Getting It Right the First Time Documentation & Coding 2013

A documentation and coding workshop

Presented by

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NEW PATIENT SERVICES		RADIOLOGY		LABORATORY		OFFICE PROCEDURES	
Straightforward or 10 min. counseling	99201	Abdomen – 1 View	74000	**Finger Stick**	**36416**	EKG	93000
Straightforward or 20 min. counseling	99202	Abdomen – 2 Views	74020	**Venipuncture**	**36415**	Audiometry	92551
Low or 30 min. counseling	99203	Ankle – 2 views	73600	B-12	82607	Cerumen Removal	69210
Moderate or 45 min. counseling	99204	Cervical Spine – 2 or 3 Views	72040	BMP	80048	Hearing Screening	92551
High or 60 min. counseling	99205	Chest – 1 View	71010	BUN	84520	Nebulizer	94640
ESTABLISHED PATIENT SERVICES		Chest – 2 Views	71020	Calcium	82565	- Duo Neb	J7620
Non MD Visit	99211	Clavicle – Complete	73000	Carbon Dioxide	82374	Nebulizer demonstration	94664
Straightforward or 10 min. counseling	99212	Coccyx/Sacrum – 2 views	72220	CBC w auto differential	85025	Spirometry – Pre/Post	94060
Low or 15 min. counseling	99213	Elbow	73070	CBC w/o auto differential	85027	Spirometry – Single	94010
Moderate or 25 min. counseling	99214	Femur - 2 Views	73550	Chloride	82435	Tympanometry	92567
High or 40 min. counseling	99215	Finger – Minimum 2 Views	73140	CMP	80053	**FOREIGN BODY REMOVAL**	
CONSULTATION SERVICES		Foot - 2 Views	73620	CPK	82550	FB removal – ear	69200
Straightforward or 15 min. counseling	99241	Hand - 2 Views	73120	Creatinine	82565	FB removal – eye, cornea	65220
Straightforward or 30 min. counseling	99242	Hip - 2 Views	73510	Flu A&B	87804	FB removal – eye, embedded	65210
Low or 40 min. counseling	99243	Humerus - 2 views	73060	GGT	82977	FB removal – eye, superficial	65205
Moderate or 60 min. counseling	99244	Knee –1 or 2 Views	73560	Glucose - FDA device	82962	FB removal – nose	30300
High or 80 min. counseling	99245	Lumbosacral Spine - 2-3 Views	72100	Glucose, w/o regent strip	82947	FB removal - skin, simple	10120
NEW / EST PT PHYSICAL & EPSDT		Nasal – 3 Views	70160	Glucose, regent strip	82948	**SKIN PROCEDURES**	
< 1 y	99381 99391	Radius and Ulna – 2 Views	73090	Hepatic Function Panel	80076	Biopsy	11100
1-4 y	99382 99392	Ribs, Unilateral - 2 Views	71100	Hgb	85018	Biopsy, each additional x ___	11101
5-11y	99383 99393	Shoulder - 2 Views	73030	HgbA1C	83036	Destroy pre-malignant lesion	17000
12-17y	99384 99394	Sinus - < 3 Views	70210	HgbA1C – FDA device	83037	Destroy Pre-mal les, 2-14 each ___	17003
18-39y	99385 99395	Sinus - 3 Views	70220	Influenza	87804	Skin tag removal 1-15	11200
40-64y	99386 99396	Skull - < 4 Views	70250	KOH	87220	**VACCINES**	
> 65y	99387 99397	Thoracic Spine – 2 Views	72070	Lipid Panel	80061	**Admin thru 18 w counseling any route**	**90460**
SCREENING CODES		Tibia & Fibia - 2 Views	73590	Liver Panel	80076	**Each additional vaccine/toxoid**	**90461**
IPPE Exam	**G0402**	Toe – 2 Views	73660	Micro albumin	82043	**Admin any age, injection**	**90471**
IPPE Exam EKG	**G0403**	Wrist - 2 Views	73100	Occult Blood – Single Card	82272	**Each additional vac: _____**	**90472**
AWV – Initial Visit	**G0438**	**MEDICATIONS**		Occult Blood – Triple Card	82270	**Admin any age intranasal or oral**	**90473**
AWV – Subsequent Visit	**G0439**	**Admin. Therapeutic/Antibiotic**	**96372**	Pap Smear	88142	**Each additional vac: _____**	**90474**
Breast / Pelvic	**G0101**	**IV; Hydration first hour**	**96360**	Potassium	84132	DT < 7	90702
Obtain Pap	**Q0091**	**each additional hour ___**	**96361**	Pregnancy, urine	81025	DTP	90701
Tobacco Cessation w c/o 3-10 min.	**99406**	Ancef 500 mg	J0690	PSA	84153	DtaP < 7	90700
Tobacco Counseling w c/o > 10 min.	**99407**	B-12 up to 1000 mcg	J3420	PT / INR	85610	Flu – 3 and > (G0008 MCR)	90658
Tobacco Cessation w/o c/o 3-10 min.	**G0436**	Bicillin 0.6 million	J0530	Renal Panel	80069	Flu 6-35 months	90657
Tobacco Cessation w/o c/o > 10 min.	**G0437**	Bicillin CR 1.2 units	J0540	Sed Rate	85651	Hepatitis – adult (G0010 MCR)	90746
Home Health Re-certification	**G0179**	Celestone 3 mg	J0702	Sodium	84295	Hepatitis – child	90744
Home Health Certification	**G0180**	Decadron 1 mg	J1100	Strep A	87880	HIB – PRP-T – 4 dose	90648
Care Plan Oversight – Home Health	**G0181**	Depo Medrol 40 mg	J1030	Strep culture	87081	HIB HbOC – 4 dose	90645
Care Plan Oversight – Hospice	**G0182**	Depo-Medrol 80 mg	J1040	Strep, rapid	86403	HIB – PRP-OMP – 3 dose	90647
TCM Moderate Risk – 14 days	**99495**	Depo-Provera (**BC only**) 150 mg	J1055	T4, free	84439	HPV	90650
TCM High Risk – 7 days	**99496**	Depo-Provera 50 mg	J1051	TB, Intradermal	86580	IPV	90713
INJECTIONS		Depo-Testosterone 100 mg	J1070	Thyroxine, total	84436	Meningococcal	90734
Arthrocentesis - small joint	20600	Gentamicin 80 mg	J1580	TSH	84443	MMR	90707
Arthrocentesis - medium joint	20605	Kenalog per 10 mg	J3301	U/A auto w/o scope	81003	Pediarix	90723
Arthrocentesis - large	20610	Lincocin up to 300 mg	J2010	U/A auto w/scope	81001	Pneumonia – adult (G0009 MCR)	90732
Carpal tunnel injection	20526	Phenergan up to 50 mg	J2550	U/A non-auto w/o micro	81002	Prevnar	90669
Trigger point – 1 or 2 muscles	20552	Rocephin 250 mg x _____	J0696	U/A non-auto w/scope	81000	Proquad	90710
Trigger point – 1 ten origin	20551	Saline, normal 1000 cc	J7030	Urine colony count	87086	Rota Teq - Oral	90680
Trigger point – 1 ten/lig	20550	Supartz (MCR Q4083)	J7319	Urine Culture	87088	TD > 7	90718
Trigger point – 3 or > muscles	20553	Toradol per 15 mg	J1885	Wet Mount	87210	Varicella	90716

ICD-9 CODES							
A-fib	427.31	Cough	786.2	Limb Pain	729.5	**E PRESCRIBING**	
Anemia	285.9	Diarrhea	787.91	Lumbago	724.2	**E-Prescribing**	**G8553**
Anxiety	300.00	Dizzy / Vertigo	780.4	Malaise and Fatigue	780.79	**At least prescription created during the encounter was generated and transmitted electronically using a qualified ERx system**	
Arthropathy	716.90	DM I, uncomplicated	250.01	Migraine	346.90		
Asthma	493.90	DM II, uncomplicated	250.00	Obesity	278.00		
B complex deficiency	266.2	DM II, with complication	250.90	Osteoarthrosis	715.00	Sinusitis, chronic	473.9
Bronchitis, acute	466.0	DM, I with complication	250.91	Painful respirations	786.52	URI	465.9
Bronchitis, chronic	491.21	Embolism and thrombosis	453.8	Pharyngitis, acute	462	Urinary Frequency	788.41
Cardiomyopathy	425.4	Epilepsy	345.00	Pneumonia	486	UTI	599.0
Carpal tunnel	354.0	Fever	780.60	Post nasal drip	784.91	Viral infection	079.99
Chest pain	786.50	Gastroenteritis	558.9	PVD	443.9	Routine child check	V20.2
CHF	428.0	Headache	784.00	Reflux	530.81	Pregnant state incidental	V22.2
Chronic Pain	338.29	HTN, benign	401.1	Rhinitis, chronic	472.0	Long term use anticoag.	V58.61
Contact dermatitis	692.9	Hypercholesterolemia, pure	272.0	Rhinitis, allergic	477.9	Long term use - high risk meds	V58.69
COPD	496	Hyperthyroidism	242.90	Sinusitis, acute	461.9	Routine adult check	V70.0
Coronary atherosclerosis	414.00	Hypothyroidism	244.9	Sinusitis, acute maxillary	461.0	Routine GYN exam	V72.31

Evaluation & Management Coding Summary – Outpatient and Office

Code	Minutes	History	Examination	Decision-Making
New/Consultation Patient Visits (3 out of 3)				
99201 99241 99251	10 15 20	*Problem Focused* • CC • 1HPI	*Problem Focused* *1995 –(1)* *1997 – (1 check)*	*Straightforward* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99202 99242 99252	20 30 40	*Exp. Problem Focused* • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 7)* *1997 – (6 checks)*	*Straightforward* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99203 99243 99253	30 40 55	*Detailed* • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (4-7 – need 4x4)*** *1997 – (12 checks)*	*Low* • Diagnosis – Limited • Data – Limited • Risk – Low **OTC, Short-term Meds, Minor Surgery**
99204 99244 99254	45 60 80	*Comprehensive* • CC • 4 HPI or status of 3 chronic conditions • **10 ROS** • Medical, Family, Social History	*Comprehensive* ***1995 – (8)*** *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate **Long term Rx or Major Surgery**
99205 99245 99255	60 80 110	*Comprehensive* • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Established Patient Visits (2 out of 3)				
99211	N/A	N/A	N/A	N/A
99212	10	*Problem Focused* • CC • 1HPI	*Problem Focused* *1995 –(1)* *1997 – (1 check)*	*Straightforward* • Diagnosis – Minimal 1 • Data – Minimal or None 1 • Risk – Minimal 1 1 stable problem
99213	15	*Exp. Problem Focused* • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 7)* *1997 – (6 checks)*	*Low* • Diagnosis – Limited 2 • Data – Limited 2 • Risk – Low 2 **2 stable problems** **1 unstable problem**
99214	25	*Detailed* • CC • **4 HPI or status of 3 chronic conditions** • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (4-7 – need 4x4)*** *1997 – (12 checks)*	*Moderate* • Diagnosis – Multiple 3 • Data – Moderate 3 • Risk – Moderate 3 **3 stable problems on meds** **1 stable and 1 unstable on meds** **2 unstable problems on meds** **New problem requiring major surg**
99215	40	*Comprehensive* • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive 4 • Data – Extensive 4 • Risk – High 4 Very sick patient with extensive data review and high risk

HPI: [ ] Location [ ] Duration [ ] Severity [ ] Timing [ ] Context [ ] Other Signs and Symptoms [ ] Modifying Factors [ ] Quality
ROS: Constitutional Eyes ENT Lymph Cardio Resp Skin GI GU Musculo Neuro Psych Allergy Endocrine or [ ] All other systems reviewed were negative (10)
Exam: Constitutional Eyes ENT Lymph Cardio Resp Skin GI GU Musculo Neuro Psych

Table of Risk

Risk	Presenting Problems	Diagnostic Procedures Ordered	Management Options Selected
MIN (L-1/2)	• 1 self-limited or minor problem (eg. Cold, insect bite, tinea corporis	• Lab tests requiring venipuncture • EKG/ EEG • Urinalysis • Ultrasound (echocardiography) • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW (L-3)	• 2 or more self-limited or minor problems • 1 stable chronic illness (eg, well controlled hypertension or non-insulin dependent diabetes, cataract, BPH) • Acute uncomplicated illness or injury (eg, cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress (eg, pulmonary function tests) • Non-cardiovascular imaging studies with contrast (eg, barium enema) • Superficial needle biopsies • Clinical lab tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives • *Short-term antibiotics*
MODERATE (L-4)	• 1 or more chronic illnesses w/mild exacerbation, progression or side effects of treatment • 2 or more stable chronic illnesses • Undiagnosed new problem w/ uncertain prognosis (eg, lump in breast) • Acute illness with systemic symptoms (eg, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (eg, head injury w/ brief loss of consciousness)	• Physiologic tests under stress (eg, cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies w/ no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies w/contrast, no identified risk factors (eg, arteriogram, cardiac catheterization) • Obtain fluid from body cavity (eg, lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous, or endoscopic) w/no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation w/o manipulation
HIGH (L-5)	• 1 or more chronic illnesses w/ severe exacerbation, progression, side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function (eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/ potential threat to self or others, peritonitis, acute renal failure • Abrupt change in neurologic status (eg, seizure, TIA, weakness, or sensory loss)	• Cardiovascular imaging studies w/contrast with identified risk factors • Cardiac eletrophysiological tests • Diagnostic endoscopies w/identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) w/identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Calculation of Data Points		Documenting Data Points
1	Review and/or order of clinical lab tests (80000)	To obtain data points, the note must clearly indicate "independent review," "decision to obtain old records," Discussed test with performing physician," "Relevant findings from the review of old records revealed:" – You must be specific.
1	Review and/or order tests in radiology section of CPT (70000)	
1	Review and/or order tests in medicine section of CPT (90000)	
1	Discussion of tests results w/performing physician	
2	Independent review of image, tracing or specimen	
1	Decision to obtain old records/history from someone other than patient	
2	Relevant findings from review of old records	
	Total	

Calculation of Diagnosis Points		High MDM when not High Risk
1	Self-limited – Max of 2	For a level 5 visit on a patient that is not "High Risk" in the office or a level 3 visit in the hospital that is not "High Risk" you need 4 data points and a new problem that requires additional work up.
1	Established Stable	
2	Established Worsening	
3	New - No Workup – Max of 1	
4	New - With Workup	
	Total	

NEW PATIENT HISTORY AND PHYSICAL

NAME _____ DOB _____ DATE _____

WHY ARE YOU HERE TODAY? _____

HISTORY OF ILLNESS - *MUST ANSWER ALL THE FOLLOWING QUESTIONS*

WHERE IS YOUR PROBLEM? _____
WHERE WERE YOU WHEN YOU NOTICED THIS PROBLEM? _____
HOW LONG HAVE YOU HAD THIS PROBLEM? _____
HOW SEVERE IS YOUR PROBLEM? _____
WHAT MAKES IT BETTER OR WORSE? _____

ALLERGIES
CURRENT MEDICATIONS

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
HEART DISEASE	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐	☐
GLAUCOMA	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐
EPILEPSY/CONVULSIONS	☐	☐	☐	☐	☐	☐
BLEEDING DISORDER	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐
THYROID DISEASE	☐	☐	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

DATE	REASON	DATE	REASON

REPRODUCTIVE HISTORY

WOMEN: LMP _____ LAST PAP SMEAR _____
WOMEN ONLY PREGNANT ☐ YES ☐ NO
PLANNING PREGNANCY? ☐ YES ☐ NO
NUMBER OF CHILDREN YOU HAVE HAD? _____
MENSTRUAL DYSFUNCTION ☐ YES ☐ NO

MEN: SEXUAL DYSFUNCTION _____ PENILE DISCHARGE _____
SEXUAL HISTORY/VENERAL DISEASE ☐ YES ☐ NO
PROSTATE DISEASE _____

PAST MEDICAL HISTORY

- ☐ HEADACHE
- ☐ SHORTNESS OF BREATH
- ☐ HEART PALPITATIONS
- ☐ HEART MURMUR
- ☐ CHEST PAIN
- ☐ DIZZINESS/FAINTING
- ☐ PERIPHERAL VASCULAR DISEASE
- ☐ ALLERGIES/HAY FEVER
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ PNEUMONIA
- ☐ ULCER
- ☐ GI DISORDER
- ☐ GALL BLADDER DISEASE
- ☐ DIABETES
- ☐ BOWEL IRREGULARITY
- ☐ VENEREAL DISEASE
- ☐ KIDNEY PROBLEMS
- ☐ HEPATITIS
- ☐ ANEMIA
- ☐ ARTHIRITS
- ☐ NERVOUSNESS
- ☐ DEPRESSION
- ☐ GOUT
- ☐ HYPERTENSION
- ☐ HEART DISEASE
- ☐ CANCER
- ☐ RHEUMATIC/SCARLET FEVER
- ☐ MUMPS
- ☐ MEASLES
- ☐ CHICKEN POX
- ☐ LUNG DISEASE
- ☐ SICKLE CELL FIBROSIS
- ☐ SEIZURES
- ☐ TUBERCULITIS
- ☐ HIV / AIDS
- ☐ BLOOD TRANSFUSION

SOCIAL HISTORY

- ☐ SNUFF: AMOUNT DAILY _____ ☐ SMOKE: AMOUNT DAILY _____
- ☐ EXERCISE ROUTINE _____ ☐ ALCOHOL: TYPE/AMOUNT _____
- ☐ DIET: SALT INTAKE _____ ☐ FAT INTAKE _____
- ☐ CONTACT W BLOOD/BODY FLUID AT WORK _____ ☐ DRUGS _____

Provider's Signature		Date		Provider's Signature		Date	
Provider's Signature		Date		Provider's Signature		Date	

SAMPLE 1995 GUIDELINES

Pt.'s Name **DOB:** **Age:** **Chart #** **Date:**

HT: **In.** **WT:** **TPR:** **/** **/** **BP:** **/** ☐ **NKDA** **Time:**

Complaints:	**Allergies**

☐ **See signed and dated NPI form dated _____ for complete M,F,S Hx**

REVIEW OFSYSTEMS

CHECK indicates normal, X indicates abnormal

	☐ Eyes	☐ **All other systems negative**
☐ Neurological	☐ ENT	☐ Cardiovascular
☐ Psychiatric	☐ GI	☐ Respiratory
☐ GU **LMP:**_____	☐ Endocrine	☐ Musculoskeletal
☐ Hematological	☐ Lymphatic	☐ Dermatological

PHYSICAL EXAM

SYSTEMS	WNL	ABN	**Abnormal Findings**
Constitutional:	☐	☐	
Eyes:	☐	☐	
ENT:	☐	☐	
Lymph / Neck:	☐	☐	
Lungs:	☐	☐	
Cardiovascular:	☐	☐	
Skin/Breast:	☐	☐	
GI / Abdomen:	☐	☐	
GU:	☐	☐	
Musculoskeletal:	☐	☐	
Neurological:	☐	☐	
Psychiatric:	☐	☐	

IMPRESSION / PLAN

☐ Counseling: Total face-to-face time: Total time counseling: (must be greater than 50% of total face-to-face time)

Topics discussed:

☐ CV ASSESSMENT	☐ GERIATRIC ASSESSMENT	☐ FOOT ASSESSMENT	☐ F/U PHARMACY	☐ TOBACCO CESSATION
☐ PMHX REVIEW	☐ PERSONAL HX REVIEW	☐ MEDS REVIEW	☐ F/U	☐ DIET/EXERCISE

Provider's Signature:

E&M	**History**	**Exam**	**MDM**		
99213-15	Cc, HPI-1, ROS	2-7 systems	2 stable problems	1 unstable problem	
99214-25	Cc, 4HPI, ROS-2, Med Hx	4-7 systems (4x4)	3 chronic stable dx (RX)	1 chronic disease (RX) & 1 chronic unstable disease(RX)	2 unstable (RX)
99203-30	Cc, 4HPI, ROS-2, Med Hx	4-7 systems (4x4)	Over the Counter Drugs	Short Term Antibiotics/Meds	Minor Surgery
99204-45	Cc, 4HPI, ROS-10, M, F, S Hx	8 systems	Prescription Drug	Undiagnosed New Problem Uncertain Prognosis	Major Surgery

Sample 1997 Guidelines

Allergies: **[ ] NKDA**

Name: **Age:** **Date:** **Chart #:**

HPI 4: Location, Severity, Duration, Timing, Context, Modifying Factors, Assoc. S/S or Status of 3

ROS: - New Pt = 10 Est. Pt = 2 Check is normal

Status of 3+ Chronic Conditions

1.

[ ] Complaints: [ ] No [ ] Yes
[ ] Compliant with meds

2.

[ ] Complaints: [ ] No [ ] Yes
[ ] Compliant with meds

3.

[ ] Complaints: [ ] No [ ] Yes
[ ] Compliant with meds

4 + HPI

[ ] PMHx, PFHx, PSH Form Dated ____/____/____ has been reviewed.

Pertinent changes: [ ] none

[ ] **Cons**: weight changes, fatigue, fever, chills, sweats.
[ ] **Skin**: rashes, sores, lumps, new changing moles
[ ] **Eyes**: HA, visual changes, pain, itching
[ ] **ENT/Allergic**: hearing loss, vertigo, tinnitus, rhinorrhea, congestion, allergies, epistaxis, hoarseness, sore throat, tooth ache
[ ] **Resp**: SOB, wheezing, cough, hemoptysis
[ ] **CV**: CP, orthopnea, PND, palpit., DoE, angina
[ ] **GI**: Appetite changes, efflux, dysphagia, NVDC bowel habit changes, pain, blood, jaundice
[ ] **GU**: Dysuria, urgency, frequency, hematuria, nocturia, incont., hesitancy, impotence, DUB, DC
[ ] **Musck**: Stiffness, pain, swelling, myalgia
[ ] **Heme**: Easy bruising, bleeding, potochiae
[ ] **Endo**: Polyuria, polydypsia, thyroid problems
[ ] **Neuro**: Weakness, deep sensation, numbness
[ ] **Psych**: Depression, anxiety, suicidal, sleep
[ ]All other systems reviewed Neg.

Physical Examination: 99202, 99213 = 6 99203, 99214 = 12 99204, 99205, 99215 = 2 from 9

Abnormal Findings

Const	[ ] HR _____ BP _____/_____ Temp _____ RR _____ WT _____ [ ] Well developed, well nourished, no acute distress.
Eyes	[ ] Sclera white, conjunctive clear. Lids are without lag. [ ] PERRLA.
ENT	[ ] Tympanic membranes translucent, non-bulging and mobile. Canal walls pink, without discharge. [ ] Mucosa and turbinates pink, septum midline. [ ] Lips pink / symmetric.
Neck	[ ] Full ROM, tracheal midline position. [ ] No thyromegaly.
Resp	[ ] Respiration even and un-labored. [ ] Lung fields - no flatness, dullness or hyperresonance. [ ] Clear/equal no adventitious sounds bilaterally.
Cardio	[ ] No lifts, heaves, or thrills. PMI present. S1 and S2 not exaggerated or diminished. [ ] RRR, w/no murmurs-rubs-gallops. [ ] No edema, no varicosities.
Chest	[ ] Breasts symmetrical. [ ] No lumps, masses, discharge or tenderness.
Abd	[ ] No masses or tenderness. Bowel sounds active x 4 quad. [ ] Liver and spleen are without tenderness or enlargement. [ ] No hernias.
GU / M	[ ] Scrotal, without tenderness, swelling or masses. [ ] Prostate, non-enlarged, symmetrical, without nodularity or tenderness
GU / F	[ ] No external masses, lesions, scars, rashes, or swelling of vulva. [ ] Bladder, non-bulging, non-tender. [ ] Cervix pink and without lesions, odor, or discharge. [ ] Uterus midline, non-tender, firm and smooth. [ ] No internal pelvic masses or tenderness.
Lymph	Areas palpated not enlarged – (2) [ ] Neck [ ] Axillary [ ] Groin [ ] Other_____
Musk	[ ] Gait coordinated and smooth. [ ] Digits are without clubbing or cyanosis.
Skin	[ ] No rashes, lesions or ulcers. No discoloration. [ ] Warm and dry, normal turgor.
Neuro	[ ] Cranial nerves intact. [ ] Deep tendon reflexes 2+ bilaterally.
Psych	[ ] Judgment and insight are within normal limits. [ ] Alert and Oriented X 3.

Data (Labs, EKG, Imaging

Assessment & Plan

Nursing Drugs/Treatments

Counseling: Total time face-to-face with patient: _____ Total time counseling: _____ must be more than 50% of total face-to-face time.

Topics Discussed:

[ ] F/U sooner if worsening, changing, new symptoms, failure to improve, or with questions. [ ] Advised to stop smoking.

[ ] Instructed to use less alcohol. [ ] Instructed to diet / exercise regularly. [ ] Samples issued w/ instructions

RTC: [ ] Days [ ] Weeks [ ] Months [ ] PRN

Provider's Signature:

Today's Date	**NEW PATIENT INFORMATION SHEET**	Single o	Widowed o
Name:	Date of Birth:	Married o	Separated o
Years in High School: Years in College:	Degrees:	Divorced o	
Occupation:	Birthplace:		

HISTORY OF THE PRESENT ILLNESS – Please answer all questions	**ALLERGIES**		
Where is your problem:	Are you allergic to:		
How long have you had this problem:	Penicillin, Sulfa, Antibiotics	o Yes	o No
What makes this better or worse:	Codeine or Morphine	o Yes	o No
How severe is your problem:	Aspirin	o Yes	o No
Any other signs and symptoms:	Insect Bites/Stings	o Yes	o No
When does this bother you more:	Any Foods:	o Yes	o No
What were you doing when you noticed this problem:	Any Medications:	o Yes	o No
Describe any discharge or odor:	List:		

Family History	**Age**	**Relatives Living. Is there health (Good or Poor)**	**Age at Death**	**Cause of Death**
Father				
Mother				
1. Brother/Sister				
2. Brother/Sister				
3. Brother/Sister				
4. Brother/Sister				
Spouse				
1. Son/Daughter				
2. Son/Daughter				
3. Son/Daughter				
4. Son/Daughter				

Has any blood relative or husband or wife ever had:	**Check if yes**	**Relationship if yes**
Allergies	o	
Asthma	o	
Arthritis	o	
Birth Defects	o	
Cancer	o	
Depression/Emotional Prob.	o	
Diabetes	o	
Glaucoma	o	
Heart Trouble	o	
High Blood Pressure	o	
Kidney Trouble	o	
Mental Retardation	o	
Sickle Cell Anemia	o	
Stroke Epilepsy/Seizures	o	
Substance Abuse	o	
Suicide	o	
Tuberculosis	o	

DATE OF YOUR LAST PHYSICAL:		Physician:

HOSPITALIZATIONS: List all, for illness or surgery, beginning with the most recent			
Date	Reason	Hospital	Physician

LIST ANY MEDICATIONS YOU TAKE:	

DIAGNOSTIC TESTING – WHEN WAS YOUR LAST			
Pap Smear:		EKG:	
Mammogram:		Stool Test (blood):	
Cholesterol:		Sigmoidoscopy:	

SOCIAL HISTORY – Answer All Sections	
Weight Now:	Do you use seat belts:
1 Year Ago:	**TOBACCO**
Desired:	Cigarettes: Packs/day:
ALCOHOLIC BEVERAGES	Cigars: Pipe:
Never:	Age started smoking:
Less than 6 drinks/week:	Age stopped smoking:
7-24 drinks/week:	Snuff:
Over 24 drinks/week:	Chewing Tobacco:
Treated for alcoholism?	**DIET**
Treated for drug dependency?	Any special diet:
Outcome of either treatment:	
	EXERCISE
	Type:

REVIEW OF SYSTEMS – Answer all questions

URINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Sexual difficulty	No	Yes
Male – testicle pain	No	Yes
Male – does regular testicle exams	No	Yes
Male – have you had a prostate exam	No	Yes
Female – pain with periods	No	Yes
Female – irregular periods	No	Yes
Female – vaginal discharge	No	Yes
Female – on birth control	No	Yes
Female – vaginal infection in past	No	Yes
Female – have you had abnormal PAP	No	Yes

SKIN

Rash or itching	No	Yes
Do you do regular breast exams	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

CONSTITUTIONAL

Good general health lately	No	Yes
Recent weight change	No	Yes
Headaches	No	Yes

EYES

Wear glasses/contact lens	No	Yes

ENT

Sinus problems	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Chest pains	No	Yes
Sudden heart beat changes	No	Yes
Swelling of feet, ankles or hands	No	Yes

RESPIRATORY

Frequent coughing	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements/constipation	No	Yes
Blood in stool	No	Yes
Stomach pain	No	Yes

ENDOCRINE

Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes

MUSCULOSKELETAL

Joint pain	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes

NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Numbness or tingling sensations	No	Yes

PSYCHIATRIC

Nervousness	No	Yes
Depression	No	Yes
Sleep problems	No	Yes

HEMATOLOGIC/LYMPHATIC

Easily bruise or bleed	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes

OTHER COMMENTS:

IMMUNIZATIONS			**YEAR**
Rubella	Yes	No	
Measles / Mumps	Yes	No	
Tetanus	Yes	No	
Polio	Yes	No	
Diphtheria	Yes	No	
Influenza	Yes	No	
Hemophilius Influenza	Yes	No	
Pneumonia	Yes	No	
Hepatitis	Yes	No	
Current Immunizations	Yes	No	

PREGNANCIES	**ANSWERS**
How many total children	
How many children born alive	
How many stillborn	
How many premature	
How many C-sections	
Haw many miscarriages	
How many abortions	

Patient's Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____

Primary Care Form - 97 Guidelines

PATIENT'S NAME: _____ o **M** o **F / DOB** ___/___/___ **TODAY'S DATE:** ____/____/____

Chief Complaint and HPI Information:	**Problems With Current Meds:** o Yes o No **See Medication Sheet:** o **See NPI Sheet:** o **Drug Allergies:** o Yes o No **Smoker:** o Yes o No **Alcohol:** o Yes o No

Flex/Colon: _____	Stress Test: _____	LMP: _____	Pap Smear: _____	Pelvic: _____
Last Heath Exam: _____	Chest X-ray: _____	DEXA: _____	Occult Blood: _____	Other: _____
Headaches o Yes o No	Blurred Vision o Yes o No	Change/Bowel Habits o Yes o No	SOB o Yes o No	Chest Pain o Yes o No
Insomnia o Yes o No	Swelling o Yes o No	Fatigue o Yes o No	Dizzy Spells o Yes o No	Increased B/P o Yes o No

o Vitals: (3) Wt _____ Ht _____ T _____ R_____ P_____ o Reg o IR BP: Sitting R___/___ L___/____

Examination Detail	*Pertinent Positives and Negatives*
CONST: o Well-developed, well-nourished, no acute distress.	
RESP: o Respiration even and un-labored. o Lung fields – no flatness, dullness or hyperresonance. o Clear /equal no adventitious sounds bilaterally.	
CARD: o RRR, w/no murmurs-rubs-gallops. o No Bruits throughout. o Pedal pulses within normal limits bilat.	
Female G/U: (7 of the following 11) o Breasts symmetrical. No masses, lumps, tenderness, dimpling or nipple discharge. o Rectal exam exhibits even sphincter tone, no hemorrhoids or masses. **Pelvic** o No external lesions. Normal hair distribution. o Urethral meatus pink, no lesions or discharge. o Urethra intact, no tenderness, masses, inflammation or discharge. o Bladder without tenderness or masses, no incontinence. o Vaginal mucosa moist and pink, without lesions or discharge. o Cervix pink, no lesions, odor, or discharge. o Uterus midline, non-tender, firm and smooth. o No adnexal masses, nodules or tenderness. o Anus and perineum intact. ___ No lesions, rashes, fissures, fistulas or external hemorrhoids. Wet Prep _____ Hemoccult **Pos. Neg.**	
ABDOMEN: o No masses, no tenderness, bowel sounds active X 4 quad. o Liver and spleen are without tenderness or enlargement.	
GI/GU: o Prostate (normal) o Rectal (normal) o Genitalia (normal)	
MUSCULO: o Joints with full ROM, no pain, crepitus or contracture. o No muscle atrophy/weakness.	
NEURO/PSYCH: o Alert and oriented X 3. o No mood disorders noted, calm affect.	
SKIN: o No rashes, lesions or ulcers. o Warm and dry, normal tugor.	

Assessment / Plan:

F/U: _____ o Days o Weeks o Months o Years oPRN

o Counseling: Total Face to Face Time: _____ minutes / Total Time Counseling: _____ minutes. ***(Must be>Than 50% of Total Face to Face Time)***

Topics Discussed:

99201 (10m), 99212 (10m)= 1chk 99202(20m), 99213 (15m) = 6 chks 99203 (30m), 99214 (25m) = 12chks 99204(45m), 99205(60m) , 99215 (40m) = 2 chks from 9 area

Welcome to Medicare (G0402)

1) Review medical and social history.
2) Review risk factors for depression and mood disorders.
3) Review functional ability and level of safety.
4) Height, Weight, BP, VA, BMI.
5) End-of-life planning, if needed.
6) Education, counseling and referrals based on above.
7) Education, counseling, and referrals for other listed services.

Initial AWV (G0438)

1) Health Risk Assessment
2) Establishment of an individual's medical and family history.
3) Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.
4) Measurement of an individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements as deemed appropriate, based on the individual's medical and family history.
5) Detection of any cognitive impairment that the individual may have.
6) Review of the individual's potential (risk factors) for depression,
7) Review of the individual's functional ability and level of safety, based on direct observation
8) Establishment of the following:
   -A written screening schedule, such as a checklist, for the next 5 to 10 years
   -A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended.
9) Furnishing of personalized health advice to the individual and a referral, as appropriate.
10) Any other element determined appropriate through the National Coverage Determination process.

Subsequent AWV (G0439)

1) Health Risk Assessment
2) An update of the individual's medical and family history.
3) An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing personalized prevention plan services.
4) Measurement of an individual's weight (or waist circumference), blood pressure, and other routine measurements as deemed appropriate, based on the individual's medical and family history.
5) Detection of any cognitive impairment, as that term is defined in this section, that the individual may have.
6) An update to both of the following:
   -The written screening schedule for the individual as that schedule was developed at the first AWV providing personalized prevention plan services. CMS-1503-FC 761
   -The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual as that list was developed at the first AWV providing personalized prevention plan services.
7) Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs as that advice and related services are defined in paragraph (a) of this section.
8) Any other element determined through the NCD process.

Outpatient Consult Converter			
Commercial	Medicare Office or Observation		Medicare ER
Code	New	Established	ER
99241	99201	99212	99281
99242	99202	99212	99282
99243	99203	99213	99283
99244	99204	99214	99284
99245	99205	99215	99285

*ONLY IF DETAILED HX/EXAM IS DOCUMENTED

Inpatient Consult Converter		
Commercial	Medicare	Nursing Home
Code	Code	Code
99251	99221*	99304*
99252	99221*	99304*
99253	99221	99304
99254	99222	99305
99255	99223	99306

Evaluation & Management Coding Summary – Hospital Services

Code	Minutes	History	Examination	Decision-Making
Initial Hospital Visits 3 out of 3				
99221	30	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (2-7 – need 4x4)*** *1997 – (12 checks)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99222	50	Comprehensive • CC • 4 HPI or status of 3 chronic conditions 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99223	70	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Subsequent Hospital Visits 2 out of 3				
99231	15	Problem Focused • CC • 1HPI	*Problem Focused* *1995 –(1)* *1997 – (1 check)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99232	25	Exp. Problem Focused • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 7)* *1997 – (6 checks)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99233	35	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (4-7 – need 4x4)*** *1997 – (12 checks)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Hospital Discharge				
99238	30	Hospital Discharge		
99239	> 30	Hospital Discharge > 30 minutes – **{Must document time}**		

Definitions	
99221	Admission – Low Risk
99222	Admission – Moderate Risk
99223	Admission – High Risk
99231	Patient is responding well
99232	Pt is responding inadequately to therapy / developed a minor complication
99233	Pt is unstable or has developed a significant complication / significant new problem

HPI: [ ] Location [ ] Duration [ ] Severity [ ] Timing [ ] Context [ ] Other Signs and Symptoms [ ] Modifying Factors [ ] Quality
ROS: Constitutional Eyes ENT Lymph Cardio Resp Skin GI GU Musculo Neuro Psych Allergy Endocrine or [ ] All other systems reviewed were negative (10)
Exam: Constitutional Eyes ENT Lymph Cardio Resp Skin GI GU Musculo Neuro Psych

Inpatient Tracking Form

PATIENT NAME:	DATE OF ADMISSION:	DATE OF BIRTH:
ADMITTING PHYSICIAN:		

DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:
DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:
DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:	DOS: MD: CODE(S): DX:

		DISCHARGE DX:	
18	INITIAL OBS STRGHT/LOW RISK	51	HOSPITAL CONSULT - STRGHT RISK
19	INITIAL OBS MODERATE RISK	52	HOSPITAL CONSULT - STRGHT RISK
20	INITIAL OBS HIGH RISK	53	HOSPITAL CONSULT - LOW RISK
24	SUB OBS – RESPONDING	54	HOSPITAL CONSULT – MODERATE RISK
25	SUB OBS – MINOR COMPLICATION	55	HOSPITAL CONSULT - HIGH RISK
26	SUB OBS – SIGNIFICANT PROBLEM/COMPLICATION	**CRITICAL CARE SERVICES – ALL AGES**	
17	OBS DISCHARGE DAY MGMT	91	CRITICAL CARE 30-74 MONTHS
34	OBS/ADMIT & DISCH. SAME DAY S/L RISK	91/92	CRITICAL CARE 75-104 MINUTES
35	OBS/ADMIT & DISCH. SAME DAY MOD RISK	92950	CPR
36	OBS/ADMIT & DISCH. SAME DAY HIGH RISK	93	INITIAL PEDIATRIC CC – AGE 29 DAYS – 24 MNTHS
21	ADMIT STRAIGHTFORWARD/LOW RISK	94	SUBQ PEDIATRIC CC – AGE 29 DAYS – 24 MNTHS
22	ADMIT MODERATE RISK	95	INITIAL NEONATAL CC - AGE 28 DAYS OR LESS
23	ADMIT HIGH RISK	96	SUBQ NEONATAL CC - AGE 28 DAYS OR LESS
31	F/U HSPT – RESPONDING	98	SUBQ CARE RECOVERING INF. < 1500 GRAMS
32	F/U HSPT – MINOR COMPLICATION	99	SUBQ CARE RECOVERING INF. 1500-2500 GRAMS
33	F/U HSPT – SIGNIFICANT PROBLEM/COMPLICATION	00	SUBQ CARE RECOVERING INF. 2501-5000 GRAMS
38	DISCHARGE < 30 MINUTES		
39	DISCHARGE > 30 MINUTES		

In-Patient Form

Date / Time:				
o Patient w/o complaints: o Patient with complaints & is being seen for:				
Headaches o Yes o No	Blurred Vision o Yes o No	Change in Bowel Hbts o Yes o No	SOB o Yes o No	Chest Pain o Yes o No
Spotting o Yes o No	Swelling o Yes o No	Fatigue o Yes o No	Dizzy Spells o Yes o No	Increased B/P o Yes o No
o Vitals: (3) T:	Respirations:	Pulse: o Reg o IR	BP: R / L /	02 Sat: I & O:

Examination Detail	*Pertinent Positives and Negatives*
CONST: o Well-developed, well-nourished, no acute distress.	
ENT: o Tympanic membranes translucent, non-bulging and mobile. Canal walls pink, without discharge. o Mucosa and turbinates pink, septum midline. o Oral mucosa pink and moist. Tongue moist, without ulcers.	
NECK: o Full ROM, tracheal midline position. o No thyromegaly.	
CHEST: ❑ Breasts symmetrical. ❑ No lumps, masses, discharge or tenderness.	
RESP: o Respiration even and un-labored. o Lung fields – no flatness, dullness or hyperresonance. o Clear /equal no adventitious sounds bilaterally.	
CARD: ❑ No lifts, heaves, or thrills. PMI present. S1 and S2 not exaggerated or diminished. ❑ RRR, w/no murmurs-rubs-gallops.	
ABDOMEN: o No masses, no tenderness, bowel sounds active X 4 quad. o Liver and spleen are without tenderness or enlargement.	
MALE GU: o Scrotal, without tenderness, swelling or masses. o Prostate, non-enlarged, symmetrical, without nodularity or tenderness.	
FEMALE GU: o No external masses, lesions, scars, rashes, or swelling of vulva. o Labia, clitoris, vaginal orifice, and urethral meatus intact without discharge. o Bladder, non-bulging, non-tender. o Cervix pink and without lesions, odor, or discharge. o Uterus midline, non-tender, firm and smooth. o No internal pelvic masses or tenderness.	
MUSCULO: o Gait coordinated and smooth. o Digits are without clubbing or cyanosis.	
SKIN: o No rashes, lesions or ulcers. o Warm and dry, normal turgor.	
NEURO: o Cranial nerves intact. o Deep tendon reflexes 2+ bilaterally.	
PSYCH: o A+O X 3. o No mood disorders noted, calm affect.	

Labs Ordered / Reviewed:	o Decision to obtain old records/history from someone other than patient.	o Discussion of tests results w/performing physician
	o Review/summarize information from above.	o Independent review of image, tracing or specimen

Assessment / Plan / Problems Addressed This Visit:	**New 3,4 points**	**Worse 2 points**	**Stable 1 points**
	o	o	o
	o	o	o
	o	o	o
	o	o	o
	o	o	o

o **Counseling: Unit/Floor Time: _____ minutes / Total Time Counseling: _____ minutes.** ***(Must be > Than 50% of Total Unit / Floor Time)***

Topics Discussed:

99231 (15m)	Patient is responding well	1 exam check / 2 dx points & low risk
99232 (25m)	Pt is responding inadequately to therapy / developed a minor complication	6 exam checks / 3 dx points & moderate risk
99233 (35m)	Pt is unstable or has developed a significant complication / significant problem	12 checks / 4 dx points & high risk

Evaluation & Management Coding Summary – Observation / Admission

Code	Minutes	History	Examination	Decision-Making
Observation/Hospital Discharge Same Day - 3 out of 3				
99234	40	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (4-7 – need 4x4)*** *1997 – (12 checks)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99235	50	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99236	55	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Observation - 3 out of 3 (first day of a multiple day observation service)				
99218	30	Detailed / Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (4-7 – need 4x4)*** *1997 – (12 checks)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99219	50	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99220	70	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or* *1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Subsequent Observation Care Visits - 2 out of 3 (day(s) after first till day before discharge)				
99224	15	Problem Focused • CC • 1HPI	*Problem Focused* *1995 –(1)* *1997 – (1 check)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99225	25	Exp. Problem Focused • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 7)* *1997 – (6 checks)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99226	35	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (4-7 – need 4x4)*** *1997 – (12 checks)*	*High* • Diagnosis – Extensive • Data – Extensive • Risk – High
Observation Discharge (final day of observation)				
99217	N/A	Observation care discharge on date other than initial observation day		

Evaluation & Management Coding Summary – Emergency Department Services

Emergency Department Services 3 of 3				
99281	N/A	*Problem Focused* • CC • 1HPI	*Problem Focused* *1995 –(1)* *1997 – (1 check)*	*Straightforward* • Diagnosis – Minimal 1 • Data – Minimal or None 1 • Risk – Minimal 1
99282	N/A	*Exp. Problem Focused* • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 7)* *1997 – (6 checks)*	*Low* • Diagnosis – Limited 2 • Data – Limited 2 • Risk – Low 2
99283	N/A	*Exp. Problem Focused* • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 7)* *1997 – (6 checks)*	*Moderate* • Diagnosis – Multiple 3 • Data – Moderate 3 • Risk – Moderate 3 The presenting problem(s) are of moderate severity
99284	N/A	*Detailed* • CC • **4 HPI or status of 3 chronic conditions** • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (4-7 – need 4x4)*** *1997 – (12 checks)*	*Moderate* • Diagnosis – Multiple 3 • Data – Moderate 3 • Risk – Moderate 3 The presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function
99285	N/A	*Comprehensive* • CC • 4 HPI or status of 3 chronic conditions 10 ROS • Medical, Family, Social History	*Comprehensive* *1995 – (8)* *1997 – (2 checks from 9 areas); or 1997(all checks in border & 1 check in others)*	*High* • Diagnosis – Extensive 4 • Data – Extensive 4 • Risk – High 4 The presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function

Critical Care Services	
Less than 30 minutes	Appropriate E/M Code
30-74 minutes	99291 x 1
75-104 minutes	99291 x 1 and 99292 x 1
105-134 minutes	99291 x 1 and 99292 x 2
135-164 minutes	99291 x 1 and 99292 x 3
165-194 minutes	99291 x 1 and 99292 x 4
195-224 minutes	**99291 x 1 abd 99292 x 5**

Provision of Critical Care Services

This is a *47 y/o white m* with *severe sepsis*. For the record I spent *60 minutes* in constant attention with this *critically ill / injured patient*. The high probability of sudden, clinically significant deterioration in the patient's condition required the highest level of my preparedness to intervene urgently. I provided critical care services requiring my direct and personal management as noted below:

Evaluation & Management Coding Summary – Preventive Medicine

Preventive Medicine Service		
Code	Age	**Preventive Medicine Services – New Patient**
99381	Under 1	If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this E&M service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier "-25" should be added to the Office/Outpatient code to indicate that a significant, separately identifiable E&M service was provided.
99382	1-4	
99383	5-11	
99384	12-17	
99385	18-39	
99386	40-64	
99387	Over 65	
Code	Age	**Preventive Medicine Services – Established**
99391	Under 1	If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this E&M service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier "-25" should be added to the Office/Outpatient code to indicate that a significant, separately identifiable E&M service was provided.
99392	1-4	
99393	5-11	
99394	12-17	
99395	18-39	
99396	40-64	
99397	Over 65	
Code	Minutes	**Counseling and/or Risk Factor Reduction Intervention**
99401	15	Individual – Don't bill with Preventive Medicine Codes
99402	30	Individual – Don't bill with Preventive Medicine Codes
99403	45	Individual – Don't bill with Preventive Medicine Codes
99404	60	Individual – Don't bill with Preventive Medicine Codes
99420	30	Group – Don't bill with Preventive Medicine Codes
99429	60	Group – Don't bill with Preventive Medicine Codes

CONFIDENTIAL INFORMATION
(This information will NEVER be released from this office)

OBSTETRIC INFORMATION
List all abortions, miscarriages, tubal pregnancies:

Date	Weeks	Abortion or miscarriage	Complications

Other pregnancies

Date	Months Pregnant	Sex of Infant	Alive or Stillborn	Living Now	Weight at Birth	Complications

CERVICAL CANCER HIGH RISK SURVEY
Was your first sexual activity prior to the age of 16? o Yes o No
Have you had more than 5 sexual partners? o Yes o No
Do you have a history of sexually transmitted disease (including HIV) infection? o Yes o No
Have you had fewer than 3 negative pap smears within the previous seven years? o Yes o No

Annual Physical Grid									
YEAR	2____	2____	2____	2____	2____	2____	2____	2____	2____
Routine PE (non-covered)	99___	99___	99___	99___	99___	99___	99___	99___	99___
E&M Visit									
Breast & Pelvic (2 yrs.) G0101									
Pap Smear (2 yrs.) Q0091									

Frequency can increase for patients deemed "high risk." Please see individual policy regarding more frequent coverage.

HCPCS/ICD-9 Codes to Use for Preventive Services

G0101 Pelvic and Breast Examination	V72.31	Once every two years	Routine gynecological exam
	V76.47	Once every two years	Screening for neoplasm of the vagina
	V76.49	Once every two years	Screening of woman without a cervix
	V76.2	Once every two years	Screening for neoplasm of cervix
	V15.89*	**Once every year**	Presenting health hazards
82270 screening (guaiac-based) or G0328 (immunoassay-based) Card sent home with patient	V76.51	**One every year**	Screening for neoplasm of colon
Q0091 Obtain Pap Smear	V72.31	Once every two years	Routine gynecological exam
	V76.47	Once every two years	Screening for neoplasm of the vagina
	V76.49	Once every two years	Screening of woman without a cervix
	V76.2	Once every two years	Screening for neoplasm of cervix
	V15.89*	**Once every year**	Presenting health hazards

***See coverage guidelines below for V15.89**

A screening pelvic examination should include at least seven of the following elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;
- Pelvic examination (with or without specimen collection for smears and cultures) including:
    - External genitalia (for example, general appearance, hair distribution, or lesions);
    - Urethra (for example, masses, tenderness, or scarring);
    - Bladder (for example, fullness, masses, tenderness);
    - Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
    - Cervix (for example, general appearance, lesions or discharge);
    - Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
    - Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); and
    - Anus and perineum.

Coverage and Payment

Screenings are covered when ordered and collected by a doctor of medicine or osteopathy or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under state law to perform the examination) under one of the following conditions:

- The beneficiary has not had a screening pap smear test during the preceding two years (use ICD-9 code **V76.2**, special screening for malignant neoplasm, cervical), or

- There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding three years, or that she is at high risk of developing cervical or vaginal cancer (use ICD-9 code **V15.89**, other specified personal history presenting hazards to health). The high risk factors for cervical and vaginal cancer are:

    1. Cervical Cancer High Risk Factors:
        - Early onset of sexual activity (under 16 years of age)
        - Multiple sexual partners (five or more in a lifetime)
        - History of a sexually transmitted disease (including HIV infection)
        - Fewer than three negative Pap smears within the previous seven years

    2. Vaginal Cancer High Risk Factors:
        - DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

Screening fecal-occult blood test (82270) is covered at a frequency of once every 12 months for beneficiaries who have attained age 50 (i.e., at least 11 months have passed following the month in which the last covered screening fecal-occult blood test was done). Screening fecal-occult blood tests mean a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. *This screening requires a written order from the beneficiary's attending physician. The term "attending physician" is defined to mean a doctor of medicine or osteopathy, who is fully knowledgeable about the beneficiary's medical condition and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.*

Home Health Plan of Care Coding Worksheet

_____

(Month)

G0180 – Initial services. Use when patient *has not received Medicare-covered home health services for at least 60 days*.

G0179 – Recertification services. *Use this after a patient has received services for at least 60 days* when the physician signs the certification after the initial certification period.

Patient Name	DOB	Date of Initial Certification	Date of Recertification Services	G0180 (Initial)	G0179 (Recertification)

Care Plan Oversight

o G0181 – Home Health Agency – Greater than 30 Minutes
Name of Home Health Agency:_____

o G0182 – Hospice Care – Greater than 30 Minutes
Name of Hospice Agency:_____

Patient Name: _____

Date (month/day/year)													**Total Time**
Development of Care													
Revision to Care Plan													
Review of Patient Reports													
Lab Reviews													
Diagnostic Test Reviews													
Communication with Other Health Care Professionals													
Integration of New Information into Treatment Plan													
Adjustment of Medial Therapy													
Total Time													

Physician Signature: _____

Form must be signed by physician!

Patient's Name: _____ **Code:** [ ] 99495 – Moderate MDM

Date of Discharge: _____/_____/_____ [ ] 99496 – High MDM

Patient is discharged from:

[ ] Acute hospital

[ ] Rehabilitation hospital

[ ] Long-term acute care hospital

[ ] Partial hospital

[ ] Observation status in a hospital

[ ] Skilled nursing facility

[ ] Nursing facility

Patient discharged to:

[ ] Patient's home

[ ] Domiciliary

[ ] Rest home or assisted living

[ ] Assisted living

Non-face-to-face services provided by clinical staff, under the direction of the physician or NPP:

Name of clinical staff individual making contact: _____

Date of initial telephone contact: _____/_____/_____ (Must be within two business days of discharge)

Name of individual you spoke with and relationship to patient if other than patient:
_____

Name of agency you spoke to if not with patient:
_____

Medication reconciliation and management must occur no later than the date of the face-to-face visit.

Current medications as below:

_____

_____

_____

Patient/family/caretaker education to support self-management, independent living, and activities of daily living:

_____

_____

Assessment and support for treatment regimen adherence and medication management:

_____

_____

Identification of available community and health resources:

_____

_____

Facilitating access to care and services needed by the patient and/or family:

_____

_____

Non-face-to-face services provided by the physician, NP or PA:

Obtaining, reviewing and findings to be communicated from the discharge summary:

_____

Reviewing need for or follow-up on pending diagnostic tests and treatments:

_____

Interaction with other qualified health care professionals who will assume care of the patient's problems:

_____

Education of patient, family, guardian, and/or caregiver:

_____

Establishment or reestablishment of referrals and arranging for needed community resources:

_____

Office Visit Occurred within:

99495 – 14 days and Moderate MDM

99496 – 7 days and High MDM

Provider's Signature: _____ Date: ____/____/_____

Top Sugery Codes and Global Periods

CPT	PROCEDURE	GLOBAL
10060	DRAINAGE OF SKIN ABSCESS	10
11055	PARING OR CUTTING OF LESIONS	0
11100	BIOPSY OF SKIN LESION	0
11200	REMOVAL OF SKIN TAGS	10
11400	REMOVAL OF SKIN LESION	10
11750	REMOVAL OF NAIL BED	10
12031	INTERMEDIATE REPAIR/CLOSURE	10
16000	TREAT 1ST DEGREE BURN	0
17000	DESTROY BENIGN/PREMAL LESION	10
17110	DESTRUCTION OF FLAT WARTS	10
17340	CRYOTHERAPY OF SKIN	10
20550	INJECTION TENDON SHEATH	0
20610	DRAIN/INJECT JOINT/BURSA	0
45330	SIGMOIDOSCOPY, DIAGNOSTIC	0
55250	VASECTOMY	90
57410	PELVIC EXAMINATION UNDER ANESTH.	0
57452	COLPOSCOPY OF CERVIX	0
57454	COLPOSCOPY OF CERVIX / BIOPSY	0
57505	ENDOCERVICAL CURETTAGE	10
58100	BIOPSY OF UTERUS LINING	0
59025	FETAL NON-STRESS TEST	0
69210	REMOVE IMPACTED EAR WAX	0

CPT	PROCEDURE	GLOBAL
59025	FETAL NON-STRESS TEST	0
59400	OBSTETRICAL CARE	0
76827	ECHO EXAM OF FETAL HEART	0
88150	CYTOPATHOLOGY, PAP SMEAR	0
76805	ECHO EXAM OF PREGNANT UTERUS	0
76815	ECHO EXAM OF PREGNANT UTERUS	0
81002	URINALYSIS NONAUTO W/O SCOPE	0
81000	URINALYSIS, NONAUTO, W/SCOPE	0
59425	ANTEPARTUM CARE ONLY	0
57410	PELVIC EXAMINATION	0
88156	TBS SMEAR (BETHESDA SYSTEM)	0
59426	ANTEPARTUM CARE ONLY	0
87210	SMEAR, STAIN & INTERPRET	0
87110	CULTURE, CHLAMYDIA	0
80055	OBSTETRIC PANEL	0
76700	ECHO EXAM OF ABDOMEN	0
76830	ECHO EXAM, TRANSVAGINAL	0
76816	ECHO EXAM FOLLOWUP OR REPEAT	0
81003	URINALYSIS, AUTO, W/O SCOPE	0
87070	CULTURE SPECIMEN, BACTERIA	0
81025	URINE PREGNANCY TEST	0

2013 Modifiers

Surgery Only

22
23
26
47
50 – bilateral
51
52
53
54
55
56
58 - staged
59 - separate
62
63
66
73
74
76
77
78 - related
79 - unrelated
80
81
82

E&M MODIFIERS ONLY

24 – unrelated E/M
25 – minor (same day)
57 – major (day of or day before)

E&M Credit Cards

NEW PATIENT VISITS (3 OF 3)		
New Patient - History	**Exam**	**MDM**
99203 or 99243	**'97-12 checks**	**Low**
Cc, 4 HPI, 2 ROS, M Hx	**'95-4-7 (4x4)**	
99204 or 99244	'97-2 from 9	**Moderate**
Cc, 4 HPI, 10 ROS, M, F, S Hx	'95-8 OS	
99205 or 99245	**'97-2 from 9**	**High**
Cc, 4 HPI, 10 ROS, M, F, S Hx	**95-8 OS**	
ESTABLISHED VISITS (2 OF 3 – MDM Should be 1 of the 2)		
Follow-Up Patient History	**Exam**	**MDM**
99213 can also be billed on time – 15 min	**'97-6 checks**	**Low**
Cc, 1 HPI, 1 ROS	**'95-2-7**	
99214 can also be billed on time – 25 min	'97-12 checks	**Moderate**
Cc, 4 HPI (***status of 3***), 2 ROS, Meds	'95-4-7 (4x4)	
99215 can also be billed on time – 40 min	**'97-2 from 9**	**High**
Cc, 4 HPI, (*status of 3)* 10 ROS, M, F, S Hx	**'95-8 OS**	

E/M BILLING TIPS

E/M ONLY MODIFIERS
24 – Unrelated E/M in global period
25 – Separately Identifiable E/M service same day as minor surgery
57 – E/M day before or day of major surgery

EXAM - (8): CONST, EYE, ENT, CV, RESP, LYMPH, MUSK, GI, GU, SKIN, NEURO, PSYCH. L = limited and D = detailed
4x4: Document four relevant findings regarding 4 parts of the body.
ROS - (10): "all other systems reviewed negative"
Counseling: I spent _____ min. face to face. Greater than 50% of that time was counseling regarding the following: (list topics discussed)

EXTRA CMS CODING – 25 on E/M
G0372 – Scooter Rx
G0101 – Pelvic and Breast Exam (CMS)
Q0091 – Obtain Pap (CMS)
G0402/G0403 – Welcome to Medicare (CMS)
G0438 – Initial AWV
G0439 – Subsequent AWV
99406: 3-10 minutes of Tobacco Cessation Counseling
99407: > 10 minutes of Tobacco Cessation Counseling

DETAILED HISTORY:
CC: Patient here today for follow-up of multiple complex conditions:

STATUS OF CHRONIC CONDITIONS
HTN – Stable on current meds
DM – Stable on current meds
OA – Stable on current meds

ROS:
CV: Denies chest pain or discomfort
Resp: Deines SOB

SOCIAL HISTORY
Patient continues to smoke

Constitutional	[ ] Vital signs listed above. [ ] Well developed, well nourished and in no acute distress. [ ] Alert and oriented X's 3. [ ] No mood disorders noted, calm affect.
Eyes	[ ] Sclera white, conjunctiva clear. [ ] Lids are without lag. [ ] PERRLA. [ ] Pupils and irises are equal and round without defect.
ENMT	[ ] TMs intact and clear, normal canals, grossly normal hearing. [ ] Gums pink, good dentition. [ ] Oropharanx clear and moist without erythema. [ ] Full range of motion
Respiratory	[ ] Chest symmetrical, respirations non-labored. [ ] No dullness or flatness. [ ] Clear bilaterally to auscultation. [ ] Non-tender to palpitation.
Cardiovascular	[ ] No lifts, heaves, or thrills felt on palpation. S1and S2. [ ] Regular Rate and Rhythm w/o murmurs, rubs or gallops. [ ] Pedal pulses +2 throughout. [ ] No peripheral edema.
Gastrointestinal	[ ] Soft, non-tender, non-distended, [ ] No hepatosplemomegaly. [ ] Normal bowel sounds. [ ] No masses noted.
Skin	[ ] Normal temperature. [ ] Normal tone and turgor. [ ] No rashes, lesions, or ulcers. [ ] Warm and dry to touch.
Musculoskeletal	[ ] No digital cyanosis or ischemia. [ ] Normal strength and tone all extremities. [ ] No atrophy or weakness. [ ] Joints with full range of motion. [ ] No misalignment, defects, or deformities
Neurological	[ ] Recent and remote memory intact. [ ] Cranial nerves II-XII grossly intact with normal sensation, reflexes, coordination, muscle strength and tone. [ ] Speech smooth and clear. [ ] Aware of current events