CMS SCENARIO #1 - E/M Services

The Teaching Physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently.

- **No Resident Note.** In the absence of a note by a resident, the Teaching Physician must document as he/she would document an E/M service in a non-teaching setting.

- **Resident Note.** Where a resident has written notes, the Teaching Physician's note may reference the resident's note. The Teaching Physician must document that he/she performed the critical or key portion(s) of the service and that he/she was directly involved in the management of the patient.

**Examples of Minimally Acceptable Documentation**

- **Admitting Note:** "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."

- **Follow-up Visit:** "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."

- **Follow-up Visit:** "Hospital Day #5. I saw and examined the patient. I agree with the resident's note, except the heart murmur is louder, so I will obtain an echo to evaluate."

**NOTE:** In any of these situations, if there are no resident's notes, the Teaching Physician must document as he/she would document an E/M service in a non-teaching setting.
CMS SCENARIO #2 - E/M Services

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

Examples of Minimally Acceptable Documentation:

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

- **Follow-up Visit:** "I saw the patient with the resident and agree with the resident’s findings and plan."
CMS SCENARIO #3 - E/M Services

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

Examples of Minimally Acceptable Documentation:

- **Initial Visit:** "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

- **Initial or Follow-up Visit:** "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

- **Follow-up Visit:** "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plan as written."

- **Follow-up Visit:** "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spin today."
CMS EXAMPLES OF UNACCEPTABLE
TEACHING PHYSICIAN DOCUMENTATION

- "Agree with above.", followed by legible countersignature or identity.

- "Rounded, Reviewed, Agree.", followed by legible countersignature or identity.

- "Discussed with resident. Agree.", followed by legible countersignature or identity.

- "Seen and agree", followed by legible countersignature or identity.

- "Patient seen and evaluated", followed by legible countersignature or identity.

- A legible countersignature or identity alone.

This type of documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement in the plan of care.
Preventive Services

Patient ______________________ MRN ______________________ Provider ______________________ Payer ______________________

**Teaching Physicians:**

- Did Teaching Physician document his/her presence? Yes No No resident
- Did Teaching Physician document his/her participation in decision making? Yes No No resident
- Did Teaching Physician document proper linkage to resident’s documentation? Yes No No resident

Was the service performed in a Primary Care exception clinic? Yes No N/A

New Patient Y N Was service provided by a Mid level? Y N

Was a co-signature required? Y N Was co-signature present? Y N

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<table>
<thead>
<tr>
<th>Health Screenings</th>
<th>Systems</th>
<th>Review of Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>Glaucoma Screening</td>
<td></td>
</tr>
<tr>
<td>Abdominal Aortic Aneurysm</td>
<td>HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td>Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advance directives</td>
<td>Immunizations</td>
<td></td>
</tr>
<tr>
<td>Breast self-exam</td>
<td>Mammogram</td>
<td></td>
</tr>
<tr>
<td>Calcium</td>
<td>Mental health/depression</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular Screening</td>
<td>Blood Screening</td>
<td></td>
</tr>
<tr>
<td>Tests</td>
<td>Prostate Cancer Screening</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Sexual behavior</td>
<td></td>
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<tr>
<td>Dental health</td>
<td>Seatbelt usage</td>
<td></td>
</tr>
<tr>
<td>Diabetes Screening Tests</td>
<td>UV exposure</td>
<td></td>
</tr>
<tr>
<td>Diet/Exercise</td>
<td>Violence &amp; guns</td>
<td></td>
</tr>
<tr>
<td>Estrogen</td>
<td></td>
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<thead>
<tr>
<th>Past Medical History</th>
<th>Family History</th>
<th>Social History</th>
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<tbody>
<tr>
<td>Past Illness</td>
<td>Family Illness</td>
<td>Tobacco Use</td>
</tr>
<tr>
<td>Past Surgeries</td>
<td>Hereditary Diseases</td>
<td>Drug Use</td>
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<td>Allergies</td>
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<td>Alcohol</td>
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<td>Current Medications</td>
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<td>Living Arrangements</td>
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<td>Past Hospitalizations</td>
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<td>Employment</td>
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<td>Injuries</td>
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<table>
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<tr>
<th>Exam Areas</th>
<th>Organ Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head/face</td>
<td>Eyes</td>
</tr>
<tr>
<td>Neck</td>
<td>ENT</td>
</tr>
<tr>
<td>Chest/Breast</td>
<td>Bottom right extremity</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Bottom left extremity</td>
</tr>
<tr>
<td>Genitalia</td>
<td>Hem/Lymph</td>
</tr>
<tr>
<td>Back</td>
<td>GI</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Medicare Screening Pelvic/Breast Exam G0101 need 7 of 11</th>
<th>Medicare Initial Physical Exam G0402</th>
<th>Medicare Annual / Subsequent Physical G0438 or G0439</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breasts</td>
<td>Height</td>
<td>Height</td>
</tr>
<tr>
<td>Rectal</td>
<td>Weight</td>
<td>Weight</td>
</tr>
<tr>
<td>External genitalia</td>
<td>Blood Pressure</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>Urethral meatus</td>
<td>BMI</td>
<td>BMI</td>
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<tr>
<td>Bladder</td>
<td>Visual Acuity</td>
<td>Assessment of Cognitive Impairment</td>
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<table>
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<tr>
<th>Comments</th>
<th>Screening Depression</th>
<th>Assessment Functional Ability</th>
<th>Assessment of Fall Risk</th>
<th>End of life Planning</th>
<th>Education/Counseling/Referrals given?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Personalized Prevention Plan</td>
<td>• Yearly Health/Wellness Schedule</td>
<td>• List Professionals caring for patient</td>
<td>Review of patient’s risk factors</td>
<td>Yes No</td>
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<tr>
<td></td>
<td>• Update personalized plan</td>
<td>• Update health/wellness schedule</td>
<td>• Update professional list</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Plan for further preventive services?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
</tbody>
</table>
Seven Elements of a Medicare IPPE

**Element 1.** Review the beneficiary’s medical and social history with attention to modifiable risk factors for disease.

Medical History. At a minimum, this must include:

a. Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries and treatments.
b. Current medications and supplements, including calcium and vitamins.
c. Family history, including a review of medical events in the beneficiary’s family, including diseases that may be hereditary or place the individual at risk.

Social History. At a minimum, this must include:

a. History of alcohol, tobacco, and illicit drug use.
b. Diet.
c. Physical Activities.

**Element 2.** Review the beneficiary’s potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the provider may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.

**Element 3.** Review the beneficiary’s functional ability and level of safety based on the use of appropriate screening questions or a screening questionnaire, which the provider may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations. This review must include, at a minimum, a review of the following areas:

a. Hearing impairment. (Excludes diagnostic hearing tests, which are separately covered under Medicare).
b. Activities of daily living.
c. Falls risk.
d. Home safety.

**Element 4.** An exam, to include measurement of the beneficiary’s height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary’s medical and social history, and current clinical standards.

**Element 5.** Performance and interpretation of an electrocardiogram. This screening electrocardiogram can be referred to another practitioner for performance and/or interpretation. If the provider does not perform or interpret the ECG, then he/she would only bill the G0344 code, but would still need to incorporate the results of the EKG into the beneficiary’s medical record to complete the IPPE. The provider of the IPPE related
APPENDIX M

EKG would report one of the following: (i) G0366 (tracing and interpretation), (ii) G0367 (tracing only), or (iii) G0368 (interpretation and report only)

Element 6. Education, counseling, and referral, as deemed appropriate by the provider, based on the results of the review and evaluation services as outlined above.

Element 7. Education, counseling, and referral, including a brief written plan such as a checklist provided to the beneficiary for obtaining the appropriate screening and other preventive services that are separately covered by Medicare.

3/10/06
### Notes on Medicare Part B Preventive Services

- **Notes**: This section provides additional information related to Medicare Part B preventive services. It includes guidance on how to use the following Health Coverage Program Codes (HCPCS) to identify services covered under Medicare Part B.

### Preventive Services Table

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Code</th>
<th>Medicare Prevention Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Visit (AWV)</td>
<td>G0439</td>
<td>C0861 (HCPCS)</td>
</tr>
<tr>
<td>Comprehensive Skin Exam</td>
<td>G0438</td>
<td>C0862 (HCPCS)</td>
</tr>
<tr>
<td>Annual Wellness Visit (AWV) (ES)</td>
<td>G0439 (ES)</td>
<td>C0861 (HCPCS)</td>
</tr>
</tbody>
</table>

### Medicare Prevention Services

- **Vision Services**: Includes vision screening, refraction, and services for eyewear.
- **Hearing Services**: Includes hearing screenings and hearing aids.
- **Nutrition Services**: Includes nutrition counseling and dietary assessment.
- **Physical Therapy Services**: Includes physical therapy and activities of daily living.
- **Occupational Therapy Services**: Includes occupational therapy and activities of daily living.
- **Speech-language Pathology Services**: Includes speech-language pathology services.

### Preventive Services for Medicare Beneficiaries

- **Wellness Visit**: Provides comprehensive health assessment and planning.
- **Flu Vaccine**: Recommended for all Medicare beneficiaries.
- **Cancer Screenings**: Includes mammography, colonoscopy, and Pap tests.
- **Diabetes Education**: For beneficiaries with diabetes.
- **Eye Exams**: For beneficiaries over 65 years old.
- **Hearing Aids**: For beneficiaries with hearing loss.
- **Home Health Services**: For beneficiaries with chronic conditions.

### Preventive Services for Medicare Advantage Beneficiaries

- **Wellness Visits**: Provide a comprehensive health assessment.
- **Flu Vaccine**: Essential for disease prevention.
- **Cancer Screenings**: Include mammograms and colonoscopies.
- **Diabetes Education**: Tailored to the needs of diabetic patients.
- **Eye Exams**: Offered to beneficiaries over 65 years old.
- **Hearing Aids**: Provided to beneficiaries with hearing impairments.
- **Home Health Services**: Offered to beneficiaries with chronic conditions.

### Preventive Services for Medicare Part D Beneficiaries

- **Wellness Visits**: Provide a comprehensive health assessment.
- **Flu Vaccine**: Essential for disease prevention.
- **Cancer Screenings**: Include mammograms and colonoscopies.
- **Diabetes Education**: Tailored to the needs of diabetic patients.
- **Eye Exams**: Offered to beneficiaries over 65 years old.
- **Hearing Aids**: Provided to beneficiaries with hearing impairments.
- **Home Health Services**: Offered to beneficiaries with chronic conditions.
February 2011 ICN 905706
Please send your suggestions regarding M/W product topics of interest to ICN. Does this go

February 2011 ICN 905706
Please send your suggestions regarding M/W product topics of interest to ICN. Does this go
Appendix O
EHR Audit

Patient Name__________________________ MRN________________________
DOS__________________________ Payer________________________

I. Authorship
A. Persons who entered into the record
Name Credentials Entry Sections Permissible

☐Yes ☐No
☐Yes ☐No
☐Yes ☐No
☐Yes ☐No

B. Did the billing provider complete the clinical staff attestation? ☐Yes ☐No
If “No” the attestation was ☐Absent ☐Not required
☐Completed by other personnel (identify)

C. Is there a Co-Author Signature on the encounter? ☐Yes ☐No
Is this correct for this encounter? ☐Yes ☐No (explain)

II. Timeliness and Amendments
A. Was the record finalized within 7 business days of the encounter?
☐Yes ☐No: it was finalized _______ business days after the encounter
Was it billed? ☐Yes When__________________________ ☐No

B. Were amendments made after finalization? ☐Yes ☐No
If yes, complete the following:
Name # of Amendments Nature of Amendments

Do the amendments render the note difficult to read: ☐Yes ☐No

III. Consistency of Documentation
A. Internal Consistency
1. Is there consistency among the Chief Complaint, HPI and final diagnosis?
☐Yes ☐No (explain)

2. Are there inconsistencies between the History of Present Illness and the Review of Systems? ☐No ☐Yes (explain)

3. Are there other inconsistencies noted in the documentation? ☐No ☐Yes (explain)

B. Consistency across visits: Obtain records for the same patient and billing provider for the encounter just prior to, and, if applicable just after the encounter being audited
1. Is the patient’s medical history consistent across the visits? □ Yes □ No (explain)

2. Does any part of the record being audited appear to be copied verbatim from the past visit? □ No □ Yes (explain)

IV. Teaching Physician Documentation
A. Review Section I.A: Did any students or trainees complete sections of the record other than vital signs, chief complaint, review of systems or past, family and social history? □ No □ Yes (explain)

B. Review the electronic version of the record for the encounter: Is there a medical student free text note? □ No □ Yes
If “Yes”, compare the student’s note to the record for the visit: Does any documentation in the record appear to be copied verbatim from the student note? □ No □ Yes (explain by whom and into what section)

C. Was a resident or fellow involved in the care of the patient? □ Yes □ No
If “Yes”, who added the teaching physician attestation? □ Teaching Physician □ Resident □ Other
Was this correct? □ Yes □ No
If “Yes”, was the correct teaching physician attestation added to the documentation (i.e., general, primary care exception, procedure)? □ Yes □ No (explain)

V. Coding
A. ICD-9: Are the ICD-9 codes reported supported by the documentation (e.g., are they active in the encounter or only present in the problem list)? □ Yes □ No

B. For E/M Services, does the documentation and level seem appropriate for the presenting complaint? □ Yes □ No (explain)

VI. E-Prescribing
A. Was prescription E-Prescribed? □ Yes □ No
If yes, was the E-Prescribing attestation completed? □ Yes □ No