Medicare Physician Guide

A Resource for Residents, Practicing Physicians, and Other Health Care Professionals

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CMS Centers for Medicare & Medicaid Services

Medicare Learning Network

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

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

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Medicare Learning Network

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CHAPTER ONE

INTRODUCTION TO THE MEDICARE PROGRAM

This chapter provides information about the Centers for Medicare & Medicaid Services (CMS), the Medicare Program, and organizations that impact the Medicare Program.

CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS is a Federal agency within the U.S. Department of Health and Human Services (HHS) that administers and oversees the Medicare Program and a portion of the Medicaid Program. CMS also regulates laboratory testing and surveys and certifies Rural Health Clinics, Federally Qualified Health Centers, Critical Access Hospitals, nursing homes, health care agencies, intermediate care facilities for the mentally retarded, and hospitals. CMS consists of a Central Office and 10 Regional Offices (RO). The Central Office is located in Baltimore, Maryland, and provides operational direction and policy guidance for the nationwide administration of the above programs. The ROs are located in major cities throughout the U.S. and support the health care provider community by:

- Conducting outreach activities;
- Establishing relationships with local and regional provider associations; and
- Helping providers and suppliers resolve disputes they may have with Contractors.

Where to Find Additional Information About the Centers For Medicare & Medicaid Services

To find additional information about CMS, visit *http://www.cms.hhs.gov/home/aboutcms.asp* on the CMS website.

CMS awards contracts to organizations called Medicare Contractors who perform claims processing and related administrative functions. Beginning in 2006, all Original Medicare Plan claims processing Contractors (Fiscal Intermediaries, Carriers, and Durable Medical Equipment Carriers) will be transitioned into Medicare Administrative Contractors.

Medicare Contractor Contact Information

The Provider Call Center Toll-Free Numbers Directory, which contains Medicare Contractor contact information, can be accessed in the Downloads Section at *http://www.cms.hhs.gov/MLNGenInfo/30_contactus.asp* on the CMS website.

THE MEDICARE PROGRAM

The Medicare Program was established by Title XVIII of the Social Security Act (the Act) on July 1, 1966. Medicare consists of the following four parts:

- Part A, hospital insurance;
- Part B, medical insurance;
- Part C, Medicare Advantage (MA); and
- Part D, prescription drug plan (PDP).

Part A and Part B are available to:

- Individuals who are age 65 or older;
- Individuals who are under age 65 with certain disabilities; and
- Individuals with End-Stage Renal Disease (ESRD).

When an individual becomes entitled to Medicare, CMS or the Railroad Retirement Board (RRB) will issue a health insurance card. The following information can be found on the health insurance card:

- Name;
- Sex;
- Medicare Health Insurance Claim (HIC) number; and
- Effective date of entitlement to Part A and/or Part B.

The HIC number on the health insurance card issued by CMS has an alpha or alphanumeric suffix and the Social Security Number (SSN), which is usually either the SSN of the insured or the spouse of the insured (depending on whose earnings eligibility is based). The HIC number on the health insurance card issued by the RRB has an alpha prefix and one or more characters and the insured's SSN, a six-digit number, or a nine-digit number.

Office staff should regularly request the beneficiary's health insurance card and picture identification to verify that services are furnished only to individuals eligible to receive Medicare benefits. Copies of the health insurance card and picture identification should be made for the beneficiary's medical file.

Part A and Part B Enrollment Periods

Individuals who want premium Part A and/or Part B may only enroll during one of the following prescribed enrollment periods:

- The Initial Enrollment Period (IEP) begins with the first day of the third month before the month premium Part A or Part B eligibility requirements are first met and ends seven months later (e.g., the IEP for the aged begins three months before the individual attains age 65 years and ends the third month after the month age 65 years is attained).

- The General Enrollment Period takes place from January 1 through March 31 of each year. Premium Part A and Part B coverage will be effective on July 1.
- The Special Enrollment Period (SEP) for the working aged and working disabled is when individuals may enroll who did not enroll in premium Part A or Part B when first eligible because they were covered under a Group Health Plan (GHP) based on their own or a spouse's current employment (or the current employment of a family member, if disabled). The individual can enroll at any time while covered under the GHP based on current employment or during the eight-month period that begins the first month employment ends or the GHP coverage ends, whichever occurs first. Individuals with ESRD are not eligible to enroll during this SEP.
- The SEP for international volunteers is when individuals may enroll who did not enroll in premium Part A or Part B when first eligible because they were performing volunteer service outside of the U.S. on behalf of a tax-exempt organization and had health insurance that provided coverage for the duration of the volunteer service. The individual can enroll during the six-month period that begins the month he or she is no longer performing volunteer service outside of the U.S.
- The Transfer Enrollment Period is when individuals who are age 65 years or over, entitled to Part B, and enrolled in a MA or Medicare 1876 cost plan may enroll in premium Part A. The individual may enroll during any month in which he or she is enrolled in the MA or Medicare 1876 cost plan or during any of the eight consecutive months following the last month he or she was enrolled in the MA or Medicare 1876 cost plan.

Premium Part A and/or Part B coverage continue until one of the following events occur:

- The individual's voluntary request for termination;
- Failure to pay premiums;
- Premium-free Part A terminates (for individuals under age 65); or
- The individual's death.

Part A – Hospital Insurance

Some of the services that Part A, hospital insurance, helps pay for include:

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

Eligibility Guidelines

To be eligible for premium-free Part A, an individual must first be insured based on his or her own earnings or the earnings of a spouse, parent, or child. To be insured, a

worker must have a specified number of quarters of coverage (QC). The exact number of required quarters is dependent on whether he or she is filing for Part A on the basis of age, disability, or ESRD. QCs are earned through payment of payroll taxes under the Federal Insurance Contributions Act (FICA) during the individual's working years. Most individuals pay the full FICA tax so that the QCs they earn can be used to insure them for both monthly Social Security benefits and Part A. Certain Federal, State, and local government employees pay only the Part A portion of the FICA tax. The QCs these employees earn can be used only to insure them for Part A and may not be used to insure them for monthly Social Security benefits.

Individuals Age 65 Years or Older

To be eligible for premium-free Part A on the basis of age, an individual must be age 65 years or older and either eligible for monthly Social Security or Railroad Retirement cash benefits or would be eligible for such benefits if the worker's QCs from government employment were regular Social Security QCs. Part A for the aged individual begins with the month age 65 years is attained, provided he or she files an application for Part A or for cash benefits and Part A within six months of the month in which age 65 years is attained. If the application is filed later than that, Part A entitlement can be retroactive for only six months. For Medicare purposes, individuals attain age 65 years the day before their actual 65th birthday and Part A is effective on the first day of the month upon attainment of age 65 years. For an individual whose 65th birthday is on the first day of the month, Part A is effective on the first day of the month preceding their birth month. For example, if an individual's birthday is on December 1, Part A is effective on November 1 since for Medicare purposes, he or she attained age 65 years on November 30. Individuals who continue to work beyond age 65 years may elect to file an application for Part A only. Part A entitlement generally does not end until the death of the individual.

A second group of aged individuals who are eligible for Part A are those individuals age 65 years or older who are not insured but elect to purchase Part A coverage by filing an application at a Social Security Administration (SSA) office. Because a monthly premium is required, this coverage is called premium Part A. The individual must be a U.S. resident and either a citizen or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously for the five-year period immediately preceding the month the application is filed. Individuals who want premium Part A can only file for coverage during a prescribed enrollment period and must also enroll or already be enrolled in
Part B.

Individuals Under Age 65 Years with Certain Disabilities

A disabled individual who is entitled to Social Security or Railroad Retirement benefits on the basis of disability is automatically entitled to Part A after 24 months of entitlement

to such benefits. In addition, disabled persons who are not insured for monthly Social Security disability benefits but would be insured for such benefits if their QCs from government employment were Social Security QCs are deemed to be entitled to disability benefits and automatically entitled to Part A after being disabled for 29 months. Part A entitlement on the basis of disability is available to the worker and to the widow, widower, or child of a deceased, disabled, or retired worker if any of them become disabled within the meaning of the Act or the Railroad Retirement Act. Beginning July 1, 2001, individuals whose disability is Amyotrophic Lateral Sclerosis are entitled to Medicare Part A the first month they are entitled to Social Security disability cash benefits. If an individual recovers from a disability, Part A entitlement ends at the end of the month after the month he or she is notified of the disability termination. However, in the case of individuals who return to work but continue to suffer from a disabling impairment, Part A entitlement will continue for at least 93 months after the individual returns to work.

Individuals with End-Stage Renal Disease

Individuals are eligible for Part A if they receive regular dialysis treatments or a kidney transplant, have filed an application, and meet one of the following conditions:

- Have worked the required amount of time under Social Security, the RRB, or as a government employee;
- Are receiving or are eligible for Social Security or Railroad Retirement benefits; or
- Are the spouse or dependent child of an individual who has worked the required amount of time under Social Security, the RRB, or as a government employee or who is receiving Social Security or Railroad Retirement benefits.

Part A coverage begins:

- The third month after the month in which a regular course of dialysis begins;
- The first month self-dialysis training begins (if training begins during the first three months of regular dialysis);
- The month of kidney transplant; or
- Two months prior to the month of transplant if the individual was hospitalized during those earlier months in preparation for the transplant.

Part A entitlement ends 12 months after the regular course of dialysis ends or 36 months after transplant.

Part B – Medical Insurance

Some of the services that Part B, medical insurance, helps pay for include:

- Medically necessary services furnished by physicians in a variety of medical settings, including but not limited to:
  - The physician's office;
  - An inpatient or outpatient hospital setting; and
  - Ambulatory Surgical Centers;
- Home health care for individuals who do not have Part A;
- Ambulance services;
- Clinical laboratory and diagnostic services;
- Surgical supplies;
- Durable medical equipment, prosthetics, orthotics, and supplies;
- Hospital outpatient services; and
- Services furnished by practitioners with limited licensing such as:
  - Audiologists;
  - Certified nurse midwives;
  - Certified registered nurse anesthetists;
  - Clinical nurse specialists;
  - Clinical psychologists;
  - Clinical social workers;
  - Independently practicing occupational therapists;
  - Independently practicing physical therapists;
  - Nurse practitioners; and
  - Physician assistants.

Eligibility Guidelines

All individuals who are eligible for premium-free Part A are eligible to enroll in Part B. Since Part B is a voluntary program that requires the payment of a monthly premium, those individuals who do not want coverage may refuse enrollment. An individual age 65 years or over who is not eligible for premium-free Part A must be a U.S. resident and either a citizen or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously for the five-year period immediately preceding the month the Part B enrollment application is filed. Individuals who refused Part B and those whose Part B coverage terminated may enroll or re-enroll in Part B only during prescribed enrollment periods.

Where to Find Additional Information About Medicare Part A and Part B

Additional information about Medicare Part A and Part B can be found at *http://www.cms.hhs.gov/MedicareGenInfo* on the CMS website.

Part C – Medicare Advantage

MA is a program through which organizations that contract with CMS furnish or arrange for the provision of health care services to Medicare beneficiaries who:

- Are entitled to Part A and enrolled in Part B;
- Permanently reside in the service area of the MA Plan; and
- Elect to enroll in a MA Plan.

Individuals with ESRD are generally excluded from enrolling in MA Plans.

Since 2006, beneficiaries have been able to enroll in regional Preferred Provider Organization (PPO) Plans throughout the U.S. In addition, beneficiaries are able to choose options such as Private Fee-for-Service Plans (PFFS), Health Maintenance Organizations, local PPOs (currently the most popular type of employer-sponsored plan), and Medicare Medical Savings Account (MSA) Plans (combines a high-deductible health plan with a MSA).

MA plans may also offer Medicare prescription drug benefits. Individuals enrolled in MA plans must receive their Medicare prescription drug benefits from their MA plan, except for MA PFFS plans that do not include drug benefits.

Medicare beneficiaries may choose to join or leave a MA Plan during one of the following election periods:

- Initial Coverage Election Period, which begins three months immediately before the individual's entitlement to both Medicare Part A and Part B and ends on the later of either the last day of the month preceding entitlement to both Part A and Part B or the last day of the individual's Part B IEP. If the beneficiary chooses to join a Medicare health plan during this period, the Plan must accept him or her unless the Plan has reached its member limit.
- Annual Coordinated Election Period (AEP), which occurs each year between November 15 and December 31. The Plan must accept all enrollments during this time unless it has reached its member limits.
- SEP, when, under certain circumstances, the beneficiary may change MA Plans or return to the Original Medicare Plan.
- Open Enrollment Period (OEP), during which time the beneficiary may leave or join another MA Plan if it is open and accepting new members. Elections made during this period must be made to the same type of plan (regarding Medicare prescription drug coverage) in which the individual is already enrolled. The OEP occurs from January 1 through March 31 of every year. If a plan chooses to be open, it must allow all eligible beneficiaries to join or enroll.

Where to Find Additional Information About Medicare Advantage and Private Fee-for-Service Plans

Additional information about MA and PFFS Plans is available as follows:

- At *http://www.cms.hhs.gov/HealthPlansGenInfo* on the CMS website; and
- At *http://www.cms.hhs.gov/PrivateFeeforServicePlans* on the CMS website.

Part D – Prescription Drug Plan

The PDP provides prescription drug coverage to all beneficiaries who elect to enroll in a PDP or MA Plan that includes Part D.

Medicare beneficiaries may choose to join or leave a Medicare PDP during the following enrollment periods:

- The IEP for Part D is the 7-month period that surrounds the individual beneficiary's first eligibility for Part D, beginning 3 months before the month of eligibility and ending on the last day of the third month following the month eligibility began.
- AEP, which occurs each year between November 15 and December 31. The Medicare PDP must accept all enrollments during this time.
- SEP, during which time beneficiaries in certain circumstances may change PDPs. The following are examples of such circumstances:
    - He or she permanently moves outside the service area;
    - He or she has both Medicare and Medicaid;
    - He or she moves into, resides in, or moves out of an institution; or
    - Other exceptions as determined by CMS.

Where to Find Additional Information About the Prescription Drug Plan

Additional information about the PDP can be found at *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn* on the CMS website.

An individual with Medicare and limited income and resources may qualify for extra help paying for Medicare prescription drug coverage costs. If the individual qualifies for extra help, he or she will receive assistance in paying for their drug plan's monthly premium, yearly deductible, and prescription copayments. Applications for extra help may be filed at the local Medicaid office or by contacting the SSA.

Social Security Administration Contact Information

The SSA contact information is as follows:

- At *http://www.socialsecurity.gov* on the Web; and
- Telephone: (800) 772-1213.

ORGANIZATIONS THAT IMPACT THE MEDICARE PROGRAM

The following organizations impact the Medicare Program:

- U.S. House of Representatives:
  - Ways and Means Committee;
  - Appropriations Committee; and
  - Energy and Commerce Committee.

- U.S. Senate:
  - Appropriations Committee;
  - Finance Committee; and
  - Energy and Commerce Committee.

- The SSA determines eligibility for Medicare benefits and enrolls individuals in Part A and/or Part B and the Federal Black Lung Benefit Program. The SSA completes the following activities:
  - Replaces lost or stolen Medicare cards;
  - Makes address changes;
  - Collects premiums from beneficiaries; and
  - Educates beneficiaries about coverage and insurance choices.

- The Office of Inspector General (OIG) protects the integrity of HHS programs and the health and welfare of beneficiaries of those programs through a nationwide network of audits, investigations, inspections, and other mission-related functions.

  ### Where to Find Additional Information About the Office of Inspector General

  Additional information about the OIG can be found at *http://www.oig.hhs.gov* on the Web.

- State Agencies survey all Medicare Part A and certain Part B providers and suppliers and make recommendations about their suitability for participation in the Medicare Program. SAs also assist providers and suppliers in sustaining quality standards.

  ### State Agency Contact Information

  Contact information for SAs can be found at *http://www.cms.hhs.gov/SurveyCertificationGenInfo/03_ContactInformation.asp* on the CMS website.

- CMS contracts with one Quality Improvement Organization (QIO) in each state, Washington, D.C., Puerto Rico, and the Virgin Islands. QIOs are private, mostly not-for-profit organizations that are staffed by professionals who are trained to review medical care, help beneficiaries with complaints about quality of care, and implement improvements in the quality of care. The mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

  ### Where to Find Additional Information About Quality Improvement Organizations

  Additional information about QIOs and a link to the directory of QIOs can be found at *http://www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp* on the CMS website.

- The State Health Insurance Assistance Program (SHIP) is a national program that offers free one-on-one counseling and assistance to individuals with Medicare and their families through interactive sessions, public education presentations and programs, and media activities. There are SHIPs in all 50 states, Washington, D.C., Puerto Rico, and the Virgin Islands. SHIP-trained counselors provide a wide range of information about long-term care insurance; Medigap; fraud and abuse; and the Medicare, Medicaid, and public benefit programs for those with limited income and assets.

  ### Where to Find Additional Information About the State Health Insurance Assistance Program

  Additional information about the SHIP and a link to State Health Insurance offices can be found at *http://www.cms.hhs.gov/Partnerships/10_SHIPS.asp* on the CMS website.

CHAPTER TWO

BECOMING A MEDICARE PROVIDER OR SUPPLIER

This chapter discusses Medicare providers and suppliers, enrolling in the Medicare Program, private contracts with Medicare beneficiaries, and promoting cultural competency in your practice.

MEDICARE PROVIDERS AND SUPPLIERS

The Medicare Program recognizes a broad range of providers and suppliers who furnish the necessary services and supplies to meet the health care needs of beneficiaries.

Part A Providers and Suppliers

Medicare makes payment under Part A for certain services furnished by the following types of entities:

- Critical Access Hospitals;
- Federally Qualified Health Centers;
- Histocompatibility Laboratories;
- Home Health Agencies (including sub-units);
- Hospice;
- Hospitals (acute care inpatient services);
- Indian Health Services Facilities;
- Inpatient Psychiatric Facilities;
- Inpatient Rehabilitation Facilities;
- Long Term Care Hospitals;
- Multiple hospital components in a medical complex;
- Organ Procurement Organizations;
- Program for All-Inclusive Care for the Elderly (PACE) providers;
- Religious Non-Medical Health Care Institutions (formerly Christian Science Sanatoriums);
- Rural Health Clinics; and
- Skilled Nursing Facilities (SNF).

Part B Providers and Suppliers

Medicare makes payment under Part B for certain services furnished by the following:

- Ambulance service suppliers;
- Ambulatory Surgical Centers (ASC);
- Clinical psychologists;
- Community Mental Health Centers;
- Comprehensive Outpatient Rehabilitation Facilities;
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers (including pharmacies);
- End-Stage Renal Disease Facilities;
- Home Health Agencies (outpatient Part B services);

- Hospitals (outpatient services);
- Independent diagnostic testing facilities;
- Mass immunization roster billers;
- Nurse practitioners;
- Occupational therapists in private practice;
- Other non-physician practitioners (NPP);
- Outpatient physical therapists;
- Outpatient speech-language pathology suppliers;
- PACE providers;
- Physical therapists in private practice;
- Physicians; and
- SNFs (outpatient services).

Physicians

The Medicare Program defines physicians to include the following:

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

In addition, the Medicare physician must be legally authorized to practice by a State in which he or she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice. The issuance by a State for a license to practice medicine constitutes legal authorization. A temporary State license also constitutes legal authorization to practice medicine. If State law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the State licensing board, the local standards are used in determining whether the physician has legal authorization. If the State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered.

Interns and Residents

Interns and residents include individuals who:

- Participate in approved Graduate Medical Education (GME) programs; or
- Are not in approved GME programs, but are authorized to practice only in a hospital setting (e.g., have temporary or restricted licenses or are unlicensed graduates of foreign medical schools). Also included in this definition are interns, residents, and fellows in GME programs recognized as approved for purposes of direct GME and Indirect Medical Education payments made by Fiscal Intermediaries (FI) or A/B Medicare Administrative Contractors (MAC). Receiving

staff or faculty appointments, participating in fellowships, or whether a hospital includes physicians in its full-time equivalency count of residents does not by itself alter the status of "resident."

Teaching Physicians

Teaching physicians are physicians (other than interns or residents) who involve residents in the care of their patients. Generally, teaching physicians must be present during all critical or key portions of the procedure and immediately available to furnish services during the entire service in order for the service to be payable under the Medicare Physician Fee Schedule (MPFS).

Practitioners

The Medicare Program defines a practitioner as any of the following to the extent that an individual is legally authorized to practice by the State and otherwise meets Medicare requirements:

- Anesthesiologist assistant (AA);
- Certified nurse midwife (CNM);
- Clinical nurse specialist (CNS);
- Certified registered nurse anesthetist (CRNA);
- Clinical psychologist (CP);
- Clinical social worker (CSW);
- Nurse practitioner (NP);
- Physician assistant (PA); or
- Registered dietician or nutrition professional.

ENROLLING IN THE MEDICARE PROGRAM

In order to enroll in and obtain reimbursement from Medicare, providers and suppliers must:

1) Obtain a national Provider Identifier (NPI); and
2) Complete the appropriate Medicare Enrollment Application.

National Provider Identifier

The NPI is a unique identification number for health care providers that is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. Covered health care providers and all health plans and health care clearinghouses must use NPIs in the administrative and financial transactions adopted under HIPAA. Providers and suppliers can apply for a NPI using one of the following methods:

- Visiting *https://nppes.cms.hhs.gov/NPPES/Welcome.do* and completing the web-based application;

- Requesting the NPI Application/Update Form (CMS-10114) by calling (800) 465-3203, sending an e-mail to customerservice@npienumerator.com, or sending a letter to:
  NPI Enumerator
  P. O. Box 6059
  Fargo, ND 58108-6059; or
- Requesting that an Electronic File Interchange Organization submit application data on your behalf.

Where to Find Additional Information About the National Provider Identifier

Additional information about the NPI can be found at *http://www.cms.hhs.gov/NationalProvIdentStand* on the Centers for Medicare & Medicaid Services (CMS) website.

Medicare Enrollment Application

In the enrollment process, CMS collects information about the applying provider or supplier and secures documentation to ensure that the he or she is qualified and eligible to enroll in the Medicare Program. Depending upon provider or supplier type, one of the following forms is completed to enroll in the Medicare Program:

- Form CMS-855A/Medicare Enrollment Application for Institutional Providers: Application: Application used by institutional providers to initiate the Medicare enrollment process or to change Medicare enrollment information;
- Form CMS-855B/Medicare Enrollment Application for Clinics/Group Practices and Certain Other Suppliers: Application used by group practices or other organizational suppliers, except DMEPOS suppliers, to initiate the Medicare enrollment process or to change Medicare enrollment information;
- Form CMS-855I/Medicare Enrollment Application for Physicians and Non-Physician Practitioners: Application used by individual physicians or NPPs to initiate the Medicare enrollment process or to change Medicare enrollment information;
- Form CMS-855R/Medicare Enrollment Application for Reassignment of Medicare Benefits: Application used by individual physicians or NPPs to initiate reassignment of a right to bill the Medicare Program and receive Medicare payments or to terminate a reassignment of benefits; and
- Form CMS-855S/Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Suppliers: Application used by DMEPOS suppliers to initiate the Medicare enrollment process or to change Medicare enrollment information.

The following forms are often required in addition to the Medicare Enrollment Application:

- Form CMS-588/Electronic Funds Transfer (EFT) Authorization Agreement: Medicare authorization agreement for EFTs (for providers who choose to have payments sent directly to their financial institution); and
- CMS Standard Electronic Data Interchange (EDI) Enrollment Form: Agreement executed by each provider of health care services, physician, or supplier that intends to submit electronic media claims (EMC) or other EDI transactions to Medicare. This form is available from Medicare Carriers, FIs, A/B MACs, and Durable Medical Equipment Medicare Administrative Contractors and must be completed prior to submitting EMC or other EDI transactions to Medicare.

The following optional form is submitted if the provider or supplier wishes to enroll as a Medicare participating provider or supplier:

- Form CMS-460/Medicare Participating Physician or Supplier Agreement: Agreement to become a Part B participating provider or supplier who will accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries. The Participating and Nonparticipating Providers and Suppliers Section of this chapter provides additional information about participating in the Medicare Program.

The above forms are available at *http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp* on the CMS website.

Additional forms, which may vary from state to state, may also be required in order to enroll in the Medicare Program. These forms include the following:

- State medical license;
- Occupational or business license; and
- Certificate of Use.

Institutional providers and suppliers must simultaneously contact their local State Agency (SA), which determines Medicare participation requirements (certain provider types may elect voluntary accreditation by a CMS-recognized accrediting organization in lieu of a SA survey).

State Agency Contact Information

Contact information for SAs can be found at *http://www.cms.hhs.gov/SurveyCertificationGenInfo/03_ContactInformation.asp* on the CMS website.

By law, in most cases Medicare must pay the provider who furnishes the service. In limited situations, however, Medicare allows physicians and practitioners who furnish services and take assignment to reassign payment to another qualified individual or

entity. This individual or entity then bills Medicare on behalf of the physician or practitioner and receives payment for the services furnished. When a physician or practitioner authorizes someone else to bill and be paid by Medicare for services that he or she furnishes, both parties are jointly responsible for ensuring that claims filed are appropriate and reflect services actually furnished. Another exception is where a physician does not participate in Medicare and does not take assignment on the claim, in which case Medicare sends payment to the beneficiary and the physician collects the limiting charge from the beneficiary.

After all forms have been completed and signed, the enrollment packet is then mailed to the appropriate Medicare Contractor for processing. CMS requires its Contractors to process enrollment applications within certain timeframes. Information about where to send the enrollment packet can be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf* on the CMS website. Alternatively, providers and suppliers may now enroll in Medicare via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). Providers and suppliers may also make changes to and track their Medicare enrollment information via PECOS.

Providers must report changes in their enrollment information to the Medicare Contractor as soon as possible and no later than 90 days after the reportable event by submitting the information on the same application that is used to initiate the Medicare enrollment process, with the exception of the following:

- Providers must report a change of ownership or managing interest control within 30 days; and
- DMEPOS suppliers must notify the National Supplier Clearinghouse of changes in their enrollment information within 30 days.

Where to Find Additional Information about Medicare Provider and Supplier Enrollment

Additional information about Medicare provider and supplier enrollment can be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll* on the CMS website.

Participating and Nonparticipating Providers and Suppliers

There are two types of providers and suppliers in Part B of the Medicare Program: participating and nonparticipating.

1) Participating providers and suppliers:
    - Accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries;
    - Receive higher MPFS allowances than nonparticipating providers and suppliers;

- Accept the Medicare allowed amount as payment in full (limiting charge provisions are not applicable); and
- Are included in the Physician and Other Healthcare Professional Directory.

By completing and signing Form CMS-460, the Medicare Participating Physician or Supplier Agreement, the provider or supplier has formally notified CMS that he or she wishes to participate in the Medicare Program and will accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries. Assignment means that the provider or supplier will be paid the Medicare allowed amount as payment in full for his or her services. The following services are always subject to assignment:

- Clinical diagnostic laboratory services and physician laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Services of AAs, CNMs, CNSs, CPs, CRNAs, CSWs, medical nutrition therapists, NPs, and PAs;
- ASC services;
- Services of mass immunization roster billers;
- Home dialysis supplies and equipment paid under Method II;
- Drugs; and
- Ambulance services.

Participation is valid for a yearlong period from January 1 through December 31. Active participants receive a participation package during the Medicare Contractor Open Enrollment Period, which is usually in mid-November of each year. During this period, participation status can be changed for the following year. Providers and suppliers who wish to continue participating in the Medicare Program do not need to sign an agreement each year. The Medicare Participating Physician or Supplier Agreement will remain in effect through December 31 of the calendar year in which the Medicare Contractor is notified about a change in status. Once the Medicare Participating Physician or Supplier Agreement is signed, CMS rarely honors a provider or supplier's decision to change participation status during the year.

2) Nonparticipating providers and suppliers:
   - May accept assignment of Medicare claims on a claim-by-claim basis;
   - Receive lower MPFS allowances than participating providers and suppliers for assigned or nonassigned claims;
   - May not submit charges for nonassigned claims that are in excess of the limiting charge amount (with the exception of pharmaceuticals, equipment, and supplies) and may collect up to the limiting charge amount at the time services are furnished, which is the maximum that can be charged for the services furnished (unless prohibited by an applicable State law); and
   - Are not included in the Physician and Other Healthcare Professional Directory.

Below is an example of a limiting charge.

MPFS Allowed Amount for Procedure "X"	$200.00
Nonparticipating Provider or Supplier Allowed Amount for Procedure "X"	$190.00 ($200.00 x .95 = 5 percent lower than MPFS allowed amount)
Limiting Charge for Procedure "X"	$218.50 ($190.00 x 1.15 = 115 percent of MPFS allowed amount)
Beneficiary Coinsurance and Limiting Charge Portion Due to Provider or Supplier	$66.50 ($38.00 plus $28.50) Coinsurance – 20 percent of MPFS allowed amount ($190.00 x .20 = $38.00) **PLUS** $218.50 – Limiting charge - 190.00 – Nonparticipating provider/supplier allowed amount $ 28.50 – Allowed amount

Limiting charges apply to the following regardless of who furnishes or bills for them:

- Physicians' services;
- Services and supplies commonly furnished in physicians' offices that are incident to physicians' services;
- Outpatient physical and occupational therapy services furnished by an independently practicing therapist;
- Diagnostic tests; and
- Radiation therapy services, including x-ray, radium, radioactive isotope therapy, materials, and technician services.

Below is an illustration of the payment amounts that participating and nonparticipating providers and suppliers receive.

	Participating Provider/ Supplier	Nonparticipating Provider/Supplier Who Accepts Assignment	Nonparticipating Provider/Supplier Who Does Not Accept Assignment
Submitted Amount	$125.00	$125.00	$109.25
MPFS Allowed Amount	$100.00	$ 95.00	$ 95.00
80 Percent of MPFS Allowed Amount	$ 80.00	$ 76.00	$ 76.00
Beneficiary Coinsurance Due to Provider/Supplier (after deductible has been met)	$ 20.00	$ 19.00	$ 33.25
Total Payment to Provider/Supplier (payment for nonassigned claims goes to the beneficiary, who is responsible for paying provider/ supplier)	$100.00	$ 95.00	$109.25 ($95.00 x 1.15 limiting charge)

PRIVATE CONTRACTS WITH MEDICARE BENEFICIARIES

The following physicians who are legally authorized to practice medicine, surgery, dentistry, podiatry, or optometry by the state in which such function or action is performed may opt-out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered:

- Doctors of medicine;
- Doctors of osteopathy;
- Doctors of dental surgery or dental medicine;
- Doctors of podiatric medicine; and
- Doctors of optometry.

AAs, CNMs, CNSs, CPs, CRNAs, CSWs, and PAs who are legally authorized to practice by the State and otherwise meet Medicare requirements may also opt-out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered.

The opt-out period is for two years unless it is terminated early or the physician or practitioner fails to maintain opt-out. Opt-outs may be renewed for subsequent two-year periods. The physician or practitioner must opt-out of Medicare for all beneficiaries and all items or services, with the exception of emergency or urgent care situations, in which case the physician or practitioner may treat a beneficiary with whom he or she does not have a private contract and bill Medicare for the treatment. Claims for emergency or urgent care require modifier GJ, "OPT-OUT physician or practitioner emergency or urgent service."

Medicare will make payment for covered medically necessary items or services that are ordered by a physician or practitioner who has opted-out of Medicare if:

- He or she has acquired a provider identifier; and
- The items or services are not furnished by a physician or practitioner who has also opted-out of Medicare.

Where to Find Additional Information About Becoming a Medicare Provider or Supplier

Additional information about how to become a Medicare provider or supplier is available as follows:

- At *http://www.cms.hhs.gov/medicareprovidersupenroll* on the CMS website; and
- In the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1) located at *http://www.cms.hhs.gov/Manuals* on the CMS website.

PROMOTING CULTURAL COMPETENCY IN YOUR PRACTICE

Racial and ethnic minorities are expected to make up approximately 40 percent of the population by 2030. With the increasing diversity of the U.S. population, providers and suppliers are more and more likely to encounter situations that require the delivery of culturally competent care, access to a vast array of language services, and supportive health care organizations. Addressing a patient's social and cultural background will assist providers in delivering high quality, effective health care and increase patient satisfaction, improve patient compliance, and reduce racial and ethnic health disparities.

The U.S. Department of Health and Human Services Office of Minority Health and Science Applications International Corporation have developed a free interactive web-based training cultural competency course titled *A Physician's Practical Guide to Culturally Competent Care*. The course assists physicians, PAs, NPs, and other health care professionals in preparing for the increasingly diverse patient population and furnishing the highest quality of care to every patient regardless of race, ethnicity,

cultural background, or ability to speak English as their primary language. The course offers a variety of continuing education credit types. The course and information about cultural competency are available at *http://thinkculturalhealth.org* on the Web.

CHAPTER THREE

MEDICARE REIMBURSEMENT

This chapter provides information about Medicare claims; deductibles, coinsurance, and copayments; coordination of benefits; incentive payments; the Medicare Physician Fee Schedule (MPFS); Medicare notices; and other health insurance plans.

MEDICARE CLAIMS

A claim is defined as a request for payment for benefits or services received by a beneficiary. Providers and suppliers who furnish covered services to Medicare beneficiaries are required to submit claims for their services and cannot charge beneficiaries for completing or filing a Medicare claim. Medicare Contactors monitor compliance with these requirements. Offenders may be subject to a Civil Monetary Penalty of up to $10,000 for each violation.

Medicare fee-for-service claims must be filed timely, which means that they must be filed on or before December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year (October through December) are considered furnished in the following year.

Exceptions to Mandatory Filing

Providers and suppliers are not required to file claims on behalf of Medicare beneficiaries when:

- The claim is for services for which Medicare is the secondary payer, the primary insurer's payment is made directly to the beneficiary, and the beneficiary has not furnished the primary payment information needed to submit the Medicare secondary claim;
- The claim is for services furnished outside the U.S.;
- The claim is for services initially paid by third-party insurers who then file Medicare claims to recoup what Medicare pays as the primary insurer (e.g., indirect payment provisions);
- The claim is for other unusual services, which are evaluated by Medicare Contractors on a case-by-case basis;
- The claim is for excluded services (some supplemental insurers who pay for these services may require a Medicare claim denial notice prior to making payment);
- He or she has opted-out of the Medicare Program by signing a private contract with the beneficiary; or
- He or she has been excluded or debarred from the Medicare Program.

Electronic Claims

As of October 16, 2003, all providers and suppliers must submit claims electronically via Electronic Data Interchange (EDI) in the Health Insurance Portability and Accountability Act format, except in limited situations.

Electronic versions of Centers for Medicare & Medicaid Services (CMS) claim forms can be found at *http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp* on the CMS website. Each provider or supplier must complete a CMS Standard EDI Enrollment Form and send it to the Medicare Contractor prior to submitting electronic media claims (EMC). A sender number, which is required in order to submit electronic claims, will then be issued. An organization that is comprised of multiple components that have been assigned Medicare provider identifiers may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which these identifiers have been assigned.

Where to Find Additional Information About Electronic Billing and Electronic Data Interchange Transactions

Additional information about electronic billing and EDI transactions is available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans* on the CMS website. The EDI Enrollment Form is available from Medicare Contractors.

Electronic Media Claims Submissions

Claims are electronically transmitted to the Medicare Contractor's system, which verifies claim data. This information is then electronically checked or edited for required information. Claims that pass these initial edits, also called front-end or pre-edits, are processed in the claims processing system according to Medicare policies and guidelines. Claims with inadequate or incorrect information may:

- Be returned to the provider or supplier for correction;
- Be suspended in the Contractor's system for correction; or
- Have information corrected by the system (in some cases).

A confirmation or acknowledgment report, which indicates the number of claims accepted and the total dollar amount transmitted, is generated to the provider or supplier. This report also indicates the claims that have been rejected and reason(s) for the rejection.

Electronic Media Claims Submission Alternatives

Providers and suppliers who do not submit electronic claims using EMC may choose to alternatively submit claims through an electronic billing software vendor or clearinghouse, billing agent, or by using Medicare's free billing software. Providers and

suppliers can obtain a list of electronic billing software vendors and clearinghouses as well as billing software from Medicare Contractors.

Medicare Contractor Contact Information

The Provider Call Center Toll-Free Numbers Directory, which contains Medicare Contractor contact information, can be accessed in the Downloads Section at *http://www.cms.hhs.gov/MLNGenInfo/30_contactus.asp* on the CMS website.

Paper Claims

To find information about the limited situations in which paper claims can be submitted, visit *http://www.cms.hhs.gov/ElectronicBillingEDITrans/05_ASCASelfAssessment.asp* on the CMS website

Non-institutional providers and suppliers use the CMS-1500 claim form to bill Medicare Contractors and Durable Medical Equipment Medicare Administrative Contractors (DME MAC). CMS-1500 claim forms can be ordered from printing companies, office supply stores and the U.S. Government Printing Office, U.S. Government Bookstore:

- At *http://bookstore.gpo.gov* on the Web; and
- Telephone: (866) 512-1800.

Institutional providers and suppliers use the CMS-1450, also known as UB-04, to bill Medicare Contractors. UB-04 claim forms can be ordered from the National Uniform Billing Committee at *http://www.nubc.org/guide.html* on the Web.

Durable Medical Equipment, Prosthetics and Orthotics, and Parenteral and Enteral Nutrition Claims

DME MACs have jurisdiction for the following claims:

- Nonimplantable durable medical equipment, prosthetics, orthotics, and supplies (including items for home use);
- Parenteral and enteral nutrition (PEN) products (other than items furnished to inpatients covered under Part A);
- Certain oral drugs billed by pharmacies; and
- Method II home dialysis.

Where to Find Additional Information About Durable Medical Equipment, Prosthetics and Orthotics, and Parenteral and Enteral Nutrition Claims

Additional information about DMEPOS and PEN claims can be found at *http://www.cms.hhs.gov/center/dme.asp* on the CMS website.

DEDUCTIBLES, COINSURANCE, AND COPAYMENTS

Providers and suppliers must collect unmet deductibles, coinsurance, and copayments from the beneficiary. The deductible is the amount a beneficiary must pay before Medicare begins to pay for covered services and supplies. These amounts can change every year. Under the Original Medicare Plan or a Private Fee-for-Service Plan, coinsurance is a percentage of covered charges that the Medicare beneficiary may pay after he or she has met the applicable deductible. Providers and suppliers should determine whether the beneficiary has supplemental insurance that will pay for deductibles and coinsurance before billing the beneficiary for them. In some Medicare health plans, a copayment is the amount that is paid by the beneficiary for each medical service. If a beneficiary is unable to pay these charges, he or she should sign a waiver that explains the financial hardship. If a waiver is not assigned, the beneficiary's medical record should reflect normal and reasonable attempts to collect the charges before they are written off. The same attempts to collect charges must be applied to both Medicare beneficiaries and non-Medicare beneficiaries. Consistently waiving deductibles, coinsurance, and copayments may be interpreted as program abuse.

On assigned claims, the beneficiary is responsible for:

- Unmet deductibles;
- Applicable coinsurance and copayments; and
- Charges for services and supplies that are not covered by Medicare.

COORDINATION OF BENEFITS

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

Medicare Secondary Payer Program

Medicare law requires that providers and suppliers determine whether Medicare is the primary or secondary payer prior to submitting a claim by asking beneficiaries or their representatives about other health insurance or coverage. In addition, primary payers must be identified on claims submitted to Medicare. Providers and suppliers should not rely on Common Working File (CWF) information alone since Medicare Secondary Payer (MSP) circumstances can change quickly. The following secondary payer information can be found via the MSP Auxiliary File in the CWF:

- MSP effective date;
- MSP termination date;
- Patient relationship;
- Subscriber name;
- Subscriber policy number;
- Insurer type;

- Insurer information (name, group number, address, city, state, and ZIP code);
- MSP type;
- Remarks code;
- Employer information (name, address, city, state, and ZIP code); and
- Employee information (identification number).

Medicare may make payment if the primary payer denies the claim and the provider or supplier includes documentation that the claim has been denied in the following situations:

- The Group Health Plan (GHP) denies payment for services because the beneficiary is not covered by the health plan, benefits under the plan are exhausted for particular services, the services are not covered under the plan, a deductible applies, or the beneficiary is not entitled to benefits;
- The no-fault or liability insurer denies payment or does not pay the bill because benefits have been exhausted;
- The Workers' Compensation (WC) Plan denies payment (e.g., when it is not required to pay for certain medical conditions); or
- The Federal Black Lung Program does not pay the bill.

In liability, no-fault, or WC situations, Medicare may make a conditional payment for covered Medicare services in order to prevent beneficiary financial hardship when:

- The claim is not expected to be paid promptly;
- The properly submitted claim was denied in whole or in part; or
- Due to the physical or mental incapacity of the beneficiary, a proper claim was not filed with the primary insurer.

When payments are made under these situations, they are made on the condition that the insurer and/or the beneficiary will reimburse Medicare to the extent that payment is subsequently made by the insurer.

Where to Find Additional Information About the Medicare Secondary Payer Program

Additional information about the MSP Program is available as follows:

- In the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1) and Medicare Secondary Payer Manual (Pub. 100-5) located at *http://www.cms.hhs.gov/Manuals* on the CMS website; and
- At *http://www.cms.hhs.gov/COBGeneralInformation* on the CMS website.

Coordination of Benefits Contractor

The Coordination of Benefits Contractor (COBC) performs activities that support the collection, management, and reporting of other health insurance or coverage for Medicare beneficiaries. The COBC also has responsibility for consolidation of the claims crossover process, which ensures that payers, including State Medicaid Agencies, have the opportunity to receive Medicare processed claims from one source for their use in calculating their supplemental payment. The COBC assists providers and suppliers with the following:

- Answering general questions regarding MSP;
- Verifying Medicare's primary/secondary status (note that insurer-specific information will not be released; information on payers primary to Medicare must be requested from the beneficiary prior to billing);
- Reporting changes to a beneficiary's health insurance or coverage; and
- Reporting a beneficiary's accident/injury.

If a provider or supplier submits a claim for primary payment on behalf of a beneficiary and there is information either on the claim form or in Medicare's system of records indicating that Medicare is properly the secondary payer, the claim will be denied unless the provider or supplier has submitted sufficient evidence to demonstrate that Medicare is properly the primary payer for the services provided. The beneficiary cannot be billed when a claim is denied because a primary payer to Medicare exists. If a provider or supplier submits a claim for secondary payment on behalf of a beneficiary but there is no information in Medicare's system of records to identify the MSP situation and the claim form does not contain sufficient information to update Medicare's system of records, the COBC will investigate in an effort to obtain the required information.

The COBC determines whether beneficiaries have health insurance that is primary to Medicare through the following mechanisms:

- Initial enrollment questionnaire, which is sent to Medicare beneficiaries approximately three months before Medicare coverage begins regarding their other health insurance or coverage;
- Internal Revenue Service, Social Security Administration, and CMS data match, which are completed by employers regarding GHP coverage for identified workers who are either entitled to Medicare or are married to a Medicare beneficiary;
- MSP claims investigation, which is a collection of data regarding health insurance or coverage that may be primary to Medicare based on information submitted on a medical claim or from other sources; and
- Voluntary MSP data match agreements that allow for electronic data exchange of GHP eligibility and Medicare information between CMS and employers or insurers.

Coordination of Benefits Contractor Contact Information

Toll-free line: (800) 999-1118

General written inquiries:
MEDICARE - COB
P.O. Box 5041
New York, NY 10274-5041

Questionnaires and correspondence:
MEDICARE - COB
Data Match Project
P.O. Box 33848
Detroit, MI 48232

Initial Enrollment Questionnaire Project:
P.O. Box 17521
Baltimore, MD 21203-7521

MSP Claims Investigation
Project:P.O. Box 33847
Detroit, MI 48232

Voluntary Agreement Project:
P.O. Box 660
New York, NY 10274-0660

Employer/Insurer Outreach:
P.O. Box 660
New York, NY 10274

Small Employer Exemptions:
P.O. Box 660
New York, NY 10274

Workers' Compensation Medicare Set-Aside Arrangements Proposal/Final Settlement:
P.O. Box 33849
Detroit, MI 48232

The COBC does not process claims nor does it handle any mistaken primary recoveries or claims-specific inquiries. Medicare Contractors are responsible for processing claims submitted for primary or secondary payment and provider/supplier-related recovery. Questions concerning Medicare claim or service denials, adjustments, and billing (e.g.,

value and occurrence codes) should be directed to the Medicare Contractor. Inappropriate Medicare payments should be returned to the Medicare Contractor.

Medicare Contractor Contact Information

The Provider Call Center Toll-Free Numbers Directory, which contains Medicare Contractor contact information, can be accessed in the Downloads Section at *http://www.cms.hhs.gov/MLNGenInfo/30_contactus.asp* on the CMS website.

INCENTIVE PAYMENTS

Health Professional Shortage Area Incentive Payment

The Omnibus Budget Reconciliation Act of 1987 established Medicare's Incentive Payment Program, which encouraged primary care physicians to work in underserved rural areas and to improve access to care for Medicare beneficiaries. It paid primary care physicians an incentive payment of five percent for services furnished to Medicare beneficiaries in Federally-designated Health Professional Shortage Areas (HPSA). Effective January 1, 1991, Congress increased the incentive payment to 10 percent and expanded eligibility to include physicians' services in both rural and urban HPSAs.

Under Section 1833(m) of the Social Security Act, physicians (including psychiatrists) who furnish care in an area that is designated as a geographic-based, primary medical care HPSA and psychiatrists who furnish care in an area that is designated as a geographic-based mental health HPSA are eligible for a 10 percent HPSA incentive payment for outpatient professional services furnished to a Medicare beneficiary. The HPSA incentive payment is available only for the physician's professional services. If a service is billed with both a professional and a technical component, only the professional component will receive the incentive payment. The incentive payment is based on the paid amount of the claim.

If the service is furnished in an area that is on the CMS list of ZIP codes that are eligible for the HPSA incentive payment, payments are automatically paid on a quarterly basis. The list of eligible ZIP codes is updated annually and is effective for services on or after January 1 of each calendar year. An area may be eligible for the HPSA incentive payment but the ZIP code may not be on the list because:

1) It does not fall within a designated full county HPSA;
2) It is not considered to fall within the county based on a determination of dominance made by the U.S. Postal Service;
3) It is partially in a sub-county HPSA; or
4) Services with dates of service on or after January 1, 2009 are provided in a Zip code area that was designated as of December 31 of the prior year but are not on the Zip code file.

In these situations, the physician must utilize an AQ modifier to receive payment for claims with dates of service on or after January 1, 2006. If the ZIP code of the place of service is not on the HPSA list for automated payment, eligibility must be verified with the Fiscal Intermediary or A/B Medicare Administrative Contractor before submitting a claim with the AQ modifier.

Where to Find Additional Information About Health Professional Shortage Area Incentive Payments

Additional information about HPSA incentive payments is available as follows:

- In Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4): *http://www.cms.hhs.gov/Manuals* on the CMS website;
- Eligible ZIP codes: *http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses* on the CMS website;
- Qualified HPSAs: *http://www.hpsafind.hrsa.gov* on the Web; and
- Census tract of place of service: *http://www.ffiec.gov/Geocode/default.aspx* on the Web.

Physician Quality Reporting Initiative Incentive Payment

Identified eligible professionals who satisfactorily report data on quality measures for covered MPFS services furnished to Part B beneficiaries may be eligible for an incentive payment under the Physician Quality Reporting Initiative (PQRI).

Where to Find Additional Information About Physician Quality Reporting Initiative Incentive Payments

Additional information about PQRI incentive payments can be found at *http://www.cms.hhs.gov/PQRI* on the CMS website.

MEDICARE PHYSICIAN FEE SCHEDULE

Medicare Part B pays for physician services based on the MPFS, which lists the more than 7,000 covered services and their payment rates. Physician services include the following:

- Office visits;
- Surgical procedures; and
- A range of other diagnostic and therapeutic services.

Physician services are furnished in all settings including:

- Physicians' offices;
- Hospitals;
- Ambulatory Surgical Centers;

- Skilled Nursing Facilities and other post-acute care settings;
- Hospices;
- Outpatient dialysis facilities;
- Clinical laboratories; and
- Beneficiaries' homes.

Payment rates for an individual service are based on three components:

1) Relative Value Units (RVU)

The three separate RVUs that are associated with the calculation of a payment under the MPFS are:

- Work RVUs reflect the relative levels of time and intensity associated with furnishing a physician fee schedule service and account for more than 50 percent of the total payment associated with a service. By statute, all work RVUs must be examined no less often than every five years.
- Practice expense (PE) RVUs reflect the costs of maintaining a practice such as renting office space, buying supplies and equipment, and staff costs. PE RVUs account for approximately 45 percent of the total payment associated with a given service.
- Malpractice RVUs represent the remaining portion of the total payment associated with a service.

2) Conversion Factor (CF)

To determine the payment rate for a particular service, each of the three separate RVUs is adjusted by the corresponding geographic cost index. The sum of the geographically adjusted RVUs is multiplied by a dollar CF. The CF is updated on an annual basis according to a formula specified by statute. The formula specifies that the update for a year is equal to the Medicare Economic Index (MEI) adjusted up or down depending on how actual expenditures compare to a target rate called the Sustainable Growth Rate (SGR). The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels. The SGR is calculated based on medical inflation, the projected growth in the domestic economy, projected growth in the number of beneficiaries in fee-for-service Medicare, and changes in law or regulation.

3) Geographic Practice Cost Indices (GPCI)

GPCIs are adjustments that are applied to each of the three relative values used in calculating a physician payment. The purpose of these adjustments is to account for geographic variations in the costs of practicing medicine in different areas within the country. We are required to review and, if necessary, adjust GPCIs at least every three years.

Where to Find Additional Information About the Medicare Physician Fee Schedule

Additional information about the MPFS is available at *http://www.cms.hhs.gov/PhysicianFeeSched/01_overview.asp* on the CMS website.

Where to Find Additional Information About Medicare Reimbursement

Additional information about Medicare reimbursement can be found in the Medicare Claims Processing Manual (Pub. 100-4) located at *http://www.cms.hhs.gov/Manuals* on the CMS website.

MEDICARE NOTICES

Advance Beneficiary Notice

An Advance Beneficiary Notice (ABN) is a written notice that a provider or supplier gives to a beneficiary under certain circumstances (e.g., lack of medical necessity) before items or services are furnished to advise him or her that specified items or services may not be covered by Medicare. Providing an ABN allows the beneficiary to make an informed decision about whether to receive the item or service in question. In general, if a provider or supplier does not provide the beneficiary with an ABN when required, the beneficiary cannot be held financially liable for the items or services if Medicare payment is denied or reduced. If the provider or supplier properly notifies the beneficiary that the items or services may not be covered, he or she may seek payment from the beneficiary. Providers and suppliers who furnish items or services to the beneficiary based on the referral or order of another provider or supplier are responsible for notifying the beneficiary that the services may not be covered by Medicare and that they can be held financially liable for the items or services if payment is denied or reduced. A copy of the ABN should be kept in the beneficiary's medical record.

Where to Find Additional Information About the Advance Beneficiary Notice

To find additional information about the ABN and ABN forms, visit *http://www.cms.hhs.gov/BNI/01_overview.asp* on the CMS website.

Certificate of Medical Necessity and Durable Medical Equipment Medicare Administrative Contractor Information Forms

Certificate of Medical Necessity (CMN) and DME MAC Information Forms (DIF), which can be found at *http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp*, are included with claims for certain items that require additional information (e.g., DME and PEN).

Remittance Advice

A Remittance Advice (RA) is a notice of payments and adjustments that is sent to the provider, supplier, or biller. After a claim has been received and processed, the Medicare Contractor produces a RA which may serve as a companion to claim payments or as an explanation when there is no payment. The RA explains reimbursement decisions, including the reasons for payments and adjustments of processed claims. The RA features valid codes and specific values that make up the claim payment. Some of these codes may identify adjustments, which refer to any changes that relate to how a claim is paid differently from the original billing. There are seven general types of adjustments:

- Denied claim;
- Zero payment;
- Partial payment;
- Reduced payment;
- Penalty applied;
- Additional payment; and
- Supplemental payment.

Where to Find Additional Information About the Remittance Advice

Additional information about the RA is available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp* on the CMS website.

Medicare Summary Notice

Beneficiaries receive the Medicare Summary Notice (MSN), which lists all services or supplies that were billed to Medicare, on a monthly basis. If a beneficiary disagrees with a claims decision, he or she has the right to file an appeal. Chapter 7 of this guide provides additional information about fee-for-service appeals.

Where to Find Additional Information About the Medicare Summary Notice

Additional information about MSNs can be found at *http://www.cms.hhs.gov/MSN/01_overview.asp* on the CMS website.

OTHER HEALTH INSURANCE PLANS

Medicare Advantage

Medicare Advantage (MA) is a program through which organizations that contract with CMS furnish or arrange for the provision of health care services to Medicare beneficiaries who:

- Are entitled to Medicare Part A and enrolled in Part B;
- Permanently reside in the service area of the MA Plan; and
- Elect to enroll in a MA Plan.

Providers and suppliers who furnish services to a Medicare beneficiary who is enrolled in a MA Plan and do not have a contract with the MA Plan to furnish the services should bill the MA Plan. Prior to furnishing services to a MA Plan enrollee under these circumstances, providers and suppliers should notify the individual that he or she may be responsible for all charges for the health care services furnished.

Where to Find Additional Information About Medicare Advantage

Additional information about MA can be found at *http://www.cms.hhs.gov/HealthPlansGenInfo* on the CMS website.

Medicaid

Medicaid is a cooperative venture funded by Federal and State governments that pays for medical assistance for certain individuals and families with low incomes and limited resources. Within broad national guidelines established by Federal statutes, regulations, and policies, each state:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

The following Medicare premium and cost-sharing payment assistance may be available through the State Medicaid Program:

- Payment of Medicare Part A and Part B premiums, deductibles, coinsurance, and copayments for Qualified Medicare Beneficiaries (QMB) who:
    - Have resources that are at or below twice the standard allowed under the Social Security Income Program; and
    - Have incomes that are at or below 100 percent of the Federal poverty level (FPL) (subject to limits that states may impose on payment rates);

- Payment of Part B premiums for Specified Low-Income Medicare Beneficiaries who:
  - Have resources similar to QMBs; and
  - Have incomes that are below 120 percent of the FPL; and
- Payment of Part A premiums for Qualified Disabled and Working Individuals (QDWI) who:
  - Previously qualified for Medicare due to disability but lost entitlement because of their return to work (despite the disability);
  - Have incomes that are below 200 percent of the FPL; and
  - Do not meet any other Medicaid assistance category.

QDWIs who do not meet these income guidelines may purchase Medicare Part A and Part B coverage.

Medicare covered services are paid first by the Medicare Program since Medicaid is always the payer of last resort.

Where to Find Additional Information About Medicaid

Additional information about Medicaid can be found at *http://www.cms.hhs.gov/MedicaidGenInfo* on the CMS website.

Medigap

Medigap is a health insurance policy sold by private insurance companies to fill gaps in Original Medicare Plan coverage. A Medigap policy is not associated with a labor or union organization. Beneficiaries must be enrolled in Medicare Part A and Part B in order to purchase a Medigap policy and, under certain circumstances, are guaranteed the right to buy a policy. Beneficiaries may authorize a reassignment of benefits on a claim-by-claim basis for participating providers and suppliers to file a claim for reimbursement of Medicare services and coinsurance amounts.

Where to Find Additional Information About Medigap

Additional information about Medigap can be found at *http://www.cms.hhs.gov/Medigap* on the CMS website.

Railroad Retirement

Some Medicare beneficiaries who are retired railroad workers have supplementary medical insurance benefits from the Railroad Retirement Board.

Part B Railroad Retirement Benefits Contact Information

Part B Railroad Retirement Benefits contact information is as follows:

Palmetto GBA
Railroad Medicare Part B Office
P. O. Box 10066
Augusta, GA 30999

Telephone: (800) 833-4455

United Mine Workers of America

Some Medicare beneficiaries are members of the United Mine Workers of America (UMWA), which provides a health insurance plan for retired coal miners, spouses, and dependents. Paper UMWA claims should be sent to:

UMWA Health and Retirement Funds
P. O. Box 619099
Dallas, TX 75261-9741

Contact Information for United Mine Workers of America

Providers may call (888) 865-5290 to obtain information about medical claims status, eligibility, medical benefits, coverage, RA, and electronic claims submissions.

CHAPTER FOUR

MEDICARE PAYMENT POLICIES

This chapter discusses Medicare covered services, the incident to provision, and the services that are not covered by Medicare.

MEDICARE COVERED SERVICES

In general, Medicare covered services are considered medically reasonable and necessary to the overall diagnosis and treatment of the beneficiary's condition. Services or supplies are considered medically necessary if they:

- Are proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the beneficiary, provider, or supplier.

For every service billed, the provider or supplier must indicate the specific sign, symptom, or beneficiary complaint necessitating the service. Although furnishing a service or test may be considered good medical practice, Medicare generally prohibits payment for services without beneficiary symptoms or complaints.

Medicare pays for provider professional services that are furnished in:

- The U.S. (the Centers for Medicare & Medicaid Services [CMS] recognizes the 50 states, the District of Columbia, Commonwealth of Puerto Rico, Virgin Islands, Guam, Northern Mariana Islands, American Samoa, and territorial waters adjoining the land areas of the U.S. as being within the U.S.); and
- The home, office, institution, or at the scene of an accident.

Part A Inpatient Hospital Services

Subject to certain conditions, limitations, and exceptions the following inpatient hospital or inpatient Critical Access Hospital (CAH) services are furnished to an inpatient of a participating hospital or participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

- Bed and board;
- Nursing and other related services;
- Use of hospital or CAH facilities;
- Medical social services;
- Drugs, biologicals, supplies, appliances, and equipment;
- Certain other diagnostic or therapeutic services;
- Medical or surgical services furnished by certain interns or residents in training; and
- Transportation services, including transport by ambulance.

An inpatient is an individual who has been admitted to a hospital for the purpose of receiving inpatient hospital services. Generally, an individual is considered an inpatient if he or she is formally admitted as inpatient with the expectation of remaining at least overnight and occupying a bed. The individual is considered an inpatient even if he or she can later be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

The physician or other practitioner responsible for an individual's care at the hospital is responsible for deciding whether he or she should be admitted as an inpatient. The physician or other practitioner should work closely with hospital staff to ensure a proper admission as an inpatient following hospital admission protocols. The physician or practitioner should also use a 24-hour period as a benchmark by ordering admission for individuals who are expected to need hospital care for 24 hours or more and treating other individuals on an outpatient basis. The decision to admit an individual is a complex medical judgment that requires the consideration of:

- The individual's medical history and current medical needs, including the severity of the signs and symptoms exhibited;
- The medical predictability of something adverse happening to the individual;
- The need for diagnostic studies that will assist in assessing whether the individual should be admitted and that do not ordinarily require him or her to remain at the hospital for 24 hours or more;
- The availability of diagnostic procedures at the time when and where the individual presents;
- The types of facilities available to inpatients and outpatients;
- The hospital's by-laws and admissions policies; and
- The relative appropriateness of treatment in each setting.

In the following situations, coverage of services on an inpatient or outpatient basis is not determined solely on the basis of length of time the individual actually spends in the hospital:

1) Minor surgery or other treatment

When an individual with a known diagnosis enters a hospital for a specific minor surgical procedure or other treatment that is expected to keep him or her in the hospital for only a limited period of time, the individual is considered an inpatient only if the physician orders an inpatient admission regardless of his or her arrival hour at the hospital, or use of a bed, or if he or she remains in the hospital past midnight.

2) Renal dialysis treatments

Renal dialysis treatments are usually covered only as outpatient services for the individual who:

- Resides at home;
- Is ambulatory;
- Has stable conditions; and
- Comes to the hospital for routine chronic dialysis treatments (not for a diagnostic workup or a change in therapy).

The following individuals who receive renal dialysis are usually inpatients:

- Those undergoing short-term dialysis until the kidneys recover from an acute illness (acute dialysis); and
- Those who have borderline renal failure and develop acute renal failure every time they have an illness and require dialysis (episodic dialysis).

An individual may begin dialysis as an inpatient and then progress to outpatient status. If noncovered services that are generally excluded from Medicare coverage are furnished in Non-Prospective Payment System hospitals, part of the billed charges or the entire admission may be denied. Appropriately admitted cases in Prospective Payment System (PPS) hospitals include the following:

- If care is noncovered because an individual does not need to be hospitalized, the admission will be denied and the Part A PPS payment will be made only under limitation on liability. Under limitation on liability, Medicare payment may be made when the provider and the beneficiary were unaware that the services were not necessary and could not reasonably be expected to know that they were not necessary. If an individual is appropriately hospitalized but receives only noncovered care (beyond routine services), the admission is denied. An admission that includes covered care, even if noncovered care was also furnished, will not be denied. Under PPS, Medicare assumes that it is paying for only the covered care furnished when covered services needed to treat and/or diagnose the illness are furnished.
- If a noncovered procedure is furnished along with covered nonroutine care, a Diagnosis Related Group change rather than an admission denial might occur. If noncovered procedures elevate costs into the cost outlier category, outlier payment will be denied in whole or in part.
- If an individual receives items or services in excess of, or more expensive than, those for which payment can be made, payment is made only for the covered items or services or the appropriate PPS amount. This provision applies to inpatient services as well as all hospital services under Medicare Part A and Part B. If items or services are requested by the beneficiary, the hospital may charge him or her the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

If an individual requires extended care services and is admitted to a bed in a hospital, he or she is considered an inpatient of the hospital. The services furnished in the hospital will not be considered extended care services and payment may not be made unless the services are extended care services furnished pursuant to a swing bed agreement granted to the hospital by the Secretary of the Department of Health and Human Services.

Part B Services

Covered Part B services include, but are not limited to, the following:

- Physician services such as surgery, consultations, office visits, institutional calls;
- Services and supplies furnished incident to physician professional services;
- Outpatient hospital services furnished incident to physician services;
- Outpatient diagnostic services furnished by a hospital;
- Outpatient physical therapy (PT) services;
- Outpatient occupational therapy (OT) services;
- Outpatient speech-language pathology (SLP) services;
- Diagnostic x-ray tests, laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy services;
- Surgical dressings and splints, casts, and other devices used for reduction of fractures and dislocations;
- Rental or purchase of durable medical equipment for use in the beneficiary's home;
- Ambulance services;
- Certain prosthetic devices that replace all or part of an internal body organ;
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes;
- Certain medical supplies used in connection with home dialysis delivery systems;
- Ambulatory Surgical Center services; and
- Preventive services.

INCIDENT TO PROVISION

To be covered incident to the services of a physician, services and supplies must meet the following four requirements:

1) Commonly furnished in physicians' offices or clinics

Services and supplies commonly furnished in physicians' offices are covered under the incident to provision. Charges for these services and supplies must be included in the physician's bill. To be covered, supplies (including drugs and biologicals) must be an expense to the physician or legal entity billing for the services or supplies.

2) Furnished by the physician or auxiliary personnel under the direct personal supervision of a physician

Services billed as incident to the services of a physician may be furnished by auxiliary personnel or non-physician practitioners (NPP) under the required level of supervision. Auxiliary personnel are individuals who act under the supervision of a physician regardless of whether the individual is an employee, leased employee, or independent contractor of the physician or of the legal entity that employs or contracts with the physician. A physician may also have the services of certain NPPs covered as incident to his or her professional service. These NPPs include the following:

- Audiologists;
- Certified nurse midwives;
- Certified registered nurse anesthetists;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- Nurse practitioners;
- Occupational therapists;
- Physical therapists; and
- Physician assistants.

The direct supervision for any service, including evaluation and management (E/M) services, can be furnished by any member of the group who is physically present on the premises and is not limited to the physician who has established the patient's plan of care. Direct supervision in the office setting means that the physician is present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service.

Services furnished by auxiliary personnel outside the office setting (e.g., in a beneficiary's home or in an institution other than a hospital or Skilled Nursing Facility [SNF]) are covered incident to a physician's service only if there is personal supervision by the physician. Personal supervision means that a physician is physically in attendance in the same room during the performance of the procedure.

3) Commonly furnished without charge or included in the physician's bill

Incident to services or supplies must represent an expense incurred by the physician or legal entity billing for the services or supplies.

4) An integral, although incidental, part of the physician's professional service

The physician must have furnished a personal professional service to initiate the course of treatment that is being furnished by the NPP as an incidental part. There must also

be subsequent service by the physician of a frequency that reflects the physician's continuing active participation in, and management of, the course of treatment. The physician or another physician in the group practice must be physically present in the same office suite and immediately available to render assistance, if necessary. Although the rehabilitative services of PT, OT, and SLP have their own benefits under the law, it is also acceptable for these services to be billed by physicians incident to their services if the rules for both the therapy benefit and the incident to benefit are met, with one exception. The staff who provide therapy services under the direct supervision of a physician must be qualified as therapists, with the exception of any licensure requirements that may apply. For example, physical therapists must be licensed and graduates of an approved PT curriculum (unless they meet other requirements for foreign or pre-1977 training). Staff who provide PT services must be graduates of an approved PT curriculum, but not necessarily licensed.

The beneficiary's medical record should document the essential requirements for incident to services.

SERVICES NOT COVERED BY MEDICARE

The services that are not covered by Medicare include the following:

- Excluded services:
    - Acupuncture;
    - Care furnished in facilities located outside the U.S., except in limited cases;
    - Cosmetic surgery, unless medically necessary as a result of accident or injury (e.g., a car accident disfigures facial structure and reconstruction is needed);
    - Custodial care (e.g., assistance with bathing and dressing) at the beneficiary's home or in a nursing home;
    - Most dental services;
    - Hearing examinations;
    - Orthopedic shoes;
    - Routine eye care;
    - Routine foot care, with the exception of certain beneficiaries with diabetes;
    - Routine or annual physical examinations (with the exception of Initial Preventive Physical Examinations);
    - Screening tests with no symptoms or documented conditions, with the exception of certain preventive screening tests;
    - Services related to excluded services; and
    - Vaccinations, with certain exceptions;

- Services that are considered not medically necessary:
  - Services furnished in a hospital or SNF that, based on the beneficiary's condition, could have been furnished elsewhere (e.g., the beneficiary's home or a nursing home);
  - Hospital or SNF services that exceed Medicare length of stay limitations;
  - E/M services that are in excess of those considered medically reasonable and necessary;
  - Therapy or diagnostic procedures that are in excess of Medicare usage limits; and
  - Services not warranted based on the diagnosis of the beneficiary; and
- Services that have been denied as bundled or included in the basic allowance of another service:
  - Fragmented services included in the basic allowance of the initial service;
  - Prolonged care (indirect);
  - Physician standby services;
  - Case management services (e.g., telephone calls to and from the beneficiary); and
  - Supplies included in the basic allowance of a procedure.

In addition, Medicare does not pay for claims that have been rejected as unprocessable. An unprocessable claim has incomplete, missing, or invalid information that is necessary for processing the claim. Claims that have been rejected as unprocessable may be corrected and resubmitted for payment.

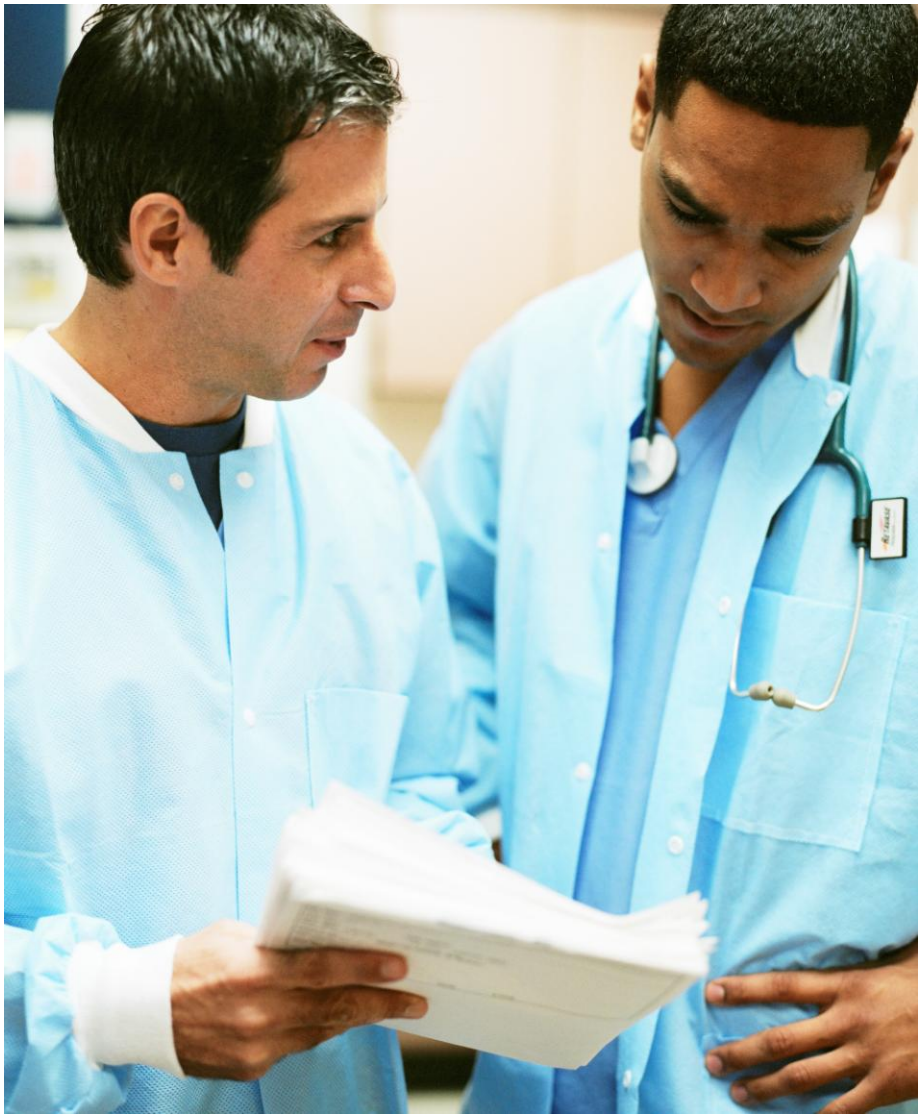
Providers and suppliers should give a beneficiary an Advance Beneficiary Notice (ABN) before items or services are furnished to advise him or her that specified items or services may not be covered by Medicare. Chapter 3 of this guide provides additional information about the ABN.

Where to Find Additional Information About Medicare Payment Policies

Additional information about Medicare payment policies can be found in the Medicare Benefit Policy Manual (Pub. 100-2) at *http://www.cms.hhs.gov/Manuals* on the CMS website.

CHAPTER FIVE

EVALUATION AND MANAGEMENT SERVICES



This chapter discusses common sets of codes and evaluation and management (E/M) documentation.

COMMON SETS OF CODES

When billing for a patient's visit, codes are selected that best represent the services furnished during the visit. The two common sets of codes that are currently used are:

- Diagnostic or International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes; and
- Procedural or American Medical Association Current Procedural Terminology (CPT) codes.

These codes are organized into various categories and levels. It is the physician's responsibility to ensure that documentation reflects the services furnished and that the codes selected reflect those services. The more work performed by the physician, the higher the level of code he or she may bill within the appropriate category. The billing specialist or alternate source reviews the physician's documented services and assists with selecting codes that best reflect the extent of the physician's personal work necessary to furnish the services.

Evaluation and Management Services

E/M services refer to visits and consultations furnished by physicians. Billing Medicare for a patient visit requires the selection of a CPT code that best represents the level of E/M service performed. For example, there are five CPT codes that may be selected to bill for office or other outpatient visits for a new patient:

- 99201 – Usually the presenting problem(s) are self limited or minor and the physician typically spends 10 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Problem focused history.
    - Problem focused examination.
    - Straightforward medical decision making.
- 99202 – Usually the presenting problem(s) are of low to moderate severity and the physician typically spends 20 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Expanded problem focused history.
    - Expanded problem focused examination.
    - Straightforward medical decision making.

- 99203 – Usually the presenting problem(s) are of moderate severity and the physician typically spends 30 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Detailed history.
    - Detailed examination.
    - Medical decision making of low complexity.
- 99204 – Usually the presenting problem(s) are of moderate to high severity and the physician typically spends 45 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Comprehensive history.
    - Comprehensive examination.
    - Medical decision making of moderate complexity.
- 99205 – Usually the presenting problem(s) are of moderate to high severity and the physician typically spends 60 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Comprehensive history.
    - Comprehensive examination.
    - Medical decision making of high complexity.

Where to Find Additional Information About the International Classification of Diseases, 9th Edition, Clinical Modification

To find additional information about ICD-9-CM, visit *http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp* on the Centers for Medicare & Medicaid Services (CMS) website.

The ICD-9-CM CD-ROM is available from the U.S. Government Printing Office, U.S. Government Bookstore:

- At *http://bookstore.gpo.gov* on the Web; and
- Telephone: (866) 512-1800.

Where to Find Additional Information About Current Procedural Terminology

To find additional information about CPT, visit *http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml* on the Web.

The *Current Procedural Terminology* book is available from the American Medical Association:

- At *http://www.amapress.org* on the Web; and
- Telephone: (800) 621-8335.

International Classification of Diseases, 10th Edition, Clinical Modification/ Procedure Coding System

The compliance date for implementation of the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) is October 1, 2013 for all Health Insurance Portability and Accountability Act covered entities. ICD-10-CM/PCS will enhance accurate payment for services rendered and facilitate evaluation of medical processes and outcomes. The new classification system provides significant improvements through greater detailed information and the ability to expand in order to capture additional advancements in clinical medicine.

ICD-10-CM/PCS consists of two parts:

- ICD-10-CM – The diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all U.S. health care treatment settings. Diagnosis coding under this system uses 3 – 7 alpha and numeric digits and full code titles, but the format is very much the same as ICD-9-CM; and
- ICD-10-PCS – The procedure classification system developed by CMS for use in the U.S. for inpatient hospital settings ONLY. The new procedure coding system uses 7 alpha or numeric digits while the ICD-9-CM coding system uses 3 or 4 numeric digits.

ICD-10-CM/PCS will not affect physicians', outpatient facilities', and hospital outpatient departments' use of CPT codes on Medicare fee-for-service claims, as CPT will continue to be utilized.

Where to Find Additional Information About the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System

To find additional information about ICD-10-CM/PCS, visit *http://www.cms.hhs.gov/ICD10* on the CMS website.

EVALUATION AND MANAGEMENT DOCUMENTATION

Medicare pays physicians based on diagnostic and procedure codes that are derived from medical documentation. E/M documentation is the pathway that translates a physician's patient care work into the claims and reimbursement mechanism. This pathway's accuracy is critical in:

- Ensuring that physicians are paid correctly for their work;
- Supporting the correct E/M code level; and
- Providing the validation required for medical review.

Providers may use either the *1995 Documentation Guidelines for Evaluation and Management Services* or the *1997 Documentation Guidelines for Evaluation and Management Services*. Medicare Contractors must conduct reviews using both the 1995 and the 1997 guidelines and apply the guidelines that are most advantageous to the provider.

Where to Find Additional Information About Evaluation and Management Services

Additional information about E/M services is available as follows:

- E/M documentation:
  - At *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp* on the CMS website; and
  - In Chapter 12, Section 100 of the Medicare Claims Processing Manual (Pub. 100-4) at *http://www.cms.hhs.gov/Manuals* on the CMS website;
- *1995 Documentation Guidelines for Evaluation & Management Services* at *http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf* on the CMS website and in the Reference Section of this guide;
- *1997 Documentation Guidelines for Evaluation & Management Services* at *http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf* on the CMS website and in the Reference Section of this guide; and
- The Medicare Learning Network publication titled *Evaluation & Management Services Guide*, which can be accessed at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website.

CHAPTER SIX

PROTECTING THE MEDICARE TRUST FUND

This chapter provides information about the Medicare medical review program, coverage determinations, and health care fraud and program abuse.

MEDICAL REVIEW PROGRAM

The goal of the medical review program is to reduce provider and supplier payment errors by identifying and addressing coverage and coding billing errors by:

- Analyzing data (e.g., profiling of providers and suppliers, services, or beneficiary utilization) and evaluating other information (e.g., complaints, enrollment, and/or cost report data);
- Taking action to prevent and/or address the identified errors;
- Publishing local medical review policies that provide guidance to the public and the medical community regarding payment eligibility under the Medicare statute.

COVERAGE DETERMINATIONS

There are two types of coverage policies that assist providers and suppliers in coding correctly and billing Medicare only for covered items and services: National Coverage Determinations (NCD) and Local Coverage Determinations (LCD).

1) National Coverage Determination

A NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. A NCD is a reasonable and necessary determination made by the Secretary of the Department of Health and Human Services (HHS). Therefore, a failure to meet the terms of the NCD will make the item or service not reasonable and necessary, which is one of the categories of items and services Medicare is prohibited from paying under Section 1862(a)(1)(A) and for which a beneficiary is given liability protection under Section 1879 of the Social Security Act if he or she did not know in advance that Medicare was prohibited from paying. An Advance Beneficiary Notice conveys this information to the beneficiary, thereby eliminating his or her liability protection. Medicare Contractors are required to follow NCDs. Prior to an NCD taking effect, the Centers for Medicare & Medicaid Services (CMS) must first issue a Manual Transmittal, ruling, or *Federal Register* Notice. If a NCD and a LCD exist concurrently regarding the same coverage policy, the NCD takes precedence.

2) Local Coverage Determination

To further define a NCD or in the absence of a specific NCD, Medicare Contractors may develop LCDs, which are coverage decisions made at their own discretion to provide guidance to the public and the medical community within a specified geographic area. LCDs cannot conflict with NCDs. LCDs are administrative and educational tools that assist providers in submitting correct claims for payment by outlining coverage criteria, defining medical necessity, and providing references upon which a policy is based and

codes that describe what is and is not covered when the codes are integral to the discussion of medical necessity. Providers and suppliers may submit requests for new or revised LCDs to Medicare Contractors.

Medicare Contractor Contact Information

The Provider Call Center Toll-Free Numbers Directory, which contains Medicare Contractor contact information, can be accessed in the Downloads Section at *http://www.cms.hhs.gov/MLNGenInfo/30_contactus.asp* on the CMS website.

The LCD development process is open to the public and includes:

- Developing a draft policy;
- Making the draft available for a minimum comment period of 45 days (if the policy requires a comment period); and
- Soliciting comments and recommendations on the draft, which health care professionals, provider organizations, and the public may electronically submit on Contractor's websites.

LCDs and NCDs that may prevent access to items and services or have resulted in claim denials can be challenged by aggrieved parties (Medicare beneficiaries or the estate of Medicare beneficiaries) who:

- Are entitled to benefits under Part A, are enrolled in Part B, or both (including beneficiaries who are enrolled in fee-for-service Medicare and Medicare Advantage);
- Are in need of coverage for items or services that are denied based upon an applicable LCD or NCD, regardless of whether the items or services were received; and
- Have obtained documentation of the need for the items or services from his or her treating physician.

If a claim is denied by a Medicare Contractor based on a LCD or NCD, the beneficiary is notified about the denial and the reasons for the denial on the Medicare Summary Notice.

Where to Find Additional Information the Medicare Coverage Determination Process

Information about the Medicare coverage determination process is available as follows:

- At *http://www.cms.hhs.gov/DeterminationProcess/01_Overview.asp* on the CMS website; and
- In the National Coverage Determinations Manual (Publication 100-03) and Medicare Program Integrity Manual (Publication 100-08) at *http://www.cms.hhs.gov/Manuals* on the CMS website.

HEALTH CARE FRAUD AND PROGRAM ABUSE

CMS emphasizes early detection and prevention of health care fraud and program abuse. An estimated 10 percent of Medicare costs are wrongly spent on incidences of fraud and abuse. Preventing and detecting fraud and abuse is a cooperative effort that involves:

- CMS;
- Beneficiaries;
- Medicare Contractors;
- Providers, suppliers, and other health care entities;
- State Medicaid Fraud Control Units;
- Quality Improvement Organizations;
- Department of HHS Office of Inspector General (OIG);
- Department of Justice (DOJ), including the Federal Bureau of Investigation; and
- Other Federal law enforcement agencies.

The efforts of these groups can help deter health care fraud and program abuse and protect beneficiaries from harm by:

- Identifying suspicious Medicare charges and activities;
- Investigating and punishing those who commit Medicare fraud and abuse; and
- Ensuring that money lost to fraud and abuse is returned to the Medicare Trust Fund.

Federal health care fraud generally involves an individual's or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another individual or entity to obtain payment for, items or services payable under a Federal health care program. Some examples of fraud are:

- Billing for services not furnished;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Violations of the physician self-referral ("Stark") prohibition;
- Using an incorrect or inappropriate provider identifier in order to be paid (e.g., using a deceased individual's provider identifier);
- Signing blank records or certification forms that are used by another entity to obtain Medicare payment;
- Selling, sharing, or purchasing Medicare Health Insurance Claim (HIC) numbers in order to bill false claims to the Medicare Program;
- Offering incentives to Medicare beneficiaries that are not offered to other patients (e.g., routinely waiving or discounting Medicare deductibles, coinsurance, or copayments);
- Falsifying information on applications, medical records, billing statements, cost reports, or on any statement filed with the government or its agents;
- Using inappropriate procedure or diagnosis codes to misrepresent the medical necessity or coverage status of the services furnished;

- Consistently using billing or revenue codes that describe more extensive services than those actually performed (upcoding); and
- Misrepresenting himself or herself as a Medicare beneficiary for the purpose of securing Medicare payment for their health care by presenting a Medicare health insurance card or Medicare HIC number that rightfully belongs to another individual.

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

Many abusive practices are subsequently determined to be fraudulent. For example, if a provider or supplier ignores Medicare guidance, education efforts, warnings, or advice that abusive conduct is inappropriate and he or she continues to engage in the same or similar conduct, the conduct could be considered fraudulent.

Significant Medicare Fraud and Abuse Provisions

1) False Statements and Kickbacks, Bribes, and Rebates

Under 42 U.S.C. Section 1320a-7b(a), if an individual or entity is determined to have engaged in any following activities, he or she shall be guilty of a felony and upon conviction shall be fined a maximum of $50,000 per violation or imprisoned for up to five years per violation, or both:

- Purposefully involved in supplying false information on an application for a Medicare benefit or payment or for use in determining the right to any such benefit or payment;
- Knows about, but does not disclose, any event affecting the right to receive a benefit;
- Knowingly submitting a claim for physician services that were not furnished by a physician; or
- Supplies items or services and asks for, offers, or receives a kickback, bribe, or rebate.

2) Anti-Kickback Statute

The Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b), prohibits offering, soliciting, paying, or receiving remuneration for referrals for services that are paid in whole or in part by the Medicare Program. In addition, the statute prohibits offering, soliciting, paying, or receiving remuneration in return for purchasing, leasing, ordering, arranging for, or recommending the purchase, lease, or order of any goods, facility, item, or service for which payment may be made in whole or part by the Medicare Program. An arrangement will be deemed to not violate the Anti-Kickback Statute if it fully complies with the terms of a safe harbor issued by the OIG. Arrangements that do not fit within a

safe harbor and thus do not qualify for automatic protection may or may not violate the Anti-Kickback Statute, depending on their facts.

3) Physician Self Referral ("Stark") Statute

The Stark Statute, 42 U.S.C. §1395nn, prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

Exceptions to the prohibition on self referrals can be found in the *Code of Federal Regulations (CFR)* at CFR 411.355-357. To access the *CFR*, visit *http://www.gpoaccess.gov/cfr/index.html* on the Web. The designated health services include the following:

- Clinical laboratory services;
- Physical therapy services;
- Occupational therapy services;
- Speech-language pathology services;
- Radiology and certain other imaging services such as magnetic resonance imaging and ultrasound;
- Radiation therapy services and supplies;
- Durable medical equipment (DME) and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services and supplies;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

The DOJ or a private relator can also file a suit under the civil False Claims Act (31 U.S.C. Section 3729) to recover any Federal losses due to false claims as well as additional amounts in the form of penalties and fines.

Potential Legal Actions

It is a Federal crime to commit fraud against the U.S. Government, including the Medicare Program. A provider, supplier, or health care organization that has been convicted of fraud may receive a significant fine, prison sentence, or be temporarily or permanently excluded from Medicare and other Federal health care programs. In some states, providers, suppliers, and health care organizations may also lose their licenses. Below is a discussion of some of the potential consequences of failure to comply with fraud and abuse laws.

Investigations

A Program Safeguard Contractor or Medicare Contractor Benefit Integrity unit identifies and documents potential fraud and abuse and, when appropriate, refers such matters to the OIG.

Civil Monetary Penalties

Many violations of Medicare laws and regulations are subject to the imposition of Civil Monetary Penalties (CMP). Depending on the violation, the CMP amount may be up to $10,000 per violation and exclusion from the Medicare Program may be imposed. Some examples of violations for which CMPs may apply include:

- Violation of Medicare assignment provisions;
- Violation of the Medicare physician or supplier agreement;
- Violation of an assignment requirement for certain diagnostic clinical laboratory tests and nurse-anesthetist services;
- Violations of the Anti-Kickback Statute, Stark Statue, and other fraud and abuse laws;
- False or misleading information expected to influence a decision to discharge;
- Refusal to supply rental DME supplies without charge after rental payments may no longer be made;
- Hospital unbundling of outpatient surgery costs; and
- Hospital and physician dumping of beneficiaries, either because they cannot pay or because of a lack of resources.

Denial or Revocation of Medicare Provider Billing Privileges

CMS has the authority to deny an individual or entity's application for Medicare provider billing privileges or revoke a provider's billing privileges if there is evidence of impropriety (e.g., previous convictions, falsifying information on the application, or State or Federal licensure or certification requirements are not met).

Suspension of Payments

CMS has the authority to suspend payment to individuals and entities when there is reliable information that an overpayment, fraud, or willful misrepresentation exists or that payments to be made may not be correct. During payment suspensions, claims that are submitted will be processed and individuals and entities will be notified about claim determinations. Actual payments due are withheld and may be used to recoup amounts that were overpaid. Individuals and entities may submit written rebuttals regarding why a suspension of payment should not be imposed.

Exclusion Authority

The OIG has the authority to exclude individuals and entities from participation in all Federal health care programs, including Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the U.S. (other than the Federal Employees Health Benefits Plan). No payment will be made by any Federal health care program for any items or services directly or indirectly furnished, ordered, or prescribed by an excluded or debarred individual or entity. Providers and suppliers who participate in or bill a Federal health care program generally may not employ or contract with an excluded or debarred individual or entity. In addition, excluded individuals are not eligible for Federally-insured loans, Federally-funded research grants, and programs administered by other Federal agencies. All types of exclusions remain in effect until the individual or entity is eligible for and reinstated by the OIG. There are two types of exclusions: mandatory and permissive.

1) Mandatory exclusions

Mandatory exclusions are imposed for a minimum statutory period of five years, although aggravating and mitigating factors may justify assessment of a lengthier exclusion. Exclusions are mandated for individuals and entities who:

- Have been convicted of any type of program-related violations;
- Have been convicted of patient abuse or neglect;
- Have felony convictions related to other health care programs; or
- Have felony convictions related to certain types of controlled substance violations.

2) Permissive exclusions

The OIG may impose permissive exclusions on individuals and entities who have misdemeanor convictions that are related to:

- Health care fraud;
- Obstruction of an investigation; and
- Certain types of controlled substance violations.

These permissive exclusions typically have a benchmark period duration of three years, although aggravating and mitigating factors may justify assessment of a lengthier exclusion.

Other permissive exclusions are based on determinations made by other agencies such as licensing boards, Federal or State health care programs, and/or recommendations from payer agencies. The period of exclusion in most of these actions varies and is subject to the discretion of the OIG.

Sanctioned and Reinstated Provider and Supplier Lists

There are two types of sanctioned and reinstated provider and supplier lists: Office of Inspector General List of Excluded Individuals/Entities (LEIE) and General Services Administration Excluded Parties List System.

1) Office of Inspector General List of Excluded Individuals/Entities

The Office of Inspector General LEIE contains information about individuals and entities that are currently excluded from participation in all Federal health care programs, including the Medicare Program. The LEIE is available at *http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp* on the Web.

2) General Services Administration Excluded Parties List System

The General Services Administration Excluded Parties List System is an index of individuals and entities that have been excluded throughout the U.S. Government from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits. The Excluded Parties List System can be found at *http://www.epls.gov* on the Web.

Incentive Reward Program

The Incentive Reward Program encourages the reporting of information regarding individuals or entities that commit fraud or abuse and could result in sanctions under any Federal health care program. Medicare offers a monetary reward for information that leads to a minimum recovery of $100.00 of Medicare funds that were inappropriately obtained. Incentive rewards are 10 percent of the amount recovered or $1,000, whichever amount is lower.

Whistle Blower Provision

Under the Whistle Blower or *qui tam* provision of the False Claim Act, any individual who has knowledge of a false claim may file a civil suit on behalf of the U.S. Government and may share a percentage of the recovery realized from a successful action.

Where to Find Additional Information About Protecting the Medicare Trust Fund

Additional information about protecting the Medicare Trust Fund can be found:

- At *http://www.oig.hhs.gov;* and
- In the Medicare Program Integrity Manual (Pub. 100-8) at *http://www.cms.hhs.gov/Manuals* on the CMS website.

Office of Inspector General Hotline Contact Information

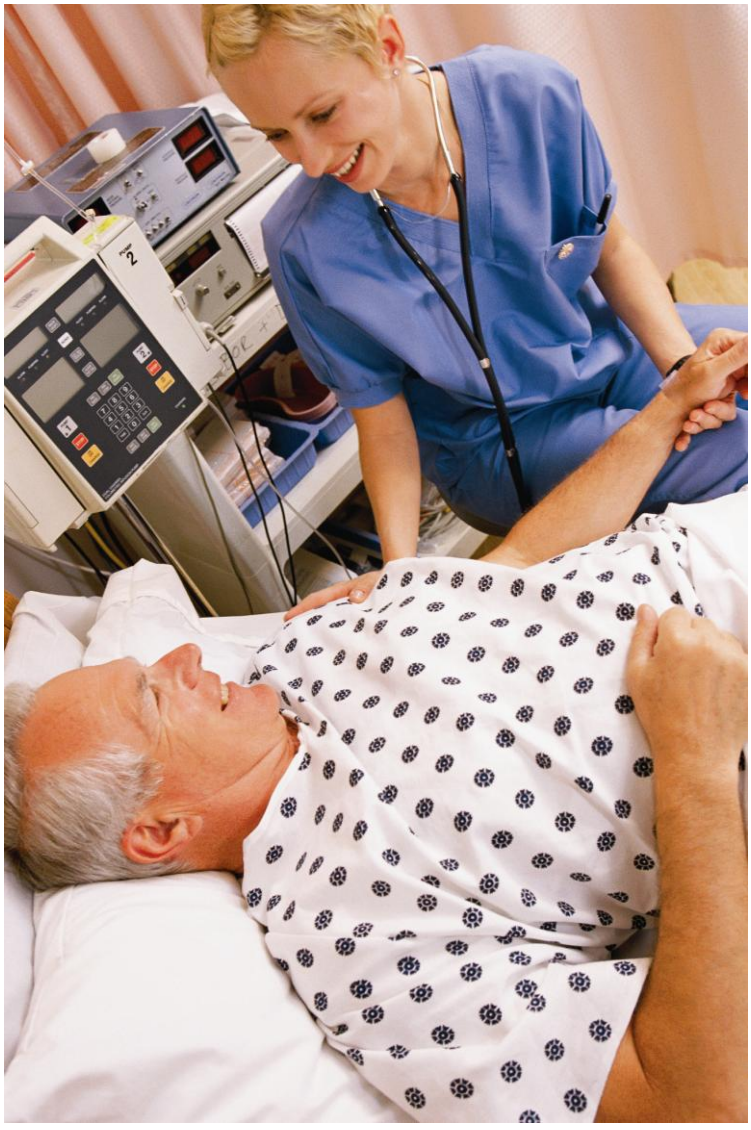
To report suspected health care fraud or program abuse, the OIG can be contacted as follows:

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

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

CHAPTER SEVEN

INQUIRIES, OVERPAYMENTS, AND FEE-FOR-SERVICE APPEALS



This chapter discusses inquiries, overpayments, and fee-for-service appeals.

INQUIRIES

Medicare providers and suppliers may submit inquiries about billing, claims, eligibility, and payment guidelines to Medicare Contractors either by telephone or in writing. Customer Service Representatives (CSR) are available to handle telephone inquiries continuously during normal business hours for all time zones of the geographic area serviced, Monday through Friday.

Contractors also provide automated self-help tools such as Interactive Voice Response (IVR) services, which are available 24 hours a day. IVR services provide information about the following topics:

- Contractor hours of operation for CSR service;
- General Medicare Program;
- Specific information about claims in process and claims completed; and
- Official definitions of the 100 most frequently used Remittance Codes (as determined by each Contractor).

Medicare Contractor Contact Information

The Provider Call Center Toll-Free Numbers Directory, which contains Medicare Contractor contact information, can be accessed in the Downloads Section at *http://www.cms.hhs.gov/MLNGenInfo/30_contactus.asp* on the Centers for Medicare & Medicaid Services (CMS) website.

OVERPAYMENTS

Overpayments are funds that a provider, supplier, or beneficiary has received in excess of amounts due and payable under Medicare statutes and regulations. Once a determination of an overpayment has been made, the overpayment becomes a debt owed to the Federal government. Federal law requires CMS to seek recovery of an overpayment, regardless of how it is identified or caused.

Overpayments are often paid due to the following:

- Duplicate submission of the same service or claim;
- Payment to the incorrect payee;
- Payment for excluded or medically unnecessary services; or
- Payment made as the primary payer when Medicare should have paid as the secondary payer.

If Medicare pays more than the correct amount in error, providers and suppliers should make voluntary/unsolicited refunds as soon as possible, without waiting for notification. Refunds are sent to the Medicare Contractor and must include the following information:

- The provider or supplier's National Provider Number (NPI);
- The NPI of the provider or supplier who should actually be paid, if applicable;
- The beneficiary's Medicare Health Insurance Claim (HIC) number;
- The date of service;
- The amount overpaid;
- A brief description regarding the reason for the refund;
- A copy of the Remittance Advice (RA), with the claims at issue highlighted; and
- A check for the overpaid amount.

When the Federal government accepts a voluntary/unsolicited refund, it does not affect or limit its right or the right of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies that arise from or related to applicable claims.

Providers and suppliers are also responsible for timely repayment when Medicare notifies them of an overpayment. When an overpayment occurs, Medicare will send a letter which states:

- The service(s) at issue;
- Why the overpayment occurred; and
- The amount being requested.

If the overpayment is not paid within the timeframe specified in the letter, interest is assessed from the date of the letter. If no response is received from the provider or supplier within 30 days after the date of the first demand letter, a second demand letter will be sent between 31 and 45 days. If a full payment is not received 40 days after the date of the first demand letter, the Medicare Contractor will start recoupment from future payments on day 41.

If a provider or supplier disagrees with the overpayment, he or she has the right to appeal the decision. Recoupment will cease as a result of a demand letter if:

- The overpayment is determined on or after October 29, 2003; and
- A valid first level appeal request has been received.

Where to Find Additional Information About Overpayments

Additional information about overpayments can be found in the Medicare Claims Processing Manual (Pub. 100-04) located at *http://www.cms.hhs.gov/Manuals* on the CMS website.

FEE-FOR-SERVICE APPEALS

An appeal is an independent review of an initial determination made by a Medicare Contractor. Generally, a party to the initial determination is entitled to an appeal if he or she is dissatisfied with the determination and files a timely appeal request that contains the necessary information needed to process the request.

A party to an initial determination may be:

- A beneficiary who files a request for payment or has a request for payment filed on his or her behalf by a provider;
- A supplier who has accepted assignment for items or services furnished to a beneficiary that are at issue in the request for payment; or
- A provider of services who files a request for payment for items or services furnished to a beneficiary.

A party to a higher level appeal may be:

- The parties to an initial determination, except when a beneficiary has assigned his or her appeal rights;
- A State Agency pursuant to the *Code of Federal Regulations (CFR)* at 42 CFR 405.908 (to access the *CFR*, visit *http://www.gpoaccess.gov/cfr/index.html* on the Web);
- A provider or supplier who accepts assignment of appeal rights for items or services furnished to a beneficiary; or
- A nonparticipating physician or supplier who does not accept assignment for items or services furnished to a beneficiary and may be obligated to make a refund pursuant to Sections 1834(a)(18), 1834(j)(4), or 1842(l) of the Social Security Act (the Act).

A provider or supplier who is not already a party to an appeal may appeal an initial determination for services furnished to a beneficiary if the beneficiary subsequently dies leaving no other party available to appeal the determination.

A party may appoint a representative if he or she wants assistance with the appeal. A physician or supplier may act as a beneficiary's appointed representative. A party may appoint a representative to act on his or her behalf by completing Form CMS-1696, Appointment of Representative. A party may also appoint a representative through a submission that meets the following requirements:

- It is in writing and is signed and dated by both the party and the individual who is agreeing to be the representative;
- It includes a statement appointing the representative to act on behalf of the party and if the party is a beneficiary, authorizing the adjudicator to release identifiable health information to the appointed representative;
- It includes a written explanation of the purpose and scope of the representation;

- It contains the name, telephone number, and address of both the party and the appointed representative;
- If the party is a beneficiary, the beneficiary's Medicare HIC number;
- It indicates the appointed representative's professional status or relationship to the party; and
- It is filed with the entity that is processing the party's initial determination or appeal.

A provider or supplier who furnishes the items or services being appealed may be appointed as the beneficiary's representative, but may not charge the beneficiary a fee for such representation and must waive their right to collect payment from the beneficiary for such items or services when the denial triggers the limitation on liability provisions of §1879 of the Act (e.g., services not medically reasonable and necessary or services considered custodial in nature).

A representative may submit arguments, evidence, or other materials on behalf of the party. The representative, the party, or both may participate in all levels of the appeals process. Once both the party and the representative have signed the Appointment of Representative Form, the appointment is valid for one year from the date of the last signature for the purpose of filing future appeals, unless it has been revoked.

As noted above, a beneficiary may also assign (transfer) his or her appeal rights to a physician or supplier who is not a party to the initial determination and who furnished the items or services at issue in the appeal. A beneficiary must assign appeal rights using Form CMS-20031, Transfer of Appeal Rights. A physician or supplier who accepts assignment of appeal rights must waive the right to collect payment from the beneficiary for the items or services at issue in the appeal, with the exception of deductible and coinsurance amounts.

After an initial claim determination is made, the appeals process is as follows:

- Redetermination by Medicare Contractor;
- Reconsideration by Qualified Independent Contractor (QIC);
- Hearing by Administrative Law Judge (ALJ);
- Appeals Council review; and
- Judicial review.

The Five Levels of Appeals

First Level of Appeal – Redetermination by Medicare Contractor

A party who is dissatisfied with the initial determination may request that a Medicare Contractor conduct a redetermination. The redetermination, which is an independent review of the initial determination, is conducted by an employee of the Contractor who was not involved in making the initial determination. A request for a redetermination

must be filed within 120 calendar days of the date the notice of initial claim determination is received. If good cause is shown, the period for filing the appeal request may be extended. At this level of appeal, a minimum monetary threshold is not required.

The request for redetermination should be sent to the Contractor that issued the original claim determination, and parties should submit all relevant documentation to support their assertion that the initial claim determination was incorrect. Parties must request redeterminations in writing by either completing Form CMS-20027, Medicare Redetermination Request, or by submitting a written request that includes the following:

- Beneficiary's name;
- Beneficiary's Medicare HIC number;
- Which items or services are at issue and the corresponding date(s) of service; and
- Name and signature of the party or authorized/appointed representative of the party.

In most cases, the Contractor will issue a decision via either a Medicare Redetermination Notice (MRN) or a revised RA or Medicare Summary Notice to all parties to the appeal within 60 days of receipt of the redetermination request.

Second Level of Appeal – Reconsideration by Qualified Independent Contractor

A party dissatisfied with the redetermination decision or dismissal may request a reconsideration by a QIC. The QICs are required to have a panel of physicians or other health care professionals that independently review medical necessity issues. Instructions for requesting a reconsideration can be found on the MRN. A party must file a written request for a reconsideration with the entity specified in the redetermination notice within 180 calendar days of the date the redetermination decision is received. If good cause is shown, the QIC may extend the period for filing the request. At this level of appeal, a minimum monetary threshold is not required. A party must file a request for reconsideration with the appropriate Contractor in writing by either completing Form CMS-20033, Medicare Reconsideration Request, or by submitting a request that includes the following:

- Beneficiary's name;
- Beneficiary's Medicare HIC number;
- Which items or services are at issue and the corresponding date(s) of service;
- Name and signature of the party or authorized/appointed representative of the party; and
- Name of the Contractor that made the redetermination.

In most cases, the QIC will issue written notice of its reconsideration decision to all parties within 60 calendar days of receipt of the request for reconsideration. In some situations (e.g., submission of additional evidence after the reconsideration request is

filed), the time limit will be extended beyond 60 days. The reconsideration decision provides detailed information regarding further appeal rights if the decision is not fully favorable. If the QIC is unable to issue a reconsideration within the applicable time limit, the QIC will notify the appellant (the party who filed the appeal request). The appellant may then file a written request with the QIC to escalate the appeal to the ALJ level.

All evidence requested by the Contractor in the redetermination decision must be submitted at the QIC reconsideration level of appeal. Failure to submit requested information at the QIC reconsideration level may lead to exclusion of such evidence at subsequent levels of appeal unless good cause is shown for submitting the evidence late.

Third Level of Appeal – Hearing by Administrative Law Judge

A party dissatisfied with the reconsideration decision or dismissal may request a hearing before an ALJ with the Department of Health and Human Services Office of Medicare Hearings and Appeals . A party must file their request for an ALJ hearing in writing within 60 calendar days of receipt of the QIC reconsideration notice. The reconsideration notice provides detailed information regarding where the request must be filed and the content required for the request. Parties may request a hearing before an ALJ by completing CMS Form 20034, Request for Medicare Hearing by an Administrative Law Judge, which is available at *http://www.hhs.gov/omha* on the Web. There is an amount in controversy (AIC) requirement, which will be adjusted annually in accordance with the percentage increase in the medical care component of the Consumer Price Index for all Urban Consumers (CPI-U).

ALJ hearings are generally conducted via video teleconferencing technology or by telephone. An appellant may request in writing that the ALJ conduct an in-person hearing. The ALJ determines on a case-by-case basis (subject to concurrence of the Managing Field Office ALJ), whether good cause has been demonstrated to conduct the hearing in person. Appellants may also request an ALJ decision without a hearing (on the record).

At the ALJ level, CMS and/or CMS Contractors may elect to either participate in the hearing or become a party to the hearing. When an appellant requests an ALJ hearing following a QIC reconsideration, the appellant must also send a copy of the request for hearing to the other parties to the QIC reconsideration. The ALJ's 90-day timeframe to issue a decision does not start until all parties to the QIC reconsideration receive notice of the requested ALJ hearing.

In most cases, the ALJ will issue a decision within 90 days of receipt of the request for hearing. The time limit may be extended for a variety of reasons, including but not limited to:

- The case being escalated from the reconsideration level;
- The submission of additional evidence that was not included with the hearing request;
- Request for an in-person hearing;
- The appellant's failure to send notice of the hearing request to other parties; and
- The initiation of discovery in cases where CMS is a party.

If the ALJ does not issue a decision within the applicable adjudication timeframe, the appellant may request that the ALJ escalate the case to the Appeals Council level.

Fourth Level of Appeal – Appeals Council Review

A party to the ALJ hearing may request Appeals Council review of the ALJ's decision or dismissal. The request for Appeals Council review must be filed within 60 calendar days of receipt of the ALJ's decision, which provides information about how to file a request for a review. The request for an Appeals Council review must specify the issues and findings that are being contested. At this level of appeal, there is no AIC requirement.

In most cases, the Appeals Council will issue a decision within 90 days of receipt of the request for review. The 90-day timeframe may be extended for various reasons including, but not limited to, the case being escalated from an ALJ hearing. If the Appeals Council does not issue a decision within the applicable timeframe, the appellant may request that the Appeals Council escalate the case to the Judicial Review level.

Fifth Level of Appeal – Judicial Review

A party to a final decision of the Appeals Council may request judicial review before a U.S. District Court judge if the AIC requirement is met and is still in controversy. The AIC will be adjusted annually in accordance with the percentage increase in the medical care component of the CPI-U. The appellant must file the request for review within 60 days of receipt of the Appeals Council's decision, which provides information about how to request judicial review.

Liability and Appeal Decisions

Liability regarding appeal decisions is as follows:

- When an original claim determination for both assigned and nonassigned claims is upheld on a review and the provider or supplier knew or could have been expected to know that payment for the service might be denied or reduced, he or she is held liable and must refund any monies collected from the beneficiary within 30 days of the review decision unless a valid Advance Beneficiary Notice was properly executed.
- When an original claim determination for an assigned claim is upheld on a review and the provider or supplier and beneficiary could not have been expected to know that payment for the service might be denied or reduced, payment is made to the provider or supplier.
- When an original claim determination for a nonassigned claim is upheld on a review and it is found that the provider or supplier could not have been expected to know that payment for the service might be denied or reduced, he or she is notified that payment may be collected from the beneficiary. If the beneficiary is found liable, a letter is sent indicating that he or she is responsible for payment.
- When an original claim determination for a nonassigned claim is upheld on a review and it is found that neither the provider or supplier nor the beneficiary could have been expected to know that payment for the service might be denied or reduced, neither party will be responsible for payment.
- When the beneficiary is not responsible for the payment of a service, the provider or supplier must refund any monies collected from the beneficiary. If the refund is not made within the specified time limits, the following actions may occur:
    - For an assigned claim, the beneficiary may submit a request to Medicare for indemnification from payment. A letter is sent to the provider or supplier indicating that a refund must be made to the beneficiary within 15 days for the amount actually paid, including any amounts applied to deductibles, coinsurance, and copayments. If the refund is not made within 15 days, Medicare will pay the beneficiary and request a refund from the provider or supplier.
    - For a nonassigned claim, the beneficiary may notify Medicare that the provider or supplier did not refund the amount due. A letter is sent to the provider or supplier indicating that a refund is due to the beneficiary within 15 days. If a refund is not made within 15 days, the provider or supplier may be subject to Civil Monetary Penalties and sanctions.

Reopenings

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or underpayment, even though the determination or decision was correct based on the evidence of record. A reopening allows the correction of minor errors or omissions without initiating a formal appeal. If a claim is denied

because a Contractor did not receive requested documentation during medical review and the party later requests a redetermination, the Contractor must process the request as a reopening. A Contractor must also process clerical errors (including human and mechanical errors on the part of the party or Contractor), such as mathematical or computational mistakes, inaccurate data entry, or denials of claims, as duplicates. A reopening is, in general, not conducted until a party's appeal rights have been exhausted. A Contractor, QIC, ALJ, or Appeal Council's decision on whether to reopen is final and not subject to appeal. A reopening may be requested by a party or initiated by a Contractor, QIC, ALJ, or Appeals Council.

The timeframes and requirements for requesting or initiating a reopening will depend on the level at which the reopening is requested (initial determination level or one of the appeals levels) and who is initiating the reopening (a party, Contractor, QIC, ALJ, or Appeals Council). When any determination or decision is reopened and revised, a Contractor, QIC, ALJ, or Appeals Council must mail its revised determination or decision to the parties. If the reopening action results in an adverse revised determination or decision, the Contractor shall mail a letter that states the rationale for the reopening, the applicable revision, and any right to appeal.

Where to Find Additional Information About the Medicare Fee-For-Service Appeals Process and Appeals Forms

Additional information about the Medicare fee-for-service appeals process is available as follows:

- At *http://www.cms.hhs.gov/OrgMedFFSAppeals* on the CMS website;
- At *http://www.cms.hhs.gov/MMCAG* on the CMS website;
- At *http://www.cms.hhs.gov/MedPrescriptDrugApplGriev* on the CMS website; and
- Chapter 29 of the Medicare Claims Processing Manual (Pub. 100-4) located at *http://www.cms.hhs.gov/Manuals* on the CMS website.

Appeals forms are available at:

- At *http://www.cms.hhs.gov/CMSForms/CMSForms* on the CMS website;
- At *http://www.hhs.gov/dab/DAB101.pdf* on the CMS website; and
- At *http://www.hhs.gov/omha* on the Web.

REFERENCE SECTION

GLOSSARY

A

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

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

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

B

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

C

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

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

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

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

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

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

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

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

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

D

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

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

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

F

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

H

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

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

I

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

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

L

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

M

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

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

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

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

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

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

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

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

N

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

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

O

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

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

P

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

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

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

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

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

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

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

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

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

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

Q

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

R

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

S

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

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

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

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

ACRONYMS

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

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

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

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

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

CONTACT INFORMATION

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Coordination of Benefits Contractor
(800) 999-1118

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OTHER ORGANIZATIONS

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

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

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

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

Railroad Medicare Part B Office
(800) 833-4455

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

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

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

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

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

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

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

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

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

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

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

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

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

1995 DOCUMENTATION GUIDELINES FOR EVALUATION & MANAGEMENT SERVICES

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

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

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

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

WHAT DO PAYERS WANT AND WHY?

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

- the site of service;

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

- that services provided have been accurately reported.

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

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

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:

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

    - assessment, clinical impression, or diagnosis;

    - plan for care; and

    - date and legible identity of the observer.

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

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

5. Appropriate health risk factors should be identified.

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

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

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II. DOCUMENTATION OF E/M SERVICES

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

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

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

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

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

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

A. DOCUMENTATION OF HISTORY

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

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

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

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

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

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

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

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

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

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

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

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

CHIEF COMPLAINT (CC)

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

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

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HISTORY OF PRESENT ILLNESS (HPI)

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

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

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

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

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

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

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

REVIEW OF SYSTEMS (ROS)

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

For purposes of ROS, the following systems are recognized:

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

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

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

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

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

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

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

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

The PFSH consists of a review of three areas:

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

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

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

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

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

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

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

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

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

B. DOCUMENTATION OF EXAMINATION

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

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

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

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

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

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

- Head, including the face

- Neck

- Chest, including breasts and axillae

- Abdomen

- Genitalia, groin, buttocks

- Back, including spine

- Each extremity

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

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

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

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

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C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

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

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

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

- the risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

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

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

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

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

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

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

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

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

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

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

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

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

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

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

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

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

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

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

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

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

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RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

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

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

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

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

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

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

Table of Risk

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

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

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

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

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1997 DOCUMENTATION GUIDELINES FOR EVALUATION & MANAGEMENT SERVICES

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I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

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

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

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

WHAT DO PAYERS WANT AND WHY?

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

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

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

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

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

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

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

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

   - **plan for care; and**

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

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

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

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

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

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

III. DOCUMENTATION OF E/M SERVICES

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

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

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

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

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

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

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

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

A. DOCUMENTATION OF HISTORY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HISTORY OF PRESENT ILLNESS (HPI)

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

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

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

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

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

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

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

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REVIEW OF SYSTEMS (ROS)

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

For purposes of ROS, the following systems are recognized:

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

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

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

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

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

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

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

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

The PFSH consists of a review of three areas:

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

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

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

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

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

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

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

B. DOCUMENTATION OF EXAMINATION

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL MULTI-SYSTEM EXAMINATIONS

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

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

SINGLE ORGAN SYSTEM EXAMINATIONS

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

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

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

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

CONTENT AND DOCUMENTATION REQUIREMENTS

General Multi-System Examination

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

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

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

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

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Content and Documentation Requirements

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

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Cardiovascular Examination

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

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

Content and Documentation Requirements

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

Ear, Nose and Throat Examination

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

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

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Content and Documentation Requirements

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

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Eye Examination

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

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

Content and Documentation Requirements

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

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Genitourinary Examination

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

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

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

Content and Documentation Requirements

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

Hematologic/Lymphatic/Immunologic Examination

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

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

Content and Documentation Requirements

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

Musculoskeletal Examination

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

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

Content and Documentation Requirements

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

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Neurological Examination

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

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

Content and Documentation Requirements

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

Psychiatric Examination

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

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

Content and Documentation Requirements

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

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Respiratory Examination

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

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

Content and Documentation Requirements

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

Skin Examination

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

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

Content and Documentation Requirements

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

C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

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

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

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

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

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

NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

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

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

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

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

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

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

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

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

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

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

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

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

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

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

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

RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

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

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

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

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

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

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

TABLE OF RISK

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

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

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

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