



Medicare Part B

HGSADMINISTRATORS DOCUMENTATION WORKSHEET

Beneficiary HIC #

Provider Number

Date of Service

Procedure Code Reported

Check one: Agree Disagree

Documented Procedure Code Level

OVERPAYMENT AMOUNT \$



E/M Documentation Auditors' Instructions

1. History

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the *RIGHT* in the table, which best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the *LEFT*, identifies the type of history.

After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 5.

HISTORY	HPI: Status of chronic conditions: <input type="checkbox"/> 1 condition <input type="checkbox"/> 2 conditions <input type="checkbox"/> 3 conditions OR HPI (history of present illness) elements: <input type="checkbox"/> Location <input type="checkbox"/> Severity <input type="checkbox"/> Timing <input type="checkbox"/> Modifying factors <input type="checkbox"/> Quality <input type="checkbox"/> Duration <input type="checkbox"/> Context <input type="checkbox"/> Associated signs and symptoms	<input type="checkbox"/> Status of 2 chronic conditions	<input type="checkbox"/> Status of 3 chronic conditions
	ROS (review of systems): <input type="checkbox"/> Constitutional (wt loss, etc) <input type="checkbox"/> Ears,nose, mouth, throat <input type="checkbox"/> GI <input type="checkbox"/> Integumentary (skin, breast) <input type="checkbox"/> Endo (Hem/lymph) <input type="checkbox"/> Eyes <input type="checkbox"/> Card/vasc <input type="checkbox"/> Musculo <input type="checkbox"/> Neuro <input type="checkbox"/> All/immuno <input type="checkbox"/> Resp <input type="checkbox"/> Psych <input type="checkbox"/> All others negative	<input type="checkbox"/> None <input type="checkbox"/> Pertinent to problem (1 system) <input type="checkbox"/> Extended (2-9 systems) <input type="checkbox"/> **Complete	<input type="checkbox"/> Extended (4 or more) <input type="checkbox"/> Complete* (2 or 3 history areas)
	PFSH (past medical, family, social history) areas: <input type="checkbox"/> Past history (the patient's past experiences with illnesses, operation, injuries and treatments) <input type="checkbox"/> Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) <input type="checkbox"/> Social history (an age appropriate review of past and current activities)	<input type="checkbox"/> None <input type="checkbox"/> Pertinent (1 history area) <input type="checkbox"/> Complete* (2 or 3 history areas)	<input type="checkbox"/> Complete* (2 or 3 history areas)
	PROBLEM FOCUSED EXP.PROB FOCUSED DETAILED COMPREHENSIVE	PROBLEM FOCUSED EXP.PROB FOCUSED DETAILED COMPREHENSIVE	PROBLEM FOCUSED EXP.PROB FOCUSED DETAILED COMPREHENSIVE

*Complete PFSH: 2 history areas: a) Established patients - office (outpatient) care, domiciliary care, home care; b) Emergency department, c) Subsequent nursing facility care; d) Subsequent hospital care; and, e) Follow-up consultations.

3 history areas: a) New patients - office (outpatient) care, domiciliary care, home care; b) Initial consultations; c) Initial hospital care; d) Hospital observation; and, e) Comprehensive nursing facility assessments.

**10 or more systems, or some systems with statement "all others negative"

2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

Limited to affected body area or organ system (one body area or system related to problem)	PROBLEM FOCUSED EXAM
Affected body area or organ system and other symptomatic or related organ system(s) (additional systems up to total of 7)	EXPANDED PROBLEM FOCUSED EXAM
Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 or more depth than above)	DETAILED EXAM
General multi-system exam (8 or more systems) or complete exam of a single organ system (complete single exam not defined in these instructions)	COMPREHENSIVE EXAM

EXAM	Body areas: <input type="checkbox"/> Head, including face <input type="checkbox"/> Chest, including breasts and axillae <input type="checkbox"/> Abdomen <input type="checkbox"/> Neck <input type="checkbox"/> Back, including spine <input type="checkbox"/> Genitalia, groin, buttocks <input type="checkbox"/> Each extremity	<input type="checkbox"/> 1 body area or system	<input type="checkbox"/> Up to 7 systems	<input type="checkbox"/> Up to 7 systems	<input type="checkbox"/> 8 or more systems
	Organ systems: <input type="checkbox"/> Constitutional (e.g., vitals, gen app) <input type="checkbox"/> Ears,nose, mouth, throat <input type="checkbox"/> Resp <input type="checkbox"/> Musculo <input type="checkbox"/> Psych <input type="checkbox"/> Eyes <input type="checkbox"/> Cardiovascular <input type="checkbox"/> GI <input type="checkbox"/> Skin <input type="checkbox"/> Hem/lymph/imm <input type="checkbox"/> Neuro	<input type="checkbox"/> 1 body area or system	<input type="checkbox"/> Up to 7 systems	<input type="checkbox"/> Up to 7 systems	<input type="checkbox"/> 8 or more systems
	PROBLEM FOCUSED EXP.PROB FOCUSED DETAILED COMPREHENSIVE	PROBLEM FOCUSED EXP.PROB FOCUSED DETAILED COMPREHENSIVE	PROBLEM FOCUSED EXP.PROB FOCUSED DETAILED COMPREHENSIVE	PROBLEM FOCUSED EXP.PROB FOCUSED DETAILED COMPREHENSIVE	

