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HEALTH SCIENCES CENTER™
Office *of* Institutional Compliance

Billing Compliance Program

Billing Monitoring Handbook

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1.0 INITIAL STEPS

1.1 SELECTING THE MONITORING ITEMS

The Billing Compliance Office at each campus shall select ten (10) encounters for each provider to be monitored during the calendar quarter in accordance with established policies and procedures. The type of encounters selected shall represent the types of services rendered by the provider and be reflective of risks for that department and/or provider. The selection shall include the monitoring number, provider name and ID/NPI, patient information and service codes for each encounter to be monitored. This information will be provided to the monitors via e-mail with merged information onto the appropriate monitoring tools.

1.2 MONITORING RESOURCES AND TOOLS

In order to conduct the monitoring, the medical record (clinic and/or hospital) must be obtained. For surgical procedures (including OB delivery) it may be necessary to review the surgery schedule for the dates being reviewed to verify whether there were two or more concurrent surgeries, which would impact how the encounter is audited.

If necessary, obtain a copy of the provider's calendar for the period of time under review/audit. This may be necessary for Primary Care Exception Clinics under the Teaching Physician Rule, surgical procedures, psychotherapy services, etc.

Make sure you have the CPT, HCPCS and ICD-9 books that were in effect during the time period under review.

1.3 ON-LINE MONITORING SUBMISSION FORM

1.3.1 Purpose

Findings are reported on the On-line Monitoring Submission Form (previously known as Appendix A) which provides the necessary information to identify and track billing errors. This information is automatically downloaded into a central database to track and identify risk areas. In addition, this information is automatically transferred to Appendix B which you are able to print following the process of entering the data into the database.

1.3.2 Instructions

1. Complete an On-line Monitoring Submission Form for **each patient encounter** (not CPT/HCPCS code) monitored. The database is located at http://www.ttuhsc.edu/compliance/Auditing/main.aspx
2. Enter your e-raider username and password and then choose "New Audit Submission."
3. Choose the appropriate campus, department, provider and quarter.
4. If a Resident was involved, select Yes in the first row; otherwise select No. Enter the date of service and the date the encounter was monitored. Enter the medical record number and also enter the monitor number consecutively, 1-10.
5. Select the box next to any finding identified (first column) and provide specific information in the comments area (second column) related to the finding.
6. After entering all data in the required fields, click Verify located at the bottom of the screen. Review the data to be sure the data is correct. If you need to correct anything, click "Go Back" and "Verify" again. If the data is correct, click "Submit".
7. After all 10 encounters have been entered, it is important to review the encounters again. Click "Edit/Review Audits" located on the left-hand side of the screen. Again, choose the campus,

department, provider and quarter. All encounters will be listed for that provider. You may edit or delete on this screen.

8. You may review the encounters again. Click "Edit/Review Audits" located on the left-hand side of the screen. Edit the encounter as appropriate or you may delete the entire encounter. Sign out when finished.

9. Printing Appendix B is the next step. The print option key is located on the left side of the submission form.

See Appendix M for Additional Comments/Examples regarding the categories of Findings on the On-line Monitoring Submission Form.

1.4 PROVIDER MONITORING REPORT WORKSHEET—APPENDIX B

1.4.1 Purpose

Appendix B is reviewed with the provider and coders(s) after the monitoring process has been completed for that provider. Review BCO 3.0 Coding and Documentation Improvement Program for further instructions. The provider must sign and date Appendix B after the review. The Coder(s) and Monitor(s) are to sign and date also. A copy of Appendix B is retained by the Department and the original is sent to the campus Billing Compliance Director. In addition, send Appendices C-J (as applicable). Send related medical record documentation to the Billing Compliance Office on those encounters with Findings. It is important that the provider receive a copy of Appendix B as part of the education and/or corrective action process. Appendix B is automatically populated after the encounters have been submitted in the On-line Monitoring Submission Form listed in Section 1.3.

1.4.2 Instructions

1. Once the On-line Monitoring Submission Form is completed, click "Print Appendix B" which is located on the left side of the screen. Choose the appropriate campus, department, provider and the appropriate quarter. Once the Provider list is displayed, click the print function key on the screen. At the top of the screen there an option to toggle to pages 2 and 3. Also, at the top of the page is an option to export Appendix B to Microsoft Word, PDF or Excel to manually type the provider/coder response and action plan which can also be saved to your PC.

2. Provider/Coder Response — Insert the provider/staff responses to the findings. In this column, identify who was responsible for the error.

3. Action — Insert final findings and corrective action for each encounter with findings, noting the responsible party, including, but not limited to:

   a. Refunds of any erroneous payments;
   b. Additional education;
   c. Oral/written notice;
   d. Required additional reviews; and
   e. Any other corrective action.

4. After reviewing Appendix B containing the results of the monitoring review with the provider, the provider must sign and date. The monitor(s) and coder(s) should also sign and date Appendix B before sending to the Billing Compliance Office. If the provider and/or coder refuse to sign Appendix B, indicate that refusal on the signature line and submit to the campus Billing Compliance Office.

5. **REMEMBER:** In addition to Appendix B, send all appendices (Appendices C-J) that were utilized during the monitoring process to the Billing Compliance Office (as applicable – see Section 1.4.1). On those encounters with findings, also send the documentation in addition to the appendices to the campus Billing Compliance Office after the monitoring is complete and the results have been reviewed with the provider.

2.0 MONITORING EVALUATION AND MANAGEMENT (E/M) SERVICES, IN OFFICE PROCEDURES, AND DIAGNOSTIC SERVICES

2.1 GENERAL PRINCIPLES (CMS' 1995 AND 1997 E/M DOCUMENTATION GUIDELINES)

Additional resources from J-4 MAC, Trailblazer:

Evaluation and Management Services Manual (September 2011):

Coding Evaluation and Management Services (September 15, 2009):

Medical Necessity for E/M Services (August 2010):

Tips for Preventing Most Common E/M Service Coding Errors (September 2011):

Five Step Process (August 2010):

2.1.1 The Medical Record

1. The medical record should be complete and legible.
2. Documentation of each patient encounter should include:
   a. Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   b. Assessment, clinical impression or diagnosis;
   c. Plan for care;
   d. Date and legible identity of the provider entering the information, including their professional designation (i.e., MD, DO, MS, ARNP, PA, RN, etc.); and
   e. Patient's name, MRN, date of service on each page of the medical record.
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.

   Documentation should support the CPT/HCPCS and ICD-9-CM codes reported on the health insurance claim form or billing statement.

2.1.2 Key Components of an E/M Service

HISTORY, EXAMINATION AND MEDICAL DECISION MAKING

NOTE: Certain patients (e.g., infants, children, pregnant women,) may have additional or modified information recorded in the history and examination areas.

OR TIME

The visit is either documented as consisting predominately (more than 50% physician patient and/or family face-to-face encounter) of counseling or coordination of care; **or,** the E/M service is a time-based code (e.g., critical care, prolonged services. etc.) In addition to time, there must be some documentation of the services provided.

2.2 E/M AND/OR IN-OFFICE PROCEDURES AND DIAGNOSTIC TESTS WORKSHEET—APPENDICES C, D AND E (AS APPLICABLE)

2.2.1 Purpose

1. Appendix C-1. Use Appendix C-1 for each encounter monitored that involves E/M services, minor procedures, in-office procedures and/or clinical laboratory tests. E/M services include, but are not limited to in-patient hospital visits, office visits, nursing home visits, consultations, critical care services, etc. Minor procedures include, but are not limited to, minor surgical procedures (i.e., stitches, injections, etc.). In-office diagnostic tests do not include invasive procedures, X-rays, or diagnostic endoscopies etc. See Section 2.2.2. Also reference Trailblazer's E/M Coding and Documentation Reference Guide.
2. Appendix C-2. Use Appendix C-2 should be used for monitoring Ophthalmology and in-office procedures and diagnostic services. See Section 2.5.
3. Appendix D-1. Appendix D-1 should be used when monitoring the Medicare Initial Preventive Physical Exam (IPPE). See Section 2.6.2.
4. Appendix D-2. Appendix D-2 should be used when monitoring Texas Medicaid Texas Health Step exams. See Section 2.6.4.
5. Appendix D-3. Appendix D-3 should be used when monitoring Medicare Annual Wellness Visits (AWV). See Section 2.6.5.
6. Appendices E. Appendices E should be used when using the 1997 E/M Documentation Guidelines to determine the level of physical examination services monitored; or, for Medicare Women's Preventive Exam (Pelvic/Pap – G0101). See Section 2.6.3.

2.2.2 Instructions (Appendix C-1)

1. The merged patient encounter information should be in the top left-hand corner of Appendix C-1.
2. Coding Outcomes Box
   a. **CPT Correct**: For non-time based E/M services, complete Sections 1-3 of Appendix C-1 to verify the level of the E/M service, listing the code(s) that should have been used in the Post-Audit CPT(s) box. See Section 2.3 for in-depth instructions for monitoring the level of E/M Service. See #10 for Time-Based Codes.
      - See Appendix M for detailed examples.
      - If the procedure and/or E/M code was coded at a lower level than it should have been coded, mark **A-1** on the On-line Monitoring Submission Form. If the CPT code was coded at a higher level than it should have been**,** mark **A-2 –** This category is to be used for procedures; when a consult was billed but did not meet criteria therefore an E/M code should have been billed (wrong E/M category); or a wrong code for laboratory service

that results in a higher level of reimbursement than what we should have received. Another example is when a patient was seen by a physician in the group practice within the past 3 years and was billed as a new patient. Since the patient was seen in the clinic within the past 3 years, this should be coded as a subsequent visit.
NOTE: An **A-1** Finding should only be reported if the physician, when informed that documentation could support a higher service, agrees with the finding.

- If the **E/M code** is upcoded by one level due to inadequate documentation (excluding Teaching Physician documentation) mark **B-2**; if upcoded by two or more levels, then mark **B-3** on the On-line Monitoring Submission Form.
- If no documentation exists at all to support the code, mark **B-4** on the On-line Monitoring Submission Form.
- If the documentation is insufficient to support the code, mark **B-5**. For example, the physician failed to document Chief Compliant which is required for any E/M service.

a. **Modifier Correct**: Mark whether or not the modifier is correct or if a modifier was improperly used or not used when it should have been used. If the answer is No, mark **A-3** on the On-line Monitoring Submission Form, **ONLY** if the error results in **upcoding** (i.e., we received a higher level of reimbursement than we should have). Mark **A-7** if the modifier finding did not result in increased reimbursement
b. **ICD-9 Correct**: Mark whether or not the ICD-9 code(s) are correct. If the ICD-9 does not accurately describe the condition or if the code is not coded to the highest level of specificity, mark **C-1** on the On-line Monitoring Submission Form. If the ICD-9 fails to support medical necessity for the service, mark **C-2** on the On-line Monitoring Submission Form.
c. **DOS Correct**: Mark whether or not the Date of Service (DOS) billed is correct. If the answer is No, mark **D-1** on the On-line Monitoring Submission Form.

3. Teaching Documentation Box

a. **Resident**: If a Resident is involved, mark Yes on the On-line Monitoring Submission Form and mark Yes on Appendix C-1. See Section 2.3 for more details regarding Teaching Physician requirements.
b. **Primary Care Exception (PCE)**: If services were provided in a PCE clinic, mark Yes and make sure the requirements were met. You will need to review the calendar to verify the number of Residents being supervised and to confirm that the supervising physician was not providing any other billable services while supervising the PCE Residents. If there were more than 4 Residents or the supervising physician was providing other billable services, mark **A-4** as those Resident's services cannot be billed.
c. **Minor Procedure/Diagnostic Scope**: Minor procedures, those that take less than 5 minutes to perform, and diagnostic scopes require the Teaching Physician's presence the entire time, from insertion to removal of the scope. Teaching Physician's presence (required for the entire procedure) can be documented by the Resident or Teaching Physician. If the answer is No, mark **B-1** on the On-line Monitoring Submission Form.
d. **Teaching Physician Documentation (General Rule)**: For E/M services not provided in the PCE Setting, the Teaching Physician must personally document his/her participation in the key or critical portion(s) of the service and management of the patient. The Resident's documentation may only be used to support the level of E/M service. If the Answer is No:
   1) Mark **B-1** on the On-line Monitoring Submission Form for insufficient Teaching Physician documentation and it will not support any billable service, or
   2) Mark **B-2 or B-3**, as appropriate on the On-line Monitoring Submission Form for insufficient Teaching Physician documentation, but Teaching Physician documentation would support a lower level code, (i.e., Teaching Physician fails to tie into Resident's note, and therefore can only code based on Teaching Physician's documentation). Mark

B-3 if upcoded by two levels (i.e., code billed was admission, but due to lack of reference to Resident documentation, Teaching Physician's documentation can only be coded as CPT code 99499 or report a subsequent hospital care code that appropriately reflects physician work and medical necessity for the service). For more information, reference Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioner. Also reference MLN MM7405 "Clarification of E/M Payment Policy."

4. POS (Place of Service): Mark Yes if the POS is coded correctly; otherwise mark No. The CPT code must correspond with the correct place of service code. If POS is incorrect, mark **D-7** on the Online Monitoring Submission Form.

5. Post-Audit codes: After determining the appropriate codes, record the post-audit CPT(s), ICD-9(s) and Modifiers on the On-line Monitoring Submission Form accordingly. See Appendix M for examples.

6. Signature: Mark either Yes or No whether the provider signed the documentation appropriately, including credentials. Mark **D-2** if the signature is inappropriate; or mark **D-3** if it was signed by another provider.

7. Medicare Advance Beneficiary Notice (ABN): If the patient is a Medicare beneficiary and services may be subject to denial as not reasonable and necessary or exceed frequency limitations, then an ABN is required. Please refer to CMS FFS Revised Advance Beneficiary notice of Noncoverage (ABN). If one was not obtained in accordance with CMS Policy check No, mark **D-4** on the On-line Monitoring Submission Form. If it does not apply to this encounter, mark NA.

8. Incident To: If the patient is a Medicare beneficiary, and services were provided by ancillary staff or a non-physician provider (NPP) "incident to" a physician's service, mark Yes. To qualify for Medicare's "incident to," the physician must be physically present during the first visit for the new condition and he/she must be on site during subsequent visits. This will require a review of previous visits to verify if Medicare's conditions were met. Please refer to CMS's Medicare "Incident To" requirements for further guidance, Medicare IOM, 100-02, Chapter 15, Section 60. If Medicare's requirements were not met, mark **A-4** on the On-line Monitoring Submission Form if services were provided by ancillary staff (e.g., nurse visit) or **D-3** if services were provided by a Medicare credentialed NPP. See Section 2.7 for more details of Medicare's requirements.

9. Legibility: Indicate legibility of clinical documentation. Mark **D-6** on the On-line Monitoring Submission Form if you and two other people are unable to read the note.

10. Critical Care Services: In addition to documentation of time by the physician (not the Resident) the patient must also be critically ill as defined by CPT. Just because the patient is in the ICU does not mean they have a critical condition supporting critical care coding. Also, a patient does not have to be in a critical care unit to qualify for critical care billing.

    For critical care encounters involving both a Teaching Physician and a Resident, the Teaching Physician must personally document:
    - the time the Teaching Physician spent providing critical care,
    - that the patient was critically ill during the time the Teaching Physician saw the patient,
    - what conditions were being treated, and
    - the nature of the treatment and management provided by the Teaching Physician.

    Time spent in teaching cannot be counted towards critical care. See *Medicare Claims Processing Manual,* IOM Pub. 100-04, Chapter 12, Section 100.1.4.
    September 2011, Trailblazer published Evaluation and Management Services guidelines, read critical care services on pages 35-47.

- Mark either Yes or No if the service was Critical Care.
- Mark either Yes or No if the patient meets criteria for critical as defined in CPT. If No, mark **A-2** on the On-line Monitoring Submission Form.
- Critical Care includes many services. Mark either Yes or No if bundled services were billed inappropriately, also mark **A-4** on the On-line Monitoring Submission Form. Select the E/M code based on total time, type of visit, place of service and amount of time which is shown for each code.

11. Time-Based Codes: If the CPT code (including E/M) is time-based, mark Yes after "Time-Based" and indicate whether or not time was documented by the Physician (not a Resident). In this case, YOU DO NOT NEED TO COMPLETE SECTIONS 1-3 OF APPENDIX C-1, BUT CIRCLE THE CODE AS APPLICABLE. If it is a time based code and the time was Not documented, mark **B-5** on the On-line Monitoring Submission Form.

    a. Counseling/Coordination of Care: If the time-based code is due to counseling/coordination of care, then the following should be documented:
        - Total time;
        - Time spent face-to-face with the patient during counseling/coordination of care activities; and
        - The general issues discussed with the patient.

    b. If any of these items are missing, the services must be coded based on the documented history, exam and medical decision-making (YOU MUST THEN COMPLETE SECTIONS 1-3 OF APPENDIX C-1). If the code is not supported by the documentation, mark either **B-2** (upcoded by one); or **B-3** (upcoded by two or more levels), whichever is applicable.

12. Were bundled services separately billed? If bundled services were performed and billed but were not a billable event or service, mark **A-4** on the On-line Monitoring Submission Form.

13. Was time documented? Indicate either Yes or No if the time is documented in the documentation. If time is not documented, the service must be billed as an E/M visit. **Mark A-2** (Upcoded) if the time is not documented and it is a time-based service.

14. EMR: Was the documentation inappropriately cloned? Mark No if the documentation is "cloned" appropriately. If the documentation is cloned inappropriately, mark Yes and mark **B-6** on the On-line Monitoring Submission Form. For example, BC Policy 7.2 states, "The provider may clone relevant portions of the patient's previous note entered by the same provider or resident in that provider's department to the extent it represents the level of work performed by the provider during the current visit and is revised to reflect any changes in the information."

15. Conflicting History Elements: Mark Yes if any element of the documentation conflicts with other parts of the history. If there are conflicting elements, do not count any conflicting elements as history. For example, chief complaint conflicts with review of systems: CC states patient has an earache but ROS states no problems with the ears. Mark **B-6** on the On-line Monitoring Submission Form if there are conflicting elements.

16. Consultation Services: If the visit was billed as a consult, verify documentation in the medical record of a written report. If no documentation indicates report was sent to the requesting physician, mark No and indicate **A-2** on the On-line Monitoring Submission Form. As of January 1, 2010, Medicare no longer reimburses codes 99241-99255 for inpatient or outpatient services. Telehealth inpatient consultations provided to a patient in the hospital or skilled nursing facility setting should be billed with the appropriate HCPCS code.

2.3 TEACHING PHYSICIAN RULES

2.3.1 Overall Teaching Physician Requirements

The Teaching Physician rules ONLY APPLY where a Teaching Physician involves a Resident in an approved Graduate Medical Education (GME) program, **not a medical student**, in the care of his/her patients. A GME Resident is an individual included in the TTUHSC's GME count. If you have any questions regarding the status of a Resident, contact J. Edward Bates, Senior Director and Designated Institutional Official for GME at TTUHSC (806) 743-2978. The Teaching Physician rules do not apply to Nurse Practitioners who involve Residents or student nurse practitioners in the care of their patients, or CRNAs who supervise student nurse anesthetists. A Resident or Fellow who is not included in the GME count is not classified as a Resident for purpose of the Teaching Physician Rules. However, the non-GME Resident or Fellow must be separately credentialed with each payer in order to bill for his/her services.

Neither the Teaching Physician nor Resident can refer (link to) or use a medical student's documentation of History of Present Illness (HPI), Exam or Medical Decision Making (MDM) to establish an E/M level of service. If the Resident has referenced the medical student's documentation of HPI, Exam or MDM, without writing a separate note, then the Teaching Physician must personally document the HPI, exam and decision making for the level billed.

The Resident and Teaching Physician can reference ancillary staff and/or medical student's documentation of Chief Complaint, Review of Systems (ROS) and Past Family, Social History (PFSH), which can be counted in determining the level of service as to those components of History only. The Teaching Physician and Resident can also refer to ancillary staff or medical student's documentation of vital signs, which can be used for purposes of counting the Constitutional element under the Exam. In all cases, the Resident and/or Teaching Physician MUST separately document their own findings of HPI, Exam and MDM.

2.3.2 General Rule E/M Services (Non-PCE Setting)

1. The Teaching Physician's documentation must link to the Resident's documentation in order to be able to use the combined Resident's and Teaching Physician's documentation to determine the level of service. (See paragraph 2 below).

2. The Teaching Physician must personally document his participation in or presence during the key or critical portion(s) of the E/M service and in the management of the patient's care. See Appendix K for Acceptable and Non-Acceptable examples of Teaching Physician documentation. The Teaching Physician's documentation DOES NOT have to be verbatim identical to the examples in Appendix K. Also review CMS Transmittal 2247 for examples of minimally acceptable documentation.

3. Pre-Printed Statements: The use of pre-printed statements as a **substitute** for personal documentation is insufficient. Prompts may be used to assist in the completion of the Teaching Physician's personal documentation of presence and participation, but there must be personal documentation by the Physician as to his/her review of the history; presence or performance of the exam; and participation in management of the patient's care.

4. Electronic Health Record (EHR) Macro Statements: An EHR macro is a command in a computer or dictation application that automatically inserts pre-determined text that is not edited by the user. An electronic macro may be used by the Teaching Physician in an EHR ONLY IF:

   - IT IS PERSONALLY ADDED BY THE TEACHING PHYSICIAN IN A SECURED (PASSWORD PROTECTED) SYSTEM; and
   - The Resident or Teaching Physician has provided customized information (patient specific) sufficient to support medical necessity. The note must sufficiently describe the specific services furnished to the specific patient on the specific date. See IOM, 100-04, Chapter 12, Section 100.

See Appendix L for acceptable macros that can be utilized in a TTUHSC EHR.

2.3.3 Primary Care Exception (PCE)

1. The Teaching Physician must be present at the clinic when the Resident performs the service, but does not have to be physically present in the exam room with the Resident (who has more than 6 months of training) and patient at the time of service. Teaching physicians may include residents with less than 6 months in a GME approved residency program in the mix of four residents under the teaching physician's supervision. However, the teaching physician must be physically present for the critical and key portions of services furnished by the resident with less than 6 months in a GME approved residency program. That is, the primary care exception does not apply in the case of residents with less than 6 months in a GME approved residency program. See Section 2.3.2 for General Teaching Physician Rules. Also reference Medicare's Claims Processing Manual, Chapter 12, Section 100.1.1 Subsection C regarding PCE clinics.

   NOTE: The Teaching Physician cannot have any other duties while supervising Residents under this exception, i.e., seeing private patients, supervising medical students, performing procedures, etc. The Teaching Physician can perform administrative duties related to his/her duties under the PCE Rule.

2. Primary Care Exception (PCE) **ONLY** applies to lower level E/M services (99201-99203; 99211-99213); Medicare IPPE (G0402); Medicare AWV (G0438, G0439) and Texas Health Steps (Medicaid) annual exams. **PCE DOES NOT apply to procedures.**

3. If the scheduled patient's problem is more complex than anticipated, the Teaching Physician may see the patient, but must meet the presence and documentation requirements under the General Teaching Physician Rule (Section 2.3.2) to bill a higher level (i.e., 99204, 99205, 99214, or 99215). The key is that at the time the patient was scheduled, the condition was not considered complex (i.e., 99204, 99205, 99214 or 99215).

4. Teaching Physician **must personally document** that:
   a. He/she reviewed patient-specific information from the Resident's notes, including diagnostic tests, and
   b. The review occurred with the Resident while the patient was in the clinic **OR** immediately after the Resident saw the patient, as applicable.

5. Phrases such as "Discussed and agree with Resident's assessment and plan" are not adequate. See Appendix K for examples of unacceptable Teaching Physician documentation. Documentation must contain patient-specific information. Also review CMS IOM 100-04 chapter 12, Section 100.1.1B for examples of minimally acceptable documentation.

2.3.4 Other Teaching Physician Rules

1. Minor procedures, i.e., less than 5 minutes, require Teaching Physician presence for the entire procedure. Teaching Physician presence can be documented by either the Resident or Teaching Physician.

2. Documentation for diagnostic endoscopic procedures must reflect that the Teaching Physician was available during the entire procedure, including insertion, viewing and removal of the scope. **For CMS information on physical presence, please refer to** CMS IOM 100-04 Chapter 12, Section 100; Definitions.

2.4 REVIEW LEVEL OF E/M SERVICES ONLY—APPENDIX C-1 (AND E, IF APPLICABLE)

2.4.1 Purpose

E/M Documentation Guidelines: You may use either the 1995 or 1997 E/M Documentation Guidelines to determine the level of E/M service. Complete Sections 1-3 of Appendix C-1 for any E/M service, other

than those E/M services determined solely on documentation of time (e.g., critical care codes, discharge codes, counseling/coordination of care >50 percent of face-to-face time with the patient). For preventive services (e.g., annual examinations), see Sections 2.5 and 2.6.

2.4.2 Instructions—Documentation of History (Appendix C-1, Section 1)

2.4.2.1 Chief Complaint (CC)

Definition—A concise statement describing the symptom, problem conditions, diagnosis, physician recommended return (i.e., follow-up for condition/symptom/disease), or other factors that is the reason for the encounter, is usually stated in the patient's words. (Health Care Financing Administration, 1997)

- The reason for the visit must be clearly evident in the Chief Complaint to understand why the patient requires care for the service to be medically reasonable and necessary. See **Trailblazer's "HISTORY IS THE KEY."** See also CMS IOM Chapter 12, Section 100.
- If the visit is for follow-up treatment of a known condition, then it is sufficient to note follow-up for ____________ (listing the complaint/condition and the symptoms that prompted the visit). For example: Medical necessity is met if the physician states, "Patient here for medication refill for hypertension." That statement supports the medical need for that patient to be seen. For more information regarding Trailblazer's definition of medical necessity read, **"A CASE FOR MEDICAL NECESSITY."**
- Subsequent inpatient hospital visits—Patient's status as an inpatient is sufficient to support a chief complaint.

Action—Mark Yes if there is a CC documented in the record and generally note the CC; otherwise mark No under CC. (**NOTE:** Using a more specific/accurate CC is important because the level of service of an encounter is appropriately determined by using the RELEVANT elements of the History and Examination that are SPECIFIC to the noted CC.) If you mark "No" for the CC, then you cannot count the HPI as an element of the exam, regardless of how much other history is documented. If that results in insufficient documentation to support the code, mark **B-5**.

2.4.2.2 History of Present Illness (HPI)

Definition— 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 (from 1995 Documentation Guidelines for E/M services and 1997 Documentation Guidelines for E/M Services). The provider must obtain this information which includes:

- **Location:** A description of specific place(s) on the patient's body where the symptom(s) are experienced. This can include a drawing with the location marked.
- **Quality:** A description of how the problem feels, looks, behaves, such as acute, chronic, stable, worsening, improving, etc.
- **Severity:** A description of how the symptom(s) feel or how bad the condition is to the patient. In some cases the patient may grade the pain on a scale of 1–10 or describe it as low, moderate, great or severe.
- **Duration:** A description of how long the patient has experienced the symptom(s), which may include information on when the symptom(s) first appeared.
- **Timing:** A description of when the patient experiences the symptom(s), such as continuous, daily, only at night.
- **Context:** A description of what caused or causes the patient to experience the symptom(s), or information that explains how the problem was identified. This includes "fell during recess", "shortness of breath while running", "found during monthly breast exam".

- **Modifying factors:** A description of steps taken by the patient or things that makes the symptom(s) better or worse.
- **Associated signs and symptoms:** A description of any additional sensations or feelings experienced by the patient when the symptom(s) occur. [This could include elements that could be used in the ROS, but can only be counted once, either in the HPI or ROS.]

(Information digested from the CPT Assistant Volume 6, Issue 4, April 1996)

Alternatively, the HPI can be documented through the status of one or more chronic conditions, e.g., **brittle** diabetic, **well-controlled** asthma, **chronic** low back pain, etc. Medical necessity must be clearly documented to warrant the reason for the visit. For more information, see **Trailblazer's "HISTORY IS THE KEY."**

Action—Mark each documented element and circle the level of HPI (as more fully described below) as either Brief or Extended. Do not count any element that conflicts with the ROS and/or PFSH. For example if the HPI states dyspnea, but the ROS states negative for the system, then do not count either one and mark **B-6** on Appendix A.

Selecting the Type of HPI

- **No HPI Documented**: This includes instances where there is either no HPI or the Teaching Physician/Resident or NPP did not document a separate HPI. In this case, there is insufficient documentation to support any history level for purposes of determining level of service requiring 3 of 3 key components. At least one HPI element must be documented for any billable E & M service because all three key components must have at least the minimally acceptable level of documentation according to payer guidelines. Review CMS 1995 guidelines for more information. Mark "N" under Coding Outcomes – CPT Correct – and mark **B-5** on Appendix A. If the service code only requires 2 of 3 components (i.e., subsequent hospital visit, established office visit) and the exam and MDM are documented, DO NOT mark "N" for lack of HPI.
- **Brief**: Circle if 1–3 elements or the status of 1-2 chronic conditions are documented.
- **Extended HPI**: Circle if 4 or more elements or the status of 3 or more chronic conditions are documented.

2.4.2.3 Review of Systems (ROS)

Definition—A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms (noted as positive or pertinent negative) that the patient may be experiencing or has experienced (Health Care Financing Administration, 1997, now CMS). This information may be obtained by ancillary staff or through use of a patient completed questionnaire, but review by the provider must be documented (e.g., signature and date; initial and date). Systems (or lack thereof) include:

- **Constitutional:** Symptom(s) or problem(s) related to temperature (afebrile, fever), weight gain or loss, fatigue.
- **Eyes:** Symptoms such as watering, itching, discharge, vision changes, history of past eye exams, injuries or infections, use of corrective lenses or diseases of the eye (i.e., glaucoma, cataracts).
- **Ears, Nose, Throat (ENT) and Mouth:** Symptoms in the ears, nose, throat or mouth, such as hearing problems, nasal discharge or bleeding, sneezing, scratchy throat, excessive salivation, sense of smell or taste, past or present lesions, last dental exam, loss of teeth, etc.
- **Respiratory:** Breathing symptoms, such as asthma, chronic coughing, wheezing, bronchitis or pneumonia, etc.

- **Cardiovascular (CV):** Heart and vascular system, such as heart palpitations, sweating, excessive thirst, fainting, swelling of arms/legs, leg pain, hypertension, chest pains, heart murmurs, pulse irregularities, etc.
- **Gastrointestinal (GI):** Digestive system, including heartburn, swallowing difficulties, hiatal hernia, nausea and/or vomiting; gall bladder problems, constipation, diarrhea, hemorrhoids, use of digestive aids including laxatives, hemocult exam results, if any, etc.
- **Allergic/Immunologic:** Responses related to the immunologic system, such as HIV status, and symptoms due to seasonal allergies, food allergies, medication allergies, etc. For example, itchy, runny nose, fatigue, rash, hives, etc.
- **Genitourinary (GU):** The male or female reproductive system or urinary system, such as number of births, vaginal discharge, genital itching, libido, urinary problems, toilet training (for children), incontinence, etc.
- **Hematologic/Lymphatic:** Responses related to the lymphatic or hematologic areas, such as anemia, bleeding, easy bruising or fatigue, blood transfusions, liver problems, etc.
- **Musculoskeletal:** Symptoms or problems experienced with the muscles, joints and tendons, such as muscle aches, joint pain/swelling/noise, spinal deformity (scoliosis), back pain, weakness, limitations on movement/activities, etc.
- **Integumentary (skin and/or breast):** Symptoms/problems on the skin or breast area, such as scars, moles, color changes, lesions, last mammography result (if relevant), pattern of breast self-exam, nipple discharge/changes, etc, breastfeeding (if relevant), etc.
- **Neurological:** Neurological experiences, such as fainting, seizure history, anticonvulsant therapy, memory loss, hallucinations, speech or language problems, sensory or motor disturbances, etc.
- **Psychiatric:** Any psychological conditions or treatment, such as auditory hallucinations, anxiety attacks, psychiatric conditions (bi-polar, schizophrenic), etc.
- **Endocrine:** Responses related to the endocrine system, such as thyroid disease, adrenal problems or diabetes, unexplained changes in height or weight, increased appetite, thirst or urinary output, heat or cold intolerance, goiter, pancreatitis, etc.

NOTE: This information may be counted in either the ROS or HPI, but not both.

(Digested from Physician Practice Coder, March 1998)

Action—Mark the documented elements and circle the level as described below entitled ROS (Review of Systems). If there is a conflict between the ROS and HPI or PFSH then do not count either conflicting statements. This is a greater risk with the advent of the EHR. For example, if the HPI states patient complains of fever for 2 days and the ROS states no fever, then do not count either item in either the HPI or ROS because they conflict. Mark **B-6** on Appendix A if there is a conflict between the ROS and HPI or PFSH.

Selecting the Type of ROS

- **No ROS**: Circle N/A.
- **Problem Pertinent ROS:** Circle Pertinent if at least 1 system related to the problem(s) identified in the HPI is documented.
- **Extended ROS:** Circle Extended if 2–9 systems related to the problem(s) identified in the HPI are documented.
- **Complete ROS:** Circle Complete if a minimum of 10 systems reviewed are documented. This can be documented as those with positive or pertinent negative responses. Our Carrier will not

accept the phrase "all other systems are negative" to meet a complete ROS each item must be documented separately.

2.4.2.4 Past Medical, Family and Social History (PFSH)

Definition—the PFSH consists of a review of items in the following areas:

- **Past Medical History:** A review of the patient's past experiences with illnesses, injuries and treatments (NOT OTHERWISE COUNTED IN THE ROS) that includes significant information about:
  a. Prior major illnesses/injuries
  b. Prior operations
  c. Prior hospitalizations
  d. Current medications
  e. Allergies
  f. Age appropriate immunization status
  g. Age appropriate feeding/dietary status
- **Family History:** A review of medical events in the patient's family that includes significant information about:
  a. Health status or cause of death of parents, siblings, children or other close blood relatives,
  b. Specific diseases related to problems identified in the CC, HPI and/or ROS
  c. Diseases of family members that may be hereditary or place the patient at risk.
- **Social History:** Age appropriate review of past and current activities, including:
  a. Marital status and/or living arrangements
  b. Current employment
  c. Occupational history
  d. Use of drugs, alcohol, and/or tobacco
  e. Level of education
  f. Sexual history
  g. Other relevant social factors

(From CPT 2007 Introduction to E/M Coding Section.)

No PFSH is required for categories of E/M services that require only an interval history (i.e., subsequent hospital care, certain nursing facility care, etc).

Action—Mark the appropriate history boxes based on documented past medical, family and social history in the row entitled Past Medical, Family and Social History (PFSH).

Selecting the Type of PFSH

- **No PFSH Required**: Mark through the row and do not consider this element in determining the level of History.
- **No PFSH Documented:** Circle N/A.
- **Pertinent PFSH:** Circle Pertinent if only 1 item from any of the 3 histories is documented.
- **Complete PFSH:** Circle Complete if:
  a. 2 PFSH areas for **established** office and subsequent nursing facility care, e.g., Past Medical History and Social History, are documented; the PFSH item is **Complete (Column 4).**
  b. All 3 PFSH areas (Past Medical, Family and Social) are required for **new** office; initial hospital care; consultations and comprehensive nursing facility assessments are documented.

If only 2 areas are documented for these types of services, circle Pertinent PFSH (Column 3). If all three areas are documented, circle Complete PFSH (Column 4).

Selecting the Level of History

- If a column has 3 circles, then circle the level of History at the bottom of that column.
- If no column has 3 circles, find the column with the circle farthest to the left and circle the level of History at the bottom of that column, e.g., if you have a Brief HPI (Column 2), Extended ROS (Column 3), and no PFSH (Column 2), the level of History is **Expanded Problem Focused (Column 2).**

Appendix C-1, Section 1

Column	1	2	3	4
HPI	Brief 1-2 chronic conditions OR 1-3 elements		Extended 3 or more chronic conditions OR 4 elements	
ROS	N/A	Pertinent (1 system)	Extended (2–9 systems)	Complete (10 systems)
PFSH	N/A	N/A	Pertinent (1)	Complete (2 Est or 3 New)
Level of History	**Problem Focused**	**Expanded Problem Focused**	**Detailed**	**Comprehensive**

2.4.2.5 Monitoring Guidance—Counting History Elements

1. The HPI, ROS and PFSH may be documented as separate elements of history, or they may be included in the description of the HPI. You can only count an element once, either in the HPI, ROS, or PFSH, not two or more places.
2. Information obtained from someone other than the patient (e.g., parent) may be counted as part of the history component(s) or as an element of MDM (data section, obtaining history from someone other than the patient). Note: If counted, proper documentation would require the name of the individual providing the information, their relationship to the patient, and the information discussed.
3. To count ROS and/or PFSH obtained during a previous encounter or as documented by ancillary staff (i.e., medical students, nursing staff) or the patient (from the patient history questionnaire form), the treating provider and/or Teaching Physician (if the treating provider is a Resident) must document his/her review and update of the previous information by either:
   a. Noting no change from previous ROS/PFSH and providing date of previous ROS/PFSH; or
   b. Noting changes from previous ROS/PFSH and providing date of previous ROS/PFSH.
4. The CC, ROS and PFSH may be completed by ancillary staff or by the patient. To count this documentation, the treating provider must document his/her review of the information (i.e., by initial or countersignature) and note any supplementing or confirming information. (See Section 2.4.2 Appendix C-1, Section 1)
5. The treating provider must document why he/she is unable to obtain any component of the history (CC, HPI, ROS and/or PFSH) from the patient or other source. In such a case, the highest level of that history component (HPI, ROS and/or PFSH) should be selected.
6. Allergy symptoms can either be counted under the ROS or past medical history, not both.

7. Medications can be counted under past medical history.

2.4.3 Instructions—Documentation of Examination (Appendix C-1, Section 2)

2.4.3.1 Elements of the Examination—1995 Guidelines

1. Body Areas (10)

Head, including the face	Neck
Chest, including breasts and axillae	Abdomen
Genitalia, groin, buttocks	Back, including spine
Right Upper Extremity	Left Upper Extremity
Right Lower Extremity	Left Lower Extremity

2. Organ Systems (12)

Eyes	Constitutional (Vitals/Appearance)
ENT and Mouth	Cardiovascular
Respiratory	Gastrointestinal
Genitourinary	Musculoskeletal
Skin	Neurologic
Psychiatric	Hematologic/Lymphatic/Immunologic

3. Examples of Acceptable Documentation for exam elements (1995)

   a. Constitutional: vital signs (3 required), such as blood pressure 110/80, respiration 16, and temperature 101°F, OR general appearance, such as: patient poorly groomed, appears poorly nourished.
   b. Eyes: PERRL (A), extraocular muscles intact, non-icteric or anicteric sclerae.
   c. ENT: Nares are clear, mucous membranes are moist.
   d. GI: Bowels sounds heard/positive; abdomen is soft, nontender.
   e. Cardiovascular: Trace of edema in extremities; RRR; No cyanosis or edema; no jugular venous distention.
   f. Musculoskeletal: No joint swelling, instability, pain; full ROM in both upper extremities.
   g. Neurological: sensation intact; reflexes 2+ in all extremities; alert, oriented x 3.
   h. Skin: No rashes, lesions, ulcers; scars from previous surgery present on abdomen.
   i. Psychiatric: Flat affect; extremely anxious, agitated, oriented x 3.

   Problem descriptors for exam are: Eyes Negative or Skin Unremarkable. In the absence of a description of the areas examined in those body areas/organ systems, the exam may only meet a limited rather than extended exam under the 1995 Guidelines as interpreted by our J-4 MAC.

   To meet a comprehensive level exam according to Trailblazer's 1995 DG guidelines as interpreted by our J-4 MAC, 8 or more organ systems/body areas means that a body area could substitute for the organ system requirement. However, if you are dealing with the breasts which is in the chest area and thyroid gland which is in the neck area as a **medically necessary** exam component, you can count the body area as long as you are not double dipping (i.e., counting both as a system in that body area and the body area itself). For example, the physician performed an exam of the Eyes, ENT, Constitutional, Cardiovascular, Respiratory, Musculoskeletal, Psychiatric and Thyroid – in this case, you would have 7 organ systems and one body area (Neck), which, if all components were **medically necessary**, this would meet a comprehensive level of exam.

4. Level of Examination (1995)

   - Do not count an exam element as both a body system and an organ system.
   - Mark the relevant body areas or organ systems documented.
   - Check and circle the appropriate level of exam.

Problem Focused	One body area or organ system documented.
Expanded Problem Focused	A limited examination of the affected body area or organ system and other symptomatic or related organ systems.
Detailed	An extended examination of the affected body area(s) and other symptomatic or related organ system(s).
Comprehensive	A general multi-system exam which includes findings in 8 or more organ systems/body areas; or complete exam of a single organ system.

(Excerpts from CPT 2011 and CMS E/M Documentation Guidelines, 1995)

2.4.3.2 Elements of the Examination—1997 Guidelines

1. Appendix E

- General Multi-System; OR
- Single Organ System (Selected ones are listed below)
    - Cardiovascular
    - ENT
    - Eye
    - Genitourinary (Male and Female)
    - Hematologic/Lymphatic/Immunologic
    - Musculoskeletal
    - Neurological
    - Psychiatric
    - Respiratory
    - Skin

The content and documentation requirements for each type and level of exam are described in detail in Appendices E. Organ systems and body areas are shown in the left column, while the content of the examination pertaining to that organ system/body area are identified by boxes in the right column.

Parenthetical examples (e.g.) are used to clarify and provide guidance regarding documentation.

Documentation for each element must satisfy any numeric requirements included in the description of the element (such as Measurement of any 3 of the following 7, requires documentation of 3 items to count 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.

(Excerpts from CMS E/M Documentation Guidelines, 1997)

2. Level of Examination (1997)

- Mark the elements documented.
- Count the marked elements, then check and circle the appropriate level of exam.

Problem Focused	1–5 bullets documented
Expanded Problem Focused	6 or more bullets documented
Detailed—Excludes Eye and Psychiatric Single Organ Exams:	12 bullets from 2 or more organ systems/body areas documented
Detailed—Eye and Psychiatric Only	9 bullets from 2 or more organ systems/body areas documented

Comprehensive - General Multi-System	18 bullets from 9 organ systems/body areas documented.
Comprehensive - Single Organ System	All elements in each bolded box and 1 element in each unbolded box documented.

2.4.3.3 Monitoring Guidance—1995 and 1997 Examinations

- Any abnormalities or relevant negative findings of the examination must be documented. A notation of **abnormal without elaboration** of **affected** body area(s) or organ system is **insufficient** and you cannot count that element of the examination.
- A brief statement or notation indicating negative or normal is **sufficient** to document **normal findings** related to **unaffected** body area(s) or asymptomatic organ system(s). Pertinent negative findings must be documented. For more information, see **Trailblazer's "INVESTIGATING THE EXAM."**
- **1995 Guidelines only**—the record should reflect documentation of 8 or more of the 12 organ systems or body areas for a comprehensive level general multi-system (GMS) examination. In distinguishing between an Expanded Problem Focused and Detailed Exam, look to the 1997 Examination guidelines for guidance. For 1995 Guidelines, it is not the number of body areas/organ systems documented, but the detail of the information for each body area/organ system examined and documented that determines whether it meets an Expanded Problem Focused or Detailed Exam.
- You **cannot** count an exam element as both a body area and organ system. For example:
  - "No jugular venous distention" can either be counted as the Neck (body area) or Cardiovascular (organ system), not both.
  - "Normal range of motion" in both upper extremities can either be counted as Right and Left Upper Extremities (2 body areas) or Musculoskeletal (1 organ system).
  - "Breasts" can be counted either as Chest (one body area) or Skin (organ system) depending on the exam.
  - "Hepatosplenomegaly" may be counted in the body area (abdomen) or organ system (GI).
- ROS elements cannot be counted in the examination nor can exam elements be counted in the History.
- The treating provider must document the entire examination, with the following exceptions:
  1) Ancillary staff, including medical students, may document vital signs.
  2) Teaching Physician Rules - the Teaching Physician may rely on Resident's documentation as long as the Teaching Physician has referred to the Resident's note AND personally documented his/her presence or participation in the key components.

2.4.3.4 Selecting the Level of Medical Decision Making

Definition—levels of E/M services recognize four types of MDM (straight-forward, low complexity, moderate complexity and high complexity). MDM 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 (Appendix C-1, Section 3; Parts A-1, Number of Diagnoses **OR** A-2, Management Options);
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed (Appendix C-1, Section 3; Part B); 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 (Appendix C-1, Section 3 Part C).

NOTE: In all cases, the information in the clinical record (history and physical) must clearly support diagnostic impressions. Diagnostic impressions listed but not supported elsewhere in the clinical record must be included in the problem list for coding purposes. For more information, see **Trailblazer's "WHAT'S YOUR DECISION?"**

2.4.3.5 Section 3; Number of Diagnoses or Management Options

1. A-1 - Number of Diagnoses (Option #1)
   - Count each new/established problem addressed by the provider where the diagnosis/treatment plan is evident with or without diagnostic confirmation assigning 1 point each.
   - Count each new/established problem for where the diagnosis/treatment plan is not evident (plausible differential diagnosis) assigning point values as indicated in A-1.
   - Add points together and place in TOTAL box at the bottom of A-1.

OR

2. A-2 - Management Options (Option #2)
   - Add points for all treatment and therapeutic options identified and place in TOTAL box at the bottom of A-2.
3. SELECT THE HIGHEST TOTAL FROM EITHER A-1 OR A-2 (DO NOT ADD THEM TOGETHER) and place in Table D, Final Result of Complexity for MDM, on the second page of Appendix C-1. Circle the appropriate number in the row for "Number of diagnosis and/or management options.

2.4.3.6 Section 3, Part B: Data Reviewed or Ordered

- Circle the number in each row for data reviewed or tests ordered and total the points.
- Provider must document independent visualization of an image, tracing or specimen in order to count. *Each* visualization and interpretation is allowed one point. **NOTE:** If the provider separately bills for the independent visualization (e.g., prepares a written report for an X-ray), do not count this for purposes of Data Reviewed as the provider is receiving separate reimbursement for this service.
- A letter sent to a requesting provider, as in a consultation, **DOES** constitute discussion of the case with another health care provider and can be so counted.
- In assigning points to ordering and/or reviewing old records, the record type and source must be noted.
- Add all point values in the last column and place in TOTAL box at the bottom of Part B.
- Bring this total down to Table D, Final Result of Complexity for MDM. Circle the appropriate number in the row for Amount and Complexity of data reviewed/ordered.

1. Section 3, Part C: Risk of Complications and/or Morbidity or Mortality

   This is based on the risks associated with the presenting problems(s), diagnostic procedures(s) and the possible management options.

   - Circle the type of each presenting problem.
   - Circle any diagnostic procedures ordered or performed, if applicable.

- Circle the management options documented in the record.
- *The highest level of risk in any one category* (presenting problem, diagnostic procedures and management options) *determines the overall risk.*
- Bring the level of risk identified to Table D, Final Result of Complexity for MDM. Circle the appropriate risk in the row for Risk.

2. Section 3, Part D: Final Results Table of Complexity for MDM Level
   - Make sure all information from Section 3's subsections A-1, A-2, B, and C have been identified in the Final Results Table, Part D.
   - If a column has 2 or 3 circles, the level of MDM is found at the bottom of that column.
   - If no column has 2 or more circles, find the column with the second circle from the left and the level of MDM is found at the bottom of that column.

2.4.3.7 Monitoring Guidance for MDM

- Symptoms of a problem with an established diagnosis should not be counted in addition to the problem itself. For example, congestion should not be counted as a problem in addition to an upper respiratory infection or seasonal allergies; knee pain should not be counted as a problem in addition to osteoarthritis of the knee.
- Assessments, clinical impressions, or diagnoses may be explicitly stated or implied in the documented decisions regarding management plans and/or further evaluation.
- A simple notation for review of tests, such as WBC elevated or chest x-ray unremarkable is acceptable documentation.
- Do not consider reporting the highest two codes of any code family when:
  - Fewer than three distinct medical conditions/complaints were evaluated and managed during the encounter; **AND**
  - No one problem evaluated and managed, without appropriate interventions, conferred at least a 50/50 likelihood of worsening, disability or death between the time of the current encounter and the next physician encounter. See Trailblazer's newsletter December 2009 regarding this advice.
- Do not consider reporting the highest code of any code family when:
  - Fewer than four distinct medical conditions/complaints were evaluated and managed during the encounter; **AND**
  - No one problem evaluated and managed, without appropriate intervention, conferred at least a 50/50 likelihood of worsening, disability or death between the time of that encounter and the next physician encounter. See Trailblazer's newsletter December 2009 regarding this advice.
- For more information regarding coding the highest code(s) in a family, see Trailblazer's Evaluation and Management Services Manual. Or see Medicare Claims Processing Manual, Section 30.6.1, revised September 2011.
- The MDM must demonstrate that during the encounter the physician **addressed the chief complaint.** For example, a practitioner obtains the history and performs an examination based upon a chief complaint of pain in the knees, followed by the MDM addressing the patient's hypertension. Though additional conditions and complaints that lead to physician work are frequently discovered via the process of obtaining the history and performing the

examination, it is important not to ignore the original reason for the encounter. Remember to address the chief complaint and document accordingly.

2.4.4 Instructions—Coding Tables (Appendix C-1)

2.4.4.1 Selecting the Code

Use the Coding Tables found on Appendix C-1 (at the bottom of the second page) to determine the level of E/M code based on documentation of the key components.

1. First determine the place of service (POS) and the status of the patient.
2. Circle the level of History as determined under Section 1 of Appendix C-1. An interval history does not require that a PFSH be documented.
3. Circle the level of Exam as determined under Section 2, Appendix C-1 1995 or 1997.
4. Circle the level of MDM as determined in Appendix C-1, Section 3.
5. If the audited service is New Outpatient Office, Inpatient Consult, New Domiciliary/Rest Home, Admit, Observation, Initial Nursing Facility Care or Emergency Medicine:
   a. If a column has three circles, select the appropriate code at the bottom of the column.
   b. If no column has three circles, select the appropriate code from the column with a circle farthest to the left.
6. If the audited service is Established Office, Established Domiciliary/Rest Home, Subsequent Inpatient, or Subsequent Nursing Facility Care:
   a. If a column has three circles, select the appropriate code at the bottom of the column.
   b. If MDM is the lowest level, select the appropriate code at the bottom of the MDM column.
   c. If History and Exam are in the same column and lower than MDM, select the appropriate code from the column corresponding to the History and Exam.

   NOTE: Established visits require two of the three elements for purposes of code level selection. MDM has to be included as one of the key elements for any E & M service when selecting a code level. You may omit the lower of the History and/or Exam, but you may not exclude MDM when selecting a code level.

2.4.4.2 Auditing E/M Time-Based Codes (Not Including Psychotherapy or Other non-E/M Time-Based Codes)

1. Critical Care—Physician's floor time for a specific patient can be included in total time for determining the level of service. Patient must have a critical condition as defined in CPT Manual and must be clearly documented in the medical record.
2. Teaching Physician Rules: Rely **ONLY** upon the Teaching Physician's documented time to determine the level of service. DO NOT COUNT Resident's time.
3. Time must be personally documented by the provider providing the service.
4. Time may be used as the sole factor in reporting the level of service when counseling and/or coordination of care represent more than 50% of the time spent with the patient. This must be documented by listing the total time of the encounter and the time involved in counseling and coordination of care. The nature of the counseling/coordination of care must also be documented in addition to the documentation of time.

2.5 OPHTHALMOLOGY & IN-OFFICE PROCEDURES AND DIAGNOSTIC SERVICES -APPENDIX C-2

2.5.1 Purpose

Use Appendix C-2 to audit Ophthalmology Services codes 92002, 92004, 92012 or 92014 including minor procedures and diagnostic services performed during the eye exam. Use Appendix C-1 for E/M services that may have been billed. Reference Trailblazer's LCD/LMRP for Medicare guidelines.

2.5.2 Instructions

1. The merged patient encounter information should be in the top left-hand corner of Appendix C-2.
2. Coding Outcomes Box
   a. **CPT Correct**: List the code(s) that should have been used in the Post-Audit CPT(s) box.
      - If the CPT code is incorrect, regardless of documentation/service (i.e., should have been coded an office visit rather than an ophthalmology code, then mark either **A-1** if it was downcoded (resulting in less revenue) or **A-2** if the CPT code was upcoded. (resulting in higher level of reimbursement) on the On-line Monitoring Submission Form. **NOTE:** An **A-1** Finding should only be reported if the physician, when informed that documentation could support a higher service, agrees with the finding.
      - If the E/M code is upcoded by one level due to inadequate documentation (excluding Teaching Physician documentation) mark **B-2**; if upcoded by two or more levels, then mark **B-3** on the On-line Monitoring Submission Form.
      - If no documentation exists at all to support the code, then mark **B-4** on the On-line Monitoring Submission Form.

   b. **Modifier Correct**: Mark whether or not the modifier is correct or if a modifier was improperly used or not used when it should be used. If the answer is No, mark **A-3** on the On-line Monitoring Submission Form, **ONLY** if the error results in upcoding (i.e., higher level of reimbursement than TTUHSC should have received if coded correctly). Mark **A-7** if modifier finding did not result in increased reimbursement.

   c. **ICD-9 Correct**: Mark whether or not the ICD-9 code(s) are correct. If the ICD-9 does not accurately describe the condition or is not coded to the highest level of specificity, mark **C-1** on the On-line Monitoring Submission Form. If the ICD-9 fails to support medical necessity for the service, mark **C-2** on the On-line Monitoring Submission Form.

   d. **DOS Correct**: Mark whether or not the Date of Service (DOS) billed is correct. If the answer is No, then mark **D-1** on the On-line Monitoring Submission Form.
3. Teaching Documentation Box
   a. **Resident**: If a Resident is involved, mark Yes on the On-line Monitoring Submission Form and check Yes on Appendix C-1. See Section 2.3 for more details regarding Teaching Physician requirements.

   b. **Minor Procedure/Diagnostic Scope**: Minor procedures, those that take less than 5 minutes to perform, and diagnostic scopes require the Teaching Physician's presence the entire time, from insertion to removal of the scope. Teaching Physician presence (required for the entire procedure) can be documented by the Resident or Teaching Physician. If the answer is No, then mark **B-1** on the On-line Monitoring Submission Form.

   c. **Teaching Physician Documentation (General Rule)**: The Teaching Physician must personally document his/her participation in the key or critical portion(s) of the service and management of the patient. The Resident's documentation may only be used to support the level of E/M service. If the Answer is No, then:
      1) Mark **B-1** on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation and it will not support any billable service, or

2) Mark **B-2 or B-3**, as appropriate on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation, but Teaching Physician documentation would support a lower level code, (i.e., Teaching Physician fails to tie into Resident's note, and therefore can only code based on Teaching Physician's documentation). Mark **B-3** if upcoded by two levels (i.e., code billed was admission, but due to lack of reference to Resident documentation, Teaching Physician's documentation can only be coded as CPT code 99499 or report a subsequent hospital care code that appropriately reflects physician work and medical necessity for the service). For more information, reference Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioner. Also reference MLN MM7405 "Clarification of E/M Payment Policy."

4. POS (Place of Service): Mark Yes if the POS is coded correctly; otherwise mark No. The CPT code must correspond with the correct place of service code. If the POS is incorrect, mark **D-7** on the On-line Monitoring Submission Form.

5. Post-Audit codes: After determining the appropriate codes, record the post-audit CPT(s), ICD-9(s) and Modifiers. Mark the On-line Monitoring Submission Form accordingly. See Appendix M for examples.

6. Signature: Mark either Yes or No whether the provider signed the documentation appropriately, including credentials. Mark **D-2** if the documentation was not signed appropriately; or mark **D-3** if it was signed by another provider.

7. Medicare Advance Beneficiary Notice (ABN): If the patient is a Medicare beneficiary and services may be subject to denial as not reasonable and necessary or exceed frequency limitations, then an ABN is required. Please refer to CMS FFS Revised Advance Beneficiary Notice of Noncoverage (ABN). If one was not obtained in accordance with CMS Policy check No, then mark **D-4** on the On-line Monitoring Submission Form. If it does not apply to this encounter, mark **N/A**.

8. Legibility: Indicate legibility of clinical documentation. Mark **D-6** on the On-line Monitoring Submission Form if you and two other people are unable to read the note.

9. Were bundled services separately billed? If bundled services were performed and billed but were not a billable event or service, mark **A-4** on the On-line Monitoring Submission Form.

10. EMR: Was the documentation inappropriately cloned? Mark No if the documentation is "cloned" appropriately. If the documentation is cloned inappropriately, mark Yes and mark **B-6** on the On-line Monitoring Submission Form. For example, BC Policy 7.2 states, "The provider may clone relevant portions of the patient previous note entered by the same provider or resident in that provider's department to the extent it represents the level of work performed by the provider during the current visit and is revised to reflect any changes in the information."

11. Conflicting Elements: Mark Yes if any element of the documentation conflicts with other parts of the documentation. If there are conflicting elements, do not count any conflicting elements. For example, chief complaint conflicts with review of systems: CC states the patient has an earache but ROS states no problems with the ears, mark **B-6** on the On-line Monitoring Submission Form if there are conflicting elements.

    Procedures that may be included as part of general ophthalmologic services and may not be reported separately nor billed are:

    - Laser interferometry
    - Potential acuity meter
    - Keratometry
    - Exophthalmometry
    - Transillumination
    - Corneal sensation

- Tear film adequacy
- Schirmer's test
- Slit lamp

12. Chief Complaint and History: If history is not documented, mark **B-5** on the On-line Monitoring Submission Form. History must represent the medical necessity of the visit and be medically reasonable. Terms such as "routine exam" or "doing well" are not acceptable. For more information regarding Trailblazer's definition of medical necessity, read **"A CASE FOR MEDICAL NECESSITY."**

13. General Medical Observation: If general medical observation is not documented, mark **B-5** on the On-line Monitoring Submission Form. Example such as alert and well, etc. is acceptable.

14. Exam: If CPT 92004 or 92014 was billed but all exam criteria are not documented, mark **B-2** on the On-line Monitoring Submission Form; documentation was insufficient for comprehensive level.

15. Diagnostic/Treatment Plan: If the response to Question #5 on Appendix C-2 is No, mark **A-2** on the On-line Monitoring Submission Form because, in such case, an E/M service should have been billed rather than an ophthalmology code.

    Initiation of diagnostic and treatment programs include:
    - Prescription of medication, lenses or other therapy.
    - Arranging for special ophthalmological, diagnostic or treatment services.
    - Request for consultation.
    - Orders for laboratory procedures.
    - Orders for radiological services as may be indicated.

    Orders such as "Return PRN" or "Return to clinic in 1 year" would not be an appropriate diagnostic and/or treatment program.

2.6 PREVENTIVE SERVICES/ANNUAL EXAMS/TEXAS WELL-CHILD VISITS

2.6.1 General Preventive Exams

Use Appendix C-1; mark N/A for CC and check the box for Annual/Preventive Exam. Mark N/A for HPI. Complete ROS and past medical, family and social history and complete Section 2 for physical exam. Section 3, Medical Decision Making, is not necessary to complete for preventive exams.

2.6.2 Medicare Initial Preventive Physician Exam (G0402-G0405) - Appendix D-1

Use Appendix D-1 for the IPPE as it contains the required elements of a Medicare IPPE. Use Appendix C-1 if a separately identifiable E/M service is also provided. Medicare requires that seven elements (components) be provided and documented in the medical record as part of the IPPE. For the 2011 list of required elements, refer to "Medicare Preventive Services Quick Reference Information."

2.6.2.1 Instructions

1. The merged patient encounter information should be in the top left-hand corner of Appendix D-1.

2. Coding Outcomes Box
    a. **CPT Correct**: List the code(s) that should have been used in the Post-Audit CPT(s) box.
        - If the CPT code is incorrect, regardless of documentation/service (i.e., should have been coded an office visit rather than a well visit code, then mark either **A-1** if it was downcoded (resulting in less revenue) or **A-2** if the CPT code was upcoded (resulting in higher level of reimbursement than would have been received if correctly coded) on the On-line Monitoring Submission Form.

NOTE: An **A-1** Finding should only be reported if the physician, when informed that documentation could support a higher service, agrees with the finding.

- If the E/M code is upcoded by one level due to inadequate documentation (excluding Teaching Physician documentation) mark **B-2**; if upcoded by two or more levels, then mark **B-3** on the On-line Monitoring Submission Form.
- If no documentation exists at all to support the code, mark **B-4** on the On-line Monitoring Submission Form.

b. **Modifier Correct**: Mark whether or not the modifier is correct or if a modifier was improperly used or not used when it should be used. If the answer is No, mark **A-3** on the On-line Monitoring Submission Form, **ONLY** if the error results in upcoding (i.e., higher level of reimbursement than TTUHSC should have received if coded correctly). Mark **A-7** if modifier finding did not result in increased reimbursement.

c. **ICD-9 Correct**: Mark whether or not the ICD-9 code(s) are correct. If the ICD-9 does not accurately describe the condition or is not coded to the highest level of specificity, mark **C-1** on the On-line Monitoring Submission Form. If the ICD-9 fails to support a well visit check-up, mark **C-2** on the On-line Monitoring Submission Form.

d. **DOS Correct**: Mark whether or not the Date of Service (DOS) billed is correct. If the answer is No, mark **D-1** on the On-line Monitoring Submission Form.

3. Teaching Documentation Box

a. **Resident**: If a Resident is involved, mark Yes on the On-line Monitoring Submission Form and on Appendix D-1. See Section 2.3 for more details regarding Teaching Physician requirements.

b. **Primary Care Exception (PCE)**: If services were provided in a PCE clinic, mark Yes and make sure the requirements were met. Review the calendar to verify the number of Residents being supervised and confirm that the supervising physician was not providing any other billable services while supervising the PCE Residents. Teaching physicians may include residents with less than 6 months in a GME approved residency program in the mix of four residents under the teaching physician's supervision. However, the teaching physician must be physically present for the critical and key portions of services furnished by the resident with less than 6 months in a GME approved residency program. If there were more than 4 Residents or the supervising physician was providing other billable services, mark **A-4** as those Resident's services cannot be billed. Reference Medicare's Claims Processing Manual, Chapter 12, Section 100.1.1 Subsection C for more information on PCE Clinics.

c. **Minor Procedure/Diagnostic Scope**: Minor procedures, those that take less than 5 minutes to perform, and diagnostic scopes require the Teaching Physician's presence the entire time, from insertion to removal of the scope. Teaching Physician's presence (required for the entire procedure) can be documented by the Resident or Teaching Physician. If the answer is No, mark **B-1** on the On-line Monitoring Submission Form.

d. **Teaching Physician Documentation (General Rule)**: The Teaching Physician must personally document his/her participation in the key or critical portion(s) of the service and management of the patient. The Resident's documentation may only be used to support the level of E/M service. If the Teaching Physician documentation does not meet the guidelines, answer No, and then:

1) Mark **B-1** on the On-line Monitoring Submission Form if there is insufficient Teaching Physician documentation and it will not support any billable service, or
2) Mark **B-2 or B-3**, as appropriate on the On-line Monitoring Submission Form if there is insufficient Teaching Physician documentation, but the Teaching Physician documentation would support a lower level code, (i.e., Teaching Physician fails to tie into Resident's note, and therefore can only code based on Teaching Physician's documentation). Mark **B-3** if upcoded by two levels. (i.e. If code billed was admission,

but due to lack of reference to Resident's documentation, Teaching Physician's documentation can only be coded as CPT 99499 or report a subsequent hospital care code that appropriately reflects physician work and medical necessity for the service). For more information, reference Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioner. Also reference MLN MM7405 "Clarification of E/M Payment Policy."

4. Post-Audit codes: After determining the appropriate codes, record the post-audit CPT(s), ICD-9(s) and Modifiers on Appendix D-1. Mark the On-line Monitoring Submission Form accordingly. See Appendix M for examples.

5. Signature: Mark either Yes or No whether the provider signed the documentation appropriately, including credentials. Mark **D-2** if the signature is not appropriate; or mark **D-3** if it was signed by another provider.

6. Medicare Advance Beneficiary Notice (ABN): If the patient is a Medicare beneficiary and services may be subject to denial as not reasonable and necessary or exceed frequency limitations, an ABN is required. Please refer to CMS FFS Revised Advance Beneficiary Notice of Noncoverage (ABN). If one was not obtained in accordance with CMS Policy check No and mark **D-4** on the On-line Monitoring Submission Form. If it does not apply to this encounter, mark NA.

7. Incident to: If the patient is a Medicare beneficiary, and services were provided by ancillary staff or a non-physician provider (NPP) "incident to" a physician's service, mark Yes. To qualify as Medicare "Incident To" the physician must be physically present during the first visit for the new condition and must be on site during subsequent visits. This will require a review of previous visits to verify Medicare's conditions were met. Please refer to CMS's Medicare "Incident To" requirements for further guidance, Medicare IOM, 100-02, Chapter 15, Section 60. If Medicare's requirements were not met, mark **A-4** on the On-line Monitoring Submission Form if services were provided by ancillary staff (e.g., nurse visit) or **D-3** if services were provided by a Medicare credentialed NPP. See Section 2.7 for more details of Medicare's requirements.

8. Legibility: Indicate legibility of clinical documentation. Mark **D-6** on the On-line Monitoring Submission Form if you and two other people are unable to read the note.

9. Were bundled services separately billed? If bundled services were performed and billed but were not a billable event or service, mark **A-4** on the On-line Monitoring Submission Form.

10. EMR: Was the documentation inappropriately cloned? Mark No if the documentation is "cloned" appropriately. If the documentation is cloned inappropriately, mark Yes and mark **B-6** on the On-line Monitoring Submission Form. For example, BC Policy 7.2 states, "The provider may clone relevant portions of the patient previous note entered by the same provider or resident in that provider's department to the extent it represents the level of work performed by the provider during the current visit and is revised to reflect any changes in the information."

11. Conflicting Elements: Mark Yes or No if any element of the documentation conflicts with other parts of the documentation. If there are conflicting elements, do not count them to determine the level of visit. For example, chief complaint conflicts with review of systems: CC states the patient has an earache but ROS states no problems with the ears, mark **B-6** on the On-line Monitoring Submission Form.

12. Is patient within Medicare's 12 month initial enrollment period? If No, see Appendix D-3 for the Annual Wellness Visit or see Appendix C-1 for an E/M service. Medicare states the IPPE must be performed within the 12 month period following the beneficiary's initial enrollment effective date.

13. If this visit warrants a separately identifiable E/M visit in addition to the IPPE visit, complete Appendix C-1 for the E/M service.

If all required elements of the IPPE components are not documented, mark **B-5.** If the Medicare beneficiary previously had an IPPE and the current service was billed as an IPPE (G0402), mark **A-4.** If the billed IPPE was provided more than 12 months after the patient's initial effective date of Medicare Part B coverage (Fee for Service), mark **A-4.**

A screening ECG is a benefit, but not required to be provided as part of the IPPE. If the beneficiary receives a screening ECG during the IPPE, then one of the following G-codes should also be included with the billing of IPPE, depending on the type of ECG service provided:

- G0403 – ECG with 12 leads; performed as a screening for the IPPE examination with interpretation and report;
- G0404 – ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the IPPE (use this code when the interpretation and report is performed by a different provider); or
- G0405 – ECT with 12 leads; interpretation and report only, performed as a screening for the IPPE (use this code when the tracing was performed by a different provider).

If the provider conducts a separately identifiable, medically necessary E/M service in addition to the IPPE, they should also complete Appendix C-1.

2.6.3 Medicare Female Pelvic/Breast/Pap (G0101): (Appendix C-1 and Appendix E-Genitourinary)

Complete Appendix C-1 (excluding the HPI and MDM) and Appendix E, Genitourinary – 1997 Guidelines for the exam component using only the Female Genitourinary (GU) component. Seven of the eleven elements must be documented to meet Medicare's requirement for a G0101. If documentation fails to meet Medicare's requirement for G0101, mark **B-5** on the On-line Monitoring Submission Form. If a pap smear is performed, code Q0091 in addition to G0101. Reference Medicare's Screening Pelvic Examinations.

2.6.4 Texas Health Steps (THSteps) Well Child Check-up (Medicaid) - Appendix D-2

Use Appendix D-2 to monitor and verify all required components of a THSteps medical checkup have been met. This contains information from the THSteps Medical Checkups Periodicity Schedule for Infants, Children and Adolescents and review Texas Health Steps Checkup Components for details of the Periodicity Schedule. Effective December 1, 2011, THSteps posted "Benefit Changes for Checkups" that affect the requirements for anemia screening, hemoglobin type, and hearing screening. Cervical screening is no longer required for service dates on or after June 1, 2011.

If the exam is an exception-to-periodicity visit, there must be an appropriate modifier to indicate the exception. See the Texas Medicaid Provider Procedures Manual, Children's Services Handbook, Section 5, "THSteps Medical", subsection 5.3.1.6 "Exception-to-Periodicity Checkups."

If the visit meets criteria to code E/M (99201-99205 or 99212-99215) in addition to the preventive service (99381-99397) and additional documentation supports that E/M, complete Appendix C-1 for that E/M code and complete Appendix D-2 for the THSteps visit code.

Reference THSteps Periodicity Schedule along with the following guidelines to complete Appendix D-2:

- To assure completion of comprehensive medical checkups and the quality of care provided, providers must document all components of the THSteps medical checkups as they are completed. Medicaid states that clinical charts are subject to quality review activities including random chart review, focused studies of well-child care and could be subject to recoupment unless there is documentation supporting why a component was not completed.

- THSteps Provider Representative, Claudia Bourland, dated July 25, 2011, states it is acceptable to document the date and results of a TB test in the medical record as long as the TB questionnaire form is available in the office for a reviewer to know what questions were asked.
- THSteps last revision was 12/1/2011. Check regularly for updates to the Periodicity Schedule.

2.6.4.1 Instructions

1. The merged patient encounter information should be in the top left-hand corner of Appendix D-2.
2. Coding Outcomes Box
   a. **CPT Correct**: List the code(s) that should have been used in the Post-Audit CPT(s) box.
      - If the CPT code is incorrect, regardless of documentation/service (i.e., should have been coded an office visit rather than a well-visit code, mark either **A-1** if it was downcoded (resulting in less revenue) or **A-2** if the CPT code was upcoded (resulting in higher level of reimbursement than would have been received if correctly coded) on the On-line Monitoring Submission Form.

        NOTE: An **A-1** Finding should only be reported if the physician, when informed that documentation could support a higher service, agrees with the finding.
      - If the E/M code is upcoded by one level due to inadequate documentation (excluding Teaching Physician documentation) mark **B-2**; if upcoded by two or more levels, then mark **B-3** on the On-line Monitoring Submission Form.
      - If no documentation exists at all to support the code, mark **B-4** on the On-line Monitoring Submission Form.

   b. **Modifier Correct**: Mark whether or not the modifier is correct or if a modifier was improperly used or not used when it should be used. If the answer is No, mark **A-3** on the On-line Monitoring Submission Form **ONLY** if the error results in upcoding (i.e., higher level of reimbursement than TTUHSC should have received if coded correctly). Mark **A-7** if modifier finding did not result in increased reimbursement.
   c. **ICD-9 Correct**: Mark whether or not the ICD-9 code(s) are correct. If the ICD-9 does not accurately describe the condition or is not coded to the highest level of specificity, mark **C-1** on the On-line Monitoring Submission Form. If the ICD-9 fails to support a well-child check-up, mark **C-2** on the On-line Monitoring Submission Form.
   d. **DOS Correct**: Mark whether or not the Date of Service (DOS) billed is correct. If the answer is No, mark **D-1** on the On-line Monitoring Submission Form.
3. Teaching Documentation Box
   a. **Resident**: If a Resident is involved, mark Yes on the On-line Monitoring Submission Form and mark Yes on Appendix D-2. See Section 2.3 for more details regarding Teaching Physician requirements.
   b. **Teaching Physician Documentation (General Rule)**: The Teaching Physician must personally document his/her participation in the key or critical portion(s) of the service and management of the patient. The Resident's documentation may only be used to support the level of E/M service. If the Teaching Physician's documentation is not appropriate, mark No, then:
      1) Mark **B-1** on the On-line Monitoring Submission Form if there is insufficient Teaching Physician documentation and it will not support any billable service, or
      2) Mark **B-2 or B-3**, as appropriate on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation, but Teaching Physician documentation would support a lower level code, (i.e., Teaching Physician fails to tie into Resident's note, and therefore can only code based on Teaching Physician's documentation). Mark

B-3 if upcoded by two levels (i.e., code billed was admission, but due to lack of reference to Resident documentation, Teaching Physician's documentation can only be coded).

4. Post-Audit codes: After determining the appropriate codes, record the post-audit CPT(s), ICD-9(s) and Modifiers. Mark the On-line Monitoring Submission Form accordingly. See Appendix M for examples.

5. Signature: Mark either Yes or No whether the provider signed the documentation appropriately, including credentials. Mark **D-2** if no signature; or mark **D-3** if it was signed by another provider.

6. Legibility: Indicate legibility of clinical documentation. Mark **D-6** on the On-line Monitoring Submission Form if you and two other people are unable to read the note.

7. Were bundled services separately billed? If bundled services were performed and billed but were not a billable event or service, mark **A-4** on the On-line Monitoring Submission Form.

8. EMR: Was the documentation inappropriately cloned? Mark No if the documentation is "cloned" appropriately. If the documentation is cloned inappropriately, mark Yes and mark **B-6** on the On-line Monitoring Submission Form. For example, BC Policy 7.2 states, "The provider may clone relevant portions of the patient previous note entered by the same provider or resident in that provider's department to the extent it represents the level of work performed by the provider during the current visit and is revised to reflect any changes in the information."

9. Conflicting Elements: Mark Yes or No if any element of the documentation conflicts with other parts of the documentation. If there are conflicting elements, do not count any conflicting elements. For example, chief complaint conflicts with review of systems: CC states the patient has an earache but ROS states no problems with the ears, mark **B-6** on the On-line Monitoring Submission Form.

10. Are the History and Physical examinations complete? If yes, continue with Appendix D-2. If No, you cannot bill THSteps Well Child Checkup.

11. Does visit include a separate identifiable E/M? If Yes and there is additional documentation, complete Appendix C-1.

To complete Appendix D-2, reference the Periodicity Schedule.

- **Comprehensive History** includes:
  - Chief Complaint (CC) – the major health problems or concerns, and its time course. CC also includes "No Complaints" if the patient comes in for a well-child visit or complaining of a runny nose. (Even if they are there for a well-child visit, they can still have some sort of complaint.)
  - History of present illness (HPI) – details about the complaints, enumerated in the CC. This could be "none" or maybe the patient has diabetes or depression or ADD or patient is taking Amoxicillin for Strep or etc.
  - Past Medical History (PMH) – including major illnesses, any previous surgery/operations, any current ongoing illness, e.g., diabetes.
  - Family Diseases – especially those relevant to the patient's chief complaint.
  - Childhood Diseases – this is especially important in pediatrics.
  - Social History (medicine) – including living arrangements, occupation, marital status, number of children, drug use (including tobacco, alcohol, and other recreational drug use), recent foreign travel, and exposure to environmental pathogens through recreational activities or pets.
  - Regular and Acute medications – including those prescribed by doctors, and others obtained over-the-counter or alternative medicine.
  - Allergies – to medications, food, latex, and other environmental factors.

- **Nutritional Screenings and Mental Health Screenings** must be reflected by documentation of either subjective or objective evaluation as indicated on the Periodicity Schedule. If it is objective, include documentation of an examination, detailed information involving testing such as lead screening. If it is subjective, documentation must indicate the item was addressed, reviewed, etc. to meet the criteria on Appendix D-2. If there is no documentation to indicate these screenings were discussed/addressed, mark **No** on Appendix D-2.
- If any component does not meet criteria, mark **B-5** on the On-line Monitoring Submission Form.
- The darker grayed out areas on Appendix D-2 indicate this area is not required for anyone in that age category. For example, Body Mass Index (BMI) does not apply to Newborn to 2 weeks of age.
- Age categories with the options Yes or No indicate this area is required for everyone in that age category. For example, a physical exam is required for age groups, newborn to 20 years of age.
- Categories with the options Yes, No or NA indicate this area is required for some ages but is not applicable (NA) for other ages in that category. For example, BMI measurements are not required if the patient is 2 months – 18 months of age, mark N/A. However, BMI measurements are required for some children in the 24 months – 30 months of age category. If there is No documentation for those ages where it is required, mark **B-5** on the On-line Monitoring Submission Form. See THSteps Medical Checkups Periodicity Schedule for more information.
- Also reference Texas Health Steps Checkup Components.

2.6.5 Medicare Annual Wellness Visit (G0438-G0439) Appendix D-3

Use Appendix D-3 for the AWV as it contains the required elements (components) of a Medicare AWV for patients who are no longer within 12 months of the effective date of his or her first Medicare Part B coverage period, and have not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. Use Appendix C-1 if a separately identifiable E/M service is also provided. For an initial AWV, G0438, Medicare requires nine elements (components) be provided and documented in the medical record. Subsequent AWV, G0439, requires seven elements (components) be provided and documented. For the 2011 list of required elements, refer to "Medicare Annual Wellness visit Quick Reference Information." For the Health Risk Assessment (HRA), reference CDC's Interim Guidance for Health Risk Assessments and their Modes of Provision for Medicare Beneficiaries. In summary, the CDC states an HRA is to address the following minimum information on every visit:

- Demographic data, including, but not limited to age, gender, race and ethnicity.
- Self assessment of health status, frailty, and physical functions.
- Psychosocial risks, including but not limited to, depression/life satisfaction, stress, anger, loneliness/social isolation, pain, and fatigue.
- Behavioral risks, including but not limited to, tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle safety (seat belt use), and home safety.
- Activities of daily living (ADLs), including but not limited to dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing.
- Instrumental activities of daily living (LADLs), including but not limited to, shopping, food preparation, using the telephone, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.

2.6.5.1 Instructions

1. The merged patient encounter information should be in the appropriate space at the top left-hand corner of Appendix D-3.
2. Coding Outcomes Box
   a. **CPT Correct**: Mark Yes or No if the CPT code is correct.
      - If the documentation/service should have been coded an office visit rather than a well visit, mark either **A-1** if it was downcoded (resulting in less revenue) or mark **A-2** if the CPT code was upcoded (resulting in a higher level of reimbursement than what should

have been received) on the on-line monitor submission form. If the E/M code was upcoded, see Category B, Documentation Errors, on the On-line Monitoring Submission Form.
NOTE: An **A-1** Finding should only be reported when the physician agrees with the finding that the service was downcoded.

- If the E/M code is upcoded by one level due to inadequate documentation, mark **B-2**; if upcoded by two or more levels, mark **B-3** on the on-line monitor submission form.
- If no documentation exists at all to support the code, mark **B-4** on the on-line monitor submission form.

b. **Modifier Correct**: Mark whether or not the modifier is correct; improperly used or was omitted. If the answer is No, mark **A-3** on the on-line monitor submission form, **ONLY** if the error results in upcoding (i.e., TTUHSC received higher level of reimbursement than what we should have received). Mark **A-7** if modifier finding did not result in increased reimbursement.

c. **ICD-9 Correct**: Mark whether or not the ICD-9 code(s) are correct. If the ICD-9 does not accurately describe the condition or is not coded to the highest level of specificity, mark **C-1** on the on-line monitor submission form. If the ICD-9 fails to support medical necessity for the service, mark **C-2** on the on-line monitor submission form.

d. **DOS Correct**: Mark whether or not the Date of Service (DOS) billed is correct. If the answer is No, mark **D-1** on the on-line monitor submission form.

3. Teaching Documentation Box

a. **Resident**: If a Resident is involved, mark Yes. See Section 2.3 for more details regarding Teaching Physician requirements.

b. **Primary Care Exception (PCE)**: If services were provided in a PCE, mark Yes and make sure the requirements were met. Review the calendar to verify the number of Residents being supervised and confirm that the supervising physician was not providing any other billable services while supervising the PCE Residents. Teaching physicians may include residents with less than 6 months in a GME approved residency program in the mix of four residents under the teaching physician's supervision. However, the teaching physician must be physically present for the critical and key portions of services furnished by the resident with less than 6 months in a GME approved residency program. If there were more than 4 Residents or the supervising physician was providing other billable services, mark **A-4** as those Resident's services cannot be billed. Reference Medicare's Claims Processing Manual, Chapter 12, Section 100.1.1 Subsection C for more information on PCE Clinics.

c. **Minor Procedure/Diagnostic Scope**: Minor procedures, those that take less than 5 minutes to perform, and diagnostic scopes require the TPs presence the entire time, from insertion to removal of the scope. TP presence (required for the entire procedure) can be documented by the Resident or Teaching Physician. If the answer is No, mark **B-1** on the On-line Monitoring Submission Form.

d. **Teaching Physician Documentation (General Rule)**: The TP must personally document his/her participation in the key or critical portion(s) of the service and management of the patient. The Resident's documentation may only be used to support the level of E/M service. If the Answer is No:

1) Mark **B-1** on the on-line monitor submission form if insufficient Teaching Physician documentation and it will not support any billable service, or
2) Mark **B-2 or B-3**, as appropriate on the on-line monitor submission form if the documentation has insufficient TP documentation, but the TP documentation would support a lower level code, (i.e., TP fails to tie into Resident's note, and therefore can only code based on TP's documentation). Mark **B-3** if upcoded by two levels (i.e., code billed was admission, but due to lack of reference to Resident documentation, TP's

documentation can only be coded as CPT code 99499 or report a subsequent code that appropriately reflects physician work and medical necessity for the service). For more information, reference Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioner. Also reference MLN MM7405 "Clarification of E/M Payment Policy."

4. Post-Audit codes: After determining the appropriate codes, record the post-audit CPT(s), ICD-9(s) and Modifiers. Mark the on-line monitor submission form accordingly. See Appendix M for examples.

5. Signature: Mark either Yes or No whether the provider signed the documentation appropriately, including credentials. Mark **D-2** if no signature; or mark **D-3** if it was signed by another provider.

6. Incident to: If the patient is a Medicare beneficiary, and services were provided by ancillary staff or a non-physician provider (NPP) "incident to" a physician's service, mark Yes. To qualify as Medicare's "Incident To" the physician must be physically present during the first visit for the new condition and must be on site during subsequent visits. This will require a review of previous visits to verify Medicare's conditions were met. Please refer to CMS's Medicare "Incident To" requirements for further guidance, Medicare IOM, 100-02, Chapter 15, Section 60. If Medicare's requirements were not met, mark **A-4** on the on-line monitor submission form if services were provided by ancillary staff (e.g., nurse visit) or **D-3** if services were provided by a Medicare credentialed NPP. See Section 2.7 for more details of Medicare's requirements.

7. Legibility: Indicate legibility of clinical documentation. Mark **D-6** on the On-line Monitoring Submission Form if you and two other people are unable to read the note.

8. EMR: Was the documentation inappropriately cloned? Mark No if the documentation is "cloned" appropriately. If the documentation is cloned inappropriately, mark Yes and mark **B-6** on the On-line Monitoring Submission Form. For example, BC Policy 7.2 states, "The provider may clone relevant portions of the patient previous note entered by the same provider or resident in that provider's department to the extent it represents the level of work performed by the provider during the current visit and is revised to reflect any changes in the information."

9. Conflicting Elements: Mark Yes or No if any element of the documentation conflicts with other parts of the documentation. If no, do not count any conflicting elements. For example, chief complaint conflicts with review of systems: CC states the patient has an earache but ROS states no problems with the ears, mark **B-6** on the on-line monitoring submission form.

10. Has more than 12 months passed since the IPPE visit or the last AWV? If No, see Appendix C-1 to determine if you can bill an E/M visit. Medicare states the IPPE must be performed within the 12 month period following the beneficiary's initial enrollment effective date. See Appendix D-1 for the IPPE monitoring tool if the beneficiary is still within the 12 month enrollment period. If it has not been 12 months since the last AWV, complete Appendix C-1 to see if you can code an E/M service.

11. Does this visit warrant an E/M visit in addition to the AWV? If Yes, complete Appendix C-1 for the E/M service.

Complete Appendix D-3 as indicated on the form. If the required elements of the AWV components are not documented, mark **B-5** on the On-line Monitoring Submission Form**.** If the Medicare beneficiary had an AWV or an IPPE visit within the past 12 months and the current visit was billed as G0438 or G0439, mark **A-4**, Service performed and billed but not a billable event or service, on the On-line Monitoring Submission Form**.** If the provider conducted a separately identifiable and medically necessary E/M service in addition to the AWV, use CPT codes 99201-99215 depending on the type and level of the encounter and modifier –25. Complete Appendix C-1 for the E/M service.

2.7 NON-PHYSICIAN PROVIDER ISSUES

2.7.1 Medicare "Incident To" Rules

If the patient is a Medicare beneficiary, and services were provided **"incident to"** a physician's service, those services need to meet Medicare's "incident to" requirements. These are:

- "Incident To" services are applicable only for office visits.
- The physician is on site (in the clinic) when "incident to" services are provided.
- "Incident To" services are provided as part of a continuing treatment plan for a condition for which the physician initially saw the patient.
- Physician participation should be at a proper frequency. Physician must have a face-to-face visit with the patient during the course of treatment (about every 3rd or 4th visit).

For CMS Information on "Incident To" services, refer to Trailblazer's Incident To Services published September 2011; and CMS Internet Only Manual 100-02, Chapter 15, Section 60.

CPT Code 99211 does not require physician documentation, but the medical record must reflect that an E/M service was provided by ancillary staff. For the evaluation component there must be documentation of a clinically relevant and necessary exchange of information (historical and/or physical data) between the provider and patient. For the management component the record must demonstrate influence by the service of the patient care (medical decision-making, provision of patient education, etc.) CPT 99211 provided by staff must meet Medicare's "Incident To" requirements, as outlined in Medicare Part B payment policy, Sections 60.1, 60.2, and 60.3, Chapter 15 in IOM 100-02.

Trailblazer Health Enterprises has provided additional details regarding the documentation of CPT 99211 services provided incident to the care of a physician. The documentation should include:

- The link between the non-physician service and the precedent (previous) physician service to which the non-physician service is incidental.
- The identity and credentials of both the individual who provided the service and the supervising physician.
- Evidence of the supervising physician's involvement with the patient care as demonstrated by one of the following:
  - Notation of the nature of involvement by the physician (the degree of which must be consistent with clinical circumstances of the care); OR
  - Documentation from other dates of service that establishes the link between the services of the two providers.

For more information, refer to Trailblazer "Incident to and Drug Administration" 10/1/2010. .

2.7.2 Shared/Split E/M Services

[Reference: IOM/00-04, Chapter 12, Section 30.6.1 - Selection of Level of E/M Service.]

Shared/Split services involve those situations where an NPP and Physician both provide services to the same patient on the same day and those documented services can be combined to bill a higher level of service. **Medicare Only:** Shared/Split services cannot be billed for new patient office visits.

Office/Clinic Setting: When an E/M service is a shared/split encounter between a physician and an NPP (NP, PA, CNS or CNM) in the office/clinic setting, the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient. If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the NPP's UPIN/PIN OR the physician's UPIN/PIN based on their own documentation, and payment will be made at the appropriate physician fee schedule payment.

Hospital Inpatient/Outpatient/Emergency Department Setting: When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN.

EXAMPLES OF SHARED VISITS

1. If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, either the physician or the NPP may bill for the service.
2. In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be billed using the NPP's UPIN/PIN using only the NP's documentation to bill for the service.
3. In the rare circumstance when a physician or NPP provides a service that does not reflect a CPT code description, the service must be reported as an unlisted service with CPT code 99499. A description of the service provided must accompany the claim. The carrier has the discretion to value the service when the service does not meet the full terms of a CPT code description (e.g., only a history is performed). The carrier also determines the payment based on the applicable percentage of the physician fee schedule depending on whether the claim is paid at the physician rate or the NPP rate. CPT modifier –52 (reduced services) must not be used with an E/M service. Medicare does not recognize modifier –52 for this purpose.

3.0 MONITORING OPERATIONS AND PROCEDURES

3.1 E/M AND/OR IN-OFFICE PROCEDURES AND DIAGNOSTIC SERVICES—APPENDIX C-1

3.1.1 Purpose

Use Appendix C-1 to audit minor procedures performed in or out of the office (i.e., removal of wart, simple suture of small wound, lumbar puncture, circumcision, etc.) and diagnostic services, including diagnostic endoscopies.

3.1.2 Definition of Minor Procedure

Medicare rules define minor procedures as those taking 5 minutes or less with minimal decision making required.

3.1.3 Teaching Physician Requirements

Minor Procedures —The Teaching Physician must be physically present for the entire procedure. The Teaching Physician's presence may be personally documented by the Resident, the Nurse, or the Teaching Physician. **Pre-printed statements are not acceptable in the paper medical record**. Macros are acceptable in the EMR.

Acceptable documentation (hand-written – paper; typed or macro in the EMR) by the Resident:

a. "Dr. [insert name of Teaching Physician] was present during the entire procedure".
b. "Dr. [insert name of Teaching Physician] observed me perform this procedure".

Diagnostic Endoscopic Procedures (Diagnostic): Documentation must reflect that the Teaching Physician was present during the entire procedure, including insertion, viewing, and removal of the scope. The Teaching Physician's Presence can be documented by the Resident, Nurse or Teaching Physician. Pre-printed statements are not acceptable.

Acceptable Documentation:

a. I was present during the entire procedure, including insertion, viewing and removal of the scope. (Personally documented or EMR macro by the Teaching Physician).
b. Dr. [insert name of Teaching Physician] was present during the viewing and insertion and removal of the scope. (Personally documented or EMR macro by the Resident).

3.2 OPERATIONS/PROCEDURES/OB DELIVERIES MONITORING TOOL—APPENDIX F

3.2.1 Purpose

Use Appendix F for each encounter involving operations and procedures, including, but not limited to, invasive radiologic procedures, OB deliveries and non-diagnostic endoscopies. This includes interventional radiologic and cardiologic services, cardiac catheterization, transesophageal echocardiography, etc. Do not use Appendix F for minor procedures (see Section 3.1).

3.2.2 Instructions

1. The merged patient encounter information should be in the appropriate space in the top left-hand corner of Appendix F.

2. Coding Outcomes Box

   a. **CPT Correct**: List the code(s) that should have been used in the Post-Audit CPT(s) box.

      - If the CPT code is incorrect, regardless of documentation/service (i.e., should have been coded an office visit rather than a surgical code, mark either **A-1** if it was downcoded (resulting in less revenue) or **A-2** if the CPT code was upcoded (resulting in higher level of reimbursement than would have been received if correctly coded) on the On-line Monitoring Submission Form.

NOTE: An **A-1** Finding should only be reported if the physician, when informed that documentation could support a higher service, agrees with the finding.

- If the E/M code is upcoded by one level due to inadequate documentation (excluding Teaching Physician documentation) mark **B-2**; if upcoded by two or more levels, mark **B-3** on the On-line Monitoring Submission Form.
- If no documentation exists at all to support the code, mark **B-4** on the On-line Monitoring Submission Form.

b. **Modifier Correct**: Mark whether or not the modifier is correct or if a modifier was improperly used or not used when it should be used. If the answer is No, mark **A-3** on the On-line Monitoring Submission Form, **ONLY** if the error results in upcoding (i.e., higher level of reimbursement than TTUHSC should have received if coded correctly). Mark **A-7** if modifier finding did not result in increased reimbursement.

c. **ICD-9 Correct**: Mark whether or not the ICD-9 code(s) are correct. If the ICD-9 does not accurately describe the condition or is not coded to the highest level of specificity, mark **C-1** on the On-line Monitoring Submission Form. If the ICD-9 fails to support medical necessity for the service, mark **C-2** on the On-line Monitoring Submission Form.

d. **DOS Correct**: Mark whether or not the Date of Service (DOS) billed is correct. If the answer is No, mark **D-1** on the On-line Monitoring Submission Form.

3. Teaching Documentation Box

a. **Resident**: If a Resident is involved, mark Yes on the On-line Monitoring Submission Form and Appendix C-1. See Section 2.3 for more details regarding Teaching Physician requirements. If the answer is No, you do not have to complete Questions 3-9 on Appendix F.

b. **Teaching Physician Documentation (General Rule)**: The Teaching Physician must personally document his/her participation in the key or critical portion(s) of the service and management of the patient. The Resident's documentation may only be used to support the level of E/M service. If the Answer is No, then:

1) Mark **B-1** on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation and it will not support any billable service, or
2) Mark **B-2 or B-3**, as appropriate on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation, but Teaching Physician documentation would support a lower level code, (i.e., Teaching Physician fails to tie into Resident's note, and therefore can only code based on Teaching Physician's documentation). Mark **B-3** if upcoded by two levels (i.e., code billed was admission, but due to lack of reference to Resident documentation, Teaching Physician's documentation can only be coded as CPT code 99499 or report a subsequent hospital care code that appropriately reflects physician work and medical necessity for the service). For more information, reference Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioner. Also reference MLN MM7405 "Clarification of E/M Payment Policy."

4. POS (Place of Service): Mark Yes if the POS is coded correctly; otherwise mark No. The CPT code must correspond with the correct place of service code. If the POS is incorrect, mark **D-7** on the On-line Monitoring Submission Form.

5. Post-Audit codes: After determining the appropriate codes, record the post-audit CPT(s), ICD-9(s) and Modifiers. Mark the On-line Monitoring Submission Form accordingly. See Appendix M for examples.

6. Signature: Mark either Yes or No whether the provider signed the documentation appropriately, including credentials. Mark **D-2** if no signature; or mark **D-3** if it was signed by another provider.

7. Medicare Advance Beneficiary Notice (ABN): If the patient is a Medicare beneficiary and services may be subject to denial as not reasonable and necessary or exceed frequency

limitations, then an ABN is required. Please refer to [CMS FFS Revised Advance Beneficiary Notice of Noncoverage (ABN)](). If one was not obtained in accordance with CMS Policy check No, mark **D-4** on the On-line Monitoring Submission Form. If it does not apply to this encounter, mark **N/A**.

8. Legibility: Indicate legibility of clinical documentation. Mark **D-6** on the On-line Monitoring Submission Form if you and two other people are unable to read the note.

9. Were bundled services separately billed? If bundled services were performed and billed but were not a billable event or service, mark **A-4** on the On-line Monitoring Submission Form.

10. EMR: Was the documentation inappropriately cloned? Mark No if the documentation is "cloned" appropriately. If the documentation is cloned inappropriately, mark Yes and mark **B-6** on the On-line Monitoring Submission Form. For example, BC Policy 7.2 states, "The provider may clone relevant portions of the patient previous note entered by the same provider or resident in that provider's department to the extent it represents the level of work performed by the provider during the current visit and is revised to reflect any changes in the information."

11. Conflicting Elements: Mark Yes or No if any element of the documentation conflicts with other parts of the documentation. If no, do not count any conflicting elements. For example, chief complaint conflicts with review of systems: CC states the patient has an earache but ROS states no problems with the ears, mark B-6 on the On-line Monitoring Submission Form.

Question 1: Note the type of service provided.
Questions 2 and 3: Indicate if a Resident was involved in the procedure. If No, STOP. If Yes, continue with Question 4.
Questions 4: Mark the appropriate box if Teaching Physician (TP) was present for the entire procedure; if TP was only present for key portions of one procedure, go to Question #13; if TP was present for two overlapping procedures, go to Question #14.
Question 5: If Teaching Physician was present during the key portions of one procedure was the Teaching Physician's presence documented? If answer is No, mark **B-1** on the On-line Monitoring Submission Form.
Question 6: If Teaching Physician was present during key portions of two overlapping procedures, did the Teaching Physician personally document his/her presence? If No, mark **B-1** on the On-line Monitoring Submission Form.
Question 7: Was another physician identified as immediately available during the other portions of the procedure? If No, mark **B-1** on the On-line Monitoring Submission Form.
Question 8: Did Teaching Physician document presence for at least one postoperative visit within the global period? If no, mark **A-3** on the On-line Monitoring Submission Form-3, Improper use of modifier.
Question 9: Answer Yes, No or NA if the encounter is an OB delivery. If the answer is No and the global was billed, then mark **A-6** on the On-line Monitoring Submission Form.

3.2.3 Teaching Physician Requirements—Operations, Surgeries, or Procedures

1. Documentation Must Reflect That:

   a. The Teaching Physician was present during all critical and key portions of a single procedure or two overlapping procedures and a teaching surgeon is immediately available at all other times.
      - Teaching Physician determines the key or critical portions.
      - Teaching Physician is not required to be present during opening or closing if that is not key /critical, as determined by the Teaching Physician.
      - Teaching Physician cannot become involved in a second overlapping procedure until the key portions of the first procedure are completed and another Teaching Surgeon is immediately available for the first procedure.

b. The Teaching Physician was immediately available (See #2 below) during the entire procedure, including opening and closing, if necessary.

c. The Teaching Physician personally performed or observed Resident perform the post-operative visit(s) considered by the Teaching Physician to be key/critical. At least one post-op visit must involve the Teaching Physician (this may occur in the hospital or clinic).

d. Unless a separate standard is required by the Billing Compliance Office, the Teaching Physician's presence may be documented by the Teaching Physician, Resident or Operating Room Nurse, unless the Teaching Physician is involved in two overlapping surgeries.

2. Immediately Available: This is defined by Medicare as being in the OR suite and able to immediately return to assist in the case. The Teaching Physician who is immediately available cannot be performing another procedure.

3. Teaching Physician is Present During Entire Procedure: The Teaching Physician, Resident or Operating Nurse may document the Teaching Physician's presence. Pre-printed statements (excluding EMR macros) are not acceptable. An example of acceptable hand-written (or EMR macro) documentation:

   "Dr. [insert name of Teaching Physician] was present during the entire procedure."

4. Teaching Physician is Present During the Key Portion(s) of a Single Procedure: The Teaching Physician shall document his/her presence during the key portion(s) and that he/she (or another qualified Teaching Physician) was immediately available at all other times during the procedure. Pre-printed statements (excluding EMR macros) are not acceptable. An example of acceptable hand-written (or EMR macro) documentation:

   "Dr. [insert name of Teaching Physician] was present during the key portions of this procedure (identify key portions) and Dr. [insert name of Teaching Physician] was immediately available at all other times."

5. Teaching Physician is Involved in Two Overlapping Surgeries: The Teaching Physician must personally document his/her presence during the key or critical portion(s) of each surgery, (which cannot occur at the same time) identifying who was immediately available at all other times. The individual who is immediately available cannot be a Resident.

   a. Cannot bill either procedure if the key or critical portions of the two separate cases occur at the same time or overlap.
   b. If key or critical portions don't overlap, the Teaching Physician must personally document his/her participation in the key portions of both operations, identifying who was immediately available at all other times for both procedures.

6. Three Concurrent Procedures: If three concurrent procedures are performed, none of the services can be billed.

7. OB Delivery:
   a. Vaginal—Documentation must reflect that the Teaching Physician was present during the delivery.
   b. Cesarean—Follow rules for documenting presence during operations.

4.0 MONITORING OTHER SERVICES

4.1 PSYCHIATRY (EXCLUDING E/M SERVICES) MONITORING TOOL —APPENDIX G

4.1.1 Purpose

Use Appendix G for each encounter involving psychotherapy services, excluding E/M services. Use Appendix C-1 to audit Psychiatry E/M services. For more information, reference Trailblazer's Psychiatry Services Manual, published October 2011.

Psychotherapy Services—General Issues:

- Time should be documented as time in and time out (e.g., 10:00–10:45).
- In addition to time, record must reflect total time as well as a general outline of services (i.e., psychotherapy) provided.
- If services involve a group, then documentation should identify all group members.
- Teaching Physician Rules: Teaching Physician must be present or personally view the service with the Resident through one-way mirror or current time video monitoring.

4.1.2 Instructions

1. The merged patient encounter information should be in the appropriate space in the top left-hand corner of Appendix G.
2. Coding Outcomes Box
    a. **CPT Correct**: List the code(s) that should have been used in the Post-Audit CPT(s) box.
    - If the CPT code is incorrect, regardless of documentation/service (i.e., should have been coded an office visit rather than a psychiatry code, then mark either **A-1** if it was downcoded (resulting in less revenue) or **A-2** if the CPT code was upcoded (resulting in higher level of reimbursement than would have been received if correctly coded) on the On-line Monitoring Submission Form.
    NOTE: An **A-1** Finding should only be reported if the physician, when informed that documentation could support a higher service, agrees with the finding.
    - If the E/M code is upcoded by one level due to inadequate documentation (excluding Teaching Physician documentation) mark **B-2**; if upcoded by two or more levels, then mark **B-3** on the On-line Monitoring Submission Form.
    - If no documentation exists at all to support the code, then mark **B-4** on the On-line Monitoring Submission Form.

    b. **Modifier Correct**: Mark whether or not the modifier is correct or if a modifier was improperly used or not used when it should be used. If the answer is No, mark **A-3** on the On-line Monitoring Submission Form, **ONLY** if the error results in upcoding (i.e., higher level of reimbursement than TTUHSC should have received if coded correctly). Mark **A-7** if modifier finding did not result in increased reimbursement.
    c. **ICD-9 Correct**: Mark whether or not the ICD-9 code(s) are correct. If the ICD-9 does not accurately describe the condition or is not coded to the highest level of specificity, mark **C-1** on the On-line Monitoring Submission Form. If the ICD-9 fails to support medical necessity for the service, mark **C-2** on the On-line Monitoring Submission Form.
    d. **DOS Correct**: Mark whether or not the Date of Service (DOS) billed is correct. If the answer is No, mark **D-1** on the On-line Monitoring Submission Form.
3. Teaching Documentation Box

a. **Resident**: If a Resident is involved, mark Yes on the On-line Monitoring Submission Form and Appendix C-1. See Section 2.3 for more details regarding Teaching Physician requirements.

b. **Teaching Physician Documentation (General Rule)**: The Teaching Physician must personally document his/her participation in the key or critical portion(s) of the service and management of the patient. The Resident's documentation may only be used to support the level of E/M service. If the Answer is No, then:

   1) Mark **B-1** on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation and it will not support any billable service, or
   2) Mark **B-2 or B-3**, as appropriate on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation, but Teaching Physician documentation would support a lower level code, (i.e., Teaching Physician fails to tie into Resident's note, and therefore can only code based on Teaching Physician's documentation). Mark **B-3** if upcoded by two levels (i.e., code billed was admission, but due to lack of reference to Resident documentation, Teaching Physician's documentation can only be coded as CPT code 99499 or report a subsequent hospital care code that appropriately reflects physician work and medical necessity for the service). For more information, reference Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioner. Also reference MLN MM7405 "Clarification of E/M Payment Policy."

4. Post-Audit codes: After determining the appropriate codes, record the post-audit CPT(s), ICD-9(s) and Modifiers. Mark the On-line Monitoring Submission Form accordingly. See Appendix M for examples.

5. Signature: Mark either Yes or No whether the provider signed the documentation appropriately, including credentials. Mark **D-2** if no signature; or mark **D-3** if it was signed by another provider.

6. Medicare Advance Beneficiary Notice (ABN): If the patient is a Medicare beneficiary and services may be subject to denial as not reasonable and necessary or exceed frequency limitations, then an ABN is required. Please refer to CMS FFS Revised Advance Beneficiary Notice of Noncoverage (ABN). If one was not obtained in accordance with CMS Policy check No, mark **D-4** on the On-line Monitoring Submission Form. If it does not apply to this encounter, mark N/A.

7. Legibility: Indicate legibility of clinical documentation. Mark **D-6** on the On-line Monitoring Submission Form if you and two other people are unable to read the note.

8. Were bundled services separately billed? If bundled services were performed and billed but were not a billable event or service, mark **A-4** on the On-line Monitoring Submission Form.

9. EMR: Was the documentation inappropriately cloned? Mark No if the documentation is "cloned" appropriately. If the documentation is cloned inappropriately, mark Yes and mark **B-6** on the On-line Monitoring Submission Form. For example, BC Policy 7.2 states, "The provider may clone relevant portions of the patient previous note entered by the same provider or resident in that provider's department to the extent it represents the level of work performed by the provider during the current visit and is revised to reflect any changes in the information.**"**

10. Conflicting Elements: Mark Yes or No if any element of the documentation conflicts with other parts of the documentation. If no, do not count any conflicting elements. For example, chief complaint conflicts with review of systems: CC states the patient has an earache but ROS states no problems with the ears, mark B-6 on the On-line Monitoring Submission Form.

Question 1: Does the practitioner meet the qualification, credentials, and licensure requirements' scope of practice as established by the payer and state? If the answer is No, mark **D5** on the On-line Monitoring Submission Form.

Question 2: Is the Medical Treatment Plan reviewed on a regular basis and revised as appropriate to address unforeseen complications or newly-diagnosed conditions? If the answer is No, mark **C-2** on the On-line Monitoring Submission Form.
Question 3: Does the diagnosis support the service? If No, mark **C-2** on the On-line Monitoring Submission Form.
Question 4: If group psychotherapy, is it medically necessary? If No, mark **C-2** on the On-line Monitoring Submission Form.

4.2 SCREENING/DIAGNOSTIC RADIOLOGY AND ANATOMICAL PATHOLOGY SERVICES MONITORING TOOL - APPENDIX H

4.2.1 Purpose

Use Appendix H to audit each encounter involving screening/diagnostic radiology services or anatomical pathology services, excluding E/M services (Appendix C-1) and invasive procedures (Appendix F).

4.2.2 Instructions

1. The merged patient encounter information should be in the appropriate space in the top left-hand corner of Appendix H.
2. Coding Outcomes Box
   a. **CPT Correct**: List the code(s) that should have been used in the Post-Audit CPT(s) box.
      - If the CPT code is incorrect, regardless of documentation/service (i.e., should have been coded an office visit rather than a radiology code, mark either **A-1** if it was downcoded (resulting in less revenue) or **A-2** if the CPT code was upcoded (resulting in higher level of reimbursement than would have been received if correctly coded) on the On-line Monitoring Submission Form.
        NOTE: An **A-1** Finding should only be reported if the physician, when informed that documentation could support a higher service, agrees with the finding.
      - If the E/M code is upcoded by one level due to inadequate documentation (excluding Teaching Physician documentation) mark **B-2**; if upcoded by two or more levels, mark **B-3** on the On-line Monitoring Submission Form.
      - If no documentation exists at all to support the code, mark **B-4** on the On-line Monitoring Submission Form.

   b. **Modifier Correct**: Mark whether or not the modifier is correct or if a modifier was improperly used or not used when it should have been used. If the answer is No, mark **A-3** on the On-line Monitoring Submission Form, **ONLY** if the error results in upcoding (i.e., higher level of reimbursement than TTUHSC should have received if coded correctly). Mark **A-7** if modifier finding did not result in increased reimbursement.
   c. **ICD-9 Correct**: Mark whether or not the ICD-9 code(s) are correct. If the ICD-9 does not accurately describe the condition or is not coded to the highest level of specificity, mark **C-1** on the On-line Monitoring Submission Form. If the ICD-9 fails to support medical necessity for the service, mark **C-2** on the On-line Monitoring Submission Form.
   d. **DOS Correct**: Mark whether or not the Date of Service (DOS) billed is correct. If the answer is No, mark **D-1** on the On-line Monitoring Submission Form.
3. Teaching Documentation Box
   a. **Resident**: If a Resident is involved, mark Yes on the On-line Monitoring Submission Form and Appendix C-1. See Section 2.3 for more details regarding Teaching Physician requirements.
   b. **Teaching Physician Documentation (General Rule)**: The Teaching Physician must personally document his/her participation in the key or critical portion(s) of the service and

management of the patient. The Resident's documentation may only be used to support the level of E/M service. If the Answer is No, then:

1) Mark **B-1** on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation and it will not support any billable service, or
2) Mark **B-2 or B-3**, as appropriate on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation, but Teaching Physician documentation would support a lower level code, (i.e., Teaching Physician fails to tie into Resident's note, and therefore can only code based on Teaching Physician's documentation). Mark **B-3** if upcoded by two levels (i.e., code billed was admission, but due to lack of reference to the Resident's documentation, Teaching Physician's documentation can only be coded as CPT code 99499 or report a subsequent hospital care code that appropriately reflects physician work and medical necessity for the service). For more information, reference Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioner. Also reference MLN MM7405 "Clarification of E/M Payment Policy."

4. Post-Audit codes: After determining the appropriate codes, record the post-audit CPT(s), ICD-9(s) and Modifiers. Mark the On-line Monitoring Submission Form accordingly. See Appendix M for examples.

5. Signature: Mark either Yes or No whether the provider signed the documentation appropriately, including credentials. Mark **D-2** if no signature; or mark **D-3** if it was signed by another provider.

6. Medicare Advance Beneficiary Notice (ABN): If the patient is a Medicare beneficiary and services may be subject to denial as not reasonable and necessary or exceed frequency limitations, then an ABN is required. Please refer to CMS FFS Revised Advance Beneficiary Notice of Noncoverage (ABN). If one was not obtained in accordance with CMS Policy check No, mark **D-4** on the On-line Monitoring Submission Form. If it does not apply to this encounter, mark **N/A**.

7. Legibility: Indicate legibility of clinical documentation. Mark **D-6** on the On-line Monitoring Submission Form if you and two other people are unable to read the note.

8. Were bundled services separately billed? If bundled services were performed and billed but were not a billable event or service, mark **A-4** on the On-line Monitoring Submission Form.

9. EMR: Was the documentation inappropriately cloned? Mark No if the documentation is "cloned" appropriately. If the documentation is cloned inappropriately, mark Yes and mark **B-6** on the On-line Monitoring Submission Form. For example, BC Policy 7.2 states, "The provider may clone relevant portions of the patient previous note entered by the same provider or resident in that provider's department to the extent it represents the level of work performed by the provider during the current visit and is revised to reflect any changes in the information."

10. Conflicting Elements: Mark Yes or No if any element of the documentation conflicts with other parts of the documentation. If no, do not count any conflicting elements. For example, chief complaint conflicts with review of systems: CC states the patient has an earache but ROS states no problems with the ears, mark **B-6** on the On-line Monitoring Submission Form.

Question 1: If there is no written report, mark B-4 on the On-line Monitoring Submission Form. STOP.

Questions 2-3: If there is a written report of the interpretation, did the Resident dictate the report? If the answer is Yes, does the documentation indicate the Teaching Physician personally interviewed the image/slide and did the Teaching Physician either agree with or edit the Resident's interpretation and findings? If No, mark B1 on the On-line Monitoring Submission Form.

4.2.3 Teaching Physician Rules – Radiology/Pathology

The Teaching Physician must independently review the image or slide. The Teaching Physician must personally document his/her review of the image or slide, and must document whether or not he/she agrees with or edits the Resident's interpretation and findings. The Resident cannot document the Teaching Physician's review of the image/slide.

4.3 ANESTHESIOLOGY SERVICES MONITORING TOOL—APPENDIX I

4.3.1 Purpose

Use Appendix I, to audit anesthesia services, including Monitored Anesthesia Care (MAC). Use the E/M monitoring worksheets, Appendix C-1, for pain management services. Reference Anesthesiology Billing – How to Ensure Proper Reimbursement and Avoid a RAC Audit by Orion HealthCorp. Also see Medicare's Claims Processing Manual, Chapter 12, Section 50, Payment for Anesthesiology Services.

4.3.2 Instructions

1. The merged patient encounter information should be in the appropriate space in the top left-hand corner of Appendix I.
2. Coding Outcomes Box
    a. **CPT Correct**: List the code(s) that should have been used in the Post-Audit CPT(s) box.
        - If the CPT code is incorrect, regardless of documentation/service, mark either **A-1** if it was downcoded (resulting in less revenue) or **A-2** if the CPT code was upcoded (resulting in higher level of reimbursement than would have been received if correctly coded) on the On-line Monitoring Submission Form.
        - If no documentation exists at all to support the code, mark **B-4** on the On-line Monitoring Submission Form.

    b. **Modifier Correct**: Mark whether or not the modifier is correct or if a modifier was improperly used or not used when it should be used. If the answer is No, mark **A-3** on the On-line Monitoring Submission Form, **ONLY** if the error results in upcoding (i.e., higher level of reimbursement than TTUHSC should have received if coded correctly). Mark **A-7** if modifier finding did not result in increased reimbursement.
    c. **ICD-9 Correct**: Mark whether or not the ICD-9 code(s) are correct. If the ICD-9 does not accurately describe the condition or is not coded to the highest level of specificity, mark **C-1** on the On-line Monitoring Submission Form. If the ICD-9 fails to support medical necessity for the service, mark **C-2** on the On-line Monitoring Submission Form.
    d. **DOS Correct**: Mark whether or not the Date of Service (DOS) billed is correct. If the answer is No, mark **D-1** on the On-line Monitoring Submission Form.
3. Teaching Documentation Box
    a. **Resident**: If a Resident is involved, mark Yes on the On-line Monitoring Submission Form and Appendix C-1.
    b. **Teaching Physician Documentation**: The Teaching Physician must personally document that he/she was present during all key or critical portion(s) of the service and document that he/she (or another teaching anesthesiologist) was immediately available at all other times. If the Answer is No, mark **B-1** on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation and it will not support any billable service. For more information, reference Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioner.
4. POS (Place of Service): Mark Yes if the POS is coded correctly; otherwise mark No. The CPT code must correspond with the correct place of service code. If the POS is incorrect, mark **D-7** on the On-line Monitoring Submission Form.

5. Post-Audit codes: After determining the appropriate codes, record the post-audit CPT(s), ICD-9(s) and Modifiers. Mark the On-line Monitoring Submission Form accordingly. See Appendix M for examples.

6. Signature: Mark either Yes or No whether the provider signed the documentation appropriately, including credentials. Mark **D-2** if signed inappropriately; or mark **D-3** if it was signed by another provider.

7. Medicare Advance Beneficiary Notice (ABN): If the patient is a Medicare beneficiary and services may be subject to denial as not reasonable and necessary or exceed frequency limitations, then an ABN is required. Please refer to CMS FFS Revised Advance Beneficiary Notice of Noncoverage (ABN). If one was not obtained in accordance with CMS Policy check No, mark **D-4** on the On-line Monitoring Submission Form. If it does not apply to this encounter, mark **N/A**.

8. Legibility: Indicate legibility of clinical documentation. Mark **D-6** on the On-line Monitoring Submission Form if you and two other people are unable to read the note.

9. Were bundled services separately billed? If bundled services were performed and billed but were not a billable event or service, mark **A-4** on the On-line Monitoring Submission Form.

Question 1: Indicate the type of anesthesiology service and indicate start and end times. Mark **B-5** on the On-line Monitoring Submission Form if start or end times are missing, or if the type of anesthesiology service cannot be determined from the documentation.
Question 2: If the answer is Yes, continue to #3; if No, then go to #4.
Question 3: If the answer to #2 is Yes, was relief documented with signature and time started? If No, mark **B-5** on the On-line Monitoring Submission Form.
Question 4: If the answer to #1 is Yes, were services billed under the provider with >50% of time on the case? If no, mark **D-3** on the On-line Monitoring Submission Form.
Question 5: Were units billed correctly based on time documented and appropriately rounded? If no, mark **A-2** if rounded more than documented time. If rounded less than documented time, mark **A-1**.

Mark which section is to be completed: MAC Procedures, or Anesthesia Services:

Section A – MD or Resident;
Section B – (Medical Direction); or
Section C – (CRNA Only)

MAC Procedures:

If any of questions 1-4 are “No”, mark B-5 on the On-line Monitoring Submission Form.

Anesthesia Procedures:

Section A

Question 1: Mark whether or not a resident was involved in the case
Question 2: If any response is No, Mark **B-5** on the On-line Monitoring Submission Form.
Question 3: If the response is “No”, mark **B-5** on the On-line Monitoring Submission Form.

Section B

Question 1: Indicate who was being medically directed during the time of this encounter, indicating the number of each as applicable.
Question 2: To answer this question, review other cases during that day. If more than 4 cases were medically directed at the time of the service, mark Yes, and mark **A-2** and **A-3** on the On-line Monitoring Submission Form.

Question 3: If there is no document to support any of the items listed from "a-g", mark **B-5** on the On-line Monitoring Submission Form.

Section C

Question 1: If any of the responses to "a-d" are No, mark **B-5** on the On-line Monitoring Submission Form.

4.4 ANESTHESIA LEVELS AND MODIFIERS

4.4.1 Personally Performed

A case is personally performed by a Physician when any of the following occur:

- Personally provided entire case (modifier –AA), or
- A single case with one Resident and the Teaching Physician's presence is documented during the key or critical portions (including induction and emergence) (modifier –AA plus –GC for Medicare only), or
- A single case with one student CRNA (modifier –AA), or
- A single case with one CRNA and the services of both are deemed medically necessary (Non-medically directed) (modifier –AA for the Physician and –QZ for the CRNA).

4.4.2 Medically Directed

A case is medically directed when:

- A single case with a CRNA or Resident and the Physician is performing medical direction (modifier –QY for the Physician and –QX for the CRNA), **or**
- Two to four concurrent cases conducted by CRNAs or two SRNAs or any combination of CRNAs and Residents in two to four concurrent cases (modifier –QK for the Physician and –QX for the CRNA).

A medically directing Physician can provide the following limited services while medically directing cases:

- an emergency of short duration in the immediate area,
- administering an epidural or caudal anesthetic to ease labor pain,
- periodic, rather than continuous, monitoring of an obstetrical patient;
- receive patients entering the operating suite for the next surgery;
- check or discharge patients in the recovery room; **or**
- handling scheduling matters without affecting fee schedule payment.

If there are more than four cases at any one time, then all services default to "medically supervised". See CMS IOM 100-4, Chapter 12, Section 50, Payment of Anesthesiology Services.

4.4.3 Medically Supervised

The anesthesiologist is involved in furnishing more than four procedures concurrently, or is performing other services (that are not allowed) while directing concurrent procedures (modifier –AD for the Physician and –QZ for the CRNA).

4.4.4 Monitored Anesthesia Care

Monitored Anesthesia Care is indicated with modifier –QS. Many payers, including Medicare, only pay for this under limited circumstances.

NOTE: For more information about which modifier to use, check Medicare's Claims Processing Manual, Section 50, Subsection K, Anesthesia Claim Modifiers. Also see Medicare's Claims Processing Manual, Section 140.3.3 Billing Modifiers for Certified Registered Nurse Anesthetist (CRNA) Services.

Also please refer to Trailblazer's Anesthesia Manual and Trailblazer's Local Coverage Determination (LCD) for Monitored Anesthesia Care (MAC).

4.5 MEDICAID GENETICS SERVICES MONITORING TOOL —APPENDIX J

4.5.1 Purpose

Use Appendix J to audit Medicaid Genetics Services codes 96040, 99402 or 99404. Use Appendix C-1 for E/M services that may have been billed as well.

4.5.2 Instructions

1. The merged patient encounter information should be in the appropriate space in the top left-hand corner of Appendix J.
2. Coding Outcomes Box
    a. **CPT Correct**: List the code(s) that should have been used in the Post-Audit CPT(s) box.
        - If the CPT code is incorrect, regardless of documentation/service (i.e., should have been coded an office visit rather than a genetic's code, mark either **A-1** if it was downcoded (resulting in less revenue) or **A-2** if the CPT code was upcoded (resulting in higher level of reimbursement than would have been received if correctly coded) on the On-line Monitoring Submission Form.
          NOTE: An **A-1** Finding should only be reported if the physician, when informed that documentation could support a higher service, agrees with the finding.
        - If the E/M code is upcoded by one level due to inadequate documentation (excluding Teaching Physician documentation) mark **B-2**; if upcoded by two or more levels, then mark **B-3** on the On-line Monitoring Submission Form.
        - If no documentation exists at all to support the code, mark **B-4** on the On-line Monitoring Submission Form.

    b. **Modifier Correct**: Mark whether or not the modifier is correct or if a modifier was improperly used or not used when it should have been used. If the answer is No, mark **A-3** on the On-line Monitoring Submission Form, **ONLY** if the error results in upcoding (i.e., higher level of reimbursement than TTUHSC should have received if coded correctly). Mark **A-7** if modifier finding did not result in increased reimbursement.
    c. **ICD-9 Correct**: Mark whether or not the ICD-9 code(s) are correct. If the ICD-9 does not accurately describe the condition or is not coded to the highest level of specificity, mark **C-1** on the On-line Monitoring Submission Form. If the ICD-9 fails to support medical necessity for the service, mark **C-2** on the On-line Monitoring Submission Form.
    d. **DOS Correct**: Mark whether or not the Date of Service (DOS) billed is correct. If the answer is No, mark **D-1** on the On-line Monitoring Submission Form.
3. Teaching Documentation Box
    a. **Resident**: If a Resident is involved, mark Yes on the On-line Monitoring Submission Form and Appendix J. See Section 2.3 for more details regarding Teaching Physician requirements.
    b. **Minor Procedure/Diagnostic Scope**: Minor procedures, those that take less than 5 minutes to perform, and diagnostic scopes require the Teaching Physician's presence the entire time, from insertion to removal of the scope. Teaching Physician presence (required for the entire procedure) can be documented by the Resident or Teaching Physician. If the answer is No, mark **B-1** on the On-line Monitoring Submission Form.
    c. **Teaching Physician Documentation (General Rule)**: The Teaching Physician must personally document his/her participation in the key or critical portion(s) of the service and management of the patient. The Resident's documentation may only be used to support the level of E/M service. If the Answer is No, then:

1) Mark **B-1** on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation and it will not support any billable service, or

2) Mark **B-2 or B-3**, as appropriate on the On-line Monitoring Submission Form if insufficient Teaching Physician documentation, but Teaching Physician documentation would support a lower level code, (i.e., Teaching Physician fails to tie into Resident's note, and therefore can only code based on Teaching Physician's documentation.) Mark **B-3** if upcoded by two levels. For more information, reference Medicare Claims Processing Manual, Chapter 12, Section 100, Teaching Physicians.

4. Post-Audit codes: After determining the appropriate codes, record the post-audit CPT(s), ICD-9(s) and Modifiers. Mark the On-line Monitoring Submission Form accordingly. See Appendix M for examples.

5. Signature: Mark either Yes or No whether the provider signed the documentation appropriately, including credentials. Mark **D-2** if no signature; or mark **D-3** if it was signed by another provider.

6. Legibility: Indicate legibility of clinical documentation. Mark **D-6** on the On-line Monitoring Submission Form if you and two other people are unable to read the note.

7. Time-Based Codes: If the CPT code (including E/M) is time-based, mark Yes after "Time-Based" and indicate whether or not time was documented by the Physician (not a Resident). In this case, If No, mark **B-5** on the On-line Monitoring Submission Form.

   a. Counseling/Coordination of Care: If the time-based code is due to counseling/coordination of care, then the following should be documented:
      - Total time;
      - Time spent face-to-face with the patient during counseling/coordination of care activities;
      - The general issues discussed with the patient.

      If any of these items are missing, then the services must be coded based on the documented history, exam and medical decision-making. If the code is not supported by the documentation, then mark either **B-2** (upcoded by one); or **B-3** (upcoded by two or more levels), whichever is applicable.

   b. Indicate either Yes or No if the time is documented in the documentation.

8. Were bundled services separately billed? If bundled services were performed and billed but were not a billable event or service, mark **A-4** on the On-line Monitoring Submission Form.

9. EMR: Was the documentation inappropriately cloned? Mark No if the documentation is "cloned" appropriately. If the documentation is cloned inappropriately, mark Yes and mark **B-6** on the On-line Monitoring Submission Form. For example, BC Policy 7.2 states, "The provider may clone relevant portions of the patient previous note entered by the same provider or resident in that provider's department to the extent it represents the level of work performed by the provider during the current visit and is revised to reflect any changes in the information."

10. Conflicting Elements: Mark Yes or No if any element of the documentation conflicts with other parts of the documentation. If no, do not count any conflicting elements. For example, chief complaint conflicts with review of systems: CC states the patient has an earache but ROS states no problems with the ears, mark **B-6** on the On-line Monitoring Submission Form.

Question 1: If any responses are No, mark **B-5** on the On-line Monitoring Submission Form.

See Reference 22.3.1.1 in Texas Medicaid Manual

5.0 AUDITING THE ICD-9 CODE

5.1 General Principles

1. Listed first should be the ICD-9-CM code for the diagnosis, condition, problem or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided. Additional codes that describe any coexisting conditions that affect patient care during the visit may be listed as well.
2. Diagnoses that are documented as probable, suspected, questionable, or rule-out should NOT be reported using the codes for the actual conditions. Code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit (i.e., an encounter with a patient who has an abnormal, chronic cough whom the physician suspects a lung cancer, would be coded for the cough unless and until a definitive diagnosis of a cancer is established and documented).
3. Chronic diseases treated on an ongoing basis will be coded and reported as many times as the patient receives treatment and care for the condition(s).
4. All documented conditions that co-exist at the time of the encounter/visit and require or affect patient care, treatment, or management should be coded. Conditions that were previously treated and that no longer exist should not be coded. However, history codes (V10-V19) may be used if the historical condition or family history has an impact on current care or influences treatment.
5. An ICD-9 screening code (V code) should be reported when a Physician orders an ancillary service such as an X-ray, EKG, ECG, mammography, etc., in the absence of illness, injury, symptoms, or active medical condition.
6. Codes must be reported to their highest specificity, e.g.:
   - 3-digit codes should be assigned only if there are no 4-digit codes within that code category;
   - 4-digit codes should be assigned only if there is no fifth digit sub-classification for that category;
   - The fifth digit sub-classification code should be assigned for those categories where it exists.
7. Where payer policies dictate specific diagnosis codes, those policies will be followed.
8. If two Physicians are treating the same patient on the same date of service for different conditions, each should report a different, appropriate diagnosis code as the primary reason for the encounter.
9. Medicare Screening Pelvic Exam and/Pap Smear —Must indicate either low risk or high risk ICD-9 code when billed. See IOM Manual 100-4, Chapter 18, Section 30.6 and 40.4
   a. Low Risk ICD-9: V73.1; V76.2; V76.47; or V76.49
   b. High Risk ICD-9: V15.89

5.2 ICD-9 Monitoring Process

1. Identify and transfer the ICD-9 codes from the charge document or the computer printout to the monitoring worksheet. If no codes are marked on the charge document or billed through the electronic billing system, return the record and the charge document to the Coder or Physician for completion.
2. Refer to the medical record and identify each (no more than four) diagnosis, condition, or other reason for the encounter as documented in the impression or the assessment.
3. Look up code in Volume II and cross reference in Volume I of ICD-9 to locate the correct, complete ICD-9 code(s) for the primary diagnosis and compare to the code listed on the charge document or from the electronic billing system.

a. If the ICD-9 code is incorrect, mark **C-1** on the On-line Monitoring Submission Form and record the appropriate code on the monitoring worksheet.
b. If the ICD-9 code is correct, is it reported to the highest level of specificity? (4th and 5th digits). If No, mark **C-1** on the On-line Monitoring Submission Form and record the appropriate ICD-9 code on the monitoring worksheet.
c. If the ICD-9 code requires an additional code to be reported (code first, use additional code, secondary malignant neoplasm) is it included? If No, mark **C-1** on the On-line Monitoring Submission Form and record the appropriate code on the monitoring worksheet.
d. Repeat for the second, third, and fourth ICD-9 codes listed.

4. If the encounter requires that an E-code(s) be included to report an external cause of injury or a poisoning, is the E-code reported? If not, (exclusive of carrier stipulations) mark **C-1** on the On-line Monitoring Submission Form and record the appropriate E-code(s).
5. Is each problem or diagnosis, that the provider is **actively managing** or that reasonably impacts the management of the patient's condition, reported? If not, mark **C-1** on the On-line Monitoring Submission Form and record the appropriate ICD-9 code on the monitoring worksheet. (A "laundry list" of problems should not be coded and reported unless the provider is truly managing each of the conditions reported.) It is not necessary to report ICD-9 code for symptoms in addition to the code(s) for a specific condition or diagnosis.
6. Each diagnosis should provide the appropriate medical necessity for the procedure, service or supply to which it is linked. Does a National Coverage Decision (NCD) or Local Medical Review Policy exist regarding each service provided for Medicare/Medicaid services? If so, does the diagnosis linked to each service fall within the list of covered conditions? If it does not, mark **C-2** on the On-line Monitoring Submission Form.

5.3 MEDICARE ADVANCE BENEFICIARY NOTICE (ABN) REQUIREMENTS

Services denied by the Medicare program as not medically necessary can be billed to the patient if the physician, provider or supplier had the patient sign a proper ABN prior to the service(s) being furnished. The ABN must be given to the beneficiary when Medicare is expected to deny payment (entirely or in part) for the item or service because it is not reasonable and necessary under Medicare program standards, or if the frequency of the service exceeds program limits. Otherwise, the service cannot be billed to the beneficiary.

The latest version of the ABN, release date 3/2011; the CMS-R-131 is the only acceptable ABN form. ABNs with release date of 3/2008 issued on or after November 1, 2011 will be considered invalid. CMS includes both the English and Spanish form and instructions in a single downloadable zip file.

Medicare has specific requirements for the written ABN, which must be followed for the ABN to be effective. The program requirements are summarized in Trailblazer's publication "Advance Beneficiary Notice of Non-Coverage (ABN)."

An ABN is NOT required for services statutorily excluded from Medicare. In other words, if Medicare NEVER pays for the service, an ABN does not have to be obtained prior to billing the beneficiary for it. For example, Medicare never pays for preventive (annual) examinations (except for annual pelvic examinations and the initial preventive service exam (IPPE). Therefore, no ABN is required in order to bill the patient for the annual preventive examinations. Examples of other statutorily excluded services are listed in the Trailblazer ABN publication cited above.

An ABN should be obtained for services that Medicare deems to be not reasonable and necessary as reflected in Medicare's NCD at the National level and Local Coverage Determinations (LCD) at the Contractor level.

See Medicare's NCDs for National Coverage Determination of CPT codes.

See Trailblazer's LCDs for more information on Local Coverage Determination.

In addition, an ABN should be obtained for covered screening services (i.e., PAP smears, mammographies) to ensure that frequency limitations have not been exceeded since the beneficiary may have already received those services from another provider.

If an item or service is provided that requires a written ABN and there is no written ABN in the file, mark **D-4** on the On-line Monitoring Submission Form.

If an item or service is provided that requires a written ABN, and there is no written ABN in the file AND the item/service was billed to Medicare or the beneficiary, mark **A-4** on the On-line Monitoring Submission Form.

Modifiers used with ABNs.

The modifier –GA must be used when providers or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they do have on file an ABN signed by the beneficiary. A copy of the ABN does not need to be included with the claim; however, a copy of the ABN must be made available to Medicare upon request.

The modifier –GY must be used when providers or suppliers want to indicate that the item or service is statutorily non-covered or is not a Medicare benefit.

The modifier –GZ must be used when providers or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an ABN signed by the beneficiary.

Do not use modifiers –GA and –GZ together. Medicare will reject the claim.

If an ABN is submitted for a service that is not reasonable and necessary according to Medicare standards (i.e., denial for secondary payer purposes) without the proper modifier, such as –GZ or –GY, mark **A-3**, on the On-line Monitoring Submission Form.

For more information about which modifier to use, check Trailblazer's Modifier Code Search.

6.0 OTHER MONITORING TIPS

6.1 CRITICAL CARE

Reference: IOM 100-04, Chapter 12, Section 30.6.12.

Make sure that all critical care time-based codes have time documented. Time-in and time-out is preferred, but is not required. Verify that only Teaching Physician time, not Resident time, was counted. The Teaching Physician must personally document his/her time spent. For more information on the CMS' 2008 updates to critical care services, refer to CMS MLN MM5993 and *Medicare Claims Processing Manual,* IOM Pub. 100-04, Chapter 12, Section 100.1.4. Also read pages 35-47 of Trailblazer's Evaluation and Management Services September 2011.

6.2 MODIFIER –25

Modifier –25 is required when a separately identifiable E/M service is provided on the same day as a procedure. An example would be: "Patient seen for sore throat and mole removed from neck." The clinical documentation must clearly distinguish between the office visit and the separately identifiable service/procedure. While two distinct notes are not required, per se, it is recommended that the clinical documentation clearly address the office visit from the separately identifiable visit or procedure. This can be accomplished by two separate documentation entries in the medical record. For example, if the patient is seen for an annual exam and the provider also addresses a problem during the visit, then you can bill the preventive service along with the appropriate level of E/M for the problem based visit provided the documentation clearly distinguishes the preventive services from the problem focused service.

For more information about which modifier to use, check Part B on Trailblazer's Modifier Code Search.

6.3 MODIFIER –59

Modifier –59 may be used to indicate that a procedure or service is distinct or independent from other services performed on the same day, e.g., separate site or separate session. It is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. It is NOT to be used for the purpose of circumventing CCI edits, resulting in unbundling. An example of appropriate use would be: surgeon performs a medial meniscectomy on the right knee and performs a lateral chondroplasty on the right knee. This would be reported as 29881, 29877-59. Note: for this example this would not apply to Medicare and other payers who will accept the G0289 code, created for the purpose of indicating a different compartment of the same knee.

For more information about which modifier to use, check Part B on Trailblazer's Modifier Code Search.

6.4 CONSULTATION REQUIREMENTS

Effective January 1, 2010, Medicare no longer reimburses codes 99241-99255. Telehealth inpatient consultations provided to a patient in the hospital or skilled nursing facility setting should be billed with the appropriate HCPCS code.

Follow CPT Guidelines for billing consultations. The intent of a consultation service is that a Physician or qualified NPP or other appropriate source is asking another Physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge. Consultations may be billed based on time if the counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the Physician or qualified NPP and the patient. The preceding requirements (request, evaluation or counseling/coordination and written report) shall also be met when the consultation is based on time for counseling/coordination.

6.4.1 Consultation Requirements

A consultation requires:

Consultation Request: A **request** (either from the requesting provider or as noted within the consultant's documentation) and **reason** for the consultation.

- A written request for a consultation from an appropriate source and the need for a consultation must be documented in the patient's medical record. **The initial request may be a verbal interaction between the requesting Physician and the Consulting Physician; however, the verbal conversation shall be documented in the patient's medical record, indicating a request for a consultation service was made by the requesting Physician or qualified NPP**.
- The reason for the consultation service shall be documented by the consultant (Physician or qualified NPP) in the patient's medical record and included in the requesting Physician or qualified NPP's plan of care. **The consultation service request may be written on a Physician order form by the requestor in a shared medical record.**

Render an Opinion: The Consulting Physician must render and document a sufficient service to meet the requirements of the code used. This may be contained in the medical record and/or written report to the Requesting Physician.

Written Report to the Requesting Physician: The report may or may not include the documentation necessary to support the level of consultation. You may need to reference written notes in the medical record in addition to the written report.

- A written report shall be furnished to the Requesting Physician or qualified NPP. In an emergency department or an inpatient or outpatient setting in which the medical record is shared between the Referring Physician or qualified NPP and the consultant, the request may be documented as part of a plan written in the Requesting Physician or qualified NPP's progress note, an order in the medical record, or a specific written request for the consultation. In these settings, the report may consist of an appropriate entry in the common medical record.
- In an office setting, the documentation requirement may be met by a specific written request for the consultation from the Requesting Physician or qualified NPP or if the consultant's records show a specific reference to the request. In this setting, the consultation report is a separate document communicated to the Requesting Physician or qualified NPP.
- **ACADEMIC EXCEPTION/SHARED MEDICAL RECORD:** In a large group practice, e.g., an academic department or a large multi-specialty group, in which there is often a shared medical record, it is acceptable to include the consultant's report in the medical record documentation and not require a separate letter from the Consulting Physician or qualified NPP to the Requesting Physician or qualified NPP. The written request and the consultation evaluation, findings and recommendations shall be available in the consultation report.

If any one of these items is missing, then the visit cannot be coded as a consultation and must be coded as either a new patient (99201-99205); established patient (99211-99215) or subsequent hospital visit (99231-99233).

6.4.2 Transfer of Care

A transfer of care occurs when a Physician or qualified NPP requests that another Physician or qualified NPP take over the responsibility for managing the patients' complete care for the condition and does not expect to continue treating or caring for the patient for that condition.

6.4.3 Initial Consultation Services

Initial Consultation Service

- In the nursing facility setting, the Consulting Physician or qualified NPP shall use the appropriate Initial Inpatient Consultation codes (99251-99255) for the initial consultation service.

- The Initial Inpatient Consultation may be reported only once per consultant per patient per facility admission. All subsequent visits during the hospital admission must be coded using subsequent hospital visit codes (99231-99233)

6.4.4 Consultation for Preoperative Clearance

Preoperative consultations are payable for new or established patients performed by any physician or qualified NPP at the request of a surgeon, as long as all of the requirements for performing and reporting the consultation codes are met and the service is medically necessary and not routine screening.

6.5 NEW PATIENT VS. ESTABLISHED PATIENT

6.5.1 New Patient

A New Patient is one who has not received any professional services (face to face) from the Physician or another Physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three (3) years.

If no E/M service is performed, the patient may be treated as a new patient. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of a face-to-face E/M service does not affect the designation of a new patient. Reference Trailblazer's Evaluation and Management Services manual under "Office/Outpatient Visits" page 20.

6.5.2 Established Patient

An established patient is one who has received professional (face-to-face) services from the physician or another physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three (3) years.

NOTE: Reference the Decision Tree for New vs Established Patients in the 2012 CPT Coding Book.

6.6 PREVENTIVE CARE, IMMUNIZATIONS, SCREENING PELVIC

1. Preventive Care codes (99381-99397) are age specific and include both new and established patients. Follow the rules for new vs. established patient to determine the patient's status.
2. If the patient is scheduled for an annual examination or other routine physical, then a preventive service should be coded
    a. Medicare patients—An ABN is not required to bill a beneficiary for routine preventive care services (excluding an annual pelvic exam or the Initial Preventive Physical Exam (IPPE) since this service is NEVER covered by Medicare.
    b. Medicare IPPE, effective January 1, 2005, updated effective January 1, 2009. See Section 2.6.2.
    c. Medicare AWV effective January 1, 2010. See Section 2.6.5.
    d. Only a significant abnormality or pre-existing condition addressed during the preventive exam, IPPE or AWV, which requires additional work to perform the key components of a problem-oriented E/M service should be coded with the appropriate E/M code (99201-99205; 99212-99215) with a modifier –25 along with the IPPE or AWV.
    e. An insignificant or trivial problem/abnormality encountered during the preventative exam should not be separately coded.
3. The comprehensive components of the preventive medicine services reflects an age and gender appropriate history/exam and is NOT synonymous with the comprehensive exam required in E/M codes 99201-99350. It is expected that the provider will conduct a comprehensive exam of various body areas/organ systems based on the patient's gender and age to determine the presence or absence of problems. **Note:** Some private payers have specific requirements for annual exams/preventive services.

4. Immunizations, diagnostic tests and other procedures performed in conjunction with the preventative service should be coded separately. Medicare may not cover certain screening tests for asymptomatic individuals (i.e., no signs or symptoms) beyond those covered under its policy.

5. Medicare covered Screening Pelvic Examination. Use the 1997 E/M Documentation Guidelines for the Single Organ Genitourinary Exam. At least seven bullets from the GU-Female body area/organ system must be documented.

   a. Use code G0101
      NOTE: Effective January 1, 1999 G0101 may be coded with an E/M visit if the E/M visit is separate from the G0101 service (i.e., problem-oriented visit other than GU).

   b. Pap smear, code Q0091, is separate from the G0101 even if performed on the same date.

E/M and/or In-Office Procedures and Diagnostic Services **(Reference: Trailblazer's E/M Guide)**

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):	**Coding Outcomes**	**Teaching Documentation**
		CPT(s) Correct? ❑ Y ❑ N	Resident? ❑ Y ❑ N
		Modifier Correct? ❑ Y ❑ N ❑ NA	PCE? ❑ Y ❑ N
		ICD-9(s) Correct? ❑ Y ❑ N	Minor Procedure? ❑ Y ❑ N
		DOS Correct? ❑ Y ❑ N	TP Doc OK? ❑ Y ❑ N ❑ NA
Post-Audit CPT(s) & ICD-9 & Modifiers:			POS: ❑ Yes ❑ No
Provider Signature? ❑ Y ❑ N	Medicare ABN? ❑ NA ❑ Error	"Incident To?" ❑ NA ❑ Error	Legible? ❑ Y ❑ N
Critical Care Service? ❑ Y ❑ N	Was the patient critical (as defined in CPT)? ❑ Y ❑ N		Time-Based? ❑ Y ❑ N
Were bundled services separately billed? ❑ Y ❑ N			Time Documented? ❑ Y ❑ N
EMR: Inappropriately Cloned Note? ❑Y ❑N	Conflicting Elements? ❑Y ❑ N	If consult, report sent to requesting physician? ❑ Y ❑ N ❑ NA	

PF = Problem Focused **EPF = Expanded Problem Focused** **D = Detailed** **C/Comp = Comprehensive**

1. HISTORY – Must Meet/Exceed All Components (CC; HPI; ROS; PFSH)				
CC (Chief Complaint) ❑ Y ❑ N ❑ N/A Annual/Preventive Exam ❑				
HPI (History of Present Illness): ❑ N/A ❑ 1 Chronic Condition ❑ 2 Chronic Conditions ❑ 3 Chronic Conditions **OR** ❑ Location ❑ Severity ❑ Timing ❑ Modifying Factors ❑ Quality ❑ Duration ❑ Context ❑ Associated Signs & Symptoms	**Brief 1-2 Chronic Conditions OR 1-3 Elements**		**Extended 3 Chronic Conditions OR 4+ Elements**	
ROS (Review of Systems): ❑ Constitutional ❑ ENT & Mouth ❑ Eyes ❑ Resp ❑ CV ❑ GI ❑ GU ❑ Musculo ❑ Skin ❑ Hem/Lymph/Imm ❑ Endo ❑ Allerg/Imm ❑ Neuro ❑ Psych	NA	**Pertinent (1 system)**	**Extended (2-9 systems)**	**Complete (10 systems)**
PFSH areas: Interval history does not require Past Medical, Family, and Social ❑ Past Medical History ❑ Family History ❑ Social History	NA	NA	**Pertinent (1)**	****Complete (2 Est or 3 New)**
***FINAL HISTORY- 3 COMPONENTS MET OR EXCEEDED (History, ROS, PFSH)**	**PF**	**EPF**	**D**	***COMP**

****Two** PFSH: Emergency room; and established patients – office and new home services.
****Three** PFSH: New patients–office, domiciliary, home care; consultations; initial hospital care, hospital observation, and, initial nursing facility care.

2. EXAMINATION – Use Either 1995 or 1997 Guidelines			
EXAM 1995 (Organ systems/Body areas)		**LEVEL**	**EXAM 1997 (Appendix E)**
Body areas: ❑ Head incl. Face ❑ Neck ❑ Chest incl. Breast & Axillae ❑ Abdomen ❑ Genitalia, Groin, Buttocks ❑ Back incl. Spine ❑ Each Extremity x_______ **Organ systems:** ❑ Constitutional ❑ ENT & Mouth ❑ Eyes ❑ Resp ❑ CV ❑ GI ❑ GU ❑ Musculo ❑ Skin ❑ Hem/Lymph/Immun ❑ Neuro ❑ Psych	1	**PF**	1-5 elements
	2-7	**EPF**	6-11 elements
	2-7 (more detailed)	**D**	12-17 elements in 2 more systems
	8 or more organ systems or body areas	**Comp GMS**	18 or more elements in 9 or more systems
	Not defined, but see 1997 for guidance	**Comp Single Organ**	Complete single system exam

3. MEDICAL DECISION MAKING (RECORD A-1 OR A-2 IN SECTION D ON PAGE 2)		**Pt**	**Total**
A-1 Number of Diagnosis			
Each new or established problem where the diagnosis and/or treatment plan is evident with or without diagnostic confirmation. __x		1	
Each new or established problem where the diagnosis and/or treatment plan is not evident:			
a. **2** plausible differential Dx, co-morbidities or complications (not separate problems) clearly stated and supported requiring Dx eval/confirmation		2	
b. **3** plausible differential Dx, co-morbidities or complications (not separate problems) clearly stated and supported requiring Dx eval/confirmation		3	
c. **4** plausible differential Dx, co-morbidities or complications (not separate problems) clearly stated and supported requiring Dx eval/confirmation		4	
		A-1 Subtotal	
A-2. Management Options			
DO NOT COUNT AS TREATMENT OPTIONS NOTATIONS SUCH AS: Continue "same" therapy or "no change" in therapy (including drug management) without further description (record does not document what the current therapy plan is nor that the physician reviewed it)		0	
Drug management, per problem. Continue "same" therapy or "no change" in therapy (record documents what the current therapy plan is and that the physician reviewed it). Dose changes for current meds not required, but record must reflect conscious decision making for no dose changes to count for coding purposes	a. ≤ 3 new/current medications per problem	1	
	b. > 3 new/current medications per problem	2	
Open or percutaneous therapeutic cardiac, surgical or radiological procedure – minor or major		1	
Physical, occupational or speech therapy or other manipulation		1	
Closed treatment for fracture or dislocation		1	
IV fluids or fluid component replacement; establish IV access when record clearly shows it involved physician decision making, not protocol		1	
Complex insulin prescription (SC or combo of SC/IV), hyper-alimentation, insulin drip or other complex IV admix prescription		2	
Conservative measures such as rest, ice, bandages, dietary		1	
Radiation therapy		1	
Joint, body cavity, soft tissue, etc. injection/aspiration __ x		1	
Patient educated on self or home care topics/techniques		1	
Decision to admit to hospital		1	
Discuss case with other physician		1	
Other-specify each one separately __ x		1	
		A-2 Subtotal	

Place the larger of the two totals A-1 or A-2 in Section D on Page 2 **TOTALS: A-1:____ OR A-2:____**

B. Data Reviewed or Ordered	Point Value	
Order and/or review **medically reasonable and necessary** clinical laboratory procedures. **Note:** Count lab panels as **one** procedure	1-3 procedures	1
	≥4 procedures	2
Order and /or review **medically reasonable and necessary** diagnostic imaging studies in Radiology section of CPT.	1-3 procedures	1
	≥4 procedures	2
Order and/or review **medically reasonable and necessary** diagnostic procedures in medical section of CPT.	1-3 procedures	1
	≥4 procedures	2
Discuss test results with performing physician.		1
Discuss case with other physician(s) involved in patient's care or consult another physician (i.e., true consultation meaning seeking opinion or advice of another physician regarding the patient's care). **This does not include referring patient to another physician for future care.**		1
Order and/or review old records. Record type and source must be noted. Review of old records must be reasonable and necessary based on the nature of the patient's condition. Practice or facility protocol-driven record ordering is not to be considered when coding E/M services. Perfunctory notation of old record ordering/review solely for coding purposes is inappropriate and counting such is not permitted.	Order/review w/o summary	1
	Order/review and summarize	2
Independent visualization and interpretation of an image, EKG or laboratory specimen **not** reported for separate payment. **Note:** Each visualization and interpretation is allowed one point	#____ X 1	
Review of significant physiologic monitoring or testing data not reported for separate payment (e.g., prolonged or serial cardiac monitoring data not qualifying for payments as rhythm electrocardiograms).		1
	TOTAL PTS	

C. Risk of Complications and/or Morbidity or Mortality

Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• 1 self-limited or minor problem (cold, insect bite, tinea corporis)	• Lab test requiring venipuncture • Chest X-rays, Urinalysis, OKH prep • EKG/EEG, Ultrasound (EKG)	• Rest • Gargle • Elastic or Superficial dressings
Low	• 2 or more self-limited or minor problems • 1 stable chronic illness (well-controlled hypertension or non-insulin dependent diabetes, cataract, BPH) • Acute uncomplicated illness or injury (cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress • Non-CV imaging studies with contrast • Superficial needle biopsies • Clinical lab tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risks • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• 1 or more chronic illnesses w/mild exacerbation • 2 or more stable chronic illnesses • Undiagnosed new problem w/uncertain prognosis (lump in breast) • Acute illness w/systemic symptoms (pyelonephritis, pneumonitis, colitis) • Acute complicated injury (head injury with brief loss of consciousness)	• Physiologic tests under stress, etc. • Diagnostic endoscopies w/no identified risk factors • Deep needle or incisional biopsy • CV imaging w/contrast, no identified risks • Obtain fluid from body cavity (lumbar procedure, thoracentesis, culdocentesis)	• Minor surgery w/identified risk factors • Elective major surgery with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture
High	• 1 or more chronic illnesses w/severe exacerbation • Acute or chronic illnesses or injuries - threat to life or bodily function (acute MI, psych w/potential threat) • An abrupt change in neurologic status (seizure, TIA, weakness or sensory loss)	• CV imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies w/identified risk factors • Discography	• Elective major surgery w/identified risks • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy w/intensive monitoring • Decision not to resuscitate or to de-escalate care because of poor prognosis

D. Final Result of Complexity for Medical Decision Making Level (requires 2 of 3 met or exceeded)

A. Number of diagnoses and/or management options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B. Amount and complexity of data reviewed/ordered	≤ 1 None/Minimal	2 Limited	3 Multiple	≥ 4 Extensive
C. Risk	Minimal	Low	Moderate	High
Type of medical decision-making	**Straightforward (SF)**	**Low Complexity (L)**	**Mod Complexity (M)**	**High Complexity (H)**

CODING TABLES (Times)

NEW OFFICE; OUTPATIENT CONSULT; INPATIENT CONSULT; DOMICILIARY (3 of 3)					
History	PF	EPF	D	C	C
Exam	PF	EPF	D	C	C
MDM	SF	SF (*L)	L (**M)	M	H
New Office Outpt Consult Inpt Consult Domiciliary	99201 (10) 99241 (15) 99251 (20) 99324 (20)	99202 (20) 99242 (30) 99252 (40) 99325(30)*	99203 (30) 99243 (40) 99253 (55) 99326(45)**	99204 (45) 99244 (60) 99254 (80) 99327 (60)	99205 (60) 99245 (80) 99255 (110) 99328(75)

INITIAL ADMIT INPATIENT/OBSERVATION (3 of 3)			
History	D/C	C	C
Exam	D/C	C	C
MDM	SF/L	M	H
Intl Hosp Observation OBS–Admit/Dischg	99221 (30) 99218 99234	99222 (50) 99219 99235	99223 (70) 99220 99236

EMERGENCY MEDICINE (3 of 3)					
History	PF	EPF	EPF	D	C
Exam	PF	EPF	EPF	D	C
MDM	SF	L	M	M	H
	99281	99282	99283	99284	99285

EST. DOMICILIARY (2 of 3) *MDM Required				
History	PF interval	EPF interval	D interval	C interval
Exam	PF	EPF	D	C
MDM	SF	LC	MC	MC/HC
	99334 (15)	99335 (25)	99336 (40)	99337 (60)

ESTABLISH OFFICE (2 OF 3) *MDM Required					
History	Staff	PF	EPF	D	C
Exam	Staff	PF	EPF	D	C
MDM	Staff	SF	L	M	H
(Time)	99211 (5)	99212 (10)	99213 (15)	99214 (25)	99215 (40)

SUBSEQUENT INPT/OBS (2 OF 3) *MDM Required			
History	PF interval	EPF interval	D interval
Exam	PF	EPF	D
MDM	SF/L	M	H
	99231/99224 (15)	99232/99225 (25)	99233/99226 (35)

INITIAL NURSING FACILITY CARE (3 of 3)			
History	D/C	C	C
Exam	D/C	C	C
MDM	SF or L	M	H
	99304 (25)	99305 (35)	99306 (45)

SUBSEQUENT NURSING FACILITY CARE (2 OF 3)				
History	PF interval	EPF interval	D interval	C interval
Exam	PF	EPF	D	C
MDM	SF	L	M	HC
	99307 (10)	99308 (15)	99309 (25)	99310 (35)

Ophthalmology Services Monitoring Tool (92002 – 92014)

Provider: *DOS:* *Patient:* *CPT(s):*	*Monitoring #* *POS:* *MRN:* *ICD-9(s):*	**Coding Outcomes** CPT(s) Correct? ❑ Y ❑ N Modifier Correct? ❑ Y ❑ N ❑ NA ICD-9(s) Correct? ❑ Y ❑ N DOS Correct? ❑ Y ❑ N	**Teaching Documentation** Resident? ❑ Y ❑ N Minor Procedure? ❑ Y ❑ N TP Doc OK? ❑ Y ❑ N ❑ NA
Post-Audit CPT(s) & ICD-9 & Modifiers:			POS? ❑ Yes ❑ No
Provider Signature? ❑ Y ❑ N		Incident To ❑ NA ❑ Error	Legible? ❑ Y ❑ N
Were bundled services separately billed? ❑ Y ❑ N			
EMR: Inappropriately Cloned Note? ❑Y ❑N Conflicting Elements? ❑Y ❑ N			

Use Appendix C-1 for E/M services that may have been billed.

1.	Chief Complaint	❑ Yes ❑ No
2.	History	❑ Yes ❑ No
3.	General Medical Observation	❑ Yes ❑ No

4. Eye Examination	
All criteria are required to bill comprehensive services (92004 and 92014).	
❑ Yes ❑ No	Test visual acuity (excluding determining refractive error)
❑ Yes ❑ No	Intraocular pressure Check box even if it is noted that it has been deferred due to trauma, infection or poor concentration
❑ Yes ❑ No	Gross visual fields
❑ Yes ❑ No	EOMs (Motility, Alignment)
❑ Yes ❑ No	Pupil and iris
❑ Yes ❑ No	Ocular adnexa
❑ Yes ❑ No	Conjunctiva (Bulbar, Palpebral)
❑ Yes ❑ No	Cornea (slit lamp)
❑ Yes ❑ No	Anterior chamber (slit lamp)
❑ Yes ❑ No	Lens
❑ Yes ❑ No	Optic nerve discs
❑ Yes ❑ No	Retina and vessels
❑ Yes ❑ No	Fundus exam through dilated pupil (Check box if documented including if medically contraindicated.)
	If any box is "No", mark intermediate exam 92002 or 92012.

5.	Is initiation of diagnostic or treatment plan documented?	❑ Yes ❑ No

Monitor's Signature: ______________________________ Date: ________________

Notes:

MEDICARE INITIAL PREVENTIVE PHYSICAL EXAM MONITORING TOOL (G0402 – G0405)

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):	**Coding Outcomes** CPT(s) Correct? ❑Y ❑N Modifier Correct? ❑Y ❑N ❑NA ICD-9(s) Correct? ❑Y ❑N DOS Correct? ❑Y ❑N	**Teaching Documentation** Resident? ❑Y ❑N PCE? ❑Y ❑N Minor Procedure? ❑Y ❑N TP Doc OK? ❑Y ❑N ❑NA
Post-Audit CPT(s) & ICD-9 & Modifiers:			
Provider Signature ❑Y ❑N		Incident To ❑ NA ❑ Error	Legible ❑Yes ❑No
EMR: Inappropriately Cloned Note ❑ Yes ❑ No	Conflicting Elements ❑ Yes ❑ No		
Is patient within Medicare's 12 month initial enrollment period? ❑Yes ❑No If No, see Appendix D-3 for AWV service.			
Does this visit warrant a separately identifiable E/M visit in addition to the IPPE visit? ❑Yes ❑No If yes, complete Appendix C-1 for E/M service.			

Components of IPPE	Elements
1. Medical and Social History	❑ Past Medical/Surgical history (experience with illnesses, hospital stays, operations, allergies, injuries and treatments ❑ Current medications and supplements (including calcium and vitamins) ❑ Family history (review of medical events in the family, including diseases that may be hereditary or place the individual at risk ❑ History of alcohol, tobacco or illicit drug use ❑ Diet ❑ Physical activities
2. History of Patient's Potential (Risk Factors) for Depression and Other Mood Disorders	Use any appropriate screening instrument recognized by national professional medical organizations to obtain current or past experiences with depression or other mood disorders
3. History of Patient's Functional Ability and Level of Safety	Use any appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas: ❑ Hearing impairment ❑ Activities of daily living ❑ Fall risk ❑ Home safety
4. Physical Examination	❑ Height ❑ Weight ❑ Blood pressure ❑ Visual acuity screen (Snellen Chart) ❑ Measurement of body mass ❑ Other factors deemed appropriate based on the patient's medical and social history and current clinical standards
5. End-of-Life Planning	❑ The beneficiary's ability to prepare an advance directive in the case that an injury or illness causes the beneficiary to be unable to make health care decisions, and ❑ Whether or not the physician is willing to follow the beneficiary's wishes as expressed in the advance directive. NOTE: Document if patient's response was verbal or written. If patient becomes upset or refuses to discuss the subject, document that information. It is recommended to document any decisions made at the time of visit, during the patient encounter. It is also recommended to include an acknowledgment that the beneficiary is able to prepare an advance directive (a written judgment) and whether or not the physician is willing to follow the patient's requests/wishes.
6. Education, Counseling, and Referral Based on the Previous Five Components	❑ Education, counseling, and referral. Examples include counseling on diet if the individual is overweight, Education on prevention of chronic diseases, Smoking and tobacco-use cessation counseling
7. Education, Counseling, and Referral for Other Preventive Services	❑ A brief written plan, such as a checklist, given to the beneficiary for obtaining appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits.

All Element boxes must be checked to bill IPPE services.

TEXAS HEALTH STEPS WELL CHILD CHECK-UP (MEDICAID)

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):	**Coding Outcomes**	**Teaching Documentation**
		CPT(s) Correct? ❑ Y ❑ N	Resident? ❑ Y ❑ N
		Modifier Correct? ❑ Y ❑ N ❑ NA	
		ICD-9(s) Correct? ❑ Y ❑ N	TP Doc OK? ❑ Y ❑ N ❑ NA
		DOS Correct? ❑ Y ❑ N	

Post-Audit CPT(s) & ICD-9 & Modifiers:

Provider Signature? ❑ Y ❑ N — Legible? ❑ Y ❑ N

Were bundled services separately billed? ❑ Y ❑ N

EMR: Inappropriately Cloned Note? ❑Y ❑N Conflicting Elements? ❑Y ❑ N

Are History and Physical examinations complete? ❑Yes ❑No If Yes, continue with audit tool. If No, cannot bill THSteps Well Child Check-up.

Does visit include a separately identifiable E/M? ❑Yes ❑No If Yes, is there additional documentation? ❑Yes ❑No

If Yes, complete Appendix C-1 for that E/M code.

	Newborn – 2 Weeks	**2 Months – 30 Months**	**3 Years – 10 Years**	**11 Years – 20 Years**
History - Comprehensive *	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Nutritional Screening *	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Developmental Surveillance				
Review of Milestones	❑Yes ❑No	❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A	
ASQ, ASQ:SE, or PEDS		❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A	
M-CHAT		❑Yes ❑No ❑N/A		
Mental Health: Psychosocial/ Behavioral Health Screening *	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
TB Questionnaire with skin test if risk identified	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Unclothed (draped suitably) Physical Examination	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Measurements including graphic recordings				
Length/Height/Weight	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Body Mass Index (BMI)		❑Yes ❑No ❑N/A	❑Yes ❑No	❑Yes ❑No
Fronto-Occipital circumference	❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A		
Blood Pressure			❑Yes ❑No	❑Yes ❑No
Visual Acuity			❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A
Subjective Vision	❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A
Newborn Hearing Test (OAE or ABR)	❑Yes ❑No ❑N/A			
Audiometric Screening			❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A
Subjective Hearing	❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A
Dental Referral		❑Yes ❑No ❑N/A	❑Yes ❑No	❑Yes ❑No
Screen for/Administer Immunizations Using ACIP Guidelines	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Newborn Screening Panel	❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A		
Blood Lead Screening (12 & 24 months of age)		❑Yes ❑No ❑N/A		
Anemia		❑Yes ❑No ❑N/A		❑Yes ❑No ❑N/A
Hyperlipidemia		❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A
Diabetes Type II			❑Yes ❑No ❑N/A	❑Yes ❑No ❑N/A
STD/STI Screening				❑Yes ❑No ❑N/A
HIV Test				❑Yes ❑No ❑N/A
Health Education and Anticipatory Guidance	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

Reference http://www.dshs.state.tx.us/thsteps/providers_components.shtm for the components of the Periodicity Schedule.
See 5.3.1.9 for Exception-to-Periodicity Schedule in the Texas Medicaid Providers Procedures Manual Vol 2. Children's Services Handbook: http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/TMPPM/2011_Texas_Medicaid_Provider_Procedures_Manual.pdf. Also reference the Texas Health Steps (THSteps) Manual: http://www.tmhp.com/Pages/Medicaid/Medicaid_THSteps_Program_Info.aspx .
*For Comprehensive History documentation, see 2.6.4 Monitoring Handbook for instructions.
*For Nutritional Screening and Mental Health Screening documentation, see 2.6.4 Monitoring Handbook for instructions.
THSteps last revision was 12/1/2011. Check regularly for updates to the periodicity schedule: http://www.dshs.state.tx.us/thsteps/providers.shtm .

MEDICARE ANNUAL WELLNESS EXAM MONITORING TOOL (G0438 – G0439)

Provider: *DOS:* *Patient:* *CPT(s):*	*Monitoring #* *POS:* *MRN:* *ICD-9(s):*	**Coding Outcomes** CPT(s) Correct? ❑Y ❑N Modifier Correct? ❑Y ❑N ❑NA ICD-9(s) Correct? ❑Y ❑N Date Correct? ❑Y ❑N	**Teaching Documentation** Resident? ❑Y ❑N PCE? ❑Y ❑N Minor Procedure? ❑Y ❑N TP Doc OK? ❑Y ❑N ❑NA
Post-Audit CPT(s) & ICD-9 & Modifiers:			
Provider Signature ❑Y ❑N		Incident To ❑ NA ❑ Error	Legible ❑Yes ❑No
EMR: Inappropriately Cloned Note ❑ Yes ❑ No	Conflicting Elements ❑ Yes ❑ No		
Has >12 months passed since the IPPE or last AWV visit? ❑Yes ❑No. If No, see Appendix D-1 for IPPE service.			
Does this visit warrant a separately identifiable E/M visit in addition to AWV visit? ❑Yes ❑No If yes, complete Appendix C-1 for E/M service.			

Components of AWV	Elements/Components	G0438 Initial	G0439 Subsequent
1. Health Risk Assessment (HRA).	❑ Review (and administer if needed) an HRA (updated HRA for subsequent AWV).	❑ Initial	❑ Update/ subsequent
2. Medical/Family History	❑ Past Medical/Surgical history (experience with illnesses, hospital stays, operations, allergies, injuries and treatments ❑ Current medications and supplements (including calcium and vitamins) ❑ Family history (medical events, including diseases that may be hereditary or place individual at risk)	❑ Initial	❑ Update/ Subsequent
3. Potential Risk Factors for Depression/Mood Disorders	Use any appropriate screening instrument recognized by national professional medical organizations to obtain current or past experiences with depression or other mood disorders.	❑ Initial	
3.History of Functional Ability and Level of Safety	Use any appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas: ❑ Hearing impairment ❑ Activities of daily living ❑ Fall risk ❑ Home safety	❑ Initial	
4. Physical Examination	❑ Height ❑ Weight ❑ Blood pressure ❑ Measurement of body mass (or waist circumference, if appropriate) ❑ Other routine measurements deemed appropriate, based on the patient's medical/family history	❑ Initial ❑ Height ❑ Weight ❑ BP ❑ Other	❑ Update/ Subsequent ❑ Height ❑ Weight ❑ Other
5. List Current Providers/Suppliers	❑ Include current providers and suppliers that are regularly involved in providing medical care to the patient and providing personalized prevention plan services.	❑ Initial	❑ Update/ Subsequent
6. Detection of any cognitive impairment	❑ Assess patient's cognitive function by direct observation, with due consideration of information obtained by patient's report and concerns raised by family members, friends, caretakers or others.	❑ Initial	
7. Written Screening Schedule/Checklist next 5-10 years, as appropriate.	Base written screening schedule on: ❑ Recommendations from the U.S. Preventive Services Task Force (USPSTF) and the Advisory committee on Immunization Practices (ACIP). ❑ The patient's health status and screening history; and ❑ Age-appropriate preventive services covered by Medicare.	❑ Initial	❑ Update/ Subsequent
8. Risk Factors and Conditions of which Primary, Secondary, or Tertiary Interventions are recommended or are underway	Include the following: ❑ Any mental conditions or any such risk factors or conditions that have been identified through an IPPE or previous AWV; ❑ A list of treatment options and their associated risks and benefits, and provide personalized prevention plan services.	❑ Initial	❑ Update/ Subsequent
9. Furnish Personalized Health Advice and a Referral, as appropriate, to health education or prevention counseling services.	Includes referrals to programs aimed at: ❑ Community-based lifestyle interventions to reduce health risks and promote self-management and wellness; ❑ Weight loss; ❑ Physical activity; ❑ Smoking cessation; ❑ Fall prevention; and ❑ Nutrition	❑ Initial	❑ Update/ Subsequent

To bill G0438 OR G0439, all items listed under the appropriate column must be documented.

GENERAL MULTI-PURPOSE EXAMINATION – 1997 Guidelines

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):

System/Body Area	Elements (Bullets)
Constitutional	❑ Vitals (3of 7): ❑ Sitting/Standing BP ❑ Supine BP ❑ Respiration ❑ Weight ❑ Height ❑ Temperature ❑ Pulse rate and regularity ❑ General appearance of patient (development, nutrition, body habitus, deformities, grooming)
Eyes	❑ Inspect conjunctivae & lids ❑ Exam pupils & irises ❑ Ophthalmoscopic exam of optic discs & posterior segments
ENT	❑ External inspection of ears and nose ❑ Otoscopic exam (external auditory canals and tympanic membranes) ❑ Assess Hearing ❑ Inspect nasal mucosa, septum and turbinates ❑ Inspect lips, teeth and gums ❑ Exam oropharynx; oral mucosa, salivary glands, hard/soft palates, tongue, tonsils and posterior pharynx.
Neck	❑ Exam neck (masses, overall appearance, symmetry, tracheal position, crepitus) ❑ Exam thyroid (enlargement, tenderness, mass)
Respiratory	❑ Assess respiratory effort (intercostal retractions, use of accessory muscles, etc.) ❑ Percussion of chest (dullness, flatness, hyper resonance) ❑ Palpate chest (tactile fremitus) ❑ Auscultation of lungs (breath sounds, adventitious sounds, rubs)
Cardiovascular	❑ Palpate heart (location, size, thrills) ❑ Auscultation of heart, noting abnormal sounds and murmurs ❑ Carotid arteries (pulse amplitude, bruits) ❑ Femoral arteries (pulse amplitude, bruits) ❑ Abdominal aorta (size, bruits) ❑ Extremities for edema and/or varicosities ❑ Pedal pulses (pulse amplitude)
Chest (Breasts)	❑ Inspect breasts (symmetry/nipple discharge) ❑ Palpate breasts and axillae (masses/lumps, tenderness)
GI (Abdomen)	❑ Exam abdomen with notation of presence of masses or tenderness ❑ Exam for presence or absence of hernia ❑ Exam liver and spleen ❑ Obtain stool sample for occult blood test when indicated ❑ Exam (when indicated) anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses
GU- Male	❑ Exam scrotal contents (hydrocele, spermatocele, tenderness of cord, testicular mass) ❑ Exam penis ❑ Digital rectal exam of prostate gland (size, symmetry, nodularity, tenderness)
GU-Female	Pelvic exam (with or without specimen collection for smears and cultures), including ❑ Exam external genitalia and vagina ❑ Exam urethra (masses, tenderness, scarring) ❑ Exam bladder (fullness, masses, tenderness) ❑ Cervix (general appearance, lesions, discharge) ❑ Uterus (size, contour, position, mobility, tenderness, consistency, descent or support) ❑ Adnexa/parametria (masses, tenderness, organomegaly, nodularity)
Lymphatic	Palpate lymph nodes in two or more areas: ❑ Neck ❑ Axillae ❑ Groin ❑ Other: ____________________
Musculoskeletal	❑ Examine gait and station ❑ Inspect/palpate digits and nails Examine 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. Exam includes: ❑ Inspect/palpate, with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions ❑ Assess range of motion with notation of pain, crepitation or contracture ❑ Assess stability with notation of any dislocation (luxation), subluxation or laxity ❑ Assess muscle strength and tone with notation of any atrophy or abnormal movements
Skin	❑ Inspect skin and subcutaneous tissue (rashes, lesions, ulcers) ❑ Palpate skin and subcutaneous tissue (induration, subcutaneous nodules, tightening)
Neurologic	❑ Test cranial nerves, noting any deficits ❑ Examine sensation (touch/pin/vibration/proprioception) ❑ Examine deep tendon reflexes, noting pathological reflexes (Babinski)
Psychiatric	❑ Description of patient's judgment and insight Brief assessment of mental status, including ❑ Orientation to time, place & person ❑ Recent and remote memory ❑ Mood & affect (depression, anxiety, agitation)

Problem Focused:	One to **five** bullets from one or more organ systems
Expanded Problem Focused:	At least **six** bullets from any organ system
Detailed:	At least **twelve** bullets in two or more body areas/organ systems
Comprehensive:	Perform all bullets in 9 organ systems or body areas and **document** at least **two bullets from each of the 9** body areas/organ systems.

CARDIOVASCULAR – 1997 Guidelines

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):

System/Body Area	Elements (Bullets)
Constitutional	❑ Vitals (3of 7): ❑ Sitting/Standing BP ❑ Supine BP ❑ Respiration ❑ Weight ❑ Height ❑ Temperature ❑ Pulse rate and regularity ❑ General appearance of patient (development, nutrition, body habitus, deformities, grooming)
Eyes	❑ Inspect conjunctivae and lids
ENT	❑ Inspect teeth, gums and palate ❑ Exam oral mucosa, noting presence of pallor or cyanosis
Neck	❑ Exam jugular veins (distension; a, v or cannon a waves) ❑ Exam thyroid (enlargement, tenderness, mass)
Respiratory	❑ Assess respiratory effort (intercostal retractions, use of accessory muscles, etc.) ❑ Auscultation of lungs (breath sounds, adventitious sounds, rubs)
Cardiovascular	❑ Palpate heart (location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) ❑ Auscultation of heart, noting abnormal sounds and murmurs ❑ Measurement of blood pressure in two or more extremities when indicated (e.g., aortic dissection, coarctation) **Examination of:** ❑ Carotid arteries (pulse amplitude, bruits) ❑ Abdominal aorta (size, bruits) ❑ Femoral arteries (pulse amplitude, bruits) ❑ Pedal pulses (pulse amplitude) ❑ Extremities for edema and/or varicosities
Chest (Breasts)	
GI (Abdomen)	❑ Examine abdomen with notation of presence of masses or tenderness ❑ Examine liver and spleen ❑ Obtain stool sample for occult blood test when indicated
GU	
Lymphatic	
Musculoskeletal	❑ Examine back with notation of kyphosis or scoliosis ❑ Examine gait with notation of ability to undergo exercise testing and /or participation in exercise programs ❑ Assess muscle strength and tone (flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements.
Extremities	❑ Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, infections, Osler's nodes) petechiae, ischemia, infections, Osler's nodes)
Skin	❑ Inspect and/or palpate skin and subcutaneous tissue (stasis dermatitis, ulcers, scars, xanthomas)
Neurological/ Psychiatric	Brief assessment of mental status, including ❑ Orientation to time, place and person ❑ Mood and affect (depression, anxiety, agitation)

Problem Focused:	**One to five** bullets from one or more organ systems
Expanded Problem Focused:	At least **six** bullets from any organ system
Detailed:	At least **twelve** bullets in **two or more** body areas/organ systems
Comprehensive:	Perform all bullets; **document every bullet in each box with a bolded border and at least one element in each box with an unbolded border.**

EYE – 1997 Guidelines

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):

System/Body Area	Elements (Bullets)
Constitutional	
Head and Face	
Eyes	❑ Test visual acuity (excluding determining refractive error) ❑ Gross visual field testing by confrontation ❑ Test ocular motility including primary gaze alignment ❑ Inspect bulbar and palpebral conjunctivae ❑ Exam ocular adnexae including lids (e.g., ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes ❑ Exam pupils and irises, including shape, direct and consensual reaction (afferent pupil), size (e.g., anisocoria) and morphology ❑ Slit lamp exam of the corneas including epithelium, stroma, endothelium, and tear film ❑ Slit lamp exam of the anterior chambers including depth, cells, and flare ❑ Slit lamp exam 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 exam through dilated pupils (unless contraindicated) of: ❑ Optic discs including size, C/D ratio, appearance (e.g., atrophy, cupping, tumor elevation) and nerve fiber layer ❑ Posterior segments including retina and vessels (e.g., exudates and hemorrhages)
Neurological/ Psychiatric	Brief assessment of mental status, including ❑ Orientation to time, place and person ❑ Mood and affect (depression, anxiety, agitation)

Problem Focused:	**One to five** bullets
Expanded Problem Focused:	At least **six** bullets
Detailed:	At least **nine** bullets
Comprehensive:	Perform all bullets; **document every bullet in each box with a bolded border and at least one element in each box with an unbolded border**.

For General Ophthalmological Services, use Appendix C-2 USE OF EYE CODES – REQUIRES INITIATION OF A DIAGNOSTIC AND TREATMENT PROGRAM – if that is missing, use an E/M code and complete Appendix C-1.

GENITOURINARY – 1997 Guidelines

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):

System/Body Area	Elements (Bullets)
Constitutional	❑ Vitals (3of 7): ❑ Sitting/Standing BP ❑ Supine BP ❑ Respiration ❑ Weight ❑ Height ❑ Temperature ❑ Pulse rate and regularity ❑ General appearance of patient (development, nutrition, body habitus, deformities, grooming)
Eyes	
ENT	
Neck	❑ Exam neck (masses, overall appearance, symmetry, tracheal position, crepitus) ❑ Exam thyroid (enlargement, tenderness, mass)
Respiratory	❑ Assess respiratory effort (intercostal retractions, use of accessory muscles, etc.) ❑ Auscultation of lungs (breath sounds, adventitious sounds, rubs)
Cardiovascular	❑ Auscultation of heart, noting abnormal sounds and murmurs ❑ Exam peripheral vascular system by observation (swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
GI (Abdomen)	❑ Examine abdomen with notation of presence of masses or tenderness ❑ Examine liver and spleen ❑ Examine for presence or absence of hernia ❑ Obtain stool sample for occult blood test when indicated
GU- Male	❑ Inspect anus and perineum Exam (with or without specimen collection for smears and cultures) of genitalia including: ❑ Scrotum (lesions, cysts, rashes) ❑ Epididymides (size, symmetry, masses) ❑ Testes (size, symmetry, masses) ❑ Urethral meatus (size, location, lesions, discharge ❑ Penis (lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities) Digital rectal exam, including: ❑ Prostate gland (size, symmetry, nodularity, tenderness) ❑ Seminal vesicles (symmetry, tenderness, masses, enlargement ❑ Sphincter tone, presence of hemorrhoids, rectal masses
GU-Female	Includes **at least seven of the following eleven** elements identified by bullets: ❑ Inspect and palpate breasts (masses, lumps, tenderness, symmetry, nipple discharge) ❑ Digital rectal exam including sphincter tone, presence of hemorrhoids, rectal masses Pelvic exam (with or without specimen collection for smears and cultures), including ❑ External genitalia (appearance, hair distribution, lesions) ❑ Urethra (masses, tenderness, scarring) ❑ Urethral meatus (size, location, lesions, prolapse) ❑ Anus and Perineum ❑ Bladder (fullness, masses, tenderness) ❑ Cervix (general appearance, lesions, discharge) ❑ Uterus (size, contour, position, mobility, tenderness, consistency, descent or support) ❑ Adnexa/parametria (masses, tenderness, organomegaly, nodularity) ❑ Vagina (appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
Lymphatic	❑ Palpate lymph nodes in neck, axillae, groin and /or other location
Musculoskeletal	
Skin	❑ Inspect and/or palpate skin and subcutaneous tissue (rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status, including ❑ Orientation to time, place and person ❑ Mood and affect (depression, anxiety, agitation)

Problem Focused:	**One to five** bullets from one or more organ systems
Expanded Problem Focused:	At least **six** bullets from any organ system
Detailed:	At least **twelve** bullets in two or more body areas/organ systems
Comprehensive:	Perform all bullets; **document every bullet in each box with a bolded border and at least one element in each box with an unbolded border**.

HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC – 1997 Guidelines

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):

System/Body Area	Elements (Bullets)
Constitutional	❑ Vitals (3of 7): ❑ Sitting/Standing BP ❑ Supine BP ❑ Respiration ❑ Weight ❑ Height ❑ Temperature ❑ Pulse rate and regularity ❑ General appearance of patient (development, nutrition, body habitus, deformities, grooming)
Head and Face	❑ Palpate and/or percuss face with notation of presence or absence of sinus tenderness
Eyes	❑ Inspect conjunctivae and lids
ENT	❑ Otoscopic exam of external auditory canals and tympanic membranes ❑ Inspect nasal mucosa, septum and turbinates ❑ Inspect teeth and gums ❑ Exam of oropharynx (oral mucosa, hard/soft palates, tongue, tonsils, posterior pharynx)
Neck	❑ Exam neck (masses, overall appearance, symmetry, tracheal position, crepitus) ❑ Exam thyroid (enlargement, tenderness, mass)
Respiratory	❑ Assess respiratory effort (intercostal retractions, use of accessory muscles, etc.) ❑ Auscultation of lungs (breath sounds, adventitious sounds, rubs)
Cardiovascular	❑ Auscultation of heart, noting abnormal sounds and murmurs ❑ Exam peripheral vascular system by observation (swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	
GI (Abdomen)	❑ Examine abdomen with notation of presence of masses or tenderness ❑ Examine liver and spleen
Genitourinary	
Lymphatic	❑ Palpate lymph nodes in neck, axillae, groin and /or other location
Musculoskeletal	
Extremities	❑ Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	❑ Inspect and/or palpate skin and subcutaneous tissue (rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status, including ❑ Orientation to time, place and person ❑ Mood and affect (depression, anxiety, agitation)

Problem Focused:	**One to five** bullets from one or more organ systems
Expanded Problem Focused:	At least **six** bullets from any organ system
Detailed:	At least **twelve** bullets in two or more body areas/organ systems
Comprehensive:	Perform all bullets; **document every bullet in each box with a bolded border and at least one element in each box with an unbolded border**.

MUSCULOSKELETAL – 1997 Guidelines

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):

System/Body Area	Elements (Bullets)
Constitutional	❑ Vitals (3of 7): ❑ Sitting/Standing BP ❑ Supine BP ❑ Respiration ❑ Weight ❑ Height ❑ Temperature ❑ Pulse rate and regularity ❑ General appearance of patient (development, nutrition, body habitus, deformities, grooming)
Eyes	
ENT	
Neck	
Respiratory	
Cardiovascular	❑ Exam peripheral vascular system by observation (swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	
GI (Abdomen)	
GU	
Lymphatic	❑ Palpate lymph nodes in neck, axillae, groin and/or other location.
Musculoskeletal	❑ Examine gait and station Examination of joints, bones and muscles/tendons **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 the given area includes: ❑ Inspect, percuss, and/or palpate, with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions ❑ Assess range of motion with notation of any pain (straight leg raising), crepitation or contracture ❑ Assess stability with notation of any dislocation (luxation), subluxation or laxity ❑ Assess muscle strength and tone (flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements **NOTE:** For the comprehensive level of exam, 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 exam, each element is counted separately for each body area. For example, assessing range of motion in two extremities = two bullets.
Skin	❑ Inspect and /or palpate skin and subcutaneous tissue (scars, rashes, lesions, café-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 exam of all four anatomic areas must be performed and documented. For the three lower levels of exam, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities = two bullets.
Neurologic/ Psychiatric	❑ Test coordination (finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children) ❑ Examine deep tendon reflexes, noting pathological reflexes (Babinski) ❑ Examine sensation (by touch, pin, vibration, proprioception) Brief assessment of mental status, including ❑ Orientation to time, place and person ❑ Mood and affect (depression, anxiety, agitation)

Problem Focused:	**One to five** bullets from one or more organ systems
Expanded Problem Focused:	At least **six** bullets from any organ system
Detailed:	At least **twelve** bullets in two or more body areas/organ systems
Comprehensive:	Perform all bullets; **document every bullet in each box with a bolded border and at least one element in each box with an unbolded border**.

NEUROLOGICAL 1997 Guidelines

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):

System/Body Area	Elements (Bullets)
Constitutional	❑ Vitals (3of 7): ❑ Sitting/Standing BP ❑ Supine BP ❑ Respiration ❑ Weight ❑ Height ❑ Temperature ❑ Pulse rate and regularity ❑ General appearance of patient (development, nutrition, body habitus, deformities, grooming)
Eyes	❑ Ophthalmoscopic exam of optic discs (size, C/D ratio, appearance) and posterior segments (vessel changes, exudates, hemorrhages)
ENT	
Neck	
Respiratory	
Cardiovascular	❑ Carotid arteries (pulse amplitude, bruits) ❑ Auscultation of heart, noting abnormal sounds and murmurs ❑ Exam of peripheral vascular system by observation (swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	
GI (Abdomen)	
GU	
Lymphatic	
Musculoskeletal	❑ Examine gait and station Assessment of motor function including: ❑ Muscle strength in upper and lower extremities ❑ Muscle tone in upper and lower extremities (flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (fasciculation, tardive dyskinesia)
Skin	
Neurological	Evaluation of higher integrative functions including: ❑ Orientation to time, place and person ❑ Recent and remote memory ❑ Attention span and concentration ❑ Language (naming objects, repeating phrases, etc) ❑ Fund of knowledge (awareness of current events, past history, vocabulary) Test the following cranial nerves: ❑ 2nd nerve (visual acuity, visual fields, fundi) ❑ 3rd, 4th, and 6th nerves (pupils, eye movement) ❑ 5th nerve (facial sensation, corneal reflexes) ❑ 7th nerve (facial symmetry, strength) ❑ 8th nerve (hearing with tuning fork, whispered voice and/or finger rub ❑ 9th nerve (spontaneous or reflex palate movement) ❑ 11th nerve (shoulder shrug strength) ❑ 12th nerve (tongue protrusion) ❑ Examine sensation (by touch, pin, vibration, proprioception) ❑ Examine deep tendon reflexes in upper and lower extremities, noting pathological reflexes (Babinski) ❑ Test coordination (finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children).
Psychiatric	

Problem Focused:	**One to five** bullets from one or more organ systems
Expanded Problem Focused:	At least **six** bullets any organ system
Detailed:	At least **twelve** bullets in two or more body areas/organ systems
Comprehensive:	Perform all bullets; **document every bullet in each box with a bolded border and at least one element in each box with an unbolded border.**

PSYCHIATRIC – 1997 Guidelines

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):

System/Body Area	Elements (Bullets)
Constitutional	❑ Vitals (3of 7): ❑ Sitting/Standing BP ❑ Supine BP ❑ Respiration ❑ Weight ❑ Height ❑ Temperature ❑ Pulse rate and regularity ❑ General appearance of patient (development, nutrition, body habitus, deformities, grooming)
Head and Face	
Eyes	
ENT	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
GI (Abdomen)	
GU	
Lymphatic	
Musculoskeletal	❑ Examine gait and station ❑ Assessment of muscle strength and tone (flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
Extremities	
Skin	
Neurological	
Psychiatric	❑ Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language) ❑ Description of thought processes including: rate of thoughts; content of thoughts (e.g., logical vs. illogical, tangential); abstract reasoning; and computation. ❑ Description of associations (e.g., 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 (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition) Complete mental status exam, including: ❑ Orientation to time, place and person. ❑ Recent and remote memory ❑ Attention span and concentration ❑ Language (e.g., naming objects, repeating phrases) ❑ Fund of knowledge (e.g., awareness of current events, past history, vocabulary) ❑ Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability)

Problem Focused:	**One to five** bullets
Expanded Problem Focused:	At least **six** bullets
Detailed:	At least **nine** bullets
Comprehensive:	Perform all bullets; **document every bullet in each box with a bolded border and at least one element in each box with an unbolded border.**

RESPIRATORY – 1997 Guidelines

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):

System/Body Area	Elements (Bullets)
Constitutional	❑ Vitals (3of 7): ❑ Sitting/Standing BP ❑ Supine BP ❑ Respiration ❑ Weight ❑ Height ❑ Temperature ❑ Pulse rate and regularity ❑ General appearance of patient (development, nutrition, body habitus, deformities, grooming)
Eyes	
ENT	❑ Inspect nasal mucosa, septum and turbinates ❑ Inspect teeth and gums ❑ Examine oropharynx (oral mucosa, hard/soft palates, tongue, tonsils and posterior pharynx).
Neck	❑ Examine neck (masses, overall appearance, symmetry, tracheal position, crepitus) ❑ Examine thyroid (enlargement, tenderness, mass) ❑ Examine jugular veins (distension; a, v or cannon a waves)
Respiratory	❑ Inspect chest, noting symmetry and expansion ❑ Assess respiratory effort (intercostal retractions, use of accessory muscles, diaphragmatic movement) ❑ Percussion of chest (dullness, flatness, hyper resonance) ❑ Palpate chest (tactile fremitus) ❑ Auscultation of lungs (breath sounds, adventitious sounds, rubs)
Cardiovascular	❑ Auscultation of heart, noting abnormal sounds and murmurs ❑ Examine peripheral vascular system by observation (swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	
GI (Abdomen)	❑ Examine abdomen with notation of presence of masses or tenderness ❑ Examine liver and spleen
GU	
Lymphatic	❑ Palpate lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	❑ Examine gait and station ❑ Assess muscle strength and tone (flaccid, cog wheel, spastic), noting any atrophy and abnormal movements
Extremities	❑ Inspect and palpate digits and nails (clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	❑ Inspect and/or palate skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status, including ❑ Orientation to time, place and person ❑ Mood and affect (depression, anxiety, agitation)

Problem Focused:	One to **five** bullets from one or more organ systems
Expanded Problem Focused:	At least **six** bullets from any organ system
Detailed:	At least **twelve** bullets in two or more body areas/organ systems
Comprehensive:	Perform all bullets; **document every bullet in each box with a bolded border and at least one element in each box with an unbolded border.**

SKIN – 1997 Guidelines

Provider: DOS: Patient: CPT(s):	Monitoring # POS: MRN: ICD-9(s):

System/Body Area	Elements (Bullets)
Constitutional	❑ Vitals (3of 7): ❑ Sitting/Standing BP ❑ Supine BP ❑ Respiration ❑ Weight ❑ Height ❑ Temperature ❑ Pulse rate and regularity ❑ General appearance of patient (development, nutrition, body habitus, deformities, grooming)
Head and Face	
Eyes	❑ Inspect conjunctivae and lids
ENT	❑ Inspect lips, teeth and gums ❑ Exam of oropharynx (oral mucosa, hard/soft palates, tongue, tonsils, posterior pharynx)
Neck	❑ Exam thyroid (enlargement, tenderness, mass)
Respiratory	
Cardiovascular	❑ Exam peripheral vascular system by observation (swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	
GI (Abdomen)	❑ Examine liver and spleen ❑ Exam of anus for condyloma and other lesions
GU	
Lymphatic	❑ Palpate lymph nodes in neck, axillae, groin and /or other location
Extremities	❑ Inspect and palpate digits and nails (clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	❑ Palpate scalp and inspect hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities Inspect and/or palpate skin and subcutaneous tissue (rashes, lesions, ulcers, susceptibility to and presence of photo damage) in **eight of the following 10* areas:** ❑ Head, including face ❑ Neck ❑ Chest, including breasts and axillae ❑ Genitalia, groin, buttocks ❑ Abdomen ❑ Back ❑ Right Upper Extremity ❑ Left Upper Extremity ❑ Right Lower Extremity ❑ Left Lower Extremity *NOTE: For the comprehensive level, the exam of at least eight anatomic areas must be performed and documented. For the three lower levels of exam, 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 constitute two elements. ❑ Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidrosis or bromhidrosis.
Neurological/ Psychiatric	Brief assessment of mental status, including: ❑ Orientation to time, place and person ❑ Mood and affect (depression, anxiety, agitation)

Problem Focused:	One to **five** bullets from one or more organ systems
Expanded Problem Focused:	At least **six** bullets from any organ system
Detailed:	At least **twelve** bullets in two or more body areas/organ systems
Comprehensive:	Perform all bullets; **document every bullet in each box with a bolded border and at least one element in each box with an unbolded border.**

Operations/Procedures/OB Deliveries Monitoring Tool

Provider: *DOS:* *Patient:* *CPT(s):*	*Monitoring #* *POS:* *MRN:* *ICD-9(s):*	**Coding Outcomes** CPT(s) Correct? ❑ Y ❑ N Modifier Correct? ❑ Y ❑ N ❑ NA ICD-9(s) Correct? ❑ Y ❑ N DOS Correct? ❑ Y ❑ N	**Teaching Documentation** Resident? ❑ Y ❑ N TP Doc OK[1]? ❑ Y ❑ N ❑ NA
Post-Audit CPT(s) & ICD-9 & Modifiers:			POS? ❑ Yes ❑ No
Provider Signature? ❑ Y ❑ N	Medicare ABN? ❑ NA ❑ Error	"Incident To?" ❑ NA ❑ Error	Legible? ❑ Y ❑ N
Were bundled services separately billed? ❑ Y ❑ N			
EMR: Inappropriately Cloned Note? ❑Y ❑N	Conflicting Elements? ❑Y ❑ N		

1. Type of Service Performed:
   ❑ Surgery/Endoscopic Procedure ❑ OB Delivery ❑ Other:________________________

2. Was the reason for the procedure documented? ❑ Yes ❑ No ❑ NA
3. If this was a pain procedure, was the visual analogue scale (VAS) pain score documented? ❑ Yes ❑ No ❑ NA
4. If this was a pain procedure, is there documentation of the patient's response to prior pain block procedures? ❑ Yes ❑ No ❑ NA
5. If a resident was not involved, STOP. If a resident was involved, continue to #6.
6. Teaching Physician was present during the:
   ❑ Entire Procedure – Go to #8; OR
   ❑ Key portions of 1 procedure– Go to #7 and #8
   ❑ Key portions of 2 overlapping procedures – Go to #7 & #8
7. If Teaching Physician was present during the key portions of one procedure was the Teaching Physician's presence documented? ❑ Yes ❑ No ❑ NA
8. If Teaching Physician was present during key portions of two overlapping procedures, did the Teaching Physician personally document his/her presence? ❑ Yes ❑ No ❑ NA
9. Was another physician identified as immediately available during the other portions of the procedure[1]? ❑ Yes ❑ No ❑ NA
10. Did Teaching Physician document presence for at least one post-operative visit within the global period? ❑ Yes ❑ No ❑ NA
11. If OB delivery and the global delivery code was billed, is there documentation that the Teaching Physician was present during the pre and postpartum for the minimum number of visits? ❑ Yes ❑ No ❑ NA

Monitor Signature: ______________________________________ Date: ___________________________

Notes:

[1] For a single procedure, the Teaching Physician must be present for the key portions and must be immediately available during the rest of the procedure.

Psychiatry (Excluding E/M Services) Monitoring Tool

Provider: *DOS:* *Patient:* *CPT(s):*	*Monitoring #* *POS:* *MRN:* *ICD-9(s):*	**Coding Outcomes** CPT(s) Correct? ❑ Y ❑ N Modifier Correct? ❑ Y ❑ N ❑ NA ICD-9(s) Correct? ❑ Y ❑ N DOS Correct? ❑ Y ❑ N	**Teaching Documentation** Resident? ❑ Y ❑ N TP Doc OK? ❑ Y ❑ N ❑ NA
Post-Audit CPT(s) & ICD-9 & Modifiers:			
Provider Signature? ❑ Y ❑ N	Medicare ABN? ❑ NA ❑ Error		Legible? ❑ Y ❑ N
			Time-Based? ❑ Y ❑ N
Were bundled services separately billed? ❑ Y ❑ N			Time Documented? ❑ Y ❑ N
EMR: Inappropriately Cloned Note? ❑Y ❑N Conflicting Elements? ❑Y ❑ N			

1. Does the practitioner meet the qualification, credentials, and licensure requirements' scope of practice as established by the payer and state? ☐ Yes ☐ No

2. Is the Medical Treatment Plan reviewed on a regular basis and revised as appropriate to address unforeseen complications or newly-diagnosed conditions? ☐ Yes ☐ No

3. Does the diagnosis support the service? ☐ Yes ☐ No

4. If group psychotherapy, is it medically necessary? ☐ Yes ☐ No ☐ N/A

Monitor Signature: ______________________________ Date: ____________________

Notes:

Radiology/Pathology Services Monitoring Tool

Provider: *DOS:* *Patient:* *CPT(s):*	*Monitoring #* *POS:* *MRN:* *ICD-9(s):*	**Coding Outcomes**	**Teaching Documentation**
		CPT(s) Correct? ❑ Y ❑ N	Resident? ❑ Y ❑ N
		Modifier Correct? ❑ Y ❑ N ❑ NA	
		ICD-9(s) Correct? ❑ Y ❑ N	
		DOS Correct? ❑ Y ❑ N	TP Doc OK? ❑ Y ❑ N ❑ NA
Post-Audit CPT(s) & ICD-9 & Modifiers:			
Provider Signature? ❑ Y ❑ N	Medicare ABN? ❑ NA ❑ Error	"Incident To?" ❑ NA ❑ Error	Legible? ❑ Y ❑ N
Were bundled services separately billed? ❑ Y ❑ N			
EMR: Inappropriately Cloned Note? ❑Y ❑N	Conflicting Elements? ❑Y ❑ N		

1. Is there a written report of the interpretation? If No, STOP. ❑Yes ❑No
2. If #1 is Yes, did Resident dictate the report? ❑Yes ❑No
3. If #2 is Yes, does the documentation indicate that the Teaching Physician personally reviewed the image/slide and the Resident's interpretation and either agrees with or edits the findings? ❑Yes ❑No

Monitor Signature: ______________________________ Date: ____________________

Notes

Anesthesiology Services Monitoring Tool

Provider: *DOS:* *Patient:* *CPT(s):*	*Monitoring #* *POS:* *MRN:* *ICD-9(s):*	**Coding Outcomes**	**Teaching Documentation**
		CPT(s) Correct? ❑ Y ❑ N	Resident? ❑ Y ❑ N
		Modifier Correct? ❑ Y ❑ N ❑ NA	
		ICD-9(s) Correct? ❑ Y ❑ N	
		DOS Correct? ❑ Y ❑ N	TP Doc OK? ❑ Y ❑ N ❑ NA
Post-Audit CPT(s) & ICD-9 & Modifiers:			POS? ❑ Yes ❑ No
Provider Signature? ❑ Y ❑ N	Medicare ABN? ❑ NA ❑ Error		Legible? ❑ Y ❑ N
Were bundled services separately billed? ❑ Y ❑ N			

1. ❑ MAC ❑ GEN ❑ Start Time: _____ ❑ End Time: _____ Units Billed: ____	❑ Yes ❑ No
2. Was the Anesthesiologist/CRNA relieved?	❑ Yes ❑ No
3. If #2 is yes, was relief documented with signature and time started?	❑ Yes ❑ No
4. If #3 is yes, were services billed under the provider with >50% of time on the case?	❑ Yes ❑ No
5. Were units billed correctly based on time documented on the anesthesia record and, appropriately rounded?	❑ Yes ❑ No
6. If a separately billable service was provided, was time for that service documented and excluded from the total time used to bill the anesthesia services?	❑ Yes ❑ No
MAC Procedures ☐	
1. Is there documentation of medical necessity?	❑ Yes ❑ No
2. Is there documentation of a pre-anesthetic exam and evaluation?	❑ Yes ❑ No
3. Is there documentation of post-anesthetic evaluations and intraoperative monitoring?	❑ Yes ❑ No
4. Is there documentation of continuous monitoring by qualified personnel?	❑ Yes ❑ No
General Anesthesia Procedures ☐	
Section A (MD or with Resident) ❑ ***Section B (Medical Direction) ❑*** ***Section C (CRNA Only) ❑***	
SECTION A (PHYSICIAN ONLY OR WITH RESIDENT)	
1. Was a resident involved in a single procedure with a Teaching Anesthesiologist?	❑ Yes ❑ No
2. Does the documentation reflect that the Anesthesiologist/Resident:	
a. Performed pre-anesthesia exam	❑ Yes ❑ No
b. Prescribed the pre-anesthesia plan	❑ Yes ❑ No
c. Completed the anesthesia record	❑ Yes ❑ No
d. Performed indicated post-anesthesia care	❑ Yes ❑ No
SECTION B (MEDICAL DIRECTION OF RESIDENT, CRNA, AA, INTERN, SRNA)	
1. ❑ CRNA ❑ Resident ❑ AA ❑ RRNA/SRNA # Directed: _____	❑ Yes ❑ No
2. Were more than four cases being medically directed at the time of this service?	❑ Yes ❑ No
3. Did the medically directing Anesthesiologist personally indicate he/she:	
a. *Performed and documented pre-anesthesia exam and evaluation.	❑ Yes ❑ No
b. *Was present during the most demanding portions including induction and emergence, where applicable?	❑ Yes ❑ No
c. *Monitored course of anesthesia administration at frequent intervals.	❑ Yes ❑ No
d. *Performed indicated post-anesthesia care.	❑ Yes ❑ No
e. *Prescribed the pre-anesthesia plan, including medications for induction, maintenance and post op-care.	❑ Yes ❑ No
f. Ensured procedures he/she does not perform are performed by qualified personnel.	❑ Yes ❑ No
g. Remained physically present and available for immediate diagnosis and treatment of emergencies.	❑ Yes ❑ No
***Anesthesiologist must personally document.**	
SECTION C (CRNA ONLY)	
1. Does the documentation reflect that the CRNA did the following:	
a. Performed pre-anesthesia exam, including vitals, assessment of airway, lungs and heart and notation of anesthesia risk?	❑ Yes ❑ No
b. Prescribed the pre-anesthesia plan including medications for induction, maintenance and post-op care?	❑ Yes ❑ No
c. Completed the anesthesia record?	❑ Yes ❑ No
d. Performed indicated post-anesthesia care?	❑ Yes ❑ No

Monitor Signature: ______________________________________ Date: ___________________________

Notes:

Medicaid Genetics Services Monitoring Tool

Provider: *DOS:* *Patient:* *CPT(s):*	*Monitoring #* *POS:* *MRN:* *ICD-9(s):*	**Coding Outcomes**	**Teaching Documentation**
		CPT(s) Correct? ❑ Y ❑ N	Resident? ❑ Y ❑ N
		Modifier Correct? ❑ Y ❑ N ❑ NA	
		ICD-9(s) Correct? ❑ Y ❑ N	Minor Procedure ?❑ Y ❑ N
		DOS Correct? ❑ Y ❑ N	TP Doc OK? ❑ Y ❑ N ❑ NA
Post-Audit CPT(s) & ICD-9 & Modifiers:			
Provider Signature? ❑ Y ❑ N			Legible? ❑ Y ❑ N
			Time-Based? ❑ Y ❑ N
Were bundled services separately billed? ❑ Y ❑ N			Time Documented? ❑ Y ❑ N
EMR: Inappropriately Cloned Note? ❑Y ❑N Conflicting Elements? ❑Y ❑ N		If consult, report sent to requesting physician? ❑ Y ❑ N ❑ NA	

Use Appendix J for CPT codes 96040, 99402 or 99404. Use Appendix C-1 for E/M services that may have been billed as well.

1. **For 96040, 99402 or 99404 were the following criteria documented?**

Prognosis	❑Yes	❑No
Recurrent risks	❑Yes	❑No
Family planning implications	❑Yes	❑No
Options available to at-risk family members	❑Yes	❑No

See Reference 22.3.1.1 in Texas Medicaid Manual.

Monitor Signature: ______________________________ Date: ____________________

Notes:

EXAMPLES OF MINIMALLY ACCEPTABLE TEACHING PHYSICIAN DOCUMENTATION FOR E/M SERVICES ONLY

EXAMPLE 1

Teaching Physician Performs Services With the Resident or After the Resident's Service

The Teaching Physician personally performs all the required elements of an E/M service without a Resident. In this scenario the Resident may or may not have performed the E/M service independently. In the absence of a note by a Resident, the Teaching Physician must document as he/she would document an E/M service in a nonteaching setting.

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

- Admitting Note: "I performed a history and physical examination of the patient and discussed his management with the Resident. I reviewed the Resident's note and agree with the documented findings and plan of care."
- Follow-up Visit: "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the Resident's note."
- Follow-up Visit: "Hospital Day #5. I saw and examined the patient. I agree with the Resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."

(**Note:** In this scenario if there are no Resident notes, the Teaching Physician must document as he/she would document an E/M service in a non-teaching setting.)

Note: The Teaching Physician's note does not have to be exactly as these examples in order to be acceptable.

EXAMPLE 2

Teaching Physician is Present While Resident Performs E/M Service

The Resident performs the elements required for an E/M service in the presence of, or jointly with, the Teaching Physician and the Resident documents the service. In this case, the Teaching Physician must document that he/she was present during the performance of the critical or key portion(s) of the service and that he/she was directly involved in the management of the patient. The Teaching Physician's note should reference the Resident's note. For payment, the composite of the Teaching Physician's entry and the Resident's entry together must support the medical necessity and the level of the service billed by the Teaching Physician.

- Initial or Follow-up Visit: "I was present with the Resident during the history and exam. I discussed the case with the Resident and agree with the findings and plan as documented in the Resident's note."

- Follow-up Visit: "I saw the patient with the Resident and agree with the Resident's findings and plan."

Note: The Teaching Physician's note does not have to be exactly as these examples in order to be acceptable.

EXAMPLE 3

Resident Performs E/M and Independently Teaching Physician Performs E/M With or Without Resident

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

- Initial Visit: "I saw and evaluated the patient. I reviewed the Resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."
- Initial or Follow-up Visit: "I saw and evaluated the patient. Discussed with Resident and agree with Resident's findings and plan as documented in the Resident's note."
- Follow-up Visit: "See Resident's note for details. I saw and evaluated the patient and agree with the Resident's finding and plans as written."
- Follow-up Visit: "I saw and evaluated the patient. Agree with Resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

Note: The Teaching Physician's note does not have to be exactly as these examples in order to be acceptable.

EXAMPLES OF UNACCEPTABLE TEACHING PHYSICIAN DOCUMENTATION

- "Agree with above.", followed by legible countersignature or identity (Fails to indicate participation in key/critical portions or management of care)
- "Rounded, Reviewed, Agree.", followed by legible countersignature or identity (Fails to indicate participation in key/critical portions or link to Resident's note)
- "Discussed with Resident. Agree.", followed by legible countersignature or identity (Fails to indicate participation in key/critical portions)
- "Seen and agree.", followed by legible countersignature or identity (Fails to indicate Teaching Physician participation in key/critical portions and fails to link to Resident's documentation)
- "Patient seen and evaluated.", followed by legible countersignature or identity (Fails to indicate Teaching Physician participation in management of patient's care or link to Resident's Note); and
- A legible countersignature or identity alone.

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the Teaching Physician was present, evaluated the patient, and/or had any involvement with the plan of care.

Teaching Physicians Electronic Medical Record Macros Only

TEACHING PHYSICIAN MACRO TITLE	TEACHING PHYSICIAN MACRO STATEMENT	ACCESS RIGHTS
E/M: Teaching Physician with Resident	I was present with the Resident during the history and exam. I discussed the case with the Resident and agree with the findings and plan as documented in the note except for my comments if noted below.	Teaching Physician
E/M: Teaching Physician and Resident Perform Separately	I saw and evaluated the patient. I reviewed the Resident's note and agree with the findings and plan as documented in the note except for my comments if noted below.	Teaching Physician
E/M: Primary Care Exception (99211-99213; 99201-99203; IPPE)	I have discussed the patient's care with the Resident. I have reviewed the patient's history and Resident's findings on exam, the patient's diagnosis/differential diagnosis and treatment plan. I concur with the treatment plan as documented by the Resident, except for my comments if noted below.	Teaching Physician
Minor Procedure (< 5 min)	I was physically present for the entire procedure.	Teaching Physician
Present for Entire Single Surgery (Includes Endoscopic Surgery)	I was physically present for the entire surgery.	Teaching Physician
Present for the Key/Critical Portions of Single Surgery/Endoscopic Surgery and Immediately Available	I was physically present for the key/critical portions of this surgery and immediately available throughout the rest of this procedure.	Teaching Physician
2 Surgeries - Key/critical portions DO NOT overlap (Each Case)	I was physically present for the key/critical portions of this case which were: [insert key/critical portions]. Dr. [Teaching Physician] was immediately available at all other times during this procedure.	Teaching Physician
Time Based Codes (Individual Medical Psychotherapy, Counseling/Coordination of Care, Critical Care, Discharge, etc.)	I was personally present for [____] minutes for this service.	Teaching Physician
Psychiatric Services (Excluding individual medical psychotherapy)	I was physically present during the psychiatric service or concurrently observed the psychiatric service by use of a one-way mirror or video equipment. [Time]	Teaching Physician
Anesthesia: One-on-one with Resident	I was physically present during all key/critical portions of this procedure.	Teaching Physician
Anesthesia: Two Concurrent Cases Involving Residents (For each Case)	I was physically present with the Resident through the pre and post anesthesia care of this case and all other key/critical portions of the procedure which represented [insert the Time].	Teaching Physician
Interpretation of Diagnostic Tests (Other than Pathology)	I personally reviewed the image and the Resident's interpretation and agree with the findings except if noted below:	Teaching Physician
Interpretation of Pathology Tests	I personally reviewed the slide and the Resident's interpretation and agree with the findings except if noted below:	Teaching Physician
Endoscopic Diagnostic Procedures (Not Surgeries)	I was personally present during the entire viewing, including insertion and removal of the endoscope.	Teaching Physician

MONITORING COMMENTS – EXAMPLES FOR ON-LINE MONITORING SUBMISSION FORM

Finding	Incorrect	Correct
A-1	Downcoded by one level	Documentation supports 99213 (instead of 99212) based on EPF History and Moderate Decision Making.
A-1	Could code a 99243 instead of 99213	This should be coded as a consultation as there was a request for opinion/advise; written evaluation and report to requesting physician
A-2	Wrong code billed (Wrong code set)	99243 (Consult code) not supported as there was no request for opinion/advise documented in the record.
A-2	Patient was established	Patient had been seen by a TTUHSC provider in that group within the past 3 years and therefore is not a new patient.
A-3	Should not use modifier 59 with CPT 76000.	According to NCCI edits, CPT 76000 is bundled into the 93529 because it was performed in conjunction with the cardiac catheterization procedure.
A-4	Billed for office visit	Post-operative E/M service is bundled within the post-operative global period and not separately billable.
A-5	Failed to bill a lab	UA not billed
A-6	No documentation of service	No documentation that flu shot (90471; 90663) was given to the patient on this DOS
A-7	Modifier missing	Failed to append modifier “22” when documentation supported more extensive work was performed.
B-1	Teaching Physician documentation issue	Teaching Physician failed to refer to the Resident’s note; thus insufficient documentation to code any level.
B-2	Documentation only supports a 99202 instead of 99203.	History was EPF; Exam was Detailed and MDM was Low for 99202. Documentation of History was EPF due to documentation of only 2 HPI.
B-3	Can only bill a 99203	History and Exam was Comprehensive but MDM was only Low Complexity because there was management of only one disease/condition which was documented as a stable, and only one lab was ordered.
B-4	No documentation	Unable to locate provider’s documentation of a service; the only information is nurse’s intake note of the ROS and PFSH for this DOS
B-5	Insufficient documentation	Provider failed to document Chief Complaint which is required for any E/M service.
B-6	History conflicts	The HPI states vomiting but ROS states GI normal
D-1	Wrong DOS	Service was billed on 1/10/10 but the note is dated 1/9/10.
D-2	No signature	Dr. [Name of Provider] failed to sign the progress note.
D-3	Wrong provider	Service performed by Dr. Jones, but billed under Dr. Smith.
D-4	No ABN	Medicare pay for this CPT (state code) for this diagnosis (state the diagnosis) and therefore an ABN is required in order to bill the patient.
D-5	Provider not licensed	Psychotherapy was provided by therapist who was not a licensed physician or psychotherapist.
D-6	Cannot read documentation	Unable to read documentation based on review by three separate individuals.
D-7	Wrong POS	Services provided in hospital outpatient setting that is not owned or leased by TTUHSC, therefore proper place of service is hospital outpatient not physician office.
D-8	Wrong patient	Service should have been billed to Patient [Name of Patient]