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

Appendix L

Patient _____ **MRN** _____ **Provider** _____ **Payer** _____

DOS_____ **Billed** _____ **Supported** _____ **Audit #**_____

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___

Health Screenings

Abuse		Glaucoma Screening	
Abdominal Aortic Aneurysm Screening		HIV/AIDS	
Advance directives		Immunizations	
Breast self-exam		Mammogram	
Calcium		Mental health/depression	
Cardiovascular Screening Blood Tests		Prostate Cancer Screening	
Colorectal Cancer Screening		Sexual behavior	
Dental health		Seatbelt usage	
Diabetes Screening Tests		UV exposure	
Diet/Exercise		Violence & guns	
Estrogen			

Review of Systems

Systems	✓	Documentation
Constitut.(fever, wt loss)		
Eyes		
Ears/Nose/Mouth/Throat		
Cardiovascular		
Respiratory		
GI (abdominal)		
GU		
Musculoskeletal		
Integumentary		
Neurological		
Psychiatric		
Endocrine		
Hematologic/Lymphatic		
Allergic/Immunologic		

☐ Documented "all other systems reviewed and are negative"

☐ **Complete ROS 10+ Systems**

Past Medical History		Family History		Social History	
Past Illness		Family Illness		Tobacco Use	
Past Surgeries		Hereditary Diseases		Drug Use	
Allergies				Alcohol	
Current Medications				Living Arrangements	
Past Hospitalizations				Employment	
Injuries				Other	

Exam Areas				**Organ Systems**			
Head/face		Upper right extremity		Eyes		GU	
Neck		Upper left extremity		ENT		Skin/Integumentary	
Chest/Breast		Bottom right extremity		Cardiovascular		Musculoskeletal	
Abdomen		Bottom left extremity		Respiratory		Neurologic	
Genitalia				Hem/Lymph		Psychiatric	
Back				GI		Constitutional	

Medicare Screening Pelvic/Breast Exam G0101 need 7 of 11				**Medicare Initial Physical Exam G0402**		**Medicare Annual / Subsequent Physical G0438 or G0439**	
Breasts		Vagina/pelvic support		Height		Height	
Rectal		Cervix		Weight		Weight	
External genitalia		Uterus		Blood Pressure		Blood Pressure	
Urethral meatus		Adnexa/parametrium		BMI		BMI	
Bladder		Anus/perineum		Visual Acuity		Assessment of Cognitive Impairment	
Comments				Hearing Assessment		Health Risk Assessment	
				Screening Depression		•Personalized Prevention Plan •Update personalized plan	
				Assessment Functional Ability		•Yearly Health/Wellness Schedule •Update health/wellness schedule	
				Assessment of Fall Risk		•List Professionals caring for patient •Update professional list	
				End of life Planning		Review of patient's risk factors	
				Update PFSH		Update PFSH	

Education/Counseling/Referrals given? Yes _____ No _____

Plan for further preventive services? Yes _____ No _____

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

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.

Medicare | PREVENTIVE SERVICES

Quick Reference Information:
The ABCs of Providing the Annual Wellness Visit

For dates of service on or after January 1, 2011, the Affordable Care Act allows for coverage of the Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS). All components of the AWV must be provided, or provided and referred, prior to submitting a claim for the AWV. Note that the AWV is a separate service from the Initial Preventive Physical Examination (IPPE), and that the AWV is not covered during the first 12 months of a beneficiary's initial enrollment into Medicare Part B. This document is divided into two sections: the first explains the elements included in the first AWV a beneficiary receives, and the second explains the elements included in all subsequent AWVs.

Elements of the FIRST AWV Providing PPPS

ACQUIRE BENEFICIARY HISTORY	DESCRIPTION
☐ Establishment of the beneficiary's medical/family history	At a minimum, collect and document the following: • Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments; • Use or exposure to medications and supplements, including calcium and vitamins; and • Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the beneficiary at increased risk.
☐ Review of the beneficiary's potential risk factors for depression, including current or past experiences with depression or other mood disorders	Use any appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.
☐ Review of the beneficiary's functional ability and level of safety	Use direct observation of the beneficiary, or any appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations to assess, at a minimum, the following topics: • Hearing impairment; • Ability to successfully perform activities of daily living; • Fall risk; and • Home safety.
BEGIN EXAMINATION	**DESCRIPTION**
☐ An examination	Obtain the following: • Height, weight, body mass index (or waist circumference, if appropriate), and blood pressure; and • Other routine measurements as deemed appropriate, based on medical and family history.
☐ Establishment of a list of current providers and suppliers	Include current providers and suppliers that are regularly involved in providing medical care to the beneficiary.
☐ Detection of any cognitive impairment that the beneficiary may have	Assess the beneficiary's cognitive function by direct observation, with due consideration of information obtained by way of patient reports and concerns raised by family members, friends, caretakers, or others.
COUNSEL BENEFICIARY	**DESCRIPTION**
☐ Establishment of a written screening schedule for the beneficiary, such as a checklist for the next 5-10 years, as appropriate	Base written screening schedule on: • Recommendations from the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP); • The beneficiary's health status and screening history; and • Age-appropriate preventive services covered by Medicare.
☐ Establishment of a list of risk factors and conditions of which the primary, secondary, or tertiary interventions are recommended or underway for the beneficiary	Include the following: • Any mental health conditions or any such risk factors or conditions that have been identified through an IPPE; and • A list of treatment options and their associated risks and benefits.
☐ Furnishing of personalized health advice to the beneficiary and a referral as appropriate to health education or prevention counseling services	Includes referrals to programs aimed at: • Community-based lifestyle interventions to reduce health risks and promote self-management and wellness; • Weight loss; • Physical activity; • Smoking cessation; • Fall prevention; and • Nutrition.

Elements of SUBSEQUENT AWVs Providing PPPS

ACQUIRE BENEFICIARY HISTORY	DESCRIPTION
☐ An update of the beneficiary's medical/family history	At a minimum, collect and document the following: • Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments; • Use or exposure to medications and supplements, including calcium and vitamins; and • Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the beneficiary at increased risk.

BEGIN EXAMINATION	DESCRIPTION
☐ An examination	Obtain the following: • Weight (or waist circumference, if appropriate) and blood pressure; and • Other routine measurements as deemed appropriate, based on medical and family history.
☐ An update of the list of current providers and suppliers, as that list was developed for the first AWV providing PPPS	Include current providers and suppliers that are regularly involved in providing medical care to the beneficiary.
☐ Detection of any cognitive impairment that the beneficiary may have	Assess the beneficiary's cognitive function by direct observation, with due consideration of information obtained by way of patient reports and concerns raised by family members, friends, caretakers, or others.

COUNSEL BENEFICIARY	DESCRIPTION
☐ Update to the written screening schedule for the beneficiary, as that schedule was developed at the first AWV providing PPPS	Base written screening schedule on: • Recommendations from the USPSTF and the ACIP; • The beneficiary's health status and screening history; and • Age-appropriate preventive services covered by Medicare.
☐ Update to the list of risk factors and conditions of which the primary, secondary, or tertiary interventions are recommended or underway for the beneficiary, as that list was developed at the first AWV providing PPPS	Include any such risk factors or conditions that have been identified.
☐ Furnishing of personalized health advice to the beneficiary and a referral as appropriate to health education or prevention counseling services	Includes referrals to programs aimed at: • Community-based lifestyle interventions to reduce health risks and promote self-management and wellness; • Weight loss; • Physical activity; • Smoking cessation; • Fall prevention; and • Nutrition.

MEDICARE PART B PREVENTIVE SERVICES	
Initial Preventive Physical Examination (IPPE)[a]	Human Immunodeficiency Virus (HIV) Screening
Bone Mass Measurements	Medical Nutrition Therapy (MNT)
Cardiovascular Screening Blood Tests	Prostate Cancer Screening
Colorectal Cancer Screening	Seasonal Influenza, Pneumococcal, and Hepatitis B Vaccinations and their Administration
Counseling to Prevent Tobacco Use[b]	Screening Mammography
Diabetes Screening Tests	Screening Pap Tests and Pelvic Examination
Diabetes Self-Management Training (DSMT)	Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)
Glaucoma Screening	

Notes on Medicare Part B Preventive Services

[a] For more information on the IPPE, refer to "The ABCs of Providing the Initial Preventive Physical Examination" (ICN 006904) at http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

[b] Effective for dates of service on or after August 25, 2010, Medicare provides coverage of counseling to prevent tobacco use.

Use the following Healthcare Common Procedure Coding System (HCPCS) codes, listed in the table below, when filing claims for the AWV.

AWV HCPCS CODES	BILLING CODE DESCRIPTORS
G0438	Annual wellness visit, includes Personalized Prevention Plan of Service (PPPS), first visit
G0439	Annual wellness visit, includes PPPS, subsequent visit

Frequently Asked Questions

Who can perform the AWV?

The AWV must be furnished by a health professional, meaning a physician (a doctor of medicine or osteopathy), a qualified non-physician practitioner (a physician assistant, nurse practitioner, or clinical nurse specialist), or by a medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of such medical professionals who are working under the direct supervision of a physician.

Is the AWV the same as a beneficiary's yearly physical?

No, this visit is a preventive wellness visit and not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. Medicare does not provide coverage for routine physical exams.

Are clinical laboratory tests part of the AWV?

No, the AWV does not include any clinical laboratory tests, but the provider may want to make referrals for such tests as part of the AWV.

Is there a deductible or coinsurance/copayment for the AWV?

No, coverage for the AWV is provided as a Medicare Part B benefit, and both the coinsurance or copayment and the Medicare Part B deductible are waived for the AWV.

Can a separate Evaluation and Management (E/M) service be billed at the same visit as the AWV?

Medicare payment can be made for a significant, separately identifiable medically necessary E/M service (Current Procedural Terminology [CPT] codes 99201-99215) billed at the same visit as the AWV when billed with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary's illness or injury, or to improve the functioning of a malformed body member.

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Who Is Eligible to Receive the AWV?

Effective for dates of service on or after January 1, 2011, Medicare will pay for an AWV for a beneficiary who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage and who has not received either an IPPE or an AWV providing PPPS within the past 12 months. Medicare pays for only one **first** AWV per beneficiary per lifetime, and pays for one subsequent AWV per year thereafter.

Preparing Eligible Medicare Beneficiaries for the AWV

Providers can help eligible Medicare beneficiaries get ready for their AWV by encouraging them to come prepared with the following information:

- Medical records, including immunization records;
- Family health history, in as much detail as possible;
- A full list of medications and supplements, including calcium and vitamins – how often and how much of each is taken; and
- A full list of current providers and suppliers involved in providing care.

Resources

"The Guide to Medicare Preventive Services" (ICN 006439)
http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

"Medicare Benefit Policy Manual" – Publication 100-02, Chapter 15
http://www.cms.gov/manuals/downloads/bp102c15.pdf

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 12, Section 30.6.1.1
http://www.cms.gov/manuals/downloads/clm104c12.pdf

"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18
http://www.cms.gov/manuals/downloads/clm104c18.pdf

Change Request 7079/Transmittal 2159CP – Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)
http://www.cms.gov/transmittals/downloads/R2159CP.pdf

Change Request 7079/Transmittal R138BP – Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)
http://www.cms.gov/transmittals/downloads/R138BP.pdf

Medicare Learning Network® (MLN) Preventive Services Educational Products Website
http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

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