



Missing Evaluation and Management Documentation

A basic requirement for the billing of covered Medicare Part B services is that documentation must support the medical necessity for the service. In addition, the E&M documentation must verify that the service was performed on the date billed, by the identified performing provider or incident to that provider, as listed on the date noted on the claim. When a service is not documented, medical necessity is determined to be unsubstantiated, and the service will be denied.

The following are **Examples of Missing Documentation identified by Medical Review**:

- No provider signature

"Medicare requires a legible identity for services provided."

- No detailed statements of abnormal responses when documenting an abnormal body area/organ system for a Review of Systems or Examination.

The 1995 and 1997 Evaluation and Management Documentation Guidelines require specific documentation. "*A notation of abnormal without elaboration is insufficient.*"

- When referencing a section from a prior date of service which has a significant bearing on the current service, that prior date of service documentation should be submitted with the requested documentation

In many E&M services that we review, a provider will refer to a past medical/family/social history and state "unchanged"; but, without documentation for the date of service referenced, we do not know the extent of the history performed. For example, the provider states that the past medical history remains unchanged from the previous past history documentation, but is billing a comprehensive E&M CPT code. Without submitting the past history documentation with the encounter note, the specific PFSH patient information cannot be accurately determined. If a provider restates the information in the encounter note, the past history documentation does not need to be submitted. Please note that prior documentation referenced must have occurred within a reasonable timeframe prior to the current service.

- No patient identification or dates of service included in the documentation submitted.

The documentation must be complete and legible, per the guidelines.

Please remember: You are familiar with the patient; however, we must make our determinations based solely on the documentation we receive. For example, only those elements present in the submitted documentation can be considered when we determine whether the level of E&M service billed is appropriate. Ultimately, the provider is responsible for submitting the appropriate documentation.

RESOURCES

CMS Internet-Only Manual (Pub.100.6; 3.90.1E and 1F)

E. "The Provider Does Not Submit Documentation to Substantiate That Services Billed to the Program Were Covered."

F. "The Provider Does Not Submit Documentation to Substantiate That He/She Performed



www.wpsmedicare.com

the Services Billed to the Program Where There is A Question as to Whether the Services Were Performed."

Medicare Resident & New Physician Guide, Chapter 6, Evaluation and Management Documentation