differences Between 1995 and 1997

E/M Components	History: History of Present Illness	History: Review of Systems	History: Past, Family and Social	Exam	Decision Making
1995	No Difference - An extended History of Present Illness may consist of status of three chronic/inactive conditions for either set of guidelines (1995 or 1997) for services performed on/after 09/10/13.	No Difference	No Difference	Body areas, body systems or complete single organ system	No Difference
1997				General multi-system or single organ system	

The following is an excerpt from the CMS Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1,

Educational Resources

- Workshop Q&A
- Care Plan Oversight Presentation (Sep 2014)
- Chronic Care Management Services Presentation (Apr 2015)
- Common E&M Errors by CERT and Medical Review Presentation (Aug 2014)
- Critical Care Billing and Coding Presentation (Feb 2015)
- Transitional Care Management Presentation (Jun 2014)
- E/M Documentation Checklist
- 1995 Documentation Guidelines for Evaluation and Management Services
- 1997 Documentation Guidelines for Evaluation and Management Services
- CMS Documentation Guidelines for Evaluation and Management (E/M) Services
- CMS Evaluation and Management Services Guide

Resources

- <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>
 - Evaluation and Management (E/M) Services Fact Sheet
 - Evaluation and Management Services Guide
 - 1995 Guidelines for Evaluation and Management Services
 - 1997 Guidelines for Evaluation and Management Services
- Current Procedural Terminology CPT Book

Resources

- Internet Only Manuals (IOMs)
 - <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>
- *Benefit Policy Manual*
 - IOM 100-02, Chapter 6, Section 20.6
- *Claims Processing Manual*
 - IOM 100-04, Chapter 4, Section 290
 - IOM 100-04, Chapter 30
 - IOM 100-04, Chapter 12, Section 30.6.8 and 30.6.12

Noridian Likes Website Feedback!

- Provide constructive/complimentary feedback to continue Noridian website growth and improvement



Thank you for visiting Noridian Medicare

Upon leaving our website, you may be selected to take part in a customer satisfaction survey. The feedback you provide will help Noridian Medicare enhance its site and serve you better in the future. All results are strictly confidential.

No thanks

Yes, I'll give feedback

This survey is conducted by an independent company ForeSee, on behalf of Noridian Medicare.



Customer Satisfaction Survey

IF YOU ARE USING A SCREEN READER, PLEASE SELECT THIS LINK

Thank you for visiting the Noridian Medicare website. You have been randomly selected to take part in this survey that is being conducted by ForeSee Results on behalf of Noridian Medicare. Please take a minute or two to provide us your opinions regarding the features of the Noridian Medicare website. The feedback you provide will help us enhance our site and serve you better in the future. If you have responded to this survey previously, we would appreciate any new comments you have regarding the changes implemented since your last survey response. All results are strictly confidential.

1: Please rate the ease of reading this site.

1=Poor 10=Excellent Don't Know

1 2 3 4 5 6 7 8 9 10

2: Please rate the clarity of site organization.

1=Poor 10=Excellent Don't Know

1 2 3 4 5 6 7 8 9 10

3: Please rate the degree to which the number of steps it took to get where you want is acceptable.

1=Poor 10=Excellent Don't Know

1 2 3 4 5 6 7 8 9 10

4: Please rate the ability to find information you want on this site.



Questions?

Thank you