

# MSSNY'S

## "HOW TO" GUIDE

An educational booklet  
containing articles on a  
variety of health plan issues



*Prepared by MSSNY'S Division of Socio-Medical Economics*  
**MEDICAL SOCIETY OF THE STATE OF NEW YORK**

2006

MSSNY's "HOW TO" GUIDE

TABLE OF CONTENTS

	<u>Page</u>
<b>WELCOME</b> .....	3
Preface.....	4
FORM: All Insurance Information.....	5-6
FORM: Medical Record Keeping For Patients.....	7-10
Record Retention.....	11-13
Special Retention rules for Mammography.....	14
Billing for "No Shows".....	15
How the Ombudsman Program Functions.....	16-17
Ombudsman Program and Audit Advice.....	18-19
 <b>MEDICARE</b>	
Toll Free Medicare Carrier Phone Numbers.....	20
Medicare Billing Options.....	21-22
Medicare Provider Enrollment Problems.....	23-24
Medicare Payment for Drugs and Biologicals.....	25
Medicare Box 32 Claim Form Information.....	26
Medicare Balance Billing.....	27
Medicare Managed Care Information.....	28-29
 <b>MEDICAID</b>	
NYSDOH/CSC/Medicaid Eligibility.....	30-31
Medicaid Reimbursement for Drugs Administered in a Physician's Office.....	32
Medicaid and Private Payments.....	33-35
 <b>WORKERS' COMPENSATION</b>	
WC Controversy and Private Plan Time Limits.....	36
 <b>CMS' DOCUMENTATION GUIDELINES FOR EVALUATION and MANAGEMENT SERVICES</b>	
1995 Documentation Guidelines.....	37-45
1997 Documentation Guidelines.....	46-68
 <b>RESOURCE INFORMATION</b>	
Resource Information.....	69-72

## **WELCOME!!!**

SUBJECT: Medical Society of the State of New York (MSSNY) and  
Making the Most of Your Membership

Dear Physician Member:

On your behalf as a member of MSSNY, the Division of Socio-Medical Economics has prepared the attached material for you and your office staff to use as you see fit. The Division of Socio-Medical Economics is here to assist you with health insurance difficulties you or your staff may have on behalf of your patients.

Through the Division, we offer members direct access to our Ombudsman Program. Through the Program, we assist doctors who are having difficulties with health plans. The issues we handle could require a policy clarification or proper payment of a bill/claim. During the first three quarters of 2004, the Division handled over 1,800 contacts with members who asked us for assistance. Questions we receive relate to Medicare, Medicaid, Workers' Compensation, No-Fault Auto programs, managed care, traditional indemnity plans, coding, billing, etc.

If the matters are more difficult or complex, we will ask the physician to provide us with documentation and write to a health plan on the physician's behalf, if necessary. During the first 9 months of this year, we initiated over 140 cases with various payers in the state. In 2004, our Ombudsman Program recovered \$64,764.58 for members. In 2005, our Ombudsman Program recovered \$66,651.86 for members. In 2006, our Ombudsman Program recovered \$49,902.04 for members.

For your information, we offer the following educational material to our members:

1. A flyer on the Medicare Managed Care Program
2. MSSNY's Medical Record Keeping Form

As you practice your profession, you should familiarize yourself with the following material that can be downloaded from the Centers for Medicare and Medicaid Services (CMS) website:

1. The CMS 1995 Evaluation/Management Guidelines at [www.cms.hhs.gov/medlearn/1995dg.pdf](http://www.cms.hhs.gov/medlearn/1995dg.pdf)
2. The CMS 1997 Evaluation/Management Guidelines at [www.cms.hhs.gov/medlearn/master1.pdf](http://www.cms.hhs.gov/medlearn/master1.pdf)
3. Medicare Secondary Payer Information at [www.cms.hhs.gov/medicare/cob/msp/msp\\_detail.asp](http://www.cms.hhs.gov/medicare/cob/msp/msp_detail.asp)

Again, welcome, and thank you for supporting our efforts on behalf of physicians throughout New York State. Please contact me or anyone on our staff if you have questions, suggestions, comments or complaints.

Sincerely,

Regina McNally, Vice President  
Division of Socio-Medical Economics  
516-488-6100, ext. 332  
Fax 516-352-4093  
[rmcnally@mssny.org](mailto:rmcnally@mssny.org)

## **PREFACE**

Hello Doctors!

The information contained in what follows happens to be a culmination of various articles that have been printed over the years in either MSSNY's ***EVPgram*** or the ***News of New York***.

Many of the articles were written with the advice that if additional information is needed on the specific subject you can feel free to contact the Division of Socio-Medical Economics at 1(516) 488-6100, ext. 318, 332, 333, 334, or 426. This contact information has remained on each piece as it was originally written. The articles were written as "*stand alone*" items and can still be used in that manner, if you wish.

This compilation will not address every consequence that you will come across during the course of your business. However, the articles have been published, republished and updated through the years and appear to be relevant to today's medical practice.

Reading through the various communiqués, might trigger your inclination for a point of clarification on additional subjects. If so, let us know and we will see what we can do for you. In the meantime, I hope you will find this current collection of material applicable to you and your staff.

The Division of Socio-Medical Economics is here to help you and your staff get through the myriad of insurance issues you deal with in your day-to-day practice and business. Give us a call, we're at your service.

**1-800-523-4405 / 516-488-6100, ext. 318, 332, 333, 334, and/or 426!**

## ALL INSURANCE INFORMATION

### *Personal Information*

Your Name	Age	Sex
First	Int.	Last
Patient's Name (if not you)		
How is the Patient related to you?	Patient's Age	Patient's Sex
HIC Number (Medicare Number)		
Basis for patient's entitlement to Medicare:		Effective Date:
<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)		

### *Group Health Plan Information (Patient's Own Coverage)*

Insurance Company		
Policy Number	Group Number	Claim Number
Insurance Plan Number		
Plan Identification Number		
Is the patient employed? <input type="checkbox"/> Yes <input type="checkbox"/> Full Time? <input type="checkbox"/> Part Time? <input type="checkbox"/> No    Retirement Date _____		
Employer Name:		
Employer Address		
City	State	Zip
Employer Phone Number		

### *Group Health Plan Information (Coverage through Spouse or Other Family Member's Insurance)*

Insured's Name	Relationship to Patient
Insurance Company	
Plan Identification Number	
Is the insured employed? <input type="checkbox"/> Yes <input type="checkbox"/> Full Time? <input type="checkbox"/> Part Time? <input type="checkbox"/> No    Retirement Date _____	
Employer Name	
Employer Address	
City	State                      Zip
Employer Phone Number	





## MEDICAL SOCIETY OF THE STATE OF NEW YORK

420 LAKEVILLE ROAD. P.O. BOX 5404, LAKE SUCCESS, N.Y. 11042 (516) 488-6100

FAX: (516) 488-1267

### MEDICAL RECORD KEEPING FOR PATIENTS

#### Why do we need a new daily record form?

Implementation of the AMA-CPT E&M codes for patients has come with a strong admonition from CMS that physicians keep detailed records of visits and procedures. Since claims procedures will be focused on the submission of code numbers...without accompanying wording for describing the services or diagnosis...CMS has repeatedly warned that a physician's medical records must include a detailed, lucid and contemporaneous report on patient visits.

In addition to the normal record keeping information (Name, date, complaint, etc.), the records must reflect the nature and complexity of the patient's history taking and examination as well as the complexity of the medical decision making undertaken by the physician. Since these three key elements...history, examination and medical decision making...are the key components in deciding the proper CPT code number, it is extremely important that records reflect the full details of the visit. Records should, in fact, be maintained in full anticipation that they will periodically be demanded by the carriers.

To facilitate the record keeping mandate of CMS, the Medical Society of the State of New York developed a one sheet daily record form as a guidance for incorporating the information that a physician must develop and record to meet the criteria for submitting the proper AMA-CPT code(s) on a claim. In addition to the information on the front of the form, there is room on the back for additional notes as well as a section that the office manager may find useful.

Please feel free to reproduce the form for your own use.

#### What is included on the new form?

The form includes the basic data for documentation of a patient's visit and the detailing of the information necessary for selection of the correct AMA-CPT code. It is intended to provide a simplified format that should be considered the minimum for a patient's chart. A new form should be completed for each visit. Patients' medical records should include:

- patient's name and date of visit;
- chief complaint or reason for visit;
- **pertinent medical history as appropriate for each visit;**

- **findings obtained from the physical exam done that day;**
- **diagnostic decisions based on the examination, history and any applicable test results;**
- indication of progress;
- notations of medication dispensed, administered or prescribed with precise dosage and regimen;
- notations of consultations or referrals with reason recommended;
- anticipated patient return for further treatment, the treatment planned and anticipated date of return;
- notations documenting medical necessity for ancillary diagnostic services;
- any other documents supporting the extent of care, services and supplies provided;
- time spent on a visit. *(NB: This is considered as a guide and is not to be considered as the prime factor in CPT code selection. Time may, however, be considered a contributory factor when it takes more than 50% of the E/M visit to counsel and/or coordinate the patient's care.)*

**PLEASE NOTE**

**The boldfaced and underlined information above should be as explicit as possible. Remember that this information (i.e.: history, examination and decision making) forms the basis of the specific AMA-CPT code selection and submission. Records must clearly support these qualifying "key components" and should be written in anticipation of the possibility of records being audited.**

**PATIENT:** \_\_\_\_\_ **CURRENT AGE:** \_\_\_\_\_

**TODAY'S DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_ **VITALS:** \_\_\_\_\_

**LAST DATE SEEN:** \_\_\_\_\_ **PLACE OF SERVICE:** \_\_\_\_\_

**PATIENT'S CHIEF COMPLAINT/REASON FOR VISIT:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PATIENT'S HISTORY:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**EXAMINATION:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL DECISION MAKING (i.e. # of possible dx's., possible treatment options, analysis of medical records and diagnostic tests, risks of complications and/or morbidity or mortality):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PROGRESS OF PATIENT:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**RECOMMENDATIONS/REFERRALS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL NECESSITY FOR ANCILLARY DIAGNOSTIC PROCEDURE(S):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_ **\*TIME:** \_\_\_\_\_

\_\_\_\_\_ **\*Please refer to guidelines.**

**EXPECTED DATE TO RETURN FOR FOLLOW-UP:** \_\_\_\_\_



## RECORD RETENTION

Physicians should be aware that record retention falls into two (2) categories. There are time frames for financial record retention and separate time frames for medical record retention.

### FINANCIAL RECORD RETENTION

As far as Financial Record Retention (i.e. superbills, claim forms, Explanation of Benefit (EOBs), Medicare Summary Notices (MSNs), Remittance Statements, etc.) is concerned, please be aware of the following:

**Medicaid** states that: "For auditing purposes, records [medical and financial] must be maintained and be available to authorized Medicaid officials for six years following the date of payment. Failure to conform within these requirements may affect payment and may jeopardize a provider's eligibility to continue as a Medicaid participant".

**Medicare**, staff from the Regional Office of the Centers for Medicare and Medicaid Services (CMS) has indicated: "With regard to the time limitation for recovery action, 31 CFR §901.3 (4) states that the government has the right to collect a debt no more than ten years after the government's action to recoup the debt first occurred.

**Contracted Health Plans** - When doctors are dealing with contracted health plans such as managed care organizations, the time limit of six years for contract law would prevail.

### MEDICAL RECORD RETENTION

The following data refers to Medical Record Retention and contains a variety of time periods depending upon the situation. Trying to summarize all the time frames is quite difficult. The MSSNY recommended standard safeguard on medical record retention is a minimum of seven years. However, some of exceptions would be:

1. Records relating to the treatment of infants should be kept for at least 6 years or until the infant reaches 19 years of age, whichever is longer.
2. Obstetric records should be retained until the infant reaches 19 years of age.
3. Most HMO agreements provide that records of a minor patient must be retained for six years from the last date of care or six years after the minor turns 18 years old (24 years old), whichever is longer.
4. For malpractice cases, in general, an action must be initiated within 2 ½ years from when the incident took place. However there are exceptions to this rule. The exceptions are called "tolling devices". There are three such "tolling devices". They are the treatment of minors exception, the continuous treatment doctrine, and the "foreign objects" exception. (For an explanation of all 3 exceptions, please refer to the additional material shown below starting at \*\*) But in any event, 10 years would be the maximum amount of time within which an action for malpractice could be brought.

In consideration of the potential for insurer audits and potential malpractice cases, it would be advisable for physicians to retain medical and financial records for at least ten (10) years from the payment (insurer or patient payment, considering that this date would be after the date of service) date with exceptions for infants, minor children, and potential "foreign object" malpractice cases.

\*\*It is also important to note that a physician must retain patient records for certain applicable time periods. Medical records must be retained for the period required by Section 6530(32) of the Education Law.

According to the section, unprofessional conduct includes:

“Failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Unless otherwise provided by law, all patient records must be retained for at least six years. Obstetrical records and records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of eighteen years”.

An intentional violation of this section of the Education Law can constitute grounds for disciplinary proceedings of professional misconduct.

According to the aforementioned section, you can destroy records if a minimum period of six years has elapsed from the last date of treatment. Keep in mind that this is a minimum requirement. You may keep records for a period longer than six years. It is generally recommended that records be kept at least seven years, as an added safeguard. Two exceptions provided in the Education Law include records relating to the treatment of infants (patients who were under 18 at the time of treatment) and obstetric records. Records relating to the treatment of infants should be kept for at least six years or until the infant reaches 19 years of age, whichever is longer. Obstetric records should be retained until the infant reaches 19 years of age.

The requirement regarding retaining medical records should not be confused with the statute of limitations. The statute of limitations is the period of time in which a plaintiff will be able to bring a lawsuit without being time barred. After July 1, 1975, the statute of limitations for a medical malpractice action has been two years, six months from the date of the alleged malpractice. Prior to July 1, 1975, the statute of limitations for a medical malpractice action was three years.

The statute of limitations has an exception to it in regard to actions brought on behalf of minors. Again, July 1, 1975 is the watershed date because of changes in the statute of limitations law. In an action brought on behalf of a minor for malpractice which occurred prior to July 1, 1975, the statute of limitations does not begin to run until after a minor reaches the age of majority (18 years of age). Technically, this suspension in time in which a minor is able to commence a lawsuit is called “tolling”. If the alleged malpractice occurred after July 1, 1975, the maximum time “within which the action must be commenced shall not be extended...beyond ten years” after the incident took place, (Civil Practice Law and Rules, Section 208).

The following examples will illustrate how these rules apply to minors:

## EXAMPLE 1

### SITUATION

Alleged malpractice occurred in 1970 to a five-year old child

### APPLICABLE LAW

Statute of limitations of three years

In Example 1, the child would have the right to sue until three years after he reaches his 18th birthday.

## EXAMPLE 2

### SITUATION

Alleged malpractice occurred in 1977 to a five-year old child

### APPLICABLE LAW

Minors are subject to a statute of limitations cap of ten years under the tolling provision for any medical malpractice which occurred to a minor after July 1, 1975.

In Example 2, the child who was five years old at the time of the alleged malpractice will be able to sue only until his 15th birthday.

Physicians are advised to retain their medical records for the duration of the statute of limitations. While section 6530(32) is not to be confused with the statute of limitations, by complying with Section 6530(32), the physician also protects himself under the statute of limitations.

It is conceivable that a medical malpractice action can be commenced after six years in an action where the plaintiff alleges that a foreign medical object was left in his body. In an alleged "foreign object" case, the plaintiff has until one year after the discovery of the foreign object, or of the date of the discovery of facts which would reasonably lead to the discovery of the foreign object, in which to bring the action.

In view of the above section of the Education Law, if you decide to entrust your patient records with the succeeding physician, an agreement should be made requiring that physician to retain the records for the time periods specified in the statute. Additionally, you should have an agreement permitting you to have access to the records upon request.

Assuming you leave your records with the succeeding physician, if a former patient chooses to be treated by a different physician and requests in writing that his records be sent to that physician, Section 17 of the Public Health Law requires the succeeding physician to comply with the request. This requirement is also applicable to you if you decide to keep the records in your own possession.

## **SPECIAL RECORD-KEEPING REQUIREMENT OF THE MAMMOGRAPHY QUALITY STANDARDS ACT (MQSA)**

On October 27, 1992, the Mammography Quality Standards Act (42 U.S.C. 263b) was enacted to establish uniform, national quality standards for mammograms. In response to public concern about breast cancer and about the quality of the mammography services women rely on for early detection of breast cancer, the act establishes a comprehensive statutory mechanism for certification and inspection of all mammography facilities in the United States. This requirement applies to all facilities producing, processing, or interpreting mammograms, whether for screening or diagnostic purposes. A "facility" for the purposes of the statute is defined as, "a hospital out-patient department, clinic, radiology practice, or mobile unit, an office of a physician, or other facility that conducts breast cancer screening or diagnosis through mammography activities." The only facilities not subject to the requirements of the federal statute are facilities located in Veteran's Hospital.

In addition to the inspection and certification requirements, the MQSA imposes record-keeping requirements which **differ from and supersede state requirements**. In interim regulations published in the Federal Register on December 21, 1993, the Food and Drug Administration imposed a requirement that each mammogram be kept for five years, and that the physician retain a patient's most recent mammogram for **ten years**. To the extent that the state law is stricter, the state law must be followed. Thus, in order to be in compliance with both the State Education Law §6530(32) and the federal MQSA, physicians must keep each mammogram for at least six years after the date of last treatment of the patient, but must keep the patient's most recent mammogram for at least ten years.

In addition, the MQSA requires that if a patient requests the **permanent transfer of her records to another institution, practice or to herself**, the physician must transfer the **original film** per the patient's request. Again, this differs from the obligations imposed under the Public Health Law §§17 and 18, which requires physicians to provide copies of medical records to patients or the patient's designee upon request. Again, the federal law supersedes the state law. Therefore, physicians who are requested to **permanently** transfer records out of the practice must provide copies of all records to the patient or the patient's designee, but **must provide the original mammogram films**, retaining a copy of the film with the original patient record.

The American College of Radiology (ACR) is a nationwide association that has been approved as an accrediting body. Physicians seeking information regarding MQSA accreditation standards may contact the ACR at (703) 648-8980.

## **BILLING FOR NO SHOWS**

If a patient is enrolled in an HMO that the doctor is participating with, can that physician charge if the patient does not keep a scheduled appointment and does not call to cancel it?

The Medical Society of the State of New York has a position on this. It is below:

*240.994 Reimbursement for Missed Appointment:*

*MSSNY, consistent with the current opinions of the AMA Council on Ethical and Judicial Affairs, Section 8.01, reaffirms the position that "A physician may charge a patient for a missed appointment or for one not canceled 24 hours in advance if the patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration for the patient and his/her circumstances." (HOD 96-263)*

However, it is also advisable to inform the doctor that if he/she is going to start billing for missed appointments, the physician will need to establish a new office policy. The physician should select an effective date and post a prominent notice for all to see near the office cashier (i.e. - From MM/DD/YY forward, patients will be charged \$XX.XX for missed appointments that are not cancelled within 24 hours of the scheduled time. This charge will not be covered by any health plan.). Note these charges could not be billed to insurers and patients need to be advised of this, as well.

As an additional note, the physician should verify whether or not this provision of billing for missed appointments is a specific exclusion in any managed care or health plan contract he/she may have signed with regard to the specific patient in question.

## HOW THE OMBUDSMAN PROGRAM FUNCTIONS

The Ombudsman Program provides education, guidance and general assistance to members concerning health insurance related issues. The staff is well versed in Medicare, Medicaid, Workers' Compensation, Auto No-Fault, traditional indemnity and managed care programs. The Division maintains an effective liaison with third party health insurers, administrators, managed care entities and pertinent federal and state agencies on behalf of MSSNY members. We provide information and assistance on medical reimbursement policies and claim processing requirements of various third party carrier operations, upon request. When or if the membership has a concern, it is common practice for clarification to be sought through our division. The majority (over 90%) of our contacts with the membership is via telephone communication involving points of clarification with any of the aforementioned plans.

However, there are situations whereby a MSSNY member does need some specific aid with regard to a particular difficulty. There may be instances when a policy clarification or a payment reimbursement issue has not been resolved to a member's satisfaction and resolution is needed from a plan, in writing. When necessary, we will intercede on behalf of our members with any health insurer.

The Ombudsman Program does not function as a collection agency. One purpose of the Program is to provide assistance to members of the Medical Society of the State of New York who perceive that they have reached a *stalemate* with a particular insurer or issue. In order to assist members who need help beyond that of a telephone call, we ask that data be provided for our case development and subsequent research with a plan, as follows:

- a cover letter on the physician(s)' letterhead which details the problem with the specific insurer or plan in some chronological order [**NOTE:** for ease in our filing and for our tracking purposes, we require one cover letter identifying a problem with only **one** specific insurer/plan, per file];
- copies of claim forms as they were originally filed;
- if there were any communications with the carrier, we will need copies of the letters sent and the subsequent carrier replies;
- depending on the nature of the problem, some medical necessity data (i.e.: operative/pathology reports or office notes) may be needed.

Upon receipt of a case from a physician or the physician's staff, we send the doctor our standard "Courtesy Receipt Letter (CRL)". This document serves two purposes. First, it is used to notify member physicians that their request(s) has been received. Second, the CRL is used to identify any additional information that may be needed in order to expedite a carrier's handling of a stalemated claim or policy situation.

After we have all pertinent data for the case in question, we communicate with the entity we believe will best service/resolve the issue as expeditiously as possible for all concerned parties. From the date of our initial referral, we allow the entity at least 20 working days before we send a follow-up communication. If a second letter from us is needed, we allow another 20 working day period before we send a third request. If the third request from us is necessary, it is sent with the proviso that our next communication will be sent to the entity's regulatory authority. For your information, we do not need to send our *third* request very often.

**It is very important to note that provisions of the state law relating to the tendering of “corporate legal advice” preclude the Medical Society from acting as your personal legal representative. The Ombudsman Program is not intended to replace any need for a physician to seek private legal counsel. Only the physician can decide whether or not to seek private legal counsel. The Ombudsman is available to assist you in attempting to resolve third party insurance problems by interceding and challenging insurer policies that may impact negatively on your practice.**

We offer this explanation to you so that you have a better understanding of the time frame(s) involved in handling a number of our cases. However, we wish to assure you that once we have confirmed receipt of a specific case that has been acknowledged by a member’s receipt of our CRL, the staff of the Ombudsman Program will handle the case to its conclusion. We will consider a case concluded when we have received a written response from the entity to which we referred the case. Upon our receipt of the entity’s reply, a letter is sent to the member explaining the resolution we have obtained.

August 2000

## OMBUDSMAN PROGRAM and AUDIT ADVICE

In previous articles, we explained how MSSNY's Ombudsman Program functions. Based on the Division of Socio-Medical Economics (DSME) staffs' past work experience, they are able to offer the MSSNY membership educational guidance and general assistance concerning various health insurance related issues. The staff is well versed in Medicare, Medicaid, Workers' Compensation, No-Fault Auto, traditional indemnity and managed care programs.

Recently, there has been an increase in the number of calls to the Ombudsman Program involving audits being conducted by various insurers, including the Medicare Program. Therefore, we would like to share the following information.

First of all, insurer audits may stem from payments to be made (pre-payment) or payments that have been made (post-payment). When Medicare is involved, the payments are coming from the Federal Trust Fund. I always stress that physicians must be cautious when dealing with all audit requests; but when Medicare is involved, physicians should be especially cautious. Dealing with the Medicare Program should be thought of in much the same manner as dealing with the IRS.

According to Medicaid regulations, a medical record should be legible and at a minimum contain the following information:

- The full name and address of the patient examined and/or treated for which a bill is presented;
- The date of the visit or treatment;
- The patient's chief complaint or reason for the visit;
- The patient's pertinent medical history as appropriate for each visit;
- The findings obtained from the physical exam done that day;
- The diagnostic decisions based on the examination, history, and any applicable test results;
- An indication of the patient's progress, if any;
- Notations of medication(s) dispensed, administered, or prescribed with the precise dosage, and regimen;
- Notations of consultations or referrals with the reason recommended;
- Notations documenting medical necessity for ancillary diagnostic services
- Any other documents supporting the extent of care, services, and supplies provided;
- A statement as to whether or not the patient is expected to return for further treatment, the treatment planned, and the anticipated date for the patient to return, if necessary; and,
- The time spent with the patient during the visit. *(NB: This is considered as a guide and is not to be considered as a prime factor in selection of an AMA-CPT code. However, time may be considered a contributory factor when it takes more than 50% of the E/M visit to counsel and/or coordinate the patient's care.)*

As indicated above, these are the requirements of Medicaid and although not all doctors participate in the Medicaid Program, the rules provide a general guide for physicians to

establish their own standards for medical record keeping. Regardless, the aforementioned bullets bear repeating in this age of increasing audits by fraud and abuse departments.

We are aware that some physicians may use symbols to annotate a chart quickly. However, a third party will not understand symbols that are clear to you or your staff for delineation of a medical sign, symptom, or condition. If another party might be involved in the treatment of the patient or if you are looking to an outside source (other than the patient) such as an insurer or health plan for payment, your records should be written as though a third party is involved.

When an insurer or carrier makes a request for copies of medical records, you should respond timely. If you have a valid reason (e.g. the plan is asking for hospital charts, a large volume of data, or you are in the midst of a staffing problem, etc.) and feel that additional time is required, you should call the author of the request to obtain an extension. If the author is unable to grant an extension, ask to speak with the author's supervisor. Regardless of the response, you should confirm your telephone request for an extension of time for reply to the medical record request in writing to the plan that has asked for the record review.

When all the records have been gathered, you should review them to ensure that they support the level of care you provided and billed. *This should have been done prior to submitting a claim for benefits.* When the auditors are reviewing your records, they do not have easy access to you, personally. Therefore, they are not able to ask you about something they cannot read due to poor or unclear penmanship.

If, upon reviewing your gathered data prior to submission for the auditor's request, you find that something is unclear, do **NOT** change the medical record itself. Instead, provide a separate note within the body of your cover letter to explain the item or service.

Before sending your medical records into the program and/or plan for review, you should be sure to make two (2) photocopies of the original records you have obtained. The original records should be returned to a safe place for future reference if necessary.

On the first set of photocopied information, you should use a "highlight pen" to indicate any place where you signed or initialed your name. Also, if you are sending hospital charts, you should highlight any time a nurse or hospital staff person may have recorded your presence with the patient (i.e.: nurses' notes, consult reports, doctors' orders, etc.). On the second set of records, you should make the identical highlighted marks. By taking this action, you will know exactly what you have sent to the carrier for their review.

In addition, you should be sure to update, at least once a year, any signature on file you may have for your patients. As always, you may feel free to call our Ombudsman staff with your concerns at (516) 488-6100, ext. 426.

January 7, 2004

## **Toll Free Telephone Access for Medicare Physicians**

Physicians interested in contacting their local Medicare Carriers may do so at the following TOLL FREE telephone numbers:

<b>GHI – Medicare</b>	1 (877) 868-7965
<b>Upstate Medicare Division</b>	1 (877) 567-7173
<b>Empire Medicare Services</b>	1 (877) 869-6504

## MEDICARE BILLING OPTIONS

**While Congress has not moved to amend the egregious SGR calculation that impacts Medicare payments, we find it necessary to republish the following information regarding your Medicare Billing Arrangement Options**

### ***Three Billing Arrangement Options***

There are basically three Medicare billing arrangement options:

- Physicians may sign a participation agreement and accept Medicare's allowed charge as payment in full.
- Physicians may elect to be a non-participating physician which permits them to bill patients for somewhat more than the Medicare allowance.
- Or they may become a private contracting physician agreeing to bill patients directly and forego any payment from Medicare either to the patient or the physician.

**Physicians who want to change their status from participating to nonparticipating or vice versa should do so as soon as possible..** Once made, the decision is irrevocable except where the physician's practice situation has changed significantly, such as relocation to a different geographic area or a different group practice. To become a private contractor, physicians must give 30 days notice before the first day of the quarter the contract takes effect. **Those who considered a change in status should have first determined that they were not bound by any contractual arrangements** which require them to be participating doctors.

### ***Participating Physicians***

Participating physicians must agree to take assignment on all Medicare claims, which means that they must accept Medicare's approved amount as payment in full for all covered services for the duration of the calendar year. The patient is still responsible for the Medicare deductible and 20% coinsurance but the physician cannot bill the patient for amounts in excess of the Medicare allowance.

Medicare provides a number of incentives for physicians to participate:

- The Medicare payment amount for participating physicians is 5% higher than the rate for non-par physicians.
- Directories of PAR physicians are provided to senior citizens groups and to individuals who request one.
- Carriers provide toll free claims processing lines to PAR physicians and processes their claims more quickly.

### ***Non-Participation (Non-PAR)***

For Non-PAR physicians, the full payment schedule is set at 95% of the full payment schedule for PAR physicians. Non-PAR approved amounts are 95% of the PAR amounts for the same service.

Limiting charges for non-PAR physicians are set at 115% of the Medicare approved amount for non-PAR physicians. Since Medicare payment schedule amounts for non-PAR physicians are 95% of payment rates for PAR physicians, the 15% limiting charge translates into only 9.25% above the PAR approved amount for the service.

### ***How to Decide***

When considering whether to participate, physicians must determine whether their total revenues from balance billing would exceed their revenues as PAR physicians, particularly in light of collection costs, bad debts, and claims for which they do accept

assignment. The 95% payment rate is not based on whether physicians accept assignment on the claim, but whether they are PAR physicians; when non-PAR physicians accept assignment for their low-income or other patients, they still receive only 95% of the amount PAR physicians receive for the same service. A non-PAR physician would need to collect the full limiting charge amount roughly 35% of the time they provided the service for the revenues from the service to equal those of PAR physicians. Remember, in NYS, the NYS limiting charge law is set at 105% of the non-PAR fee schedule amount for all Medicare covered services, except 99201 - 99215 and 99341 - 99353 (office and home visits, respectively). For every \$100.00 participating fee impacted by the NYS limiting charge law, the non-participating physician loses \$0.25.

Assignment acceptance, for either a PAR or non-PAR physician, also means that the Medicare carrier pays the physician the 80% Medicare payment. For unassigned claims, even though the physician is required to submit the claim to Medicare, the program pays the patient, and the physician must then collect the entire amount for the service from the patient.

### ***Private Contracting***

Provisions in the Balanced Budget Act of 1997 give physicians and their Medicare patients the freedom to privately contract to provide health care services outside the Medicare system.

Private contracts must meet specific requirements:

- **The physician must sign and file an affidavit agreeing to forgo receiving any payment from Medicare for items or services provided to any Medicare beneficiary for the following 2-year period** (either directly, on a capitated basis, or from an organization that received Medicare reimbursement directly or on a capitated basis);
- Medicare does not pay for the services provided or contracted for;
- the contract must be in writing and must be signed by the beneficiary before any item or service is provided;
- the contract cannot be entered into at a time when the beneficiary is facing an emergency or an urgent health situation.

In addition, the contract must state unambiguously that by signing the private contract, the beneficiary: gives up all Medicare payment for services furnished by the "opt out" physician; agrees not to bill Medicare or ask the physician to bill Medicare; is liable for all of the physician's charges, without any Medicare balance billing limits; acknowledges that Medigap or any other supplemental insurance will not pay toward the services; and acknowledges that he or she has the right to receive services from physicians for whom Medicare coverage and payment would be available.

To opt out, a physician must file an affidavit that meets the above criteria and is received by the carrier at least 30 days before the first day of the next calendar quarter. There is a 90-day period after the effective date of the first opt-out affidavit during which a physician may revoke the opt-out and return to Medicare as if they had never opted out.

*This document contains excerpts from the AMA-published Medicare RBRVS: The Physicians Guide 2005.*

## MEDICARE PROVIDER ENROLLMENT PROBLEMS

Some physicians have alerted MSSNY to the fact that they have been experiencing difficulties or delays in obtaining Medicare Provider Identification Numbers (PINs) for the purpose of billing claims on behalf of their patients. In an ongoing effort to help our members with these delays, we contacted Empire Medicare Services to learn what might be some of the causes for any delays.

The carrier identified a short list of the most common errors providers make when submitting the Medicare Provider Enrollment applications:

**CMS 855I** – This form is used for an **individual** physician to obtain an individual number for him/herself.

**CMS 855B** – This form is used to obtain a PIN for **an incorporated solo practice (PC), or any organization** or a **group practice** of two or more persons that would provide medical service.

**CMS 855R** – This form is used for individuals of a group to **reassign** Medicare benefits to the group or corporation.

### For CMS 855I:

**Section 2D** - This section refers to businesses that the applicant OWNS.

The instructions are clear that if the business is incorporated, providers **MUST** submit the CMS 855B and the CMS 855R. Many physicians are completing this section without completing the CMS 855B and CMS 855R. As a result, the business does not get enrolled, the application is not completed, and the physicians are not happy.

**Section 3** - Adverse Legal History and Overpayment information. This section **MUST** be checked either Yes or No. Physicians indicating "N/A" for not applicable is not acceptable. The carrier is not able to process the application. The carrier must return the section and obtain/seek a certification statement for confirmation before being able to proceed with the processing of the enrollment.

**Section 4B** - Date you started practicing at this location. The carrier **MUST** have this section completed, as well. If it is blank, the carrier must return the section and obtain/seek a certification statement for confirmation before being able to proceed with the processing of the enrollment.

This date is used to identify the effective date of the PIN.

The carrier is also having trouble with changes of information in this section. If the practitioner is **adding** a location, and wants an additional PIN assigned, the carrier needs to have this identified by the physician to them.

Now with jurisdictional payment, the carrier is trying to discourage practitioners from obtaining PINs for each practice. If the **PAY TO** address is the same for the physician, PINs for each practice location are no longer needed.

## **For CMS 855B**

All professional corporations that wish to enroll **MUST** be registered with the New York State Department of Education, as well as the New York State Department of State.

The carrier **MUST** have an IRS issued document for the tax information. The W9 is not acceptable.

Also, the providers need to remember that whoever signs the CMS 855B as the authorized representative is the **ONLY** person authorized to make changes. This includes adding new members to the practice. If the group wants to delegate authority to someone else, that person must complete **Section 6** and sign **Section 16**.

These are the biggest issues that have been identified by the carrier, presently. When or if other causes of provider enrollment difficulties/delays are identified, the carrier will advise.

It is believed that as some obstacles to the enrollment process are eliminated, the process can be made more expedient. If you are experiencing other difficulties in obtaining a Medicare PIN, please alert the Division of Socio-Medical Economics by calling 516-488-6100, extension 426. We will be happy to offer any assistance that we can.

## **MEDICARE PAYMENT for DRUGS and BIOLOGICALS**

Effective April 1, 1999, drugs and biologicals not paid on a cost or prospective payment basis are paid based on 80% of the lower of the billed charge or 95 percent of the AWP as reflected in sources such as the **Red Book**, **Blue Book**, or **Medispan**.

Examples of drugs that are paid on this basis are drugs furnished incident to a physician's service, drugs furnished by pharmacies under the durable medical equipment benefit, covered oral anti-cancer drugs, and drugs furnished by independent dialysis facilities that are not included in the end stage renal disease composite rate payment.

## IMPORTANT CHANGE ON MEDICARE CLAIM FORM

The Medical Society of the State of New York would like to advise all physicians of an important change regarding your submissions to Medicare.

Please note that for claims received on or after **April 1, 2004**, Medicare now requires that for all places of service (except POS-12, patient's home), **Box 32 must include the name, address and zip code of where the service was actually rendered** on the CMS 1500 Medicare Part B claim form. This change in policy will allow the Medicare carrier to process and pay a Medicare claim utilizing the appropriate regional reimbursement rate for the services provided, and **applies to all paper and electronic submissions**.

Carrier jurisdiction depends on where the service was rendered. Out of jurisdiction addresses will be returned as being unable to process.

Further clarification can be obtained by calling Empire Medicare support staff at 1-866-837-0241 or found on the Medicare web site at [www.empiremedicare.com](http://www.empiremedicare.com)

## **MEDICARE BALANCE BILLING**

The NYS Balanced Billing law continues to be in effect. By federal law, Medicare participating physicians can charge patients for the co-insurance and deductible amounts for covered services and can charge patients for non-covered Medicare services.

Non-participating Medicare physicians can also charge patients for non-covered Medicare services. However, for covered Medicare services, non-participating Medicare physicians are limited in their balance billing to Medicare patients.

For AMA-CPT codes 99201 through 99215 and 99341 through 99353, the Medicare federal limit of 115% of the non-par fee schedule applies.

Balance billing Medicare beneficiaries for **ALL** other Medicare covered services is limited to 105% of the non-par fee schedule amount.

## MEDICARE MANAGED CARE INFORMATION

January 24, 1997

Medicare beneficiaries who are enrolled in the Medicare Contracting Managed Care/HMO Program are expected to receive care and services from the HMO's participating physicians and providers. The plan's physician or provider in turn receives payment from the HMO for the services provided to the Medicare beneficiary. But what happens when the beneficiary receives emergency or urgently needed care services (outside the HMO service areas) by a non-participating physician or provider of the Medicare Managed Care Plan or HMO?

Under the Medicare Managed Care/HMO Program, a provider may collect payment from a Medicare beneficiary whose HMO has made an initial determination to deny payment. However, if the type of HMO contract (i.e.: Risk or Cost) is unknown to the physician, it is strongly advised that a claim be filed with the local Medicare Part-B carrier (**if this action was not previously taken**). If the patient is enrolled in an HMO with a "COST" Contract, the local Medicare carrier will provide benefits for covered Medicare services. If the patient is enrolled in a "RISK" Contract, the local Medicare Carrier will, regrettably, deny benefits for the Medicare covered services.

If **both** the local Medicare carrier and the patient's HMO deny claim payment, Medicare participating providers may charge the beneficiary up to 100% of the Medicare fee schedule amount for participating providers. Non-participating providers in New York State may charge the patient for the Medicare fee schedule amount for non-participation, plus the Federal or New York State limiting charge (i.e.: 115% or 105%, respectively).

Please note, there should be no balance billing to a Medicare beneficiary beyond the appropriate fee schedule amount for participating Medicare physicians nor beyond the limiting charge for non-participating Medicare physicians. When initially receiving an adverse determination from the Medicare Contracting HMO, the Medicare beneficiary is advised of the right to appeal. Physicians may wish to reiterate to their patients that right to appeal when receiving an initial determination that payment is being denied.

The foregoing information advises you of the recourse to be taken for denials under Medicare Managed Care. The following will provide information for Medicare Contracting Managed Care Plans in New York State.

For your information, we have listed the contract type (i.e.: RISK or COST) associated with each Medicare Managed Care Plan. We have also provided each of the entities' Plan Name, Plan Number, and the Plan's address and telephone number. Health Maintenance Organizations (HMOs) and competitive Medical Plans (CMPs) with Medicare contracts must provide the full range of all Medicare covered services. Medicare beneficiaries enrolled in a risk contract are "locked-in" to receiving all covered care from the Plan, except for emergency or urgently needed care away from the Plan's service area. If the member goes outside the Plan for unauthorized care, neither the Plan nor Medicare will pay. In this instance, the patient is at "risk" for payment.

Conversely, beneficiaries are not “locked-in” to receiving services from a Plan with a Cost contract. While the Plan will not pay if the member uses non-plan providers, Medicare will still pay its share for covered services. In such instances, the member would be responsible for paying Medicare’s coinsurance and deductible, just as if the member was receiving care under the traditional fee-for-service system.

In addition to risk and cost contracts, Medicare has agreements with health care prepayment plans (HCPPs). They are unlike other plans in that they may only provide a limited range of Part B services. Medicare enrollees can go outside the HCPP for any medical or hospital services and are responsible for paying coinsurance and deductibles as in fee-for-service Medicare.

Prepared by:

Regina McNally  
Division of Socio-Medical Economics  
MSSNY

## **NYSDOH/CSC/Medicaid Eligibility**

Recently, several physicians have called the Division of Socio-Medical Economics (DSME) concerning a recent mailing from the Department of Health (DOH) about the replacement for their *Card Swipe* machines. DSME contacted DOH and Computer Sciences Corporation (CSC), the State's Medicaid Intermediary.

**In order to file a claim and get paid by Medicaid, physicians must verify the recipient's Medicaid eligibility and obtain a "service authorization" before submitting a claim for services rendered.** To verify Medicaid eligibility and obtain a "service authorization", physicians could use telephone verification [which is around a 21 step process through an Automated Response Unit (ARU) system] or use a *Card Swipe* machine called a POINT OF SERVICE DEVICE. Because of HIPAA, the State is required to replace the TRANZ 330 POS device with a HIPAA Compliant VeriFone OMNI 3750 POS device. The TRANZ 330, based on CSC's contact with the Centers for Medicare and Medicaid (CMS), is not HIPAA compliant and cannot be programmed to handle the HIPAA Transaction Standards for eligibility verification. The DOH letter advises physicians to order the new device for a fee of \$817.00, plus tax. With tax at 8.25%, the total price would be \$884.40. Many physicians expressed displeasure with the price of the machine and indicated that the Medicaid fee schedule does not make this a cost-effective purchase. One physician indicated that for the \$30.00 office visit fee, he would need to provide around 30 visits to recoup his cost for purchasing the machine. Based on the May issue of the **Medicaid Update**, about 10,000 Medicaid providers currently use the TRANZ 330 machine and will be affected by this change.

### **OPTIONS:**

1. Physicians can still use the telephone ARU system. This would be the option for any physician who will continue to bill via paper format and not be deemed a covered entity under HIPAA.
2. Physicians can use the new ePACES web-based program, which will be available to Medicaid providers at no cost. ePACES will be available for physician "sign-in" and procurement of a User ID# on September 9, and will be available for eligibility verification and claim filing activity on September 27, 2003.
3. Or, physicians can purchase the HIPAA Compliant VeriFone OMNI 3750 POS device for a fee of \$817.00, plus tax.

The DOH Website can be accessed at <http://www.health.state.ny.us>.

The following DOH websites will also provide some useful information:

<http://www.emedny.org/index.html> &

[http://www.emedny.org/manuals/mevs\\_manual.html#ARUIntro](http://www.emedny.org/manuals/mevs_manual.html#ARUIntro) &

<http://www.health.state.ny.us/nysdoh/mancare/omm/2003/jun2003.htm#paces> &

<http://www.health.state.ny.us/nysdoh/mancare/omm/2003/jun2003.htm#pos>.

These last two sites stem from the June issue of the Medicaid Update. On the last item, the following paragraph is included:

***Please note! As an alternative to using the POS device, the Medicaid eligibility field software replacement program, called ePACES, will be available in September***

*of this year. ePACES will be available to providers at no cost. Please see this month's article on ePACES for more information on the new ePACES application.*

Physicians should continue to consult the **Medicaid Update** for any additional HIPAA, eMedNY, and ePACES instructions that will benefit their practices. For questions concerning this and other Medicaid information, physicians may call CSC provider relations at: 1-800-522-5518 or (518) 447-9860. Or, if we can be of help, physicians may call MSSNY's DSME at 1-516-488-6011, ext. 426.

## **MEDICAID REIMBURSEMENT FOR DRUGS ADMINISTERED IN A PHYSICIAN'S OFFICE**

The New York State Medicaid Program reimburses for drugs furnished by physicians to their patients on the basis of the acquisition cost to the practitioner of the drug dose administered to the patient. For all drugs furnished in this fashion it is expected that the physician will maintain auditable records of the actual itemized invoice cost of the drug, including the numbers of doses of the drug represented on the invoice. To facilitate electronic claim submission and timely payment to physicians, the Medicaid Program consults national pricing references such as First DataBank to establish a maximum reimbursable amount (MRA) on its procedure code reference file. Claims submitted for most physician-supplied drugs will be paid automatically up to the MRA price.

However, drugs listed in the Medicaid Physician Fee Schedule with a notation of BR (By Report) under the Maximum Fee column must be submitted on paper Medicaid HCFA 1500 Claim Forms with attached itemized invoice as documentation.

It is important to remember that, regardless of whether a particular drug is designated as BR (By Report) in the Medicaid Physician Fee Schedule, New York State Medicaid does NOT intend to pay more than the acquisition cost of the drug dosage, as established by invoice, to the practitioner. Regardless of whether an invoice must be submitted to Medicaid for payment, the physician is expected to limit his or her Medicaid claim amount to the actual invoice cost of the drug dosage administered.

## **MEDICAID AND PRIVATE PAYMENTS**

### ***Update on Medicaid Private Pay Option***

By Federal regulation, physicians have the option of treating or not treating Medicaid patients or of treating Medicaid patients as "private pay." If the "private pay" option is chosen, physicians should be sure the patient has a clear understanding of the "private pay" arrangement and any special conditions. Remember, the "private pay" provision applies only to Medicaid, and does not exist under the Medicare program.

MSSNY's Division of Socio-Medical Economics suggests that physicians using the "private pay" option obtain verification of the arrangement from the patient in writing. Under the "private pay" option, the physician may not submit a claim to the Medicaid program.

### ***Exclusions from Private Pay Option***

The Medicaid "private pay" arrangements are not acceptable when the Medicaid recipient is a participant in any Medicaid Managed Care plan. The "private pay" option is also specifically excluded for any physician who has signed a contract with any Medicaid Managed Care plan. Medicaid Managed Care patients should be instructed to seek care from their own network.

If, however, a Medicaid recipient arrives at an ER seeking treatment which, to a prudent layperson, appears to be life- or- limb threatening, the service must, under New York State law, be covered by the managed care plan. Once covered by a Medicaid Managed Care plan, with payment to the physician, the physician would not be permitted to render any balanced billing to a Medicaid recipient or the Medicaid Program.

## **EXCERPT from the July 2003 Edition of MEDICAID UPDATE**

### **MEDICAID RECIPIENTS CANNOT BE BILLED**

This is a reminder to all hospitals, free-standing clinics and individual practitioners about requirements of the Medicaid program related to requesting compensation from Medicaid recipients, including Medicaid recipients who are enrolled in a managed care plan and in Family Health Plus.

### **Acceptance and Agreement**

When a provider accepts a Medicaid recipient as a patient, the provider agrees to bill Medicaid for services provided or, in the case of Medicaid managed care enrollee, agrees to bill the recipient's managed care plan for services covered by the contract. The provider is prohibited from requesting any monetary compensation from the recipient, or his/her responsible relative, except for any applicable Medicaid co-payments.

A provider may charge a Medicaid recipient, including a Medicaid recipient enrolled in a managed care plan, **ONLY** when both parties have agreed **PRIOR** to the rendering of the service that the recipient is being seen as a private pay patient. This must be a mutual and voluntary agreement. It is suggested that the provider maintain the patient's signed consent to be treated as private pay in the patient record.

A provider who participates in Medicaid fee-for-service but does not participate in the recipient's Medicaid managed care plan may not bill Medicaid fee-for-service for any services included in the managed care plan, with the exception of family planning services. Neither may such a provider bill the recipient for services that are covered by the recipient's Medicaid managed care contract unless there is prior agreement with the recipient that he/she is being seen as a private patient as described above. The provider must inform the recipient that the services may be obtained at no cost to the recipient from a provider that participates in the recipient's managed care plan.

### **Claim Submission**

The prohibition on charging a Medicaid recipient applies when a participating Medicaid provider fails to submit a claim to Computer Sciences Corporation (CSC) or the recipient's managed care plan within the required timeframe. It also applies when a claim is submitted to CSC or the recipient's managed care plan and the claim is denied for reasons other than that the patient was not Medicaid eligible on the date of service.

### **Collections**

A Medicaid recipient, including a Medicaid managed care enrollee, must not be referred to a collection agency for collection of unpaid medical bills or otherwise billed, except for applicable Medicaid co-payments, when the provider has accepted the recipient as a Medicaid patient. Providers may, however, use any legal means to collect applicable unpaid Medicaid co-payments.

## **Emergency Medical Care**

A hospital that accepts a Medicaid recipient as a patient, including a Medicaid recipient enrolled in a managed care plan, accepts the responsibility of making sure that the patient receives all medically necessary care and services. Other than for legally established co-payments, a Medicaid recipient should never be required to bear any out-of-pocket expenses for medically necessary inpatient services or medically necessary services provided in a hospital based emergency room (ER). This policy applies regardless of whether the individual practitioner treating the recipient in the facility is enrolled in the Medicaid program. When reimbursing for ER services provided to Medicaid recipients in managed care, health plans must apply the Prudent Layperson Standard, provisions of the Medicaid Managed Care Model Contract and Department directives.

## **Claiming Problems**

If a problem arises with a claim submission, the provider must first contact CSC or, if the claim is for a service included in the Medicaid managed care benefit package, the enrollee's Medicaid managed care plan. If CSC or the managed care plan is unable to resolve an issue because some action must be taken by the recipient's local department of social services (e.g., investigation of recipient eligibility issues), the provider must contact the local department of social services for resolution.

For questions regarding Medicaid managed care, please call the Office of Managed Care at (518) 473-0122.

For questions regarding Medicaid fee-for-service, please call the Office of Medicaid Management at (518) 473-2160.

## **WORKERS' COMPENSATION CONTROVERSY and PRIVATE PLAN TIME LIMITS**

MSSNY's Division of Socio-Medical Economics has been made aware of definitive concerns for the membership with regard to potential controverted Workers' Compensation (WC) claims and time limit restrictions by private health insurance plans.

Initially, we want to assure you that the old "A-9" form is still utilized and recognized by the Workers' Compensation Board (WCB). The A-9 form is an agreement to pay medical costs in the event a claimant fails to prosecute a controverted case.

Secondly, we need to apprise the membership of two methods of handling potential controversy on WC claims:

- a) If a WC carrier denies payment for causal relationship, the physician will have to await a scheduled hearing to resolve the matter. If an Administrative Law Judge subsequently confirms the denial, a Notice of Decision will be issued to all parties of interest. Upon receipt of the Notice of Decision, the physician should file a claim with the claimant's private insurer if there is another health plan. The date the Notice of Decision is filed should be the date that the other plan should use for any time limit restrictions it may have (Note: Not all plans will honor this format. Please refer to the note below).
- b) If the physician has the insight to discern that there will be controversy on a WC claim, it may prove beneficial in the long-term to simultaneously file a claim with the private plan. It is recommended that simultaneous filing to the non-WC plan specifically identify that the physician is notifying the private plan for informational purposes only. Theoretically, the physician is placing the private plan on notice of the potential for receipt of a claim for payment should WC controvert its liability. In taking this tact, members should attempt to ensure that the private plan make no payment until WC has finalized its consideration.

NOTE: If a member has followed this protocol and the private insurer refuses to consider the claim based on its time limitations, the member is asked to notify MSSNY's Department of Socio-Medical Economics at (516) 488-6100, extension 426.

For more detailed information on Workers' Compensation and/or No-Fault Auto, I urge you to review MSSNY's Guides to these programs. MSSNY's Guides are located under the Practice Management Page of the Members Only Section of MSSNY's website ([www.mssny.org](http://www.mssny.org)).

# 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 health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.
- communication and continuity of care among physicians and other health care 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.

### 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. 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	<b><i>Problem Focused</i></b>
Brief	Problem Pertinent	N/A	<b><i>Expanded Problem Focused</i></b>
Extended	Extended	Pertinent	<b><i>Detailed</i></b>
Extended	Complete	Complete	<b><i>Comprehensive</i></b>

- **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 or 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.*

**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.*

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 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; and home care, 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             | • Genitalia, groin, buttocks |
| • Neck                                 | • Back, including spine      |
| • Chest, including breasts and axillae | • Each extremity             |
| • Abdomen                              |                              |

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

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

The extent of examinations performed and documented is dependent upon clinical judgement 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.*

**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.**

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

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 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.*

### **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**

<b>Level of Risk</b>	<b>Presenting Problem(s)</b>	<b>Diagnostic Procedure(s) Ordered</b>	<b>Management Options Selected</b>
<b>Minimal</b>	<ul style="list-style-type: none"> <li>One self-limited or minor problem, eg cold, insect bite, tinea corporis</li> </ul>	<ul style="list-style-type: none"> <li>Laboratory tests requiring venipuncture</li> <li>Chest x-rays</li> <li>EKG/EEG</li> <li>Urinalysis</li> <li>Ultrasound, eg, echocardiography</li> <li>KOH prep</li> </ul>	<ul style="list-style-type: none"> <li>Rest</li> <li>Gargles</li> <li>Elastic bandages</li> <li>Superficial dressings</li> </ul>
<b>Low</b>	<ul style="list-style-type: none"> <li>Two or more self-limited or minor problems</li> <li>One stable chronic illness, eg well controlled hypertension or non-insulin dependent diabetes, cataract, BPH</li> <li>Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain</li> </ul>	<ul style="list-style-type: none"> <li>Physiologic tests not under stress, eg, pulmonary function tests</li> <li>Non-cardiovascular imaging studies with contrast, eg, barium enema</li> <li>Superficial needle biopsies</li> <li>Clinical laboratory tests requiring arterial puncture</li> <li>Skin biopsies</li> </ul>	<ul style="list-style-type: none"> <li>Over-the-counter drugs</li> <li>Minor surgery with no identified risk factors</li> <li>Physical therapy</li> <li>Occupational therapy</li> <li>IV fluids without additives</li> </ul>
<b>Moderate</b>	<ul style="list-style-type: none"> <li>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</li> <li>Two or more stable chronic illnesses</li> <li>Undiagnosed new problem with uncertain prognosis, eg, lump in breast</li> <li>Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis</li> <li>Acute complicated injury, eg head injury with brief loss of consciousness</li> </ul>	<ul style="list-style-type: none"> <li>Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test</li> <li>Diagnostic endoscopies with no identified risk factors</li> <li>Deep needle or incisional biopsy</li> <li>Cardiovascular imaging studies with contrast and no identified risk factors, eg arteriogram, cardiac catheterization</li> <li>Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis</li> </ul>	<ul style="list-style-type: none"> <li>Minor surgery with identified risk factors</li> <li>Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</li> <li>Prescription drug management</li> <li>Therapeutic nuclear medicine</li> <li>IV fluids with additives</li> <li>Closed treatment of fracture or dislocation without manipulation</li> </ul>
<b>High</b>	<ul style="list-style-type: none"> <li>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</li> <li>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</li> <li>An abrupt change in neurologic status, eg seizure, TIA, weakness, or sensory loss</li> </ul>	<ul style="list-style-type: none"> <li>Cardiovascular imaging studies with contrast with identified risk factors</li> <li>Cardiac electrophysiological tests</li> <li>Diagnostic Endoscopies with identified risk factors</li> <li>Discography</li> </ul>	<ul style="list-style-type: none"> <li>Elective major surgery (open, percutaneous or endoscopic) with identified risk factors</li> <li>Emergency major surgery (open, percutaneous or endoscopic)</li> <li>Parenteral controlled substances</li> <li>Drug therapy requiring intensive monitoring for toxicity</li> <li>Decision not to resuscitate or to de-escalate care because of poor prognosis</li> </ul>

**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.*

# 1997 Documentation Guidelines for Evaluation and Management Services

## TABLE OF CONTENTS

<b>Introduction</b>	
What Is Documentation and Why is it Important? .....	1
What Do Payers Want and Why?.....	1
<b>General Principles of Medical Record Documentation.....</b>	<b>1</b>
<b>Documentation of E/M Services .....</b>	<b>2</b>
<b>Documentation of History.....</b>	<b>2-4</b>
Chief Complaint (CC) .....	3
History of Present Illness (HPI) .....	3
Review of Systems (ROS).....	4
Past, Family and/or Social History (PFSH) .....	4
<b>Documentation of Examination .....</b>	<b>5-19</b>
General Multi-System Examinations .....	5
Single Organ System Examinations.....	6
Content and Documentation Requirements.....	7-19
<i>General Multi-System Examination</i> .....	7/8
<i>Cardiovascular Examination</i> .....	9
<i>Ear, Nose and Throat Examination</i> .....	10
<i>Eye Examination</i> .....	11
<i>Genitourinary Examination</i> .....	12/13
<i>Hematologic/Lymphatic/Immunologic Examination</i> .....	14
<i>Musculoskeletal Examination</i> .....	15
<i>Neurological Examination</i> .....	16
<i>Psychiatric Examination</i> .....	17
<i>Respiratory Examination</i> .....	18
<i>Skin Examination</i> .....	19
<b>Documentation of the Complexity of Medical Decision Making .....</b>	<b>20-22</b>
Number of Diagnoses or Management Options.....	20
Amount and/or Complexity of Data to Be Reviewed.....	21
Risk of Significant Complications, Morbidity, and/or Mortality.....	21
Table of Risk.....	22
<b>Documentation of an Encounter Dominated by Counseling or Coordination of Care .....</b>	<b>22</b>

# 1997 Documentation Guidelines for Evaluation and 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 health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.
- communication and continuity of care among physicians and other health care 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.

### 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 (e.g., 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 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	<i>Problem Focused</i>
Brief	Problem Pertinent	N/A	<i>Expanded Problem Focused</i>
Extended	Extended	Pertinent	<i>Detailed</i>
Extended	Complete	Complete	<i>Comprehensive</i>

- **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 or 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, usually stated in the patient's 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.

## 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.*

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 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 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; domiciliary care, established patient; and home care, established patient.*
- **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; and 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, "(e.g., ...)", 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 shaded or unshaded box.
- **Expanded Problem Focused Examination**--should include performance and documentation of at least six elements identified by a bullet (•), whether in a shaded or unshaded box.
- **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 shaded or unshaded box.

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

- **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 each unshaded box is expected.

# CONTENT AND DOCUMENTATION REQUIREMENTS

## General Multi-System Examination

System/Body Area	Elements of Examination
<b>Constitutional</b>	<ul style="list-style-type: none"> <li>• Measurement of <b>any three of the following seven</b> 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)</li> <li>• General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)</li> </ul>
<b>Eyes</b>	<ul style="list-style-type: none"> <li>• Inspection of conjunctivae and lids</li> <li>• Examination of pupils and irises (e.g., reaction to light and accommodation, size and symmetry)</li> <li>• Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)</li> </ul>
<b>Ears, Nose, Mouth and Throat</b>	<ul style="list-style-type: none"> <li>• External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses)</li> <li>• Otoscopic examination of external auditory canals and tympanic membranes</li> <li>• Assessment of hearing (e.g., whispered voice, finger rub, tuning fork)</li> <li>• Inspection of nasal mucosa, septum and turbinates</li> <li>• Inspection of lips, teeth and gums</li> <li>• Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx</li> </ul>
<b>Neck</b>	<ul style="list-style-type: none"> <li>• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)</li> <li>• Examination of thyroid (e.g., enlargement, tenderness, mass)</li> </ul>
<b>Respiratory</b>	<ul style="list-style-type: none"> <li>• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)</li> <li>• Percussion of chest (e.g., dullness, flatness, hyperresonance)</li> <li>• Palpation of chest (e.g., tactile fremitus)</li> <li>• Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)</li> </ul>
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>• Palpation of heart (eg, location, size, thrills)</li> <li>• Auscultation of heart with notation of abnormal sounds and murmurs</li> </ul> <p>Examination of:</p> <ul style="list-style-type: none"> <li>• carotid arteries (eg, pulse amplitude, bruits)</li> <li>• abdominal aorta (eg, size, bruits)</li> <li>• femoral arteries (eg, pulse amplitude, bruits)</li> <li>• pedal pulses (eg, pulse amplitude)</li> <li>• extremities for edema and/or varicosities</li> </ul>
<b>Chest (Breasts)</b>	<ul style="list-style-type: none"> <li>• Inspection of breasts (eg, symmetry, nipple discharge)</li> <li>• Palpation of breasts and axillae (eg, masses or lumps, tenderness)</li> </ul>
<b>Gastrointestinal (Abdomen)</b>	<ul style="list-style-type: none"> <li>• Examination of abdomen with notation of presence of masses or tenderness</li> <li>• Examination of liver and spleen</li> <li>• Examination for presence or absence of hernia</li> <li>• Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses</li> <li>• Obtain stool sample for occult blood test when indicated</li> </ul>
<b>Genitourinary</b>	<p><b>MALE:</b></p> <ul style="list-style-type: none"> <li>• Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass)</li> <li>• Examination of the penis</li> <li>• Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness)</li> </ul>

	<p><b>FEMALE:</b> Pelvic examination (with or without specimen collection for smears and cultures), including</p> <ul style="list-style-type: none"> <li>• Examination of external genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)</li> <li>• Examination of urethra (eg, masses, tenderness, scarring)</li> <li>• Examination of bladder (eg, fullness, masses, tenderness)</li> <li>• Cervix (eg, general appearance, lesions, discharge)</li> <li>• Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support)</li> <li>• Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)</li> </ul>
<b>Lymphatic</b>	<p>Palpation of lymph nodes in <b>two or more</b> areas:</p> <ul style="list-style-type: none"> <li>• Neck</li> <li>• Axillae</li> <li>• Groin</li> <li>• Other</li> </ul>
<b>Musculoskeletal</b>	<ul style="list-style-type: none"> <li>• Examination of gait and station</li> <li>• Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)</li> </ul> <p>Examination of joints, bones and muscles of <b>one or more of the following six</b> 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:</p> <ul style="list-style-type: none"> <li>• Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions</li> <li>• Assessment of range of motion with notation of any pain, crepitation or contracture</li> <li>• Assessment of stability with notation of any dislocation (luxation), subluxation or laxity</li> <li>• Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements</li> </ul>
<b>Skin</b>	<ul style="list-style-type: none"> <li>• Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)</li> <li>• Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)</li> </ul>
<b>Neurologic</b>	<ul style="list-style-type: none"> <li>• Test cranial nerves with notation of any deficits</li> <li>• Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski)</li> <li>• Examination of sensation (eg, by touch, pin, vibration, proprioception)</li> </ul>
<b>Psychiatric</b>	<ul style="list-style-type: none"> <li>• Description of patient's judgment and insight</li> </ul> <p>Brief assessment of mental status including:</p> <ul style="list-style-type: none"> <li>• orientation to time, place and person</li> <li>• recent and remote memory</li> <li>• mood and affect (eg, depression, anxiety, agitation)</li> </ul>

### Content and Documentation Requirements

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

## CARDIOVASCULAR EXAMINATION

System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> <li>Measurement of <b>any three of the following seven</b> vital signs:               <ol style="list-style-type: none"> <li>sitting or standing blood pressure,</li> <li>supine blood pressure,</li> <li>pulse rate and regularity,</li> <li>respiration,</li> <li>temperature,</li> <li>height,</li> <li>weight (May be measured and recorded by ancillary staff)</li> </ol> </li> <li>General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)</li> </ul>
Head and Face	
Eyes	<ul style="list-style-type: none"> <li>Inspection of conjunctivae and lids (eg, xanthelasma)</li> </ul>
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> <li>Inspection of teeth, gums and palate</li> <li>Inspection of oral mucosa with notation of presence of pallor or cyanosis</li> </ul>
Neck	<ul style="list-style-type: none"> <li>Examination of jugular veins (eg, distension; a, v or cannon a waves)</li> <li>Examination of thyroid (eg, enlargement, tenderness, mass)</li> </ul>
Respiratory	<ul style="list-style-type: none"> <li>Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)</li> <li>Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)</li> </ul>
Cardiovascular	<ul style="list-style-type: none"> <li>Palpation of heart (eg, location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4)</li> <li>Auscultation of heart including sounds, abnormal sounds and murmurs</li> <li>Measurement of blood pressure in two or more extremities when indicated (eg, aortic dissection, coarctation)</li> </ul> Examination of: <ul style="list-style-type: none"> <li>Carotid arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay)</li> <li>Abdominal aorta (eg, size, bruits)</li> <li>Femoral arteries (eg, pulse amplitude, bruits)</li> <li>Pedal pulses (eg, pulse amplitude)</li> <li>Extremities for peripheral edema and/or varicosities</li> </ul>
Chest (Breasts)	
Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> <li>Examination of abdomen with notation of presence of masses or tenderness</li> <li>Examination of liver and spleen</li> <li>Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy</li> </ul>
Genitourinary (Abdomen)	
Lymphatic	
Musculoskeletal	<ul style="list-style-type: none"> <li>Examination of the back with notation of kyphosis or scoliosis</li> <li>Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs</li> <li>Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements</li> </ul>
Extremities	<ul style="list-style-type: none"> <li>Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)</li> </ul>
Skin	<ul style="list-style-type: none"> <li>Inspection and/or palpation of skin and subcutaneous tissue (eg, stasis dermatitis, ulcers, scars, xanthomas)</li> </ul>
Neurological/ Psychiatric	Brief assessment of mental status including <ul style="list-style-type: none"> <li>Orientation to time, place and person,</li> <li>Mood and affect (eg, depression, anxiety, agitation)</li> </ul>

Content and Documentation Requirements	
Level of Exam	Perform and Document:
<b>Problem Focused</b> <b>Expanded Problem Focused</b> <b>Detailed</b> <b>Comprehensive</b>	<b>One to five</b> elements identified by a bullet. <b>At least six</b> elements identified by a bullet. <b>At least twelve</b> elements identified by a bullet Perform <b>all elements</b> identified by a bullet; document every element in each shaded box and at least one element in each unshaded box.

## Ear, Nose and Throat Examination

System/Body Area	Elements of Examination
<b>Constitutional</b>	<ul style="list-style-type: none"> <li>• Measurement of <b>any three of the following seven</b> 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)</li> <li>• General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)</li> <li>• Assessment of ability to communicate (eg, use of sign language or other communication aids) and quality of voice</li> </ul>
<b>Head and Face</b>	<ul style="list-style-type: none"> <li>• Inspection of head and face (eg, overall appearance, scars, lesions and masses)</li> <li>• Palpation and/or percussion of face with notation of presence or absence of sinus tenderness</li> <li>• Examination of salivary glands</li> <li>• Assessment of facial strength</li> </ul>
<b>Eyes</b>	<ul style="list-style-type: none"> <li>• Test ocular motility including primary gaze alignment</li> </ul>
<b>Ears, Nose, Mouth and Throat</b>	<ul style="list-style-type: none"> <li>• 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)</li> <li>• External inspection of ears and nose (eg, overall appearance, scars, lesions and masses)</li> <li>• Inspection of nasal mucosa, septum and turbinates</li> <li>• Inspection of lips, teeth and gums</li> <li>• Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx (eg, asymmetry, lesions, hydration of mucosal surfaces)</li> <li>• Inspection of pharyngeal walls and pyriform sinuses (eg, pooling of saliva, asymmetry, lesions)</li> <li>• 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)</li> <li>• Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae and eustachian tubes (Use of mirror not required in children)</li> </ul>
<b>Neck</b>	<ul style="list-style-type: none"> <li>• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)</li> <li>• Examination of thyroid (eg, enlargement, tenderness, mass)</li> </ul>
<b>Respiratory</b>	<ul style="list-style-type: none"> <li>• Inspection of chest including symmetry, expansion and/or assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)</li> <li>• Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)</li> </ul>
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>• Auscultation of heart with notation of abnormal sounds and murmurs</li> <li>• Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)</li> </ul>
<b>Chest (Breasts)</b>	
<b>Gastrointestinal (Abdomen)</b>	
<b>Genitourinary</b>	
<b>Lymphatic</b>	<ul style="list-style-type: none"> <li>• Palpation of lymph nodes in neck, axillae, groin and/or other location</li> </ul>
<b>Musculoskeletal</b>	
<b>Extremities</b>	
<b>Skin</b>	
<b>Neurological/ Psychiatric</b>	<ul style="list-style-type: none"> <li>• Test cranial nerves with notation of any deficits</li> </ul> <p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> <li>• Orientation to time, place and person,</li> <li>• Mood and affect (eg, depression, anxiety, agitation)</li> </ul>

### Content and Documentation Requirements

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

## EYE EXAMINATION

System/Body Area	Elements of Examination
<b>Constitutional</b>	
<b>Head and Face</b>	
<b>Eyes</b>	<ul style="list-style-type: none"> <li>• Test visual acuity (Does not include determination of refractive error)</li> <li>• Gross visual field testing by confrontation</li> <li>• Test ocular motility including primary gaze alignment</li> <li>• Inspection of bulbar and palpebral conjunctivae</li> <li>• Examination of ocular adnexae including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes</li> <li>• Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology</li> <li>• Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film</li> <li>• Slit lamp examination of the anterior chambers including depth, cells, and flare</li> <li>• Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus</li> <li>• Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)</li> </ul> <p>Ophthalmoscopic examination through dilated pupils (unless contraindicated) of</p> <ul style="list-style-type: none"> <li>• Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer</li> <li>• Posterior segments including retina and vessels (eg, exudates and hemorrhages)</li> </ul>
<b>Ears, Nose, Mouth &amp; Throat</b>	
<b>Neck</b>	
<b>Respiratory</b>	
<b>Cardiovascular</b>	
<b>Chest (Breasts)</b>	
<b>Gastrointestinal (Abdomen)</b>	
<b>Genitourinary</b>	
<b>Lymphatic</b>	
<b>Musculoskeletal</b>	
<b>Extremities</b>	
<b>Skin</b>	
<b>Neurological/ Psychiatric</b>	<p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> <li>• Orientation to time, place and person</li> <li>• Mood and affect (eg, depression, anxiety, agitation)</li> </ul>

<b>Content and Documentation Requirements</b>	
Level of Exam	Perform and Document:
<b>Problem Focused</b>	<b>One to five</b> elements identified by a bullet.
<b>Expanded Problem Focused</b>	<b>At least six</b> elements identified by a bullet.
<b>Detailed</b>	<b>At least nine</b> elements identified by a bullet
<b>Comprehensive</b>	Perform <b>all elements</b> identified by a bullet; document every element in each shaded box and at least one element in each unshaded box.

## GENITOURINARY EXAMINATION

System/Body Area	Elements of Examination
<b>Constitutional</b>	<ul style="list-style-type: none"> <li>• Measurement of <b>any three of the following seven</b> 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)</li> <li>• General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)</li> </ul>
<b>Head and Face</b>	
<b>Eyes</b>	
<b>Ears, Nose, Mouth &amp; Throat</b>	
<b>Neck</b>	<ul style="list-style-type: none"> <li>• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)</li> <li>• Examination of thyroid (eg, enlargement, tenderness, mass)</li> </ul>
<b>Respiratory</b>	<ul style="list-style-type: none"> <li>• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)</li> <li>• Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)</li> </ul>
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>• Auscultation of heart with notation of abnormal sounds and murmurs</li> <li>• Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)</li> </ul>
<b>Chest (Breasts)</b>	[See genitourinary (female)]
<b>Gastrointestinal (Abdomen)</b>	<ul style="list-style-type: none"> <li>• Examination of abdomen with notation of presence of masses or tenderness</li> <li>• Examination for presence or absence of hernia</li> <li>• Examination of liver and spleen</li> <li>• Obtain stool sample for occult blood test when indicated</li> </ul>
<b>Genitourinary</b>	<p><b>MALE:</b></p> <ul style="list-style-type: none"> <li>• Inspection of anus and perineum</li> </ul> <p>Examination (with or without specimen collection for smears and cultures) of genitalia including</p> <ul style="list-style-type: none"> <li>• Scrotum (eg, lesions, cysts, rashes)</li> <li>• Epididymides (eg, size, symmetry, masses)</li> <li>• Testes (eg, size, symmetry, masses)</li> <li>• Urethral meatus (eg, size, location, lesions, discharge)</li> <li>• Penis (eg, lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities)</li> </ul> <p>Digital rectal examination including:</p> <ul style="list-style-type: none"> <li>• Prostate gland (eg, size, symmetry, nodularity, tenderness)</li> <li>• Seminal vesicles (eg, symmetry, tenderness, masses, enlargement)</li> <li>• Sphincter tone, presence of hemorrhoids, rectal masses</li> </ul>
<b>Genitourinary</b>	<p><b>FEMALE:</b> Includes <b>at least seven of the following eleven</b> elements identified by bullets:</p> <ul style="list-style-type: none"> <li>• Inspection and palpation of breasts (eg, masses or lumps, tenderness, symmetry, nipple discharge)</li> <li>• Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses</li> </ul> <p>Pelvic examination (with or without specimen collection for smears and cultures) including:</p> <ul style="list-style-type: none"> <li>• External genitalia (eg, general appearance, hair distribution, lesions)</li> <li>• Urethral meatus (eg, size, location, lesions, prolapse)</li> <li>• Urethra (eg, masses, tenderness, scarring)</li> <li>• Bladder (eg, fullness, masses, tenderness)</li> <li>• Vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)</li> <li>• Cervix (eg, general appearance, lesions, discharge)</li> <li>• Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support)</li> <li>• Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)</li> <li>• Anus and perineum</li> </ul>
<b>Lymphatic</b>	<ul style="list-style-type: none"> <li>• Palpation of lymph nodes in neck, axillae, groin and/or other location</li> </ul>
<b>Musculoskeletal</b>	
<b>Extremities</b>	
<b>Skin</b>	<ul style="list-style-type: none"> <li>• Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)</li> </ul>
<b>Neurological/ Psychiatric</b>	<p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> <li>• Orientation (eg, time, place and person) and</li> <li>• Mood and affect (eg, depression, anxiety, agitation)</li> </ul>

<b>Content and Documentation Requirements</b>	
Level of Exam	Perform and Document:
<b>Problem Focused</b> <b>Expanded Problem Focused</b> <b>Detailed</b> <b>Comprehensive</b>	<b>One to five</b> elements identified by a bullet. <b>At least six</b> elements identified by a bullet. <b>At least twelve</b> elements identified by a bullet Perform <b>all elements</b> identified by a bullet; document every element in each shaded box and at least one element in each unshaded box.

## Hematologic/Lymphatic/Immunologic Examination

System/Body Area	Elements of Examination
<b>Constitutional</b>	<ul style="list-style-type: none"> <li>Measurement of <b>any three of the following seven</b> 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)</li> <li>General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)</li> </ul>
<b>Head and Face</b>	<ul style="list-style-type: none"> <li>Palpation and/or percussion of face with notation of presence or absence of sinus tenderness</li> </ul>
<b>Eyes</b>	<ul style="list-style-type: none"> <li>Inspection of conjunctivae and lids</li> </ul>
<b>Ears, Nose, Mouth and Throat</b>	<ul style="list-style-type: none"> <li>Otoscopic examination of external auditory canals and tympanic membranes</li> <li>Inspection of nasal mucosa, septum and turbinates</li> <li>Inspection of teeth and gums</li> <li>Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)</li> </ul>
<b>Neck</b>	<ul style="list-style-type: none"> <li>Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)</li> <li>Examination of thyroid (eg, enlargement, tenderness, mass)</li> </ul>
<b>Respiratory</b>	<ul style="list-style-type: none"> <li>Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)</li> <li>Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)</li> </ul>
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>Auscultation of heart with notation of abnormal sounds and murmurs</li> <li>Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)</li> </ul>
<b>Chest (Breasts)</b>	
<b>Gastrointestinal (Abdomen)</b>	<ul style="list-style-type: none"> <li>Examination of abdomen with notation of presence of masses or tenderness</li> <li>Examination of liver and spleen</li> </ul>
<b>Genitourinary</b>	
<b>Lymphatic</b>	<ul style="list-style-type: none"> <li>Palpation of lymph nodes in neck, axillae, groin, and/or other location</li> </ul>
<b>Musculoskeletal</b>	
<b>Extremities</b>	<ul style="list-style-type: none"> <li>Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)</li> </ul>
<b>Skin</b>	<ul style="list-style-type: none"> <li>Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, ecchymoses, bruises)</li> </ul>
<b>Neurological/ Psychiatric</b>	<p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> <li>Orientation to time, place and person</li> <li>Mood and affect (eg, depression, anxiety, agitation)</li> </ul>

<b>Content and Documentation Requirements</b>	
Level of Exam	Perform and Document:
<b>Problem Focused</b>	<b>One to five</b> elements identified by a bullet.
<b>Expanded Problem Focused</b>	<b>At least six</b> elements identified by a bullet.
<b>Detailed</b>	<b>At least twelve</b> elements identified by a bullet
<b>Comprehensive</b>	Perform <b>all elements</b> identified by a bullet; document every element in each shaded box and at least one element in each unshaded box.

## Musculoskeletal Examination

System/Body Area	Elements of Examination
<b>Constitutional</b>	<ul style="list-style-type: none"> <li>Measurement of <b>any three of the following seven</b> 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)</li> <li>General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)</li> </ul>
<b>Head and Face</b>	
<b>Eyes</b>	
<b>Ears, Nose, Mouth &amp; Throat</b>	
<b>Neck</b>	
<b>Respiratory</b>	
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)</li> </ul>
<b>Chest (Breasts)</b>	
<b>Gastrointestinal (Abdomen)</b>	
<b>Genitourinary</b>	
<b>Lymphatic</b>	<ul style="list-style-type: none"> <li>Palpation of lymph nodes in neck, axillae, groin and/or other location</li> </ul>
<b>Musculoskeletal</b>	<ul style="list-style-type: none"> <li>Examination of gait and station</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions</li> <li>Assessment of range of motion with notation of any pain (eg, straight leg raising), crepitation or contracture</li> <li>Assessment of stability with notation of any dislocation (luxation), subluxation or laxity</li> <li>Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements</li> </ul> <p><b>NOTE:</b> 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.</p>
<b>Extremities</b>	[See musculoskeletal and skin]
<b>Skin</b>	<ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>NOTE:</b> 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.</p>
<b>Neurological/ Psychiatric</b>	<ul style="list-style-type: none"> <li>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)</li> <li>Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (eg, Babinski)</li> <li>Examination of sensation (eg, by touch, pin, vibration, proprioception)</li> </ul> <p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> <li>Orientation to time, place and person</li> <li>Mood and affect (eg, depression, anxiety, agitation)</li> </ul>

### Content and Documentation Requirements

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

## Neurological Examination

System/Body Area	Elements of Examination
<b>Constitutional</b>	<ul style="list-style-type: none"> <li>Measurement of <b>any three of the following seven</b> 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)</li> <li>General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)</li> </ul>
<b>Head and Face</b>	
<b>Eyes</b>	<ul style="list-style-type: none"> <li>Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)</li> </ul>
<b>Ears, Nose, Mouth &amp; Throat</b>	
<b>Neck</b>	
<b>Respiratory</b>	
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>Examination of carotid arteries (eg, pulse amplitude, bruits)</li> <li>Auscultation of heart with notation of abnormal sounds and murmurs</li> <li>Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)</li> </ul>
<b>Chest (Breasts)</b>	
<b>Gastrointestinal (Abdomen)</b>	
<b>Genitourinary</b>	
<b>Lymphatic</b>	
<b>Musculoskeletal</b>	<ul style="list-style-type: none"> <li>Examination of gait and station</li> </ul> <p>Assessment of motor function including:</p> <ul style="list-style-type: none"> <li>Muscle strength in upper and lower extremities</li> <li>Muscle tone in upper and lower extremities (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (eg, fasciculation, tardive dyskinesia)</li> </ul>
<b>Extremities</b>	[See musculoskeletal]
<b>Skin</b>	
<b>Neurological</b>	<p>Evaluation of higher integrative functions including:</p> <ul style="list-style-type: none"> <li>Orientation to time, place and person</li> <li>Recent and remote memory</li> <li>Attention span and concentration</li> <li>Language (eg, naming objects, repeating phrases, spontaneous speech)</li> <li>Fund of knowledge (eg, awareness of current events, past history, vocabulary)</li> </ul> <p>Test the following cranial nerves:</p> <ul style="list-style-type: none"> <li>2nd cranial nerve (eg, visual acuity, visual fields, fundi)</li> <li>3rd, 4th and 6th cranial nerves (eg, pupils, eye movements)</li> <li>5th cranial nerve (eg, facial sensation, corneal reflexes)</li> <li>7th cranial nerve (eg, facial symmetry, strength)</li> <li>8th cranial nerve (eg, hearing with tuning fork, whispered voice and/or finger rub)</li> <li>9th cranial nerve (eg, spontaneous or reflex palate movement)</li> <li>11th cranial nerve (eg, shoulder shrug strength)</li> <li>12th cranial nerve (eg, tongue protrusion)</li> <li>Examination of sensation (eg, by touch, pin, vibration, proprioception)</li> <li>Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (eg, Babinski)</li> <li>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)</li> </ul>
<b>Psychiatric</b>	

### Content and Documentation Requirements

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

## Psychiatric Examination

System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> <li>Measurement of <b>any three of the following seven</b> 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)</li> <li>General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)</li> </ul>
Head and Face	
Eyes	
Ears, Nose, Mouth & Throat	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	<ul style="list-style-type: none"> <li>Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements</li> <li>Examination of gait and station</li> </ul>
Extremities	
Skin	
Neurological	
Psychiatric	<ul style="list-style-type: none"> <li>Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language)</li> <li>Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation</li> <li>Description of associations (eg, loose, tangential, circumstantial, intact)</li> <li>Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions</li> <li>Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition)</li> </ul> <p>Complete mental status examination including</p> <ul style="list-style-type: none"> <li>Orientation to time, place and person</li> <li>Recent and remote memory</li> <li>Attention span and concentration</li> <li>Language (eg, naming objects, repeating phrases)</li> <li>Fund of knowledge (eg, awareness of current events, past history, vocabulary)</li> <li>Mood and affect (eg, depression, anxiety, agitation, hypomania, liability)</li> </ul>

Content and Documentation Requirements	
Level of Exam	Perform and Document:
<b>Problem Focused</b>	<b>One to five</b> elements identified by a bullet.
<b>Expanded Problem Focused</b>	<b>At least six</b> elements identified by a bullet.
<b>Detailed</b>	<b>At least nine</b> elements identified by a bullet
<b>Comprehensive</b>	Perform <b>all elements</b> identified by a bullet; document every element in each shaded box and at least one element in each unshaded box.

## Respiratory Examination

System/Body Area	Elements of Examination
<b>Constitutional</b>	<ul style="list-style-type: none"> <li>Measurement of <b>any three of the following seven</b> 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)</li> <li>General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)</li> </ul>
<b>Head and Face</b>	
<b>Eyes</b>	
<b>Ears, Nose, Mouth and Throat</b>	<ul style="list-style-type: none"> <li>Inspection of nasal mucosa, septum and turbinates</li> <li>Inspection of teeth and gums</li> <li>Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx)</li> </ul>
<b>Neck</b>	<ul style="list-style-type: none"> <li>Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)</li> <li>Examination of thyroid (eg, enlargement, tenderness, mass)</li> <li>Examination of jugular veins (eg, distension; a, v or cannon a waves)</li> </ul>
<b>Respiratory</b>	<ul style="list-style-type: none"> <li>Inspection of chest with notation of symmetry and expansion</li> <li>Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)</li> <li>Percussion of chest (eg, dullness, flatness, hyperresonance)</li> <li>Palpation of chest (eg, tactile fremitus)</li> <li>Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)</li> </ul>
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>Auscultation of heart including sounds, abnormal sounds and murmurs</li> <li>Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)</li> </ul>
<b>Chest (Breasts)</b>	
<b>Gastrointestinal (Abdomen)</b>	<ul style="list-style-type: none"> <li>Examination of abdomen with notation of presence of masses or tenderness</li> <li>Examination of liver and spleen</li> </ul>
<b>Genitourinary</b>	
<b>Lymphatic</b>	<ul style="list-style-type: none"> <li>Palpation of lymph nodes in neck, axillae, groin and/or other location</li> </ul>
<b>Musculoskeletal</b>	<ul style="list-style-type: none"> <li>Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements</li> <li>Examination of gait and station</li> </ul>
<b>Extremities</b>	<ul style="list-style-type: none"> <li>Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)</li> </ul>
<b>Skin</b>	<ul style="list-style-type: none"> <li>Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)</li> </ul>
<b>Neurological/ Psychiatric</b>	Brief assessment of mental status including <ul style="list-style-type: none"> <li>Orientation to time, place and person</li> <li>Mood and affect (eg, depression, anxiety, agitation)</li> </ul>

Content and Documentation Requirements	
Level of Exam	Perform and Document:
<b>Problem Focused</b>	<b>One to five</b> elements identified by a bullet.
<b>Expanded Problem Focused</b>	<b>At least six</b> elements identified by a bullet.
<b>Detailed</b>	<b>At least twelve</b> elements identified by a bullet
<b>Comprehensive</b>	Perform <b>all elements</b> identified by a bullet; document every element in each shaded box and at least one element in each unshaded box.

## Skin Examination

System/Body Area	Elements of Examination
<b>Constitutional</b>	<ul style="list-style-type: none"> <li>Measurement of any <b>three of the following seven</b> 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)</li> <li>General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)</li> </ul>
<b>Head and Face</b>	
<b>Eyes</b>	Inspection of conjunctivae and lids
<b>Ears, Nose, Mouth &amp; Throat</b>	<ul style="list-style-type: none"> <li>Inspection of lips, teeth and gums</li> <li>Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)</li> </ul>
<b>Neck</b>	<ul style="list-style-type: none"> <li>Examination of thyroid (eg, enlargement, tenderness, mass)</li> </ul>
<b>Respiratory</b>	
<b>Cardiovascular</b>	<ul style="list-style-type: none"> <li>Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)</li> </ul>
<b>Chest (Breasts)</b>	
<b>Gastrointestinal (Abdomen)</b>	<ul style="list-style-type: none"> <li>Examination of liver and spleen</li> <li>Examination of anus for condyloma and other lesions</li> </ul>
<b>Genitourinary</b>	
<b>Lymphatic</b>	<ul style="list-style-type: none"> <li>Palpation of lymph nodes in neck, axillae, groin and/or other location</li> </ul>
<b>Musculoskeletal</b>	
<b>Extremities</b>	<ul style="list-style-type: none"> <li>Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)</li> </ul>
<b>Skin</b>	<ul style="list-style-type: none"> <li>Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities</li> <li>Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, susceptibility to and presence of photo damage) in <b>eight of the following ten</b> areas: <ul style="list-style-type: none"> <li>Head, including the face and</li> <li>Neck</li> <li>Chest, including breasts and axillae</li> <li>Abdomen</li> <li>Genitalia, groin, buttocks</li> <li>Back</li> <li>Right upper extremity</li> <li>Left upper extremity</li> <li>Right lower extremity</li> <li>Left lower extremity</li> </ul> </li> </ul> <p>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.</p> <ul style="list-style-type: none"> <li>Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses or bromhidrosis</li> </ul>
<b>Neurological/ Psychiatric</b>	<p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> <li>Orientation to time, place and person</li> <li>Mood and affect (eg, depression, anxiety, agitation)</li> </ul>

Content and Documentation Requirements	
Level of Exam	Perform and Document:
<b>Problem Focused</b>	<b>One to five</b> elements identified by a bullet.
<b>Expanded Problem Focused</b>	<b>At least six</b> elements identified by a bullet.
<b>Detailed</b>	<b>At least twelve</b> elements identified by a bullet
<b>Comprehensive</b>	Perform <b>all elements</b> identified by a bullet; document every element in each shaded box and at least one element in each unshaded box.

### C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straightforward, 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/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	<b><i>Straightforward</i></b>
Limited	Limited	Low	<b><i>Low Complexity</i></b>
Multiple	Moderate	Moderate	<b><i>Moderate Complexity</i></b>
Extensive	Extensive	High	<b><i>High Complexity</i></b>

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**

<i>Level of Risk</i>	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
<b>Minimal</b>	One self-limited or minor problem, eg, cold, insect bite, tinea corporis	<ul style="list-style-type: none"> <li>• Laboratory tests requiring venipuncture</li> <li>• Chest x-rays</li> <li>• EKG/EEG</li> <li>• Urinalysis</li> <li>• Ultrasound, eg, echocardiography</li> <li>• KOH prep</li> </ul>	<ul style="list-style-type: none"> <li>• Rest</li> <li>• Gargles</li> <li>• Elastic bandages</li> <li>• Superficial dressings</li> </ul>
<b>Low</b>	<ul style="list-style-type: none"> <li>• Two or more self-limited or minor problems</li> <li>• One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH</li> <li>• Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain</li> </ul>	<ul style="list-style-type: none"> <li>• Physiologic tests not under stress, eg, pulmonary function tests</li> <li>• Non-cardiovascular imaging studies with contrast, eg, barium enema</li> <li>• Superficial needle biopsies</li> <li>• Clinical laboratory tests requiring arterial puncture</li> <li>• Skin biopsies</li> </ul>	<ul style="list-style-type: none"> <li>• Over-the-counter drugs</li> <li>• Minor surgery with no identified risk factors</li> <li>• Physical therapy</li> <li>• Occupational therapy IV fluids without additives</li> </ul>
<b>Moderate</b>	<ul style="list-style-type: none"> <li>• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</li> <li>• Two or more stable chronic illnesses</li> <li>• Undiagnosed new problem with uncertain prognosis, eg, lump breast</li> <li>• Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis</li> <li>• Acute complicated injury, eg, head injury with brief loss of consciousness</li> </ul>	<ul style="list-style-type: none"> <li>• Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test</li> <li>• Diagnostic endoscopies with no identified risk factors</li> <li>• Deep needle or incisional biopsy</li> <li>• Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization</li> <li>• Obtain fluid from body cavity, eg, lumbar puncture, thoracentesis, culdocentesis</li> </ul>	<ul style="list-style-type: none"> <li>• Minor surgery with identified risk factors</li> <li>• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</li> <li>• Prescription drug management Therapeutic nuclear medicine</li> <li>• IV fluids with additives</li> <li>• Closed treatment of fracture or dislocation without manipulation</li> </ul>
<b>High</b>	<ul style="list-style-type: none"> <li>• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</li> <li>• 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</li> <li>• An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss</li> </ul>	<ul style="list-style-type: none"> <li>• Cardiovascular imaging studies with contrast with identified risk factors</li> <li>• Cardiac electrophysiological tests</li> <li>• Diagnostic Endoscopies with identified risk factors</li> <li>• Discography</li> </ul>	<ul style="list-style-type: none"> <li>• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors</li> <li>• Emergency major surgery (open, percutaneous or endoscopic)</li> <li>• Parenteral controlled substances</li> <li>• Drug therapy requiring intensive monitoring for toxicity</li> <li>• Decision not to resuscitate or to de-escalate care because of poor prognosis</li> </ul>

**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.*

## RESOURCE INFORMATION

### HELP!

MSSNY's Ombudsman Program is available to help member physicians resolve problems related to disputes with third party carriers. Assistance is available when reimbursement is denied or delayed unduly, or when any problems or questions arise. There is no fee for MSSNY members inquiring about policy or points of clarification.

Contact:

**Division of Socio-Medical Economics  
Medical Society of the State of New York  
420 Lakeville Road, PO Box 5404  
Lake Success NY 11042  
1-800-523-4405 / 516-488-6100, ext. 318**

### WC FEE SCHEDULE

The *Official New York Workers' Compensation Medical Fee Schedule* is the fee schedule that must be used on or after April 1, 2000. The latest update is effective October 1, 2003. It contains all current procedural terminology codes as well as rules and regulations. Please note NYSWC is using AMA-CPT coding. A binder version is available for \$65.00. An ASCII file disk plus binder costs \$295. To purchase the *Official New York Workers' Compensation Medical Fee Schedule*, please call:

**INGENIX  
1-800-765-6023**

### MSSNY's WC GUIDEBOOK

MSSNY's *New York State Workers' Compensation Guide* assists physicians in understanding the procedures of the Workers' Compensation process, including reporting requirements, advance authorizations, arbitration, hearings, etc. It is regularly updated, and is available to MSSNY members for FREE (\$30 non-members, plus tax) from:

**Division of Socio-Medical Economics  
1-800-523-4405 / 516-488-6100, ext. 426**

Or, you may want to consider downloading the document from the Members Only ***Payer Relations*** Section of the MSSNY website:

[www.mssny.org](http://www.mssny.org)

### NO FAULT INSURANCE

Physicians desirous of treating patients injured in auto accidents should notify the NYS Insurance Department. A Workers' Compensation rating is *not* required to treat no-fault cases. Unrated physicians should indicate their specialties on insurance forms, with the appropriate letters designating they have passed their respective boards. Such physicians should also notify the Superintendent of Insurance *in writing* of their credentials as specialists.

Direct these communications to:

**Superintendent of Insurance  
Empire State Plaza  
Agency Building One  
Albany NY 12257**

## **MSSNY's NEW YORK STATE NO-FAULT GUIDEBOOK**

MSSNY's *New York State No-Fault Guide* offers valuable information for physicians regarding claim procedures when patients have been injured in auto accidents. The publication is available for FREE for MSSNY members (\$25 nonmembers plus tax) from:

**Division of Socio-Medical Economics  
at 1-800-523-4405 / 516-488-6100, ext. 426**

Or, you may want to consider downloading the document from the *Practice Management* Section of the *Members Only* Section of the MSSNY website:

[www.mssny.org](http://www.mssny.org)

## **INFORMATION**

MSSNY publishes *Physician Contracting Guidelines for Health Care Delivery Systems*, which provides a checklist against which you should review all managed care contracts. The cost is \$25 for MSSNY members, \$75 for nonmembers (plus \$4 shipping charge and applicable sales tax). This is an invaluable aid when considering a contract with a managed care organization.

**Division of Socio-Medical Economics  
1-800-523-4405 / 516-488-6100, ext. 426**

## **MEDICAID**

### **MEDICAID PROVIDER NUMBERS**

In order to treat Medicaid patients, you need a provider enrollment number. Contact:

**State of New York Department of Health  
Office of Medicaid Management  
99 Washington Avenue, Suite 611  
Albany NY 12210  
1-800-541-2831 / 518-486-9440**

### **MEDICAID CLAIM FORMS**

Medicaid claim forms are automatically sent to enrolled Medicaid providers based on utilization of the forms from:

**Computer Sciences Corporation  
Medicaid Management Information System  
Practitioner Unit  
800 North Pearl Street  
Albany NY 12204  
1-800-522-5518**

### **MEDICAID REIMBURSEMENT**

Due to MSSNY's advocacy, a new Medicaid fee schedule went into effect on October 1, 2000. This is the first such adjustment since the inception of the program thirty-five years ago. Physician reimbursement for services to Medicaid recipients will now increase from a low of \$7 to \$30 for basic office codes.

MSSNY believes it is in physicians' best interests to improve access for Medicaid patients and to support a shift from inappropriate and high cost settings, such as emergency rooms, to private physicians' offices. It is predicted that Medicaid will cover eventually half the patients in New York State. Increased participation in the program by physicians will lend credibility to future appeals for parity in Medicaid reimbursements and will thereby further improve access for this population.

## **MEDICARE**

### **MEDICARE PROVIDER NUMBERS**

In order to treat Medicare patients, you must have a Medicare provider identification number. Contact your Medicare carrier:

*Upstate*

**Upstate Medicare Division –  
Part B  
33 Lewis Road  
Binghamton, NY 13905  
607-766-6000**

*Downstate (excluding Queens County)*

**Empire Medicare Services  
Medicare Part B  
Provider Education and Training  
2651 Strang Blvd.  
Yorktown Heights, NY 10598  
877-869-6504**

*Queens County*

**GHI Medicare  
25 Broadway  
\*New York, NY 10004  
877-868-7965**

For questions regarding the National Provider System, contact

**MS #N3-09-16**

**Centers for Medicare and Medicaid  
7500 Security Boulevard  
Baltimore MD 21244  
410-786-7065**

### **MEDICARE CLAIM FORMS**

Medicare providers are required to use the *Health Insurance Claim Form, HCFA-1500*. These may be purchased from the AMA, from medical book publishers or from printers. Different formats and styles are available. AMA members receive a discount.

**American Medical Association**

**1-800-621-8335**

**FAX 312-464-5600**

**order online: [www.ama-assn.org/catalog](http://www.ama-assn.org/catalog)**

**Triangle Business Forms**

**PO Box 5789**

**\*Endicott, NY 13763**

**607-754-5544**

(Triangle also sells other medical forms.)

**US Government Printing Office**

**Superintendent of Documents**

**\*Washington, DC 20402**

## **FLYERS**

To assist you with Medicare reporting, MSSNY has informative publications available for the following:

1. Medicare Managed Care Program Flyer
2. Medical Record Keeping

Contact      **Division of Socio-Medical Economics**  
**1-800-523-4405 / 516-488-6100, ext. 426**

## **ELECTRONIC BILLING**

The federal government released its final rule on the new standardized electronic forms required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The rule sets content and format standards for filing electronic claims or making similar electronic transactions. It establishes simpler formats which most insurers and providers will be required to accept by October 2002. (Some small insurers will have an additional year before compliance is required.)

Although providers are still allowed to use paper forms, the government expects that electronic filing will become the norm. Another aspect that must be considered in all claim filing are the new privacy protections. To learn more about these regulations, please be sure to review MSSNY's website and the following governmental website on this matter:

**<http://aspe.hhs.gov/admnsimp/final/txfin00.htm>**

For physicians choosing to use a billing service rather than their own computer system, MSSNY offers members a broad scope of outsource billing and accounts receivable management and electronic data interchange services.

**Department of Marketing Services**  
**1-800-523-4405 / 516-488-6100, ext. 424**