Facilitator's Guide

Medicare Physician Guide

A Resource for Residents, Practicing Physicians, and

Other Health Care Professionals

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

ICN: 006352 October 2009

Medicare Learning Network

FACILITATOR'S GUIDE

COMPANION TO MEDICARE PHYSICIAN GUIDE: A RESOURCE FOR RESIDENTS, PRACTICING PHYSICIANS, AND OTHER HEALTH CARE PROFESSIONALS

October 2009
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PREFACE

Physician and health care professional outreach has been, and continues to be, one of the Centers for Medicare & Medicaid Services' (CMS) top priorities. The Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program is a customized instructor-led course that has been delivered to learners at medical schools and other organizations throughout the United States. The goal of this program is to provide general information and resources to residents, practicing physicians, and other health care professionals who are new to the Medicare Program. The Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program is open to all health care professionals. The primary target audience of this program is residents who are preparing to establish their own medical practice within six months of attending a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program course.

Disclaimer

This guide was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This guide was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. CMS employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This guide is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Medicare Learning Network

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website.

CPT Notice and Disclaimer

ICD-9-CM Notice

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

INSTRUCTIONS FOR FACILITATORS

The Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN) has developed the following materials specifically for facilitators who plan to conduct a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program course:

1) **Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals**
   This comprehensive guide, which is available in print, CD-ROM, and downloadable formats, offers learners an overview of the Medicare Program.

2) **Facilitator's Guide**
   This guide, which is available in CD-ROM and downloadable formats, provides everything needed to prepare for and conduct a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program course. Included are the following materials:
   - Promotional Flyer;
   - Program Sign-In Sheet;
   - 3-Hour Medicare Program Training Module;
   - Pre- and Post-Assessments;
   - Pre- and Post-Assessment Master Answer Keys;
   - Course Evaluation (to be completed by learners);
   - Reference Information (hand outs); and
   - Request for Centers for Medicare & Medicaid Services-Led In-Person Course.

3) **Video – Medicare Resident, Practicing Physician, and Other Health Care Professional Training: An Introduction**
   Short video, available in DVD format, offers learners basic Medicare information and resources.

These materials are available free of charge from the MLN. To place your order, visit *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website. On this web page, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Course Administration

The Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program is a customized instructor-led course that has been delivered to learners at medical schools and other organizations throughout the United States. The goal of this program is to provide general information and resources to residents, practicing physicians, and other health care professionals who are new to the Medicare Program.

Audience

All health care professionals may attend this course. The primary target audience of this program is residents who are preparing to establish their own medical practice within six months of attending a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program course.

Software Requirements

Course documents were developed with the following software:

- Adobe Acrobat 8.0;
- Microsoft PowerPoint 2007; and
- Microsoft Word 2007.

You must have one of the following software versions to download and customize the course:

- Adobe Acrobat 7.0;
- Microsoft PowerPoint 2003 or above; and
- Microsoft Word 2003 or above.

Pre- Assessment

Prior to conducting the course, ask learners to complete the appropriate Pre-Assessment, Word file(s) labeled “06 Chapter 1 Pre Post Assessment” – “12 Chapter 7 Pre Post Assessment.” The purpose of the Pre-Assessment is to determine learners’ knowledge of Medicare prior to attending the course.

Please make copies of completed Pre-Assessment answer sheets for your locked, confidential file and mail originals to:

Ann Palmer
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-13-07
Baltimore, MD 21244

Learning Objectives

Learning objectives reflect what the learners will achieve as a result of attending this course. Learning objectives also assist facilitators in determining the information that should be included in the course. The 3-Hour Medicare Program Training Module learning objectives are listed below.

Chapter 1 – Introduction to the Medicare Program

- Identify Medicare's four parts.
- Determine the individuals who are eligible for Medicare Part A and Part B, Medicare Advantage, and the prescription drug plan.
- Identify the organizations that impact the Medicare Program.

Chapter 2 – Becoming a Medicare Provider or Supplier

- Identify Part A and Part B providers and suppliers.
- Define the Medicare physician and practitioner.
- Describe the Medicare Program enrollment process.
- Identify how providers and suppliers can promote cultural competency.

Chapter 3 – Medicare Reimbursement

- Describe how Medicare providers and suppliers are reimbursed for the items and services they furnish.
- Identify when Medicare is the secondary payer.
- Recognize incentive payments.
- Describe the Medicare Physician Fee Schedule.
- Identify notices you may use or receive from Medicare.
- Describe the other health insurance plans beneficiaries may be enrolled in.

Chapter 4 – Medicare Payment Policies

- Determine Medicare covered services.
- Identify incident to services.
- Determine the services that are not covered by Medicare.

Chapter 5 – Evaluation and Management Services

- Describe the two common sets of codes that are currently in use and the new classification system that will be used beginning on October 1, 2013.
- Identify the seven general principles of documentation.
- Identify the seven components that define the levels of evaluation and management services.

Chapter 6 – Protecting the Medicare Trust Fund

- Identify the goal of the Medicare Integrity Program.
- Describe the medical review process.
- Determine the two types of coverage determinations.
- Define Federal health care fraud.
- Define program abuse.
- Identify the potential legal actions that may be imposed if a provider, supplier, or health care organization has committed health care fraud and program abuse.

Chapter 7 – Inquiries, Overpayments, and Fee-for-Service Appeals

- Describe how providers and suppliers can find answers to inquiries.
- Identify the reasons overpayments are often paid.
- Identify the five levels of the fee-for-service appeals process.
- Define a reopening.

Let's Review Section

At the end of each chapter is a "Let's Review" Section that facilitators may use to review the information that was covered and to generate discussion among the learners. The correct answer to each review question is provided.

Post-Assessment

After conducting the course, ask learners to complete the appropriate Post-Assessment, Word File(s) labeled "06 Chapter 1 Pre Post Assessment" – "12 Chapter 7 Pre Post Assessment." The purpose of the Post-Assessment is to determine learners' knowledge of Medicare after attending the course.

Please make copies of completed Post-Assessment answer sheets for your locked, confidential file and mail originals to:

Ann Palmer
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-13-07
Baltimore, MD 21244

Evaluations

After each course has been conducted, please encourage learners to complete the Course Evaluation, Word file labeled "14 Course Evaluation." This important tool is used to measure how well learners received the Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program.

Please make copies of the Course Evaluations completed by learners for your locked, confidential file and mail originals to:

Ann Palmer
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-13-07
Baltimore, MD 21244

After you have conducted the course, please complete the *Medicare Resident, Practicing Physician, and Other Health Care Professional Training Facilitator's Kit* Evaluation. This evaluation can be found on the MLN Product Ordering Page, which can be accessed by visiting *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website. On this web page, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

Feedback received from learners and facilitators is very valuable to CMS. It assists in ensuring that our training materials and the Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program meet the needs of facilitators and health care professionals.

Questions

If you have questions about the Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program, please e-mail them to Residenttraining@cms.hhs.gov.

Preparing to Deliver the Course

Checklist

Facilitators should have the following materials available on the day(s) the course will be conducted:

- √ 3-Hour Medicare Program Training Module
- √ *Facilitator's Guide*
- √ *Medicare Resident, Practicing Physician, and Other Health Care Professional Training: An Introduction* Video
- √ Educational Products
    - o Six weeks prior to the scheduled date of course, facilitators should order the *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* for each learner from the MLN. To place your order, visit the MLN Product Ordering Page, which can accessed by visiting *http://www.cms.hhs.gov/MLNGenInfo*. On this web page, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."
- √ Slide Hand Outs
- √ Pre- and Post-Assessments
- √ Course Evaluations
- √ Reference Information (Hand Outs)
- √ Sign-In Sheets
- √ Markers and Highlighters
- √ Personal Computer
- √ Projector and Projection Screen
- √ Flipchart Stand and Paper
- √ Pencils and Pens

Errata Sheets

Errata sheets assist in ensuring that the Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program course contains the most up-to-date information. When corrections or changes are identified, an errata sheet for the *Medicare Physician Guide* and *Facilitator's Guide* will be posted at *http:www.cms.hhs.gov/MLNProducts/MPUB/list.asp* on the CMS website. On this web page, under "Select From The Following Options," enter the title of the publication to be taken to the errata sheet link. Facilitators can also sign up to be notified when errata sheets are posted by subscribing to the Resident Training listserv. To subscribe to the listserv, visit *https://list.nih.gov* on the Web.

Instructional Strategy

Facilitators may choose to present all chapters of the training module or tailor their own course by choosing the chapters that best meet the needs of learners. The training module is based on information found in the *Medicare Physician Guide*.

Facilitators may also show learners the *Medicare Resident, Practicing Physician, and Other Health Care Professional Training: An Introduction* video. The video features Valerie Haugen, director of the Division of Provider Information Planning and Development at CMS, who presents information and resources that will assist physicians and other health care professionals in navigating the Medicare Program.

Estimated Delivery Times
Below are the estimated delivery times for each chapter of the training module. Note that delivery times may vary depending on:

- Pace of the facilitator;
- Course information presented; and
- Number and complexity of learners' questions.

	TITLE	APPROXIMATE DELIVERY TIME
Chapter 1	Introduction to the Medicare Program	30 minutes
Chapter 2	Becoming a Medicare Provider or Supplier	35 minutes
Chapter 3	Medicare Reimbursement	20 minutes
Chapter 4	Medicare Payment Policies	15 minutes
Chapter 5	Evaluation and Management Services	45 minutes
Chapter 6	Protecting the Medicare Trust Fund	15 minutes
Chapter 7	Inquiries, Overpayments, and Fee-for-Service Appeals	20 minutes

Customizing and Printing the Promotional Flyer

- Open the PowerPoint file labeled “03 Promotional Flyer.”
- Place the cursor at “Insert Name of Organization” located at the top of the flyer and enter the name of your organization.
- Place the cursor after “Date,” “Time,” “Place,” “Local Point of Contact,” and “Telephone Number” located at the bottom of the flyer and enter course and contact information.
- Select FILE | PRINT. In the “Copies” section of the Print dialog box, enter the number of flyers you will need and select OK. **Optional**: Print one copy of the flyer and make additional copies using a copy machine.
- Select FILE | SAVE.
- Select FILE | CLOSE.
- Notify learners about the upcoming course by posting the promotional flyers.

Customizing and Printing the Sign-In Sheet

- Open the Word file labeled “04 Program Sign In Sheet.”
- Place the cursor at “Insert Name of Organization” located at the top of the sheet and enter the name of your organization.
- Place the cursor at “Insert Date of Course” located at the top of the sheet and enter the date the course will be conducted.
- Select FILE | PRINT. In the “Copies” section of the Print dialog box, enter the required number of Sign-In Sheets you will need based on the expected number of learners and select OK. **Optional**: Print one copy of the Sign-In Sheet and make additional copies using a copy machine.
- Select FILE | SAVE.
- Select FILE | CLOSE.
- Please make copies of completed Sign-In Sheets for your locked, confidential file and mail original Sign-In Sheets to:

  Ann Palmer
  Centers for Medicare & Medicaid Services
  7500 Security Boulevard, Mail Stop C4-13-07
  Baltimore, MD 21244

Customizing the 3-Hour Medicare Program Training Module

- Open the PowerPoint file labeled “05 3 Hour Medicare Program Training Module.”

- Select VIEW | HEADER and FOOTER from the menu bar.

- Select the “Notes and Handouts” tab from the “Header and Footer” dialog box and check the following boxes:
    - Date and time;
    - Fixed;
    - Header;
    - Page number; and
    - Footer.

- In the header section, place the cursor at “Name of Organization" and enter the name of your organization.

- In the footer section, place the cursor at “Date of Course” and enter the date the course will be conducted.

- Select “Apply to All.”

- Select FILE | SAVE.

- Select FILE | CLOSE.

Customizing and Printing the Pre- and Post-Assessments

- Each chapter of the training module has a separate Pre- and Post-Assessment package. Learners should receive the corresponding package, depending on which chapter(s) of the training module you will be presenting. Open the appropriate Pre- and Post-Assessment Word file(s) labeled “06 Chapter 1 Pre Post Assessment” – “12 Chapter 7 Pre Post Assessment.”

- Select VIEW | HEADER and FOOTER from the menu bar. Place the cursor at “Insert Name of Organization” in the header section and enter the name of your organization. Place the cursor at “Insert Date of Course” and enter the date the course will be conducted.

- Select FILE | PRINT from menu bar. In the “Copies” section of the Print dialog box, enter the required number of Pre- and Post-Assessments based on the expected number of learners and select OK. **Optional**: Print one copy of each Pre- and Post-Assessment file and make additional copies using a copy machine.

- Select FILE | SAVE.

- Select FILE | CLOSE.

- Please make copies of completed Pre- and Post-Assessment answer sheets for your locked, confidential file and mail original answer sheets to:

  Ann Palmer
  Centers for Medicare & Medicaid Services
  7500 Security Boulevard, Mail Stop C4-13-07
  Baltimore, MD 21244

Preparing the Request for a Centers for a Medicare & Medicaid Services-Led In-Person Course

- If you would like to request a CMS Regional Office (RO)-led in-person Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program course, open the file labeled “16 Request for Course.”

- Select FILE | PRINT.

- Select FILE | CLOSE.

- In the table on page 2, circle the number that you believe best represents the importance of each chapter as it relates to the needs of the learners. Count the number of 2s and 3s that you circled. Add up the time required to present the chapters that you circled. Enter this information on page 3.

- Ensure that the total time for the chapters you have selected does not exceed the time available for learners to attend the course.

- See page 3 for instructions regarding where to mail or fax the request to your CMS RO.

Please note that resource constraints may limit a RO’s ability to conduct in-person courses.

The Medicare
Resident, Practicing Physician, and Other Health Care Professional Training Program

is coming to

[Insert Name of Organization]

This course offers residents, physicians,
and other health care professionals
an overview of the Medicare Program

Date:

Time:

Place:

Local Point of Contact:

Telephone Number:

The developers of this program have no conflicts of interests disclose.

MEDICARE RESIDENT, PRACTICING PHYSICIAN, AND OTHER HEALTH CARE PROFESSIONAL TRAINING PROGRAM

SIGN-IN SHEET

[Insert Name of Organization]
[Insert Date of Course]

NAME (Please print)	DEPARTMENT	TELEPHONE #	POSITION
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________
			❒ Student ❒ Resident ❒ New Physician ❒ Fellow ❒ Other (please specify) ____________________

FACILITATORS: Please make copies of completed Sign-In Sheets for your locked, confidential file and mail original Sign-In Sheets to:

Ann Palmer
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Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program

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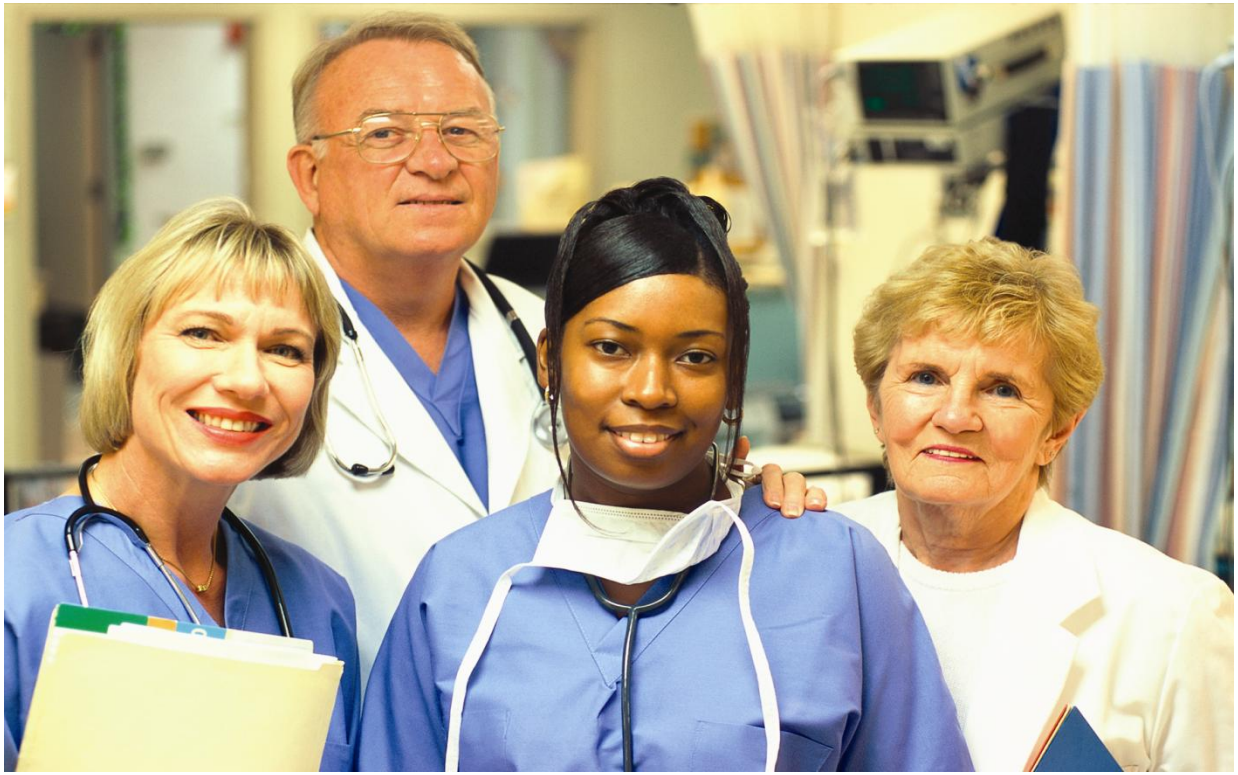


Pre-Assessment

CHAPTER 1

INTRODUCTION TO THE MEDICARE PROGRAM

The Medicare Program

- Largest health insurance program
- Over 1 billion claims annually
- Over 44 million individuals entitled

Identifying Beneficiaries

- Health insurance card contains
  - Name
  - Sex
  - Medicare Health Insurance Claim number
  - Date of entitlement

Introduction to the Medicare Program

- 4 parts
  - Part A, hospital insurance
  - Part B, medical insurance
  - Part C, Medicare Advantage
  - Part D, prescription drug plan

Part A
Hospital Insurance

- Inpatient hospital care
- Inpatient care in a Skilled Nursing Facility following covered hospital stay
- Some home health care
- Hospice care

Part A Eligibility

- Individuals age 65 years and older
  - Insured
  - Not insured

Part A Eligibility

- Individuals under age 65 with certain disabilities
- Individuals with End-Stage Renal Disease

Part B
Medical Insurance

Physician and practitioner services

Home health care

Ambulance services

Clinical laboratory and diagnostic services

Surgical supplies

Durable medical equipment, prosthetics, orthotics, and supplies

Hospital outpatient services

Part B Eligibility

- All individuals eligible for premium-free Part A are eligible to enroll

Part C
Medicare Advantage

- Contract with CMS to furnish or arrange for provision of health care services to beneficiaries who
  - Are entitled to Part A and enrolled in Part B
  - Permanently reside in service area of Plan
  - Elect to enroll in Medicare Advantage Plan

Part D
Prescription Drug Plans

- All who elect to enroll are covered
- Individuals with limited resources may qualify for help paying for prescription drug costs

Organizations That Impact Medicare

- Social Security Administration
- Office of Inspector General
- Quality Improvement Organizations
- State Health Insurance Assistance Program

Let's Review

- What are Medicare’s 4 parts?
- Which Medicare beneficiaries are eligible to enroll in Medicare Advantage?

CHAPTER 2

BECOMING A MEDICARE PROVIDER OR SUPPLIER

Part A Providers and Suppliers

- Critical Access Hospitals
- Federally Qualified Health Centers
- Home Health Agencies
- Hospice
- Hospitals (acute care inpatient)
- Inpatient Rehabilitation Facilities
- Long Term Care Hospitals
- Rural Health Clinics
- Skilled Nursing Facilities

Part B Providers and Suppliers

- Ambulances service suppliers
- Ambulatory Surgical Centers
- Comprehensive Out-patient Rehabilitation Facilities
- End-Stage Renal Disease Facilities
- Home Health Agencies
- Hospitals (outpatient)
- Mass immunization roster billers
- Other non-physician practitioners
- Physicians
- Skilled Nursing Facilities (outpatient)

Medicare Physicians

Must be legally authorized to practice by State

- Chiropractors
- Doctors of dental surgery or dental medicine
- Doctors of medicine and osteopathy
- Doctors of optometry
- Doctors of podiatry or surgical chiropody

Interns and Residents

- Participate in approved Graduate Medical Education programs
- Not in approved programs, but authorized to practice only in hospital setting
  - Also includes interns, residents, and fellows in programs approved for purposes of direct Graduate Medical Education and Indirect Medical Education payments

Teaching Physicians

- Involve residents in care of their patients
- Present during all critical or key portions of procedure
- Immediately available to furnish services during entire service

Practitioners

Legally authorized to practice by State and otherwise meet Medicare requirements

- Anesthesiologist assistant
- Certified nurse midwife
- Clinical nurse specialist
- Certified registered nurse anesthetist
- Clinical psychologist
- Clinical social worker
- Nurse practitioner
- Physician assistant
- Registered dietician or nutrition professional

Enrolling in Medicare

- Obtain National Provider Identifier
- Complete Medicare Enrollment Application

Enrolling in Medicare

- Include with Medicare Enrollment Application
  - Form CMS-588
  - CMS Standard Electronic Data Interchange Enrollment Form
  - Form CMS-460 (optional)
  - State medical license
  - Occupational or business license
  - Certificate of Use

Participating Provider/Supplier

- Accepts assignment
- 1 year participation period

Participating Provider/ Supplier Benefits

- Higher Medicare Physician Fee Schedule allowances
- Limiting charge provisions not applicable
- Included in Physician and Other Healthcare Professional Directory

Nonparticipating Provider/Supplier

- May accept assignment of claims on claim-by-claim basis
- May not submit charges for nonassigned claims in excess of limiting charge amount
- May collect up to the limiting charge amount

Limiting Charge Example

MPFS Allowed Amount for Procedure “X”	$200.00
Nonparticipating Provider/ Supplier Allowed Amount for Procedure “X”	$190.00
Limiting Charge for Procedure “X”	$218.50
Beneficiary Coinsurance and Limiting Charge Portion Due to Provider/Supplier	$ 66.50

Payment Amounts Example

	Participating Provider/ Supplier	Nonparticipating Provider/Supplier Who Accepts Assignment	Nonparticipating Provider/Supplier Who Does Not Accept Assignment
Submitted Amount	$125.00	$125.00	$109.25
MPFS Allowed Amount	$100.00	$ 95.00	$ 95.00
80 Percent of MPFS Allowed Amount	$ 80.00	$ 76.00	$ 76.00
Beneficiary Coinsurance	$ 20.00	$ 19.00	$ 33.25
Total Payment To Provider/ Supplier	$100.00	$ 95.00	$109.25 ($95.00 x 1.15 limiting charge)

Cultural Competency

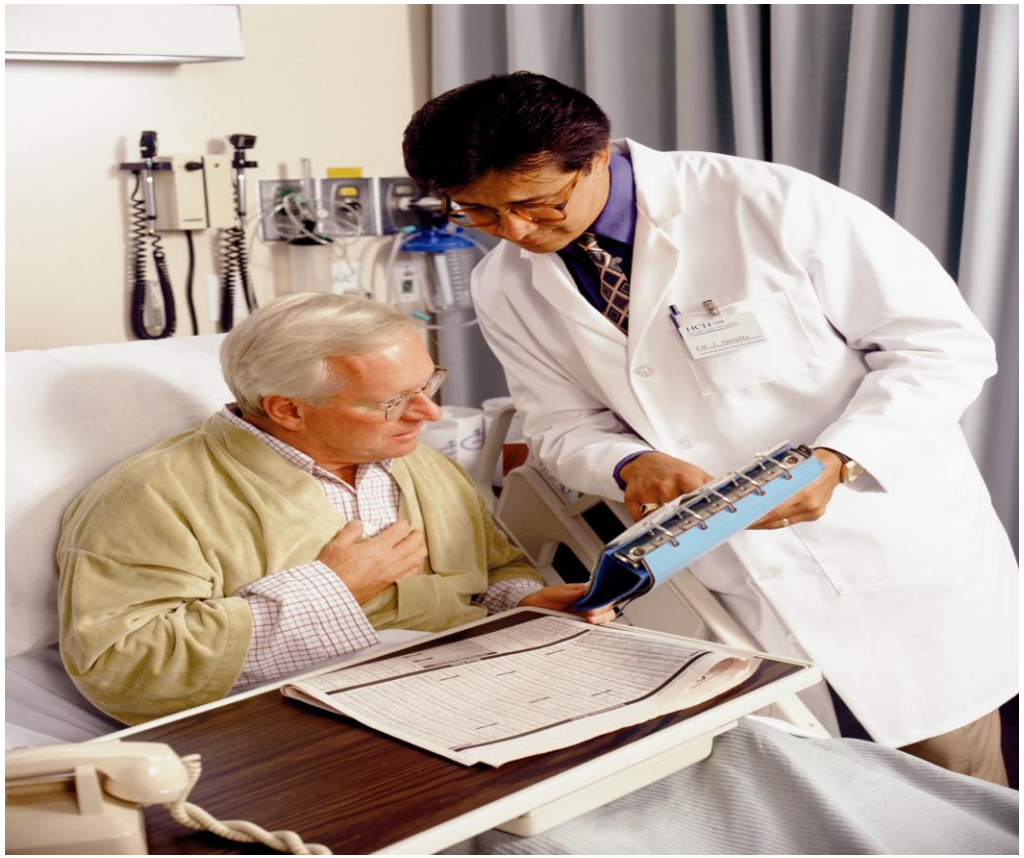
- Addressing a patient's social and cultural background assists in delivering high quality, effective health care

Let's Review

- What are the steps that must be taken in order to enroll in and obtain reimbursement from Medicare?
- What are the benefits of becoming a Medicare participating provider or supplier?

CHAPTER 3

MEDICARE REIMBURSEMENT



Medicare Claims

- Must submit claims for services
- Cannot charge for completing or filing claim
- File on or before December 31 of calendar year following the year in which the services were furnished
- Services furnished in last quarter of year considered furnished in following year

Exceptions to Mandatory Filing

- Certain secondary payer claims
- Services furnished outside the U.S.
- Services initially paid by third-party insurers
- Claims for unusual or excluded services
- Claims when provider/supplier opted out, excluded, or debarred

Electronic Claims

- Claims must be submitted electronically, except in limited situations, using
  - Electronic media claims
  - Electronic billing software vendor or clearinghouse
  - Billing agent
  - Medicare's free billing software

Deductible, Coinsurance, and Copayment

- Deductible – amount beneficiary must pay before Medicare begins to pay
- Coinsurance – percentage of covered charges beneficiary may pay after meeting deductible
- Copayment – amount beneficiary pays for each medical service

Medicare Secondary Payer

- Must determine whether Medicare is the primary or secondary payer prior to submitting a claim
- Coordination of Benefits Contractor – provides assistance to providers and suppliers

Incentive Payments

- Health Professional Shortage Area Incentive Payment
- Physician Quality Reporting Initiative Incentive Payment

Medicare Physician Fee Schedule

- Basis for payment of physician services under Medicare Part B
- 3 components
  - Relative Value Units
  - Conversion Factor
  - Geographic Practice Cost Indices

Medicare Notices

- Advance Beneficiary Notice
- Certificate of Medical Necessity and Durable Medical Equipment Medicare Administrative Contractor Information Forms
- Remittance Advice
- Medicare Summary Notice

Other Health Insurance Plans

- Medicare Advantage
- Medicaid
- Medigap

Let's Review

- What is a Health Professional Shortage Area incentive payment?
- What is the Advance Beneficiary Notice?

CHAPTER 4

MEDICARE PAYMENT POLICIES

Medicare Covered Services

Services and supplies must be medically reasonable and necessary

- Proper and needed for diagnosis or treatment of medical condition
- Furnished for diagnosis, direct care, and treatment of medical condition
- Meet standards of good medical practice
- Not mainly for convenience

Part A Inpatient Hospital Services

- Bed and board
- Nursing and related services
- Use of hospital or Critical Access Hospital facilities
- Medical social services
- Drugs, biologicals, supplies, appliances, and equipment
- Diagnostic or therapeutic services
- Medical or surgical services furnished by interns or residents in training
- Transportation services

Part B Services

Surgery, consultations, office visits, and institutional calls

Services, supplies, and outpatient hospital services furnished incident to physician services

Outpatient physical, occupational, and speech-language pathology services

Diagnostic tests

Ambulance services

Preventive services

Incident to Provision

- Commonly furnished in physicians' offices or clinics
- Furnished by physician or auxiliary personnel under direct personal supervision of physician
- Furnished without charge or included in physician's bill
- Integral, although incidental, part physician's professional service

Services not Covered by Medicare

- Excluded services
- Services considered not medically necessary
- Services denied as bundled or included in basic allowance of another service

Medicare also does not pay for claims rejected as unprocessable

Let's Review

- What are medically reasonable and necessary services and supplies?
- What services are not covered by Medicare?

CHAPTER 5

EVALUATION AND MANAGEMENT SERVICES

Currently Used Common Sets of Codes

- Diagnostic or International Classification of Diseases, 9th Edition, Clinical Modification Codes
- Procedural or Current Procedural Terminology Codes

Evaluation and Management Services

- Visits
- Consultations

ICD-10-CM/PCS

- Compliance date for implementation of new classification system –

  October 1, 2013
- Two parts:
  - ICD-10-CM
  - ICD-10-PCS

Medical Record Documentation

- Records pertinent facts, findings, and observations about patient's health history
- Facilitates
  - Evaluating and planning treatment and monitoring treatment and health of patient
  - Communication and continuity of care
  - Claims review and payment
  - Utilization review and quality of care evaluations
  - Collection of data

7 General Principles of Documentation

1. Medical record should be complete and legible

7 General Principles of Documentation

2. Each encounter should include
   - Reason for encounter and relevant history, physical examination findings, and prior test results
   - Assessment, clinical impression, or diagnosis
   - Plan for care
   - Date and legible identity of observer

7 General Principles of Documentation

3. Rationale for ordering diagnostic tests and ancillary services should be easily inferred if not documented
4. Past and present diagnoses accessible to treating and/or consulting physician
5. Appropriate health risk factors identified

7 General Principles of Documentation

6. Patient's progress, response to and changes in treatment, and revision of diagnosis documented
7. CPT and ICD codes reported on health insurance claim form or billing statement supported by documentation in medical record

Levels of Evaluation and Management Services

History

Examination

Medical decision making

Counseling

Coordination of care

Nature of presenting problem

Time

3 Key Components

Procedure Code	History	Examination	Medical Decision Making
99201	Problem Focused	Problem Focused	Straightforward
99202	Expanded Problem Focused	Expanded Problem Focused	Straightforward
99203	Detailed	Detailed	Low Complexity
99204	Comprehensive	Comprehensive	Moderate Complexity
99205	Comprehensive	Comprehensive	High Complexity

History

4 LEVELS

Problem Focused

Expanded Problem Focused

Detailed

Comprehensive

ELEMENTS

Chief complaint

History of present illness

Review of systems

Past, family, and/or social history

History

HPI	ROS	PFSH	Level of History
Brief (1 – 3 elements)	N/A	N/A	Problem Focused
Brief (1 – 3 elements)	Problem Pertinent	N/A	Expanded Problem Focused
Extended (4 or more elements)	**Extended**	**Pertinent**	**Detailed**
Extended (4 or more elements)	Complete	Complete	Comprehensive
<u>Elements</u>: location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms	<u>ROS</u>: constitutional, eyes, ears nose, mouth, throat, cardiovascular, respiratory, gastrointestinal, gastro-urinary, musculoskeletal integumentary, neuro-logical, psychiatric, endocrine, hematologic/ lymphatic, allergic/ immunologic	<u>PFHS areas</u>: past history family history social history	

History

Procedure Code	History	Examination	Medical Decision Making
99201	Problem Focused	Problem Focused	Straightforward
99202	Expanded Problem Focused	Expanded Problem Focused	Straightforward
99203	**Detailed**	Detailed	Low Complexity
99204	Comprehensive	Comprehensive	Moderate Complexity
99205	Comprehensive	Comprehensive	High Complexity

Examination

- 4 types
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive
- General multi-system or single organ system

General Multi-System Examination

Level of Examination	Perform and Document
Problem Focused	1– 5 elements identified by a bullet in 1 or more organ system(s) or body area(s)
Expanded Problem Focused	At least 6 elements identified by a bullet in 1 or more organ system(s) or body area(s)
Detailed	At least 2 elements identified by a bullet from at least 6 organ systems or body areas or at least 12 elements identified by a bullet in 2 or more organ systems or body areas
Comprehensive	All elements identified by a bullet in at least 9 organ systems or body areas; for each system/area, at least 2 elements identified by a bullet

General Multi-System Examination

- Elements of examination

General Multi-System Examination

Level of Examination	Perform and Document
Problem Focused	1– 5 elements identified by a bullet in 1 or more organ system(s) or body area(s)
Expanded Problem Focused	At least 6 elements identified by a bullet in 1 or more organ system(s) or body area(s)
Detailed	At least 2 elements identified by a bullet from at least 6 organ systems or body areas or at least 12 elements identified by a bullet in 2 or more organ systems or body areas
Comprehensive	All elements identified by a bullet in at least 9 organ systems or body areas; for each system/area, at least 2 elements identified by a bullet

Single Organ System Examination

Level of Examination	Perform and Document
Problem Focused	1 – 5 elements identified by bullet in box with either **shaded** or **unshaded** border
Expanded Problem Focused	At least 6 elements identified by bullet in box with either **shaded** or **unshaded** border
Detailed	At least 12 elements identified by bullet in box with either **shaded** or **unshaded** border (except eye and psychiatric examinations)
Comprehensive	Perform all elements identified by bullet in box with either **shaded** or **unshaded** border; document every element in each box with **shaded** border and at least 1 element in box with **unshaded** border

New Patient Visit

Procedure Code	History	Examination	Medical Decision Making
99201	Problem Focused	Problem Focused	Straightforward
99202	Expanded Problem Focused	Expanded Problem Focused	Straightforward
99203	**Detailed**	**Detailed**	Low Complexity
99204	Comprehensive	Comprehensive	Moderate Complexity
99205	Comprehensive	Comprehensive	High Complexity

Medical Decision Making

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

Medical Decision Making

Number of Diagnoses/ Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications, Morbidity, and/or Mortality	Type of Medical Decision Making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

Medical Decision Making

Number of Diagnoses/ Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications, Morbidity, and/or Mortality	Type of Medical Decision Making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

Medical Decision Making

Number of Diagnoses/ Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications, Morbidity, and/or Mortality	Type of Medical Decision Making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	**Moderate**	Moderate Complexity
Extensive	**Extensive**	High	**High Complexity**

New Patient Visit

Procedure Code	History	Examination	Medical Decision Making
99201	Problem Focused	Problem Focused	Straightforward
99202	Expanded Problem Focused	Expanded Problem Focused	Straightforward
99203	**Detailed**	**Detailed**	Low Complexity
99204	Comprehensive	Comprehensive	Moderate Complexity
99205	Comprehensive	Comprehensive	**High Complexity**

Established Patient Visit

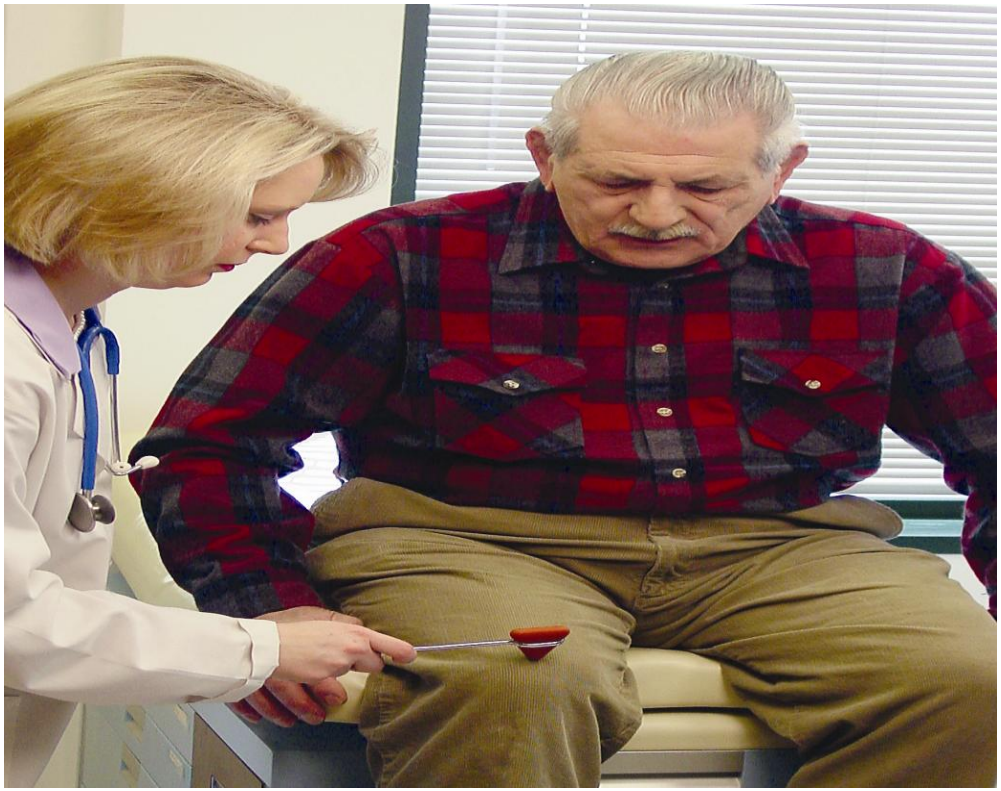
Procedure Code	History	Examination	Medical Decision Making
99211	N/A	N/A	N/A
99212	Problem Focused	Problem Focused	Straightforward
99213	Expanded Problem Focused	Expanded Problem Focused	Low Complexity
99214	**Detailed**	**Detailed**	Moderate Complexity
99215	Comprehensive	Comprehensive	**High Complexity**

Let's Review

- What are the 7 components that define the levels of evaluation and management services?
- What is the compliance date for implementation of the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)?

CHAPTER 6

PROTECTING THE MEDICARE TRUST FUND



Medical Review Program

- Analyze data
- Take action to prevent and/or address identified errors
- Publish local medical review policies

National Coverage Determination

- Sets forth extent to which Medicare covers specific services, procedures, or technologies on a national basis

Local Coverage Determination

- Developed to further define a National Coverage Determination or in absence of a specific National Coverage Determination
- Made at Contractor's discretion to provide guidance to public and medical community within specified geographic area

Deterring Health Care Fraud and Program Abuse

- Identify suspicious Medicare charges and activities
- Investigate and punish those who commit Medicare fraud and abuse
- Ensure money is returned to Medicare Trust Fund

Federal Health Care Fraud

- Intentional use of false statements or fraudulent schemes to obtain payment for, or to cause another person or entity to obtain payment for, items or services payable under a Federal health care program

Program Abuse

- Intentional or unintentional
- Directly or indirectly results in unnecessary or increased costs to the Medicare Program

Potential Legal Actions

- Fine
- Prison sentence
- Temporary or permanent exclusion from Medicare and other health care programs
- Lose license
- Civil Monetary Penalties

Potential Legal Actions

- Deny individual's or entity's application for Medicare provider billing privileges
- Revoke provider's billing privileges
- Suspend payment

Report Suspected Fraud or Abuse

Office of Inspector General
Department of Health and Human Services
ATTENTION: HOTLINE
P. O. Box 23489
Washington, DC 20026

Telephone – (800) 447-8477
E-mail – HHSTips@oig.hhs.gov
Fax – (800) 223-8164

Let's Review

- What are the 2 types of coverage determinations that assist providers and suppliers in coding correctly and billing Medicare only for covered items and services?
- What is program abuse?

CHAPTER 7

INQUIRIES, OVERPAYMENTS, AND FEE-FOR-SERVICE APPEALS

Inquiries

- Submit by telephone or in writing
- Interactive Voice Response Services

Overpayments

- Funds that a provider, supplier, or beneficiary received in excess of amounts due and payable

5 Levels of Fee-For-Service Appeals

- First level – Redetermination by Medicare Contractor
- Second level – Reconsideration by Qualified Independent Contractor

5 Levels of Fee-For-Service Appeals

- Third level – Hearing by Administrative Law Judge
- Fourth level – Appeals Council Review
- Fifth level – Judicial Review

Reopening

- Remedial action to change a final determination or decision that resulted in an overpayment or an underpayment
- Allows correction of minor errors or omissions without initiating a formal appeal

Let's Review

- Under what circumstances are overpayments often paid?
- What are the 5 levels in the appeals process?

Post-Assessment Course Evaluation

Thank You
for
Your Feedback

PRE-ASSESSMENT
CHAPTER 1

Directions

- Complete the Pre-Assessment when directed by the course facilitator.
- Mark your answers on the attached answer sheet.
- Please hand in your completed answer sheet prior to exiting today's course.

1. Part C of the Medicare Program is:

A. Long term care insurance
B. Medicare Advantage
C. Disability insurance
D. Medical insurance

2. Medicare Part A is available to insured individuals age 65 or older, individuals under age 65 with certain disabilities, and individuals with End-Stage Renal Disease.

A. True
B. False

3. An example of a Part B service is inpatient hospital care.

A. True
B. False

PRE-ASSESSMENT ANSWER SHEET
CHAPTER 1

	A	B	C	D
1.	0	0	0	0
2.	0	0	0	0
3.	0	0	0	0

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Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-13-07
Baltimore, MD 21244

POST-ASSESSMENT
CHAPTER 1

Directions

- Complete the Post-Assessment when directed by the course facilitator.
- Mark your answers on the attached answer sheet.
- Please hand in your completed answer sheet prior to exiting today's course.

1. Part C of the Medicare Program is:

A. Long term care insurance
B. Medicare Advantage
C. Disability insurance
D. Medical insurance

2. Medicare Part A is available to insured individuals age 65 or older, individuals under age 65 with certain disabilities, and individuals with End-Stage Renal Disease.

A. True
B. False

3. An example of a Part B service is inpatient hospital care.

A. True
B. False

POST-ASSESSMENT ANSWER SHEET
CHAPTER 1

	A	B	C	D
1.	0	0	0	0
2.	0	0	0	0
3.	0	0	0	0

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PRE-ASSESSMENT
CHAPTER 2

Directions

- Complete the Pre-Assessment when directed by the course facilitator.
- Mark your answers on the attached answer sheet.
- Please hand in your completed answer sheet prior to exiting today's course.

1. End-Stage Renal Disease facilities are an example of an entity that receives payment under Part A of the Medicare Program.

A. True
B. False

2. The National Provider Identifier is a unique identification number for health care providers that is a Health Insurance Portability and Accountability Act Administrative Simplification Standard.

A. True
B. False

3. Participating providers and suppliers are held to a limiting charge.

A. True
B. False

PRE-ASSESSMENT ANSWER SHEET
CHAPTER 2

	A	B
1.	0	0
2.	0	0
3.	0	0

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POST-ASSESSMENT
CHAPTER 2

Directions

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- Please hand in your completed answer sheet prior to exiting today's course.

1. End-Stage Renal Disease facilities are an example of an entity that receives payment under Part A of the Medicare Program.

A. True
B. False

2. The National Provider Identifier is a unique identification number for health care providers that is a Health Insurance Portability and Accountability Act Administrative Simplification Standard.

A. True
B. False

3. Participating providers and suppliers are held to a limiting charge.

A. True
B. False

POST-ASSESSMENT ANSWER SHEET
CHAPTER 2

	A	B
1.	0	0
2.	0	0
3.	0	0

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PRE-ASSESSMENT
CHAPTER 3

Directions

- Complete the Pre-Assessment when directed by the course facilitator.
- Mark your answers on the attached answer sheet.
- Please hand in your completed answer sheet prior to exiting today's course.

1. Providers and suppliers must collect which of the following from the beneficiary:

A. Coinsurance
B. Unmet deductibles
C. Copayments
D. All of the above

2. Medigap is a health insurance policy that fills gaps in Original Medicare Plan coverage.

A. True
B. False

3. Health Professional Shortage Area Incentive Payments include both a professional and a technical component.

A. True
B. False

PRE-ASSESSMENT ANSWER SHEET
CHAPTER 3

	A	B	C	D
1.	0	0	0	0
2.	0	0	0	0
3.	0	0	0	0

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POST-ASSESSMENT
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A. True
B. False

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A. True
B. False

POST-ASSESSMENT ANSWER SHEET
CHAPTER 3

	A	B	C	D
1.	0	0	0	0
2.	0	0	0	0
3.	0	0	0	0

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PRE-ASSESSMENT
CHAPTER 4

Directions

- Complete the Pre-Assessment when directed by the course facilitator.
- Mark your answers on the attached answer sheet.
- Please hand in your completed answer sheet prior to exiting today's course.

1. Services or supplies are considered medically reasonable and necessary if they are mainly for the convenience of the beneficiary, provider, or supplier.

A. True
B. False

2. Services that are included in the basic allowance of another service are covered by Medicare.

A. True
B. False

3. One requirement for coverage of incident to services of a physician is that the services and supplies are commonly furnished without charge or included in the physician's bill.

A. True
B. False

PRE-ASSESSMENT ANSWER SHEET
CHAPTER 4

	A	B
1.	0	0
2.	0	0
3.	0	0

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POST-ASSESSMENT
CHAPTER 4

Directions

- Complete the Post-Assessment when directed by the course facilitator.
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- Please hand in your completed answer sheet prior to exiting today's course.

1. Services or supplies are considered medically reasonable and necessary if they are mainly for the convenience of the beneficiary, provider, or supplier.

A. True
B. False

2. Services that are included in the basic allowance of another service are covered by Medicare.

A. True
B. False

3. One requirement for coverage of incident to services of a physician is that the services and supplies are commonly furnished without charge or included in the physician's bill.

A. True
B. False

POST-ASSESSMENT ANSWER SHEET
CHAPTER 4

	A	B
1.	0	0
2.	0	0
3.	0	0

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PRE-ASSESSMENT
CHAPTER 5

Directions

- Complete the Pre-Assessment when directed by the course facilitator.
- Mark your answers on the attached answer sheet.
- Please hand in your completed answer sheet prior to exiting today's course.

1. The physician must ensure that documentation reflects the services furnished and that the codes selected reflect those services.

A. True
B. False

2. The compliance date for implementation of the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) is October 1, 2011.

A. True
B. False

3. Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option.

A. True
B. False

PRE-ASSESSMENT ANSWER SHEET
CHAPTER 5

	A	B
1.	0	0
2.	0	0
3.	0	0

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POST-ASSESSMENT
CHAPTER 5

Directions

- Complete the Post-Assessment when directed by the course facilitator.
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1. The physician must ensure that documentation reflects the services furnished and that the codes selected reflect those services.

A. True
B. False

2. The compliance date for implementation of the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) is October 1, 2011.

A. True
B. False

3. Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option.

A. True
B. False

POST-ASSESSMENT ANSWER SHEET
CHAPTER 5

	A	B
1.	0	0
2.	0	0
3.	0	0

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PRE-ASSESSMENT
CHAPTER 6

Directions

- Complete the Pre-Assessment when directed by the course facilitator.
- Mark your answers on the attached answer sheet.
- Please hand in your completed answer sheet prior to exiting today's session.

1. Local Coverage Determinations are developed to further define a National Coverage Determination (NCD) or in the absence of a specific NCD.

A. True
B. False

2. Program abuse involves an individual's or entity's intentional use of false statements or fraudulent schemes to obtain payment for, or to cause another person or entity to obtain payment for, items or services payable under a Federal health care program.

A. True
B. False

3. Federal health care fraud, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs to the Medicare Program.

A. True
B. False

PRE-ASSESSMENT ANSWER SHEET
CHAPTER 6

	A	B
1.	0	0
2.	0	0
3.	0	0

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POST-ASSESSMENT
CHAPTER 6

Directions

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1. Local Coverage Determinations are developed to further define a National Coverage Determination (NCD) or in the absence of a specific NCD.

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B. False

2. Program abuse involves an individual's or entity's intentional use of false statements or fraudulent schemes to obtain payment for, or to cause another person or entity to obtain payment for, items or services payable under a Federal health care program.

A. True
B. False

3. Federal health care fraud, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs to the Medicare Program.

A. True
B. False

POST-ASSESSMENT ANSWER SHEET
CHAPTER 6

	A	B
1.	0	0
2.	0	0
3.	0	0

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PRE-ASSESSMENT
CHAPTER 7

Directions

- Complete the Pre-Assessment when directed by the course facilitator.
- Mark your answers on the attached answer sheet.
- Please hand in your completed answer sheet prior to exiting today's course.

1. Medicare Contractors do not accept inquiries via telephone.

A. True
B. False

2. An example of an overpayment is when an incorrect payee is paid.

A. True
B. False

3. There are three levels of fee-for-service appeals.

A. True
B. False

PRE-ASSESSMENT ANSWER SHEET
CHAPTER 7

	A	B
1.	0	0
2.	0	0
3.	0	0

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POST-ASSESSMENT
CHAPTER 7

Directions

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1. Medicare Contractors do not accept inquiries via telephone.

A. True
B. False

2. An example of an overpayment is when an incorrect payee is paid.

A. True
B. False

3. There are three levels of fee-for-service appeals.

A. True
B. False

POST-ASSESSMENT ANSWER SHEET
CHAPTER 7

	A	B
1.	0	0
2.	0	0
3.	0	0

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MEDICARE RESIDENT, PRACTICING PHYSICIAN, AND OTHER HEALTH CARE PROFESSIONAL TRAINING PROGRAM

MASTER ANSWER KEYS

CHAPTER 1	
QUESTION	**CORRECT ANSWER**
1. Part C of the Medicare Program is: A. Long term care insurance B. Medicare Advantage C. Disability insurance D. Medical insurance	B
2. Medicare Part A is available to insured individuals age 65 or older, individuals under age 65 with certain disabilities, and individuals with End-Stage Renal Disease. A. True B. False	A
3. An example of a Part B service is inpatient hospital care. A. True B. False	B

Master Answer Keys

CHAPTER 2	
QUESTION	**CORRECT ANSWER**
1. End-Stage Renal Disease facilities are an example of an entity that receives payment under Part A of the Medicare Program. A. True B. False	B
2. The National Provider Identifier is a unique identification number for health care providers that is a Health Insurance Portability and Accountability Act Administrative Simplification Standard. A. True B. False	A
3. Participating providers and suppliers are held to a limiting charge. A. True B. False	B

Master Answer Keys

CHAPTER 3	
QUESTION	**CORRECT ANSWER**
1. Providers and suppliers must collect which of the following from the beneficiary: A. Coinsurance B. Unmet deductibles C. Copayments D. All of the above	D
2. Medigap is a health insurance policy that fills gaps in Original Medicare Plan coverage. A. True B. False	A
3. Health Professional Shortage Area Incentive Payments include both a professional and a technical component. A. True B. False	B

Master Answer Keys

CHAPTER 4	
QUESTION	**CORRECT ANSWER**
1. Services or supplies are considered medically reasonable and necessary if they are mainly for the convenience of the beneficiary, provider, or supplier. A. True B. False	B
2. Services that are included in the basic allowance of another service are covered by Medicare. A. True B. False	B
3. One requirement for coverage of incident to services of a physician is that the services and supplies are commonly furnished without charge or included in the physician's bill. A. True B. False	A

Master Answer Keys

CHAPTER 5	
QUESTION	**CORRECT ANSWER**
1. The physician must ensure that documentation reflects the services furnished and that the codes selected reflect those services. A. True B. False	A
2. The compliance date for implementation of the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) is October 1, 2011. A. True B. False	B
3. Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option. A. True B. False	A

Master Answer Keys

CHAPTER 6	
QUESTION	**CORRECT ANSWER**
1. Local Coverage Determinations are developed to further define a National Coverage Determination (NCD) or in the absence of a specific NCD. A. True B. False	A
2. Program abuse involves an individual's or entity's intentional use of false statements or fraudulent schemes to obtain payment for, or to cause another person or entity to obtain payment for, items or services payable under a Federal health care program. A. True B. False	B
3. Federal health care fraud, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs to the Medicare Program. A. True B. False	B

Master Answer Keys

CHAPTER 7	
QUESTION	**CORRECT ANSWER**
1. Medicare Contractors do not accept inquiries via telephone. A. True B. False	B
2. An example of an overpayment is when an incorrect payee is paid. A. True B. False	A
3. There are three levels of fee-for-service appeals. A. True B. False	B

This evaluation tool should not be modified.

MEDICARE RESIDENT, PRACTICING PHYSICIAN, AND OTHER HEALTH CARE PROFESSIONAL TRAINING PROGRAM

COURSE EVALUATION

Date of Training Program:_____ Name of Organization:_____

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
FACILITY					
Rate the location of the facility	**5**	**4**	**3**	**2**	**1**
Rate the comfort of the meeting room, including seating and temperature	**5**	**4**	**3**	**2**	**1**
PROGRAM					
How well did the training program meet your expectation?	**5**	**4**	**3**	**2**	**1**
Rate the length of the training program	**5**	**4**	**3**	**2**	**1**
Rate the program schedule, including start time, breaks, and end time	**5**	**4**	**3**	**2**	**1**
Rate the relevance of the program to your current or future work	**5**	**4**	**3**	**2**	**1**
Rate your knowledge of the subject matter before the training program	**5**	**4**	**3**	**2**	**1**
Rate your knowledge of the subject matter after the training program	**5**	**4**	**3**	**2**	**1**
Rate how well the program objectives were met	**5**	**4**	**3**	**2**	**1**

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
INSTRUCTOR					
Rate the instructor's subject matter knowledge and ability to answer questions	**5**	**4**	**3**	**2**	**1**
Rate the instructor's ability to present the information in an understandable way	**5**	**4**	**3**	**2**	**1**
Rate the instructor's effectiveness as a communicator	**5**	**4**	**3**	**2**	**1**
Rate the preparedness of the instructor	**5**	**4**	**3**	**2**	**1**
MATERIALS					
How well did the training materials relate to your skill level?	**5**	**4**	**3**	**2**	**1**
How effective or useful are the training materials?					
How useful are the audiovisual aids and hand outs in communicating the training information?					
How effective are the hand outs as a resource?					

1. What methods of delivery do you prefer to receive training? (Please check all that apply.)

___Computer or Web-Based Training
___In-Person Training
___Print
___CD-ROM
___DVD
___Audio CD
___Web Streaming/Webinar
___Podcast
___Teleconference Call/Telephone
___Radio/Satellite Radio
___Video Conferencing
___Fax
___Cable Television/Network Television
___Direct Mail from CMS

2. Please provide us with your comments or suggestions regarding any aspect of the Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program.

_____
_____
_____
_____
_____

Thank you for your feedback. We will use your input to improve our Medicare training courses and products.

Facilitators:
Please make copies of completed evaluations for your locked, confidential file and mail original evaluations to:

Ann Palmer
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-13-07
Baltimore, MD 21244

REFERENCE SECTION

GLOSSARY

A

Advance Beneficiary Notice
A written notice that a provider or supplier gives to a beneficiary under certain circumstances (e.g., lack of medical necessity) before items or services are furnished to advise him or her that specified items or services may not be covered by Medicare.

Appeal
Complaint a beneficiary, provider of services, or supplier can make if he or she disagrees with a Medicare coverage or payment decision.

Assignment
When a provider or supplier is paid the Medicare allowed amount as payment in full for his or her services.

B

Beneficiary
Individual eligible to receive Medicare or Medicaid payment and/or services.

C

Carrier
Centers for Medicare & Medicaid Services Contactor that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments (see Medicare Administrative Contractor).

Centers for Medicare & Medicaid Services
The Federal agency that administers and oversees the Medicare Program and a portion of the Medicaid Program. It also regulates laboratory testing and surveys and certifies Rural Health Clinics, Federally Qualified Health Centers, Critical Access Hospitals, nursing homes, health care agencies, intermediate care facilities for the mentally retarded, and hospitals.

Claim
A request for payment of benefits or services received by a beneficiary.

Code of Federal Regulations
Official compilation of Federal rules and requirements.

Coinsurance
Under the Original Medicare Plan or a Private Fee-for-Service Plan, a percentage of covered charges that the Medicare beneficiary may pay after he or she has met the applicable deductible.

Coordination of Benefits
The process that determines the respective responsibilities of two or more payers that have some financial responsibility for a medical claim.

Copayment
In some Medicare health plans, the amount that is paid by the beneficiary for each medical service.

Cost Report
Report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare Program.

Covered Service
A reasonable and necessary service furnished to Medicare or Medicaid beneficiaries and reimbursable to the provider, supplier, or beneficiary.

D

Deductible
Amount a beneficiary must pay before Medicare begins to pay for covered services and supplies.

Durable Medical Equipment
Medical equipment ordered by a physician or, if Medicare allows, a nurse practitioner, physician assistant or clinical nurse specialist for use in the home. The item must be reusable (e.g., walkers, wheelchairs, or hospital beds).

Durable Medical Equipment Medicare Administrative Contractor
A private company that contracts with Medicare to pay bills for durable medical equipment.

F

Fiscal Intermediary
Centers for Medicare & Medicaid Services Contractor that processes claims for services covered under Medicare Part A and most types of claims for services covered under Medicare Part B (see Medicare Administrative Contractor).

H

Health Care Fraud
Generally involves an individual's or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another individual to obtain payment for, items or services payable under a Federal health care program.

Health Professional Shortage Area Incentive Payment
A 10 percent payment made to physicians (including psychiatrists) who furnish care in an area that is designated as a geographic-based, primary medical care Health Professional Shortage Area (HPSA) and psychiatrists who furnish care in an area that is designated as a geographic-based mental health HPSA for outpatient professional services furnished to a Medicare beneficiary.

I

Incentive Reward Program
A program that encourages the reporting of information regarding individuals or entities that commit fraud or abuse and could result in sanctions under any Federal health care program.

Incident to Provision
Services and supplies must meet four requirements to be covered under the incident to provision: services are commonly furnished in physicians' offices or clinics; services are furnished by the physician or auxiliary personnel under the direct personal supervision of a physician; services are commonly furnished without charge or included in the physician's bill; and services or supplies are an integral, although incidental, part of the physician's professional service.

L

Local Coverage Determination
A coverage decision developed by Medicare Contractors at their own discretion to further define a National Coverage Determination (NCD) or in the absence of a specific NCD to provide guidance to the public and the medical community within a specified geographic area.

M

Medicaid
A cooperative venture funded by Federal and State governments that pays for medical assistance for certain individuals and families with low incomes and limited resources.

Medically Necessary
Services or supplies that are proper and needed for the diagnosis or treatment of the beneficiary's medical condition; furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition; meet the standards of good medical practice; and are not mainly for the convenience of the beneficiary, provider, or supplier.

Medicare Administrative Contractor
All Medicare work performed by Fiscal Intermediaries, Carriers, and Durable Medical Equipment Carriers will be replaced by these Centers for Medicare & Medicaid Services Contractors by 2011, as mandated in Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Medicare Advantage; Part C of the Medicare Program
A program through which organizations that contract with the Centers for Medicare & Medicaid Services furnish or arrange for the provision of health care services to Medicare beneficiaries (with the exception of individuals with End-Stage Renal Disease who are generally excluded from enrolling in Medicare Advantage [MA] Plans) who are entitled to Part A and enrolled in Part B, permanently reside in the service area of the MA Plan, and elect to enroll in a MA Plan.

Medicare Economic Index
A measure of inflation faced by physicians with respect to their practice costs and general wage levels.

Medicare Physician Fee Schedule
The basis for which Medicare Part B pays for physician services. It lists the more than 7,000 covered services and their payment rates.

Medicare Summary Notice
Notice that beneficiaries receive on a monthly basis that lists all services or supplies that were billed to Medicare.

Medigap
A health insurance policy sold by private insurance companies to fill gaps in Original Medicare Plan coverage.

N

National Coverage Determination
A coverage policy that sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis.

National Provider Identifier
Unique identification number for health care providers that that is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Standard. Covered health care providers and all health plans and health care clearinghouses must use this identification number in the administrative and financial transactions adopted under HIPAA.

O

Office of Inspector General
Organization that protects the integrity of Department of Health and Human Services programs and the health and welfare of beneficiaries of those programs through a nationwide network of audits, investigations, inspections, and other mission-related functions.

Overpayment
Funds that a provider, supplier, or beneficiary has received in excess of amounts due and payable under Medicare statutes and regulations.

P

Part A of the Medicare Program
Hospital insurance that helps pay for inpatient hospital care, inpatient care in a Skilled Nursing Facility following a covered hospital stay, some home health care, and hospice care.

Part B of the Medicare Program
Medical insurance that helps pay for medically necessary services furnished by physicians in a variety of medical settings; home health care for individuals who do not have Part A; ambulance services; clinical laboratory and diagnostic services; surgical supplies; durable medical equipment, prosthetics, orthotics, and supplies; hospital outpatient services; and services furnished by practitioners with limited licensing.

Part C of the Medicare Program; Medicare Advantage
A program through which organizations that contract with the Centers for Medicare & Medicaid Services furnish or arrange for the provision of health care services to Medicare beneficiaries (with the exception of individuals with End-Stage Renal Disease) who are entitled to Part A and enrolled in Part B, permanently reside in the service area of the Medicare Advantage (MA) Plan, and elect to enroll in a MA Plan.

Part D of the Medicare Program; Prescription Drug Plan
Plan that provides prescription drug coverage to all beneficiaries who elect to enroll in a prescription drug plan or Medicare Advantage Plan that includes Part D.

Participating Provider or Supplier
A provider or supplier who agrees to participate in Part B and accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries.

Physician
Defined by Medicare to include chiropractors, doctors of dental surgery or dental medicine, doctors of medicine and doctors of osteopathy, doctors of optometry, or doctors of podiatry or surgical chiropody. In addition, the physician must be legally authorized to practice by a State in which he or she performs this function.

Practitioner
Defined by Medicare as any of the following to the extent that an individual is legally authorized to practice by the State and otherwise meets Medicare requirements: anesthesiologist assistant, certified nurse midwife, clinical nurse specialist, certified registered nurse anesthetist, clinical psychologist, clinical social worker, nurse practitioner, physician assistant, or registered dietician or nutrition professional.

Prescription Drug Plan; Part D of the Medicare Program
Plan that provides prescription drug coverage to all beneficiaries who elect to enroll in a prescription drug plan or Medicare Advantage Plan that includes Part D.

Program Abuse
In general, may be intentional or unintentional and directly or indirectly results in unnecessary or increased costs to the Medicare Program.

Prospective Payment System
Method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.

Q

Quality Improvement Organization
Private, mostly not-for-profit organizations that are staffed by professionals who are trained to review medical care, help beneficiaries with complaints about quality of care, and implement improvements in the quality of care.

R

Remittance Advice
A notice of payments and adjustments that is sent to the provider, supplier, or biller.

S

Social Security Act (the Act)
Public Law 74-271 that was enacted on August 14, 1935, with subsequent amendments.

Social Security Administration
The Federal agency that determines eligibility for Medicare benefits and enrolls individuals in Part A and/or Part B and the Federal Black Lung Benefit Program.

Swing Bed
Bed that a small rural hospital can use for either Skilled Nursing Facility or hospital acute-level care on an as-needed basis if the hospital has obtained approval from the Department of Health and Human Services.

U.S. Department of Health and Human Services
The Federal department that administers many health and welfare programs for citizens of the U.S. and is the parent agency of the Centers for Medicare & Medicaid Services.

ACRONYMS

AA	Anesthesiologist Assistant
ABN	Advance Beneficiary Notice
AEP	Annual Coordinated Election Period
AIC	Amount in Controversy
ALJ	Administrative Law Judge
ASC	Ambulatory Surgical Center
CAH	Critical Access Hospital
CF	Conversion Factor
CFR	Code of Federal Regulations
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalties
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CNS	Certified Nurse Specialist
COB	Coordination of Benefits
COBC	Coordination of Benefits Contractor
CP	Clinical Psychologist
CPI-U	Consumer Price Index for All Urban Consumers
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist

CSR	Customer Service Representative
CSW	Clinical Social Worker
CWF	Common Working File
DIF	Durable Medical Equipment Medicare Administrative Contractor Information Form
DME	Durable Medical Equipment
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DOJ	Department of Justice
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
E/M	Evaluation and Management
EMC	Electronic Media Claims
ESRD	End-Stage Renal Disease
FI	Fiscal Intermediary
FICA	Federal Insurance Contributions Act
FPL	Federal Poverty Level
GHP	Group Health Plan
GME	Graduate Medical Education
GPCI	Geographic Practice Cost Indices
HHS	Department of Health and Human Services

HIC	Health Insurance Claim
HIPAA	Health Insurance Portability and Accountability Act
HPSA	Health Professional Shortage Area
ICD-9-CM	International Classification of Diseases, 9th Edition, Clinical Modification
ICD-10-CM/PCS	International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System
IEP	Initial Enrollment Period
IVR	Interactive Voice Response
LCD	Local Coverage Determination
LEIE	List of Excluded Individuals/Entities
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MEI	Medicare Economic Index
MLN	Medicare Learning Network
MPFS	Medicare Physician Fee Schedule
MRN	Medicare Redetermination Notice
MSA	Medical Savings Account
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
NCD	National Coverage Determination
NP	Nurse Practitioner
NPI	National Provider Identifier

NPP	Non-Physician Practitioner
OEP	Open Enrollment Period
OIG	Office of Inspector General
OT	Occupational Therapy
PA	Physician Assistant
PACE	Program for All-Inclusive Care for the Elderly
PDP	Prescription Drug Plan
PE	Practice Expense
PECOS	Provider Enrollment, Chain and Ownership System
PEN	Parenteral and Enteral Nutrition
PFFS	Private Fee-for-Service
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PQRI	Physician Quality Reporting Initiative
PT	Physical Therapy
QC	Quarters of Coverage
QDWI	Qualified Disabled and Working Individual
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RO	Regional Offices

RRB	Railroad Retirement Board
RVU	Relative Value Unit
SA	State Agency
SEP	Special Enrollment Period
SGR	Sustainable Growth Rate
SHIP	State Health Insurance Program
SLP	Speech-Language Pathology
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSN	Social Security Number
UMWA	United Mine Workers of America
WC	Workers' Compensation

CONTACT INFORMATION

CENTERS FOR MEDICARE & MEDICAID SERVICES

About CMS
http://www.cms.hhs.gov/home/aboutcms.asp

Administrative Simplification Compliance Act Self Assessment
http://www.cms.hhs.gov/ElectronicBillingEDITrans/05_ASCASelfAssessment.asp

All Fee-for-Service Providers
http://www.cms.hhs.gov/center/provider.asp

Ambulance Services Center
http://www.cms.hhs.gov/center/ambulance.asp

Anesthesiologists Center
http://www.cms.hhs.gov/center/anesth.asp

Beneficiary Notices Initiative (Advance Beneficiary Notice)
http://www.cms.hhs.gov/BNI/01_overview.asp

CMS Forms
http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp

Coordination of Benefits – General Information
http://www.cms.hhs.gov/COBGeneralInformation

Documentation Guidelines for E & M Services
http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Durable Medical Equipment Center
http://www.cms.hhs.gov/center/dme.asp

Electronic Billing & EDI Transactions
http://www.cms.hhs.gov/ElectronicBillingEDITrans

Electronic Billing & EDI Transactions
Administrative Simplification Compliance Act Self Assessment
http://www.cms.hhs.gov/ElectronicBillingEDITrans/05_ASCASelfAssessment.asp

Electronic Billing & EDI Transactions
Health Care Payment and Remittance Advice
http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp

HPSA/PSA (Physician Bonuses)
http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses

Health Care Payment and Remittance Advice
http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp

Health Insurance Portability and Accountability Act – General Information
http://www.cms.hhs.gov/HIPAAGenInfo

Health Plans – General Information (Medicare Advantage)
http://www.cms.hhs.gov/HealthPlansGenInfo

Home Health Agency Center
http://www.cms.hhs.gov/center/hha.asp

Hospice Center
http://www.cms.hhs.gov/center/hospice.asp

Hospital Center
http://www.cms.hhs.gov/center/hospital.asp

ICD-9-CM
http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp

ICD-10-CM/PCS
http://www.cms.hhs.gov/ICD10

Manuals
http://www.cms.hhs.gov/Manuals

Medicaid Program – Contact Information
http://www.cms.hhs.gov/apps/firststep/content/medicaid-contact.html

Medicaid Program – General Information
http://www.cms.hhs.gov/MedicaidGenInfo

Medicare (beneficiaries)
http://www.medicare.gov
(800) 633-4227

Medicare Contracting Reform
http://www.cms.hhs.gov/MedicareContractingReform

Medicare Coordination of Benefits Contractor
(800) 999-1118

Medicare Coverage Center
http://www.cms.hhs.gov/center/coverage.asp

Medicare Coverage Database
http://www.cms.hhs.gov/mcd/search.asp

Medicare Coverage Determination Process
http://www.cms.hhs.gov/DeterminationProcess/01_Overview.asp

Medicare Fee-for-Service Provider Enrollment Contact List
http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

Medicare Fee-for-Service Provider Listservs
http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/downloads/Provider_Listservs.pdf

Medicare Learning Network
http://www.cms.hhs.gov/MLNGenInfo

Medicare Managed Care Appeals & Grievances
http://www.cms.hhs.gov/MMCAG

Medicare Prescription Drug Appeals & Grievances
http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/

Medicare Program – General Information
http://www.cms.hhs.gov/MedicareGenInfo

Medicare Provider-Supplier Enrollment
http://www.cms.hhs.gov/MedicareProviderSupEnroll

Medicare Summary Notices
http://www.cms.hhs.gov/MSN/01_overview.asp

Medicare Supplement Health Insurance (Medigap)
http://www.cms.hhs.gov/Medigap

National Plan and Provider Enumeration System
https://nppes.cms.hhs.gov

National Provider Identifier Standard
http://www.cms.hhs.gov/NationalProvIdentStand

Open Door Forums
http://www.cms.hhs.gov/OpenDoorForums

Original Medicare (Fee-for-Service) Appeals
http://www.cms.hhs.gov/OrgMedFFSAppeals

Pharmacist Center
http://www.cms.hhs.gov/center/pharmacist.asp

Physician Center
http://www.cms.hhs.gov/center/physician.asp

Physician Fee Schedule
http://www.cms.hhs.gov/PhysicianFeeSched/01_overview.asp

Physician Fee Schedule Look-Up
http://www.cms.hhs.gov/PFSlookup

Physician Quality Reporting Initiative
http://www.cms.hhs.gov/PQRI

Physicians Regulatory Issues Team
http://www.cms.hhs.gov/PRIT

Practice Administration Center
http://www.cms.hhs.gov/center/practice.asp

Practicing Physicians Advisory Council
http://www.cms.hhs.gov/FACA/03_ppac.asp

Prescription Drug Coverage – General Information
http://www.cms.hhs.gov/PrescriptionDrugCovGenIn

Private Fee-for-Service Plans
http://www.cms.hhs.gov/PrivateFeeforServicePlans

Provider Call Center Toll-Free Numbers Directory
http://www.cms.hhs.gov/MLNGenInfo/30_contactus.asp

Newsroom Center
http://www.cms.hhs.gov/center/press.asp

Quality Improvement Organizations
http://www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp

Quarterly Provider Updates
http://www.cms.hhs.gov/QuarterlyProviderUpdates

Regulations & Guidance
http://www.cms.hhs.gov/home/regsguidance.asp

Resident Training Listserv
https://list.nih.gov

State Health Insurance and Assistance Programs
http://www.cms.hhs.gov/Partnerships/10_SHIPS.asp

Survey & Certification – General Information
http://www.cms.hhs.gov/SurveyCertificationGenInfo/03_ContactInformation.asp

Therapy Services
http://www.cms.hhs.gov/TherapyServices

OTHER ORGANIZATIONS

American Medical Association
Bookstore (Current Procedural Terminology and Healthcare Common Procedure Coding System publications)
http://www.amapress.org
(800) 621-8335

American Medical Association
Current Procedural Terminology Information
http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml

Federal Financial Institutions Examination Council (census tracts)
http://www.ffiec.gov/Geocode/default.aspx

National Uniform Billing Committee
http://www.nubc.org/guide.html

Railroad Medicare Part B Office
(800) 833-4455

United Mine Workers of America
Electronic Medical Claims Submission Information
(888) 865-5290

U.S. Department of Health and Human Services
Administration on Aging
http://www.aoa.gov

U.S. Department of Health and Human Services
Health Resources and Services Administration
http://www.hrsa.gov

U.S. Department of Health and Human Services
Health Resources and Services Administration
Shortage Areas by State and County
http://www.hpsafind.hrsa.gov

U.S. Department of Health and Human Services
Office of Inspector General
http://www.oig.hhs.gov

U.S. Department of Health and Human Services
Office of Inspector General
List of Excluded Individuals/Entities
http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp

U.S. Department of Health and Human Services
Office of Inspector General
National Hotline
(800) 447-8477

U.S. Department of Health and Human Services
Office of Medicare Hearings and Appeals
http://www.hhs.gov/omha

U.S. Department of Health and Human Services
Office of Minority Health
Cultural Competency Continuing Education Programs
http://thinkculturalhealth.org

U.S. General Services Administration
Excluded Parties List System
http://www.epls.gov

U.S. Government Printing Office
Code of Federal Regulations
http://www.gpoaccess.gov/cfr/index.html

U.S. Government Printing Office
U.S. Government Bookstore (CMS-1500 claim forms and ICD-9-CM CD-ROM)
http://bookstore.gpo.gov
(866) 512-1800

U.S. Social Security Administration
http://www.ssa.gov
(800) 772-1213

1995 DOCUMENTATION GUIDELINES FOR EVALUATION & MANAGEMENT SERVICES

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time;
- communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;

1

- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or

- that services provided have been accurately reported.

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:

    - reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results;

    - assessment, clinical impression, or diagnosis;

    - plan for care; and

    - date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

2

II. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three ***key*** components of E/M services and for visits which consist predominately of counseling or coordination of care. The three key components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. **Documentation guidelines are identified by the symbol • DG.**

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (i.e., history, examination and medical decision making) are the ***key*** components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E/M service.

For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, information on growth and development and/or nutrition will be recorded. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

The extent of history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history, **all three elements in the table must be met.** (A chief complaint is indicated at all levels.)

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

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- *DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.*

- *DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*

    - *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*

    - *noting the date and location of the earlier ROS and/or PFSH.*

- *DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*

- *DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.*

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

- *DG: The medical record should clearly reflect the chief complaint.*

5

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- location;
- quality;
- severity;
- duration;
- timing;
- context;
- modifying factors; and
- associated signs and symptoms.

Brief and ***extended*** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A ***brief*** HPI consists of one to three elements of the HPI.

- *DG: The medical record should describe one to three elements of the present illness (HPI).*

An ***extended*** HPI consists of four or more elements of the HPI.

- *DG: The medical record should describe four or more elements of the present illness (HPI) or associated comorbidities.*

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

A ***problem pertinent*** ROS inquires about the system directly related to the problem(s) identified in the HPI.

- *DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.*

An ***extended*** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

- *DG: The patient's positive responses and pertinent negatives for two to nine systems should be documented.*

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A ***complete*** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

- *DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.*

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- past history (the patient's past experiences with illnesses, operations, injuries and treatments);

- family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and

- social history (an age appropriate review of past and current activities).

For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an "interval" history. It is not necessary to record information about the PFSH.

A ***pertinent*** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- *DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.*

A ***complete*** PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- *DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.*

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- *DG: At least one specific item from <u>each</u> of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and homecare, new patient.*

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on four types of examination that are defined as follows:

- ***Problem Focused*** -- a limited examination of the affected body area or organ system.

- ***Expanded Problem Focused*** -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

- ***Detailed*** -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

- ***Comprehensive*** -- a general multi-system examination or complete examination of a single organ system.

For purposes of examination, the following ***body areas*** are recognized:

- Head, including the face

- Neck

- Chest, including breasts and axillae

- Abdomen

- Genitalia, groin, buttocks

- Back, including spine

- Each extremity

For purposes of examination, the following ***organ systems*** are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

- *DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.*
- *DG: Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.*
- *DG: A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).*
- *DG: The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.*

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C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straight-forward, low complexity, moderate complexity, and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;

- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and

- the risk of 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.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	***Straightforward***
Limited	Limited	Low	***Low Complexity***
Multiple	Moderate	Moderate	***Moderate Complexity***
Extensive	Extensive	High	***High Complexity***

Each of the elements of medical decision making is described on the following page.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered 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.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

- *DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*

    - *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*

    - *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible," "probable," or "rule out" (R/O) diagnoses.*

- *DG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*

- *DG: If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On

occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who
prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- *DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray, should be documented.*

- *DG: The review of lab, radiology and/or other diagnostic tests should be documented. An entry in a progress note such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

- *DG: A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.*

- *DG: Relevant finding from the review of old records, and/or the receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*

- *DG: The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

- *DG: The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.*

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RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

- *DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*

- *DG: If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure eg, laparoscopy, should be documented.*

- *DG: If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*

- *DG: The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is **minimal**, **low**, **moderate**, or **high**. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

Table of Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem, eg, cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, eg, echocardiography KOH prep	Rest Gargles Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	Physiologic tests not under stress, eg, pulmonary function tests Non-cardiovascular imaging studies with contrast, eg, barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, eg, lump in breast Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness	Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic Endoscopies with identified risk factors Discography	Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

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D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

- *DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

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1997 DOCUMENTATION GUIDELINES FOR EVALUATION & MANAGEMENT SERVICES

TABLE OF CONTENTS

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- **the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time.**
- **communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;**
- **accurate and timely claims review and payment;**
- **appropriate utilization review and quality of care evaluations; and**
- **collection of data that may be useful for research and education.**

An appropriately documented medical record can reduce many of the hassles associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- **the site of service;**
- **the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or**
- **that services provided have been accurately reported.**

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. **The medical record should be complete and legible.**

2. **The documentation of each patient encounter should include:**

   - **reason for encounter and relevant history, physical examination findings, and prior diagnostic test results;**

   - **assessment, clinical impression, or diagnosis;**

   - **plan for care; and**

   - **date and legible identity of the observer.**

3. **If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.**

4. **Past and present diagnoses should be accessible to the treating and/or consulting physician.**

5. **Appropriate health risk factors should be identified.**

6. **The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.**

7. **The CPT and ICD-9-CM codes reported on the health insurance claim form should be supported by the documentation in the medical record.**

III. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits which consist predominately of counseling or coordination of care. The three *key* components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. Documentation guidelines are identified by the symbol • DG.

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- **history;**
- **examination;**
- **medical decision making;**
- **counseling;**
- **coordination of care;**
- **nature of presenting problem; and**
- **time.**

The first three of these components (i.e., history, examination and medical decision making) are the key components in selecting the level of E/M services. In the case of visits which consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (eg, examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

These Documentation Guidelines for E/M services reflect the needs of the typical adult population. For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants,

children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four levels of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- **Chief complaint (CC)**
- **History of present illness (HPI)**
- **Review of systems (ROS) and**
- **Past, family, and/or social history (PFSH).**

The extent of the history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history all three elements in the table must be met. (A chief complaint is indicated at all levels.)

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

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- ***DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.***

- ***DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:***

    - ***describing any new ROS and/or PFSH information or noting there has been no change in the information; and***

    - ***noting the date and location of the earlier ROS and/or PFSH.***

- ***DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.***

- ***DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a history.***

Definitions and specific documentation guidelines for each of the elements of history are listed below.

<u>CHIEF COMPLAINT (CC)</u>
The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's own words.

- ***DG: The medical record should clearly reflect the chief complaint.***

HISTORY OF PRESENT ILLNESS (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

- **location ,**
- **quality ,**
- **severity,**
- **duration,**
- **timing,**
- **context ,**
- **modifying factors, and**
- **associated signs and symptoms.**

***Brief* and *extended* HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).**

A *brief* HPI consists of one to three elements of the HPI.

- ***DG: The medical record should describe one to three elements of the present illness (HPI).***

An *extended* HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

- ***DG: The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions.***

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REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized:

- **Constitutional Symptoms (eg, fever, weight loss)**
- **Eyes**
- **Ears, Nose, Mouth, and Throat**
- **Cardiovascular**
- **Respiratory**
- **Gastrointestinal**
- **Genitourinary**
- **Musculoskeletal**
- **Integumentary (skin and/or breast)**
- **Neurological**
- **Psychiatric**
- **Endocrine**
- **Hematologic/Lymphatic**
- **Allergic/Immunologic**

A *problem pertinent* ROS inquires about the system directly related to the problem(s) identified in the HPI.

- ***DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.***

An *extended* ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems*.*

- ***DG: The patient's positive responses and pertinent negatives for two to nine systems should be documented.***

A *complete* ROS inquires about the system(s) directly related to the problem(s) identified in the HPI, *plus* all additional body systems*.*

- ***DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.***

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PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- **past history (the patient's past experiences with illnesses, operations, injuries and treatments);**
- **family history (a review of medical events in the patient's family, including diseases which maybe hereditary or place the patient at risk); and**
- **social history (an age appropriate review of past and current activities).**

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care.

A *pertinent* PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- ***DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.***

A *complete* PFSH is a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- ***DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient.***

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- ***DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; home care, new patient.***

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on four types of examination:

- ***Problem Focused* – a limited examination of the affected body area or organ system.**

- ***Expanded Problem Focused* – a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).**

- ***Detailed* – an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).**

- ***Comprehensive* – a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).**

These types of examinations have been defined for general multi-system and the following single organ systems:

- **Cardiovascular**
- **Ears, Nose, Mouth, and Throat**
- **Eyes**
- **Genitourinary (Female)**
- **Genitourinary (Male)**
- **Hematologic/Lymphatic/Immunologic**
- **Musculoskeletal**
- **Neurological**
- **Psychiatric**
- **Respiratory**
- **Skin**

A general multi-system examination or a single organ system examination may be performed by any physician, regardless of specialty. The type (general multi-system or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s).

The content and documentation requirements for each type and level of examination are summarized below and described in detail in tables beginning on page 13. In the tables, organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (•) in the right column.

Parenthetical examples "(eg,…)", have been used for clarification and to provide guidance regarding documentation. Documentation for each element must satisfy any numeric requirements (such as "Measurement of *any three of the following seven*...") included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as "Examination of *liver* and *spleen*") require documentation of at least one component. It is possible for a given examination to be expanded beyond what is defined here. When that occurs, findings related to the additional systems and/or areas should be documented.

- ***DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.***

- ***DG: Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.***

- ***DG: A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).***

GENERAL MULTI-SYSTEM EXAMINATIONS

General multi-system examinations are described in detail beginning on page 13. To qualify for a given level of multi-system examination, the following content and documentation requirements should be met:

- ***Problem Focused Examination* – should include performance and documentation of one to five elements identified by a bullet (•) in one or more organ system(s) or body area(s).**
- ***Expanded Problem Focused Examination* – should include performance and documentation of at least six elements identified by a bullet (•) in one or more organ system(s) or body area(s).**
- ***Detailed Examination* – should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet (•) is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet (•) in two or more organ systems or body areas.**
- ***Comprehensive Examination* – should include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet (•) should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by a bullet is expected.**

SINGLE ORGAN SYSTEM EXAMINATIONS

The single organ system examinations recognized by CPT are described in detail beginning on page 18. Variations among these examinations in the organ systems and body areas identified in the left columns and in the elements of the examinations described in the right columns reflect differing emphases among specialties. To qualify for a given level of single organ system examination, the following content and documentation requirements should be met:

- ***Problem Focused Examination* – should include performance and documentation of one to five elements identified by a bullet (•), whether in a box with a shaded or unshaded border.**
- ***Expanded Problem Focused Examination* – should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.**
- ***Detailed Examination* – examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet (•), whether in a box with a shaded or unshaded border.**

  Eye and psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

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- ***Comprehensive Examination* – should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected**.

CONTENT AND DOCUMENTATION REQUIREMENTS

General Multi-System Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Inspection of conjunctivae and lids • Examination of pupils and irises (eg, reaction to light and accommodation, size and symmetry) • Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	• External inspection of ears and nose (eg, overall appearance, scars, lesions, masses) • Otoscopic examination of external auditory canals and tympanic membranes • Assessment of hearing (eg, whispered voice, finger rub, tuning fork) • Inspection of nasal mucosa, septum and turbinates • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)

System/Body Area	Elements of Examination
Respiratory	• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (eg, dullness, flatness, hyperresonance) • Palpation of chest (eg, tactile fremitus) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Palpation of heart (eg, location, size, thrills) • Auscultation of heart with notation of abnormal sounds and murmurs Examination of: • carotid arteries (eg, pulse amplitude, bruits) • abdominal aorta (eg, size, bruits) • femoral arteries (eg, pulse amplitude, bruits) • pedal pulses (eg, pulse amplitude) • extremities for edema and/or varicosities
Chest (Breasts)	• Inspection of breasts (eg, symmetry, nipple discharge) • Palpation of breasts and axillae (eg, masses or lumps, tenderness)
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Examination for presence or absence of hernia • Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses • Obtain stool sample for occult blood test when indicated

System/Body Area	Elements of Examination
Genitourinary	**MALE:** • Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass) • Examination of the penis • Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness) **FEMALE:** Pelvic examination (with or without specimen collection for smears and cultures), including • Examination of external genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Examination of urethra (eg, masses, tenderness, scarring) • Examination of bladder (eg, fullness, masses, tenderness) • Cervix (eg, general appearance, lesions, discharge) • Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) • Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)
Lymphatic	Palpation of lymph nodes in **two or more** areas: • Neck • Axillae • Groin • Other

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System/Body Area	Elements of Examination
Musculoskeletal	• Examination of gait and station • Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) Examination of joints, bones and muscles of **one or more of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions • Assessment of range of motion with notation of any pain, crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
Skin	• Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers) • Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)
Neurologic	• Test cranial nerves with notation of any deficits • Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski) • Examination of sensation (eg, by touch, pin, vibration, proprioception)
Psychiatric	• Description of patient's judgment and insight Brief assessment of mental status including: • orientation to time, place and person • recent and remote memory • mood and affect (eg, depression, anxiety, agitation)

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Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least two** elements identified by a bullet **from each of six areas/systems** OR **at least twelve** elements identified by a bullet **in two or more areas/systems**.
Comprehensive	Perform **all elements** identified by a bullet in **at least nine** organ systems or body areas and document **at least two** elements identified by a bullet **from each of nine areas/systems.**

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Cardiovascular Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	• Inspection of conjunctivae and lids (eg, xanthelasma)
Ears, Nose, Mouth and Throat	• Inspection of teeth, gums and palate • Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	• Examination of jugular veins (eg, distension; a, v or cannon a waves) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Palpation of heart (eg, location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) • Auscultation of heart including sounds, abnormal sounds and murmurs • Measurement of blood pressure in two or more extremities when indicated (eg, aortic dissection, coarctation) Examination of: • Carotid arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay) • Abdominal aorta (eg, size, bruits) • Femoral arteries (eg, pulse amplitude, bruits) • Pedal pulses (eg, pulse amplitude) • Extremities for peripheral edema and/or varicosities

System/Body Area	Elements of Examination
Chest (Breasts)	
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
Genitourinary (Abdomen)	
Lymphatic	
Musculoskeletal	• Examination of the back with notation of kyphosis or scoliosis • Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, stasis dermatitis, ulcers, scars, xanthomas)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person, • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Ear, Nose and Throat Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming) • Assessment of ability to communicate (eg, use of sign language or other communication aids) and quality of voice
Head and Face	• Inspection of head and face (eg, overall appearance, scars, lesions and masses) • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness • Examination of salivary glands • Assessment of facial strength
Eyes	• Test ocular motility including primary gaze alignment
Ears, Nose, Mouth and Throat	• Otoscopic examination of external auditory canals and tympanic membranes including pneumo-otoscopy with notation of mobility of membranes • Assessment of hearing with tuning forks and clinical speech reception thresholds (eg, whispered voice, finger rub) • External inspection of ears and nose (eg, overall appearance, scars, lesions and masses) • Inspection of nasal mucosa, septum and turbinates • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx (eg, asymmetry, lesions, hydration of mucosal surfaces) • Inspection of pharyngeal walls and pyriform sinuses (eg, pooling of saliva, asymmetry, lesions) • Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords and mobility of larynx (Use of mirror not required in children) • Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae and eustachian tubes (Use of mirror not required in children)

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System/Body Area	Elements of Examination
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	• Inspection of chest including symmetry, expansion and/or assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	
Skin	
Neurological/ Psychiatric	• Test cranial nerves with notation of any deficits Brief assessment of mental status including • Orientation to time, place and person, • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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Eye Examination

System/Body Area	Elements of Examination
Constitutional	
Head and Face	
Eyes	• Test visual acuity (Does not include determination of refractive error) • Gross visual field testing by confrontation • Test ocular motility including primary gaze alignment • Inspection of bulbar and palpebral conjunctivae • Examination of ocular adnexae including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes • Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology • Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film • Slit lamp examination of the anterior chambers including depth, cells, and flare • Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus • Measurement of intraocular pressures (except in children and patients with trauma or infectious disease) Ophthalmoscopic examination through dilated pupils (unless contraindicated) of • Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer • Posterior segments including retina and vessels (eg, exudates and hemorrhages)
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	

System/Body Area	Elements of Examination
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	
Extremities	
Skin	
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Genitourinary Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (e.g. pulses, temperature, edema, tenderness)
Chest (Breasts)	[See genitourinary (female)]
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination for presence or absence of hernia • Examination of liver and spleen • Obtain stool sample for occult blood when indicated

System/Body Area	Elements of Examination
Genitourinary	**MALE:** • Inspection of anus and perineum Examination (with or without specimen collection for smears and cultures) of genitalia including: • Scrotum (eg, lesions, cysts, rashes) • Epididymides (eg, size, symmetry, masses) • Testes (eg, size, symmetry, masses) • Urethral meatus (eg, size, location, lesions, discharge) • Penis (eg, lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities) Digital rectal examination including: • Prostate gland (eg, size, symmetry, nodularity, tenderness) • Seminal vesicles (eg, symmetry, tenderness, masses, enlargement) • Sphincter tone, presence of hemorrhoids, rectal masses

System/Body Area	Elements of Examination
Genitourinary (Cont'd)	**FEMALE:** Includes **at least seven of the following eleven** elements identified by bullets: • Inspection and palpation of breasts (eg, masses or lumps, tenderness, symmetry, nipple discharge) • Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses Pelvic examination (with or without specimen collection for smears and cultures) including: • External genitalia (eg, general appearance, hair distribution, lesions) • Urethral meatus (eg, size, location, lesions, prolapse) • Urethra (eg, masses, tenderness, scarring) • Bladder (eg, fullness, masses, tenderness) • Vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Cervix (eg, general appearance, lesions, discharge) • Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) • Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity) • Anus and perineum
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation (eg, time, place and person) and • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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Hematologic/Lymphatic/Immunologic Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	• Palpation and/or percussion of face with notation of presence or absence of sinus tenderness
Eyes	• Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	• Otoscopic examination of external auditory canals and tympanic membranes • Inspection of nasal mucosa, septum and turbinates • Inspection of teeth and gums • Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx)
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
Genitourinary	

System/Body Area	Elements of Examination
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Musculoskeletal	
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, ecchymoses, bruises)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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Musculoskeletal Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	• Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location

System/Body Area	Elements of Examination
Musculoskeletal	• Examination of gait and station Examination of joint(s), bone(s) and muscle(s)/ tendon(s) of **four of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions • Assessment of range of motion with notation of any pain (eg, straight leg raising), crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements NOTE: For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.
Extremities	[See musculoskeletal and skin]
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, scars, rashes, lesions, cafe-au-lait spots, ulcers) in **four of the following six** areas: 1) head and neck; 2) trunk; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. NOTE: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.
Neurological/ Psychiatric	• Test coordination (eg, finger/nose, heel/ knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children) • Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (eg, Babinski) • Examination of sensation (eg, by touch, pin, vibration, proprioception) Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Neurological Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	• Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	• Examination of carotid arteries (eg, pulse amplitude, bruits) • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	

System/Body Area	Elements of Examination
Musculoskeletal	• Examination of gait and station Assessment of motor function including: • Muscle strength in upper and lower extremities • Muscle tone in upper and lower extremities (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (eg, fasciculation, tardive dyskinesia)
Extremities	[See musculoskeletal]
Skin	
Neurological	Evaluation of higher integrative functions including: • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases, spontaneous speech) • Fund of knowledge (eg, awareness of current events, past history, vocabulary) Test the following cranial nerves: • 2nd cranial nerve (eg, visual acuity, visual fields, fundi) • 3rd, 4th and 6th cranial nerves (eg, pupils, eye movements) • 5th cranial nerve (eg, facial sensation, corneal reflexes) • 7th cranial nerve (eg, facial symmetry, strength) • 8th cranial nerve (eg, hearing with tuning fork, whispered voice and/or finger rub) • 9th cranial nerve (eg, spontaneous or reflex palate movement) • 11th cranial nerve (eg, shoulder shrug strength) • 12th cranial nerve (eg, tongue protrusion) • Examination of sensation (eg, by touch, pin, vibration, proprioception) • Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (eg, Babinski) • Test coordination (eg, finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)
Psychiatric	

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Psychiatric Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	• Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	
Skin	
Neurological	

System/Body Area	Elements of Examination
Psychiatric	• Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language) • Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (eg, loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions • Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition) Complete mental status examination including • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases) • Fund of knowledge (eg, awareness of current events, past history, vocabulary) • Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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Respiratory Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	• Inspection of nasal mucosa, septum and turbinates • Inspection of teeth and gums • Examination of oropharynx (eg, oral mucosa, hard and soft palate, tongue, tonsils and posterior pharynx)
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass) • Examination of jugular veins (eg, distention, a, v or cannon a waves)
Respiratory	• Inspection of chest with notation of symmetry and expansion • Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (eg, dullness, flatness, hyperresonance) • Palpation of chest (eg, tactile fremitus) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	

System/Body Area	Elements of Examination
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
Genitourinary	
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	• Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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Skin Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	• Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	• Inspection of teeth and gums • Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)
Neck	• Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	
Cardiovascular	• Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	• Examination of liver and spleen • Examination of anus for condyloma and other lesions
Genitourinary	
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)

System/Body Area	Elements of Examination
Skin	• Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities • Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, susceptibility to and presence of photo damage) in **eight of the following ten** areas: • Head, including the face and • Neck • Chest, including breasts and axillae • Abdomen • Genitalia, groin, buttocks • Back • Right upper extremity • Left upper extremity • Right lower extremity • Left upper extremity NOTE: For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and the left upper extremity constitutes two elements. • Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses or bromhidrosis
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straight-forward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of 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.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	***Straightforward***
Limited	Limited	Low	***Low Complexity***
Multiple	Moderate	Moderate	***Moderate Complexity***
Extensive	Extensive	High	***High Complexity***

Each of the elements of medical decision making is described below.

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered 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.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

DG: *For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.*

- *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*

- *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible", "probable", or "rule out" (R/O) diagnosis.*

DG: *The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*

DG: *If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

DG: *If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray, should be documented.*

DG: *The review of lab, radiology and/or other diagnostic tests should be documented. A simple notation such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

DG: *A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.*

DG: *Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*

DG: *The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

DG: *The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.*

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RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

DG: *Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.*

DG: *If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, eg, laparoscopy, should be documented.*

DG: *If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*

DG: *The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is *minimal*, *low*, *moderate*, or *high*. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. **The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.**

TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem, eg, cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, eg, echocardiography KOH prep	Rest Gargles Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	Physiologic tests not under stress, eg, pulmonary function tests Non-cardiovascular imaging studies with contrast, eg, barium enema Superficial needle biopsies Clinical laboratory tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, eg, lump in breast Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness	Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic Endoscopies with identified risk factors Discography	Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

DG: *If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

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MEDICARE RESIDENT, PRACTICING PHYSICIAN, AND OTHER HEALTH CARE PROFESSIONAL TRAINING PROGRAM

REQUEST FOR CENTERS FOR MEDICARE & MEDICAID SERVICES-LED IN-PERSON COURSE

The Centers for Medicare & Medicaid Services (CMS) has a strong commitment to communicate accurate, consistent, and timely information about the Medicare Program to the nation's health care professionals. The goal of the Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program is to inform residents, practicing physicians, and other health care professionals who are new to the Medicare Program about the benefits of participation in the Program and the resources available to them as a Medicare provider.

The 3-Hour Medicare Program Training Module consists of seven chapters that are based on information found in the *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*. The table on page 2 lists the learning objectives for each chapter. Please circle the number that you believe best represents the importance of each chapter as it relates to the needs of the learners. Count the number of 2s and 3s that you circled. Add up the time required to present the chapters that you circled. Enter this information on page 3.

Please note that resource constraints may limit a Regional Office's (RO) ability to conduct in-person courses.

1 = **Less** Important 2 = **Somewhat** Important 3 = **Very** Important

CHAPTER	LEARNING OBJECTIVES	TIME	LEVEL OF IMPORTANCE
1 Introduction to the Medicare Program	- Identify Medicare's four parts - Determine the individuals who are eligible for Medicare Part A and Part B, Medicare Advantage, and the prescription drug plan - Identify the organizations that impact the Medicare Program	30 minutes	1 2 3
2 Becoming a Medicare Provider or Supplier	- Identify Part A and Part B providers and suppliers - Define the Medicare physician and practitioner - Describe the Medicare Program enrollment process - Identify how providers and suppliers can promote cultural competency	35 minutes	1 2 3
3 Medicare Reimbursement	- Describe how Medicare providers and suppliers are reimbursed for the items and services they furnish - Identify when Medicare is the secondary payer - Recognize incentive payments - Describe the Medicare Physician Fee Schedule - Identify notices you may use or receive from Medicare - Describe the other health insurance plans beneficiaries may be enrolled in	20 minutes	1 2 3
4 Medicare Payment Policies	- Determine Medicare covered services - Identify incident to services - Determine the services that are not covered by Medicare	15 minutes	1 2 3
5 Evaluation and Management Services	**-** Describe the two common sets of codes that are currently in use and the new classification system that will be used beginning on October 1, 2013. - Identify the seven general principles of documentation - Identify the seven components that define the levels of evaluation and management services	45 minutes	1 2 3
6 Protecting the Medicare Trust Fund	- Identify the goal of the Medicare Integrity Program - Describe the medical review process - Determine the two types of coverage determinations - Define Federal health care fraud - Define program abuse - Identify the potential legal actions that may be imposed if a provider, supplier, or health care organization has committed health care fraud and program abuse	15 minutes	1 2 3
7 Inquiries, Overpayments, and Fee-for-Service Appeals	- Describe how providers and suppliers can find answers to inquiries - Identify the reasons overpayments are often paid - Identify the five levels of the fee-for-service appeals process - Define a reopening	20 minutes	1 2 3

- Count the number of 2s and 3s that you circled on page 2.

  Number of 2s and 3s circled = _____

- Add up the time required to present the chapters that you circled.

  Time required to present all chapters = _____

Please ensure that the total time for the chapters you have selected does not exceed the time available for learners to attend the course.

To request a CMS-led in-person Medicare Resident, Practicing, and Other Health Care Professional Training Program course, please mail or fax this form directly to your CMS Regional Office, ATTENTION: Request For Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program Course. CMS RO mailing addresses and fax numbers can be found at *http://www.cms.hhs.gov/RegionalOffices* on the CMS website.

The developers of this program have no conflicts of interest to disclose.