Doing It Right The First Time

A documentation and coding workshop

Presented by

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MAG Mutual Healthcare Solutions, Inc.
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Consulting, Publications and Seminars for the Medical Profession

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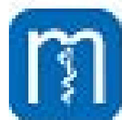

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NEW PATIENT SERVICES	
Straightforward or 10 min. counseling	99201
Straightforward or 20 min. counseling	99202
Low or 30 min. counseling	99203
Moderate or 45 min. counseling	99204
High or 60 min. counseling	99205

ESTABLISHED PATIENT SERVICES	
Non MD Visit	99211
Straightforward or 10 min. counseling	99212
Low or 15 min. counseling	99213
Moderate or 25 min. counseling	99214
High or 40 min. counseling	99215

CONSULTATION SERVICES	
Straightforward or 15 min. counseling	99241
Straightforward or 30 min. counseling	99242
Low or 40 min. counseling	99243
Moderate or 60 min. counseling	99244
High or 80 min. counseling	99245

NEW / EST PT PHYSICAL & EPSDT		
< 1 y	99381	99391
1-4 y	99382	99392
5-11y	99383	99393
12-17y	99384	99394
18-39y	99385	99395
40-64y	99386	99396
> 65y	99387	99397

SCREENING CODES	
Power Mobility Rx	**G0372**
Home Health Certification	**G0180**
Home Health Re-certification	**G0179**
IPPE Exam	**G0402**
IPPE Exam EKG	**G0403**
Breast / Pelvic	**G0101**
Obtain Pap	**Q0091**
Digital Rectal Exam	**G0102**
Occult Blood – triple card	**82270**
Tobacco Counseling 3-10 min.	**99406**
Tobacco Counseling > 10 min.	**99407**

MEDICAID SCREENING SERVICES	
Hearing Screening	92551
Obtain Pap	Q0091M
Vision Screening	99173

INJECTIONS	
Arthrocentesis - small joint	20600
Arthrocentesis - medium joint	20605
Arthrocentesis - large	20610
Carpal tunnel injection	20526
Trigger point – 1 or 2 muscles	20552
Trigger point – 1 ten origin	20551
Trigger point – 1 ten/lig	20550
Trigger point – 3 or > muscles	20553

RADIOLOGY	
Abdomen – 1 View	74000
Abdomen – 2 Views	74020
Ankle – 2 views	73600
Cervical Spine – 2 or 3 Views	72040
Chest – 1 View	71010
Chest – 2 Views	71020
Clavicle – Complete	73000
Coccyx/Sacrum – 2 views	72220
Elbow	73070
Femur - 2 Views	73550
Finger – Minimum 2 Views	73140
Foot - 2 Views	73620
Hand - 2 Views	73120
Hip - 2 Views	73510
Humerus - 2 views	73060
Knee –1 or 2 Views	73560
Lumbosacral Spine - 2-3 Views	72100
Nasal – 3 Views	70160
Radius and Ulna – 2 Views	73090
Ribs, Unilateral - 2 Views	71100
Shoulder - 2 Views	73030
Sinus - < 3 Views	70210
Sinus - 3 Views	70220
Skull - < 4 Views	70250
Thoracic Spine – 2 Views	72070
Tibia & Fibia - 2 Views	73590
Toe – 2 Views	73660
Wrist - 2 Views	73100

MEDICATIONS	
Admin. Therapeutic/Antibiotic	**96372**
IV; Hydration first hour	**96360**
each additional hour ___	**96361**
Ancef 500 mg	J0690
B-12 up to 1000 mcg	J3420
Bicillin 0.6 million	J0530
Bicillin CR 1.2 units	J0540
Celestone 3 mg	J0702
Decadron 1 mg	J1100
Depo Medrol 40 mg	J1030
Depo-Medrol 80 mg	J1040
Depo-Provera (**BC only**) 150 mg	J1055
Depo-Provera 50 mg	J1051
Depo-Testosterone 100 mg	J1070
Gentamicin 80 mg	J1580
Kenalog per 10 mg	J3301
Lincocin up to 300 mg	J2010
Phenergan up to 50 mg	J2550
Rocephin 250 mg x _______	J0696
Saline, normal 1000 cc	J7030
Supartz (MCR Q4083)	J7319
Toradol per 15 mg	J1885

LABORATORY	
Finger Stick	**36416**
Venipuncture	**36415**
B-12	82607
BMP	80048
BUN	84520
Calcium	82565
Carbon Dioxide	82374
CBC w auto differential	85025
CBC w/o auto differential	85027
Chloride	82435
CMP	80053
CPK	82550
Creatinine	82565
Flu A&B	87804
GGT	82977
Glucose - FDA device	82962
Glucose, w/o regent strip	82947
Glucose, regent strip	82948
Hepatic Function Panel	80076
Hgb	85018
HgbA1C	83036
HgbA1C – FDA device	83037
Influenza	87804
KOH	87220
Lipid Panel	80061
Liver Panel	80076
Micro albumin	82043
Occult Blood – Single Card	82272
Occult Blood – Triple Card	82270
Pap Smear	88142
Potassium	84132
Pregnancy, urine	85025
PSA	84153
PT / INR	85610
Renal Panel	80069
Sed Rate	85651
Sodium	84295
Strep A	87880
Strep culture	87081
Strep, rapid	86403
T4, free	84439
TB, Intradermal	86580
Thyroxine, total	84436
TSH	84443
U/A auto w/o scope	81003
U/A auto w/scope	81001
U/A non-auto w/o micro	81002
U/A non-auto w/scope	81000
Urine colony count	87086
Urine Culture	87088
Wet Mount	87210

OFFICE PROCEDURES	
EKG	93000
Audiometry	92551
Cerumen Removal	69210
Hearing Screening	92551
Nebulizer	94640
- Duo Neb	J7620
Nebulizer demonstration	94664
Spirometry – Pre/Post	94060
Spirometry – Single	94010
Tympanometry	92567

FOREIGN BODY REMOVAL	
FB removal – ear	69200
FB removal – eye, cornea	65220
FB removal – eye, embedded	65210
FB removal – eye, superficial	65205
FB removal – nose	30300
FB removal - skin, simple	10120

SKIN PROCEDURES	
Biopsy	11100
Biopsy, each additional x ___	11101
Destroy pre-malignant lesion	17000
Destroy Pre-mal les, 2-14 each ___	17003
Skin tag removal 1-15	11200

VACCINES	
Admin <8 w/counsel, injection	**90465**
Each additional vac: _______	**90466**
Admin <8 w/counsel, nasal/oral	**90467**
Each additional vac: _______	**90468**
Admin any age, injection	**90471**
Each additional vac: _______	**90472**
DT < 7	90702
DTP	90701
DtaP < 7	90700
Flu – 3 and > (G0008 MCR)	90658
Flu 6-35 months	90657
Hepatitis – adult (G0010 MCR)	90746
Hepatitis – child	90744
HIB – PRP-T – 4 dose	90648
HIB HbOC – 4 dose	90645
HIB – PRP-OMP – 3 dose	90647
HPV	90650
IPV	90713
Meningococcal	90734
MMR	90707
Pediarix	90723
Pneumonia – adult (G0009 MCR)	90732
Prevnar	90669
Proquad	90710
Rota Teq - Oral	90680
TD > 7	90718
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-rx generated**	**G8443**
Anxiety	300.00	Dizzy / Vertigo	780.4	Malaise and Fatigue	780.79	**E-rx not generated, no rx given**	**G8445**
Arthropathy	716.90	DM I, uncomplicated	250.01	Migraine	346.90	**E-rx not generated, state law, system down**	**G8446**
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

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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 – (2-7 – need 4x2)*** *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 – (2-7 – need 4x2)*** *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**
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 or [ ] All other systems reviewed were negative (10)
Exam: Constitutional Eyes ENT Lymph Cardio Resp Skin GI GU Musculo Neuro Psych

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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, phychiatric 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	
1	Review and/or order of clinical lab tests (80000)
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

Documenting Data Points

To obtain data point, 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.

Calculation of Diagnosis Points	
1	Self-limited – Max of 2
1	Established Stable
2	Established Worsening
3	New - No Workup – Max of 1
4	New - With Workup
	Total

High MDM when not High Risk

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.

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Primary Care Form - 95 Guidelines

PATIENT'S NAME: ____________________________ **CHART #:** ____________________________________

TODAY'S DATE: _____/_____/_____ DOB: ____/____/____ **IMMUNIZATIONS:** UTD ? **LMP:** ____/____/____

HEIGHT:		WEIGHT:		BP:		RESP:		PULSE:		TEMP:	

ALLERGIES: CC / HPI (4+)	Status of 3 Chronic Conditions	Medications
	1. o Stable o C/O's	
	2. o Stable o C/O's	
	3. o Stable o C/O's	
	4. o Stable o C/O's	
	5. o Stable o C/O's	

MEDICAL HX:	
FAMILY HX:	**Negative**
SOCIAL HX:	Tobacco _________ ETOH _________ Caff/Car _________ Single / Married / Widowed / Divorced Children ___________ Work: ___________

ROS	o **All systems negative except as noted**	**Unable to fully assess due to:**	**Altered LOC**	**Pt. condition**	**Other:**			
CON	Fever	Chills	Sweats	Weight loss	Fatigue	Dizzy	Generalized weakness	
EYE	Redness	Discharge	Visual loss	Pain	Blurred	VA Changes	Watery / Itchy	
ENT	Sore throat	Congestion	PND	Hoarse	Nosebleeds	Hearing Loss	Ear Pain - R L	
RES	Cough prod/non prod		Hemoptysis	Wheezing	SOB	Pleuritic CP	DOE	PND
CV	Chest pain	LE edema	Palpitations	Orthopenea	PND			
GI	Nausea	Vomiting	Cramps	Diarrhea	Dysphagia	Pain	Constipation	Hemotachezia
GU	Incont.	Dysuria	Discharge	Frequency	Flank / S-P pain	Hematuria	Hesitancy	Nocturia
GYN	D/C	Itching	Dyspareunia	Irreg. Menses	Amenorrhea	Odor		
NEU	Headache	Numbness/parasthesias		Focal/Weakness	LOC	Change speech	Sensation ft nl	
PSY	Change MS	Agitation	Suicidal	Confusion	Depression	Anxiety	Loss of motivation	
MUS	Weakness R L	Sciatica	Myalgias	Neck / thoracic / lumbar / arm / leg pain			Arthralgias	Heat
SKIN	Rash:			Bruising	Swelling	Abrasions	Breakdown	Dry Bite

EXAMINATION	**Normal**	**Physical Examination**						
EYE		PERRLA	EOMI	Conj. Inflamed	Purulent drainage	F.B.	Fundi:	
ENT		Rhinorrhea	TURB Swelling	Ear/TM:	Pharyngeal erythema		Exudate	
LYMPH neck		Thyromegaly	Nodule	Lymphadenopathy	JVD Present	Carotid Bruits	Decreased Pulse	
CV		Rate – reg. irreg.	Gallops	Murmur				
RESP		Wheezing	Rales	Rhonchi	Decreased Aeration			
GI/ABD		Tenderness	Guarding/Rebound	Hepatomegaly	Splenomegaly	Mass	Bowel Sounds ↑ → ↓	
RECTAL		Tenderness	Mass	Nodule	Symmetric	Smooth	Scrotal Mass	Hemorrhoid
GU		Vulva -	Vagina -	Cervix -	Discharge		**FOOT EXAM**	**R** **L**
MUS Ext.		Tenderness	Deformities	Joint Effusion	Edema	Cyanosis	**Pulse**	+ – + –
MUS Spine		Neck/thoracic/lumbar tenderness		MVMT	↓ ROM	SLR + –	**Sensation**	+ – + –
NEURO		Alert/Oriented	Weakness	Numbness	Reflex – nml / abn	Tremor	Rhomberg + –	
PSY		Affect: Flat OK	Anxious	Tearful	Agitated	↓ Eye Contact		
SKIN		Rash:		Dry	Bruising	Icterus		

ASSESSMENT / PLAN:

Counseling: Total Face to Face Time: ______ minutes / Total Time Counseling: ______ minutes. ***(Must be>Than 50% of Total Face to Face Time)***
Topics Discussed:

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NEW PATIENT HISTORY AND PHYSICAN

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	

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PROGRESS NOTES

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

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

Complaints:	Allergies

☐ See NPI form for HPI & complete M,F,S Hx

REVIEW OFSYSTEMS

CHECK indicates normal, X indicates abnormal

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

PHYSICAL EXAM

SYSTEMS	WNL	ABN	**Abnormal Findings**
Constitutional:	☐	☐	
Eyes:	☐	☐	
ENT:	☐	☐	
Lymph / Neck:	☐	☐	
Lungs:	☐	☐	
Cardiovascular:	☐	☐	
Breast / Skin:	☐	☐	
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, HPI-4, ROS-2, Med Hx	2-7 systems (4x2)	3 chronic stable dx (RX)	1 chronic disease (RX) & 1 chronic unstable disease(RX)	2 unstable (RX)
99203-30	Cc, 4PHI, ROS-2, Med Hx	2-7 systems (4x2)	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

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PROBLEM LIST

NAME: ___________________ CHART ID: _________ DOB: _________

ALLERGIES: ____

Problem List			Medication List		
No.	Date	Problem	No.	Date	Medication
1			1		
2			2		
3			3		
4			4		
5			5		
6			6		
7			7		
8			8		
9			9		
10			10		
11			11		
12			12		
13			13		
14			14		
15			15		
16			16		
17			17		
18			18		
19			19		
20			20		
21			21		
22			22		

Prevention Information						
Service	Colonoscopy	Pap	PSA	Mammogram	Diabetic Patients	
					Ophthalmology	Podiatry
Date						

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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, inflamation 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.	

Labs:

Assessment / Plan:

F/U: ______________________ o **Days** o **Weeks** o **Months** o **Years** o**PRN**

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)= 1 3 99202(20m), 99213 (15m) = 6 3s 99203 (30m), 99214 (25m) = 12 3s 99204(45m), 99205(60m) , 99215 (40m) = 2 3s from 9 areas

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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 4x2)*** *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 – (2-7 – need 4x2)*** *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

Code	Definition
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

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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:

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

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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

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Evaluation & Management Coding Summary – Observation / Admission

Observation/Hospital Discharge Same Day 3 out of 3				
Code	Minutes	History	Examination	Decision-Making
99234	N/A	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (2-7 – need 4x2)*** *1997 – (12 checks)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99235	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)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99236	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 • Data – Extensive • Risk – High
Observation More than One Day 3 out of 3				
99218	N/A	Detailed / Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (2-7 – need 4x2)*** *1997 – (12 checks)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99219	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)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99220	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 • Data – Extensive • Risk – High
Observation Discharge				
99217	N/A	Observation care discharge on date other than initial observation day		
Definitions				
Remember		Hospital run on calendar days and not hours		

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Evaluation & Management Coding Summary – Nursing Home

Code	Minutes	History	Examination	Decision-Making
Initial Nursing Facility Care (3 out of 3)				
99304	25	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (2-7 – need 4x2)*** *1997 – (12 checks)*	*Straightforward / Low* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99305	35	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Social and Family 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
99306	45	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Social, Family 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 Nursing Facility Care (2 out of 3)				
99307	10	Problem Focused • CC • 1HPI	*Problem Focused* *1995 –(1)* *1997 – (1 check)*	*Straightforward* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99308	15	Exp. Problem Focused • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 7)* *1997 – (6 checks)*	*Low* • Diagnosis – Limited • Data – Limited • Risk – Low
99309	25	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (2-7 – need 4x2)*** *1997 – (12 checks)*	*Moderate / High* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99310	35	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Social, Family 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
Nursing Facility Discharge				
99315	0-30	Nursing home discharge		
99316	>30	Nursing facility discharge > 30 minutes		
Annual Nursing Facility Assessment (3 out of 3)				
99318	30	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Social, Family 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

Definitions	
99307	Usually, the patient is stable, recovering, or improving.
99308	Usually, the patient is responding inadequately to therapy or has minor complication
99309	Usually, the patient has developed a significant complication or sig. new problem
99310	Pt. is unstable or developed significant new problem requiring immediate attention.

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Nursing Home Tracking Sheet

NAME OF NURSHING HOME		DATE OF VISIT:	
PHYSICIAN PERFORMING ROUNDS: Dr. Jodi Gilstrap			
PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:
PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:
PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:
PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:
PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:	PATIENT NAME: CODE: DX:

Initial Nursing Facility Care				
99304	Like 99203	Status of 3 Chronic Conditions	25 min	Low MDM
99305	Like 99204	Status of 3 Chronic Conditions	35 min	Moderate MDM
99306	Like 99205	Status of 3 Chronic Conditions	45 min	High MDM
Subsequent Nursing Facility Care				
99307	Like 99212		10 min	Straightforward MDM
99308	Like 99213		15 min	Low MDM
99309	Like 99214	Status of 3 Chronic Conditions	25 min	Moderate MDM
99310	Like 99215	Status of 3 Chronic Conditions	35 min	High MDM
Nursing Facility Discharge				
99315	Standard Discharge			
99316	> 30 min Discharge			
Annual Nursing Facility Assessment				
99318	Annual nursing facility assessment			

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NURSING HOME FORM

Any New Complaints	1. DM	Problems With Current Meds: o Yes o No
	2. HTN	See Medication Sheet: o
	3. Malnutrition	Drug Allergies: o Yes o No
	4. Heart Disease	Smoker: o Yes o No
	5. Pulmonary Disease	Cancers:
	6. Dementia / Depression	Family Hx:
	7. GI Problems	
	8. Stroke	
	9. Arthritis	

ROS: Weight Loss o Y o N	Blurred Vision o Y o N	Constipation / Impaction o Y o N	Respiratory o Y o N	Chest Pain o Y o N
Insomnia o Y o N	Swelling o Y o N	Abdominal Pain o Y o N	Seizures o Y o N	Increased B/P o Y o N
Fever / Chills / Cough / Cold / Congestion o Y o N		Mental Status o Y o N	Falls o Y o N	Bed Sores o Y o N

Examination Detail	*Pertinent Positives and Negatives*
CONST: o Vitals: (3) Wt: T: R: P: __Reg. __Irreg. BP: R___/___ L___/____ ❑ W-D W-N NAD	
EYES: ❑ Sclera white, conjunctive clear. Lids are without lag. ❑ PERRLA. ❑ Discs flat, no hemorrhages or exudates noted.	
EARS: ❑ No scars, lesions, or masses. ❑ Hearing non-impaired. ❑ Tympanic membranes translucent, non-bulging and mobile. Canal walls pink, without discharge. **NOSE:** ❑ Mucosa and turbinates pink, septum midline. **MOUTH:** ❑ Lips pink and symmetrical, gums pink. **THROAT:** ❑ Oral mucosa pink and moist. Salivary glands intact. Soft and hard palates contiguous. Tongue moist.	
RESP: o Respiration even and un-labored. o Lung fields – no flatness, dullness or hyperresonance. o Clear /equal no adventitious sounds bilaterally.	
CV: o RRR, w/no murmurs-rubs-gallops. o No Bruits throughout the Carotid arteries, pulse amp____. o Pedal pulses within normal limits bilat., pulse amplitude ____.	
ABD: ❑ No masses or tenderness. Bowel sounds active x 4 quad. ❑ Liver and spleen are w/o tenderness or enlargement.	
GI/GU:	
MUSCULO: o Joints with full ROM, no pain, crepitus or contracture. o No muscle atrophy/weakness.	
SKIN: o No rashes, lesions or ulcers. o Warm and dry, normal tugor.	
NEURO: o A+O. o CN Intact. o DTRs.	
PSYCHIATRIC: ❑ Judgement and insight are within normal limits. ❑ Alert and Oriented X 3.	
EXTREMETIES: o No Edema. o Pulses: ___ Good ___ Bad	
BED SORE:	

Labs:

Assessment 1. ________________________________ 2. ________________________________	Plan:

Provider's Signature: ____

99304 = 12 ✓ s/99305 = 2 ✓ s from 9 areas/99306 = 2 ✓ s from 9 areas	99307 =1 ✓ /99308 = 6 ✓ s/99309 = 12 ✓ s /99310 = 2 ✓ s from 9 areas/99318 = 2 ✓ s from 9 areas

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Evaluation & Management Coding Summary – Domiciliary / Rest Home

Code	Minutes	History	Examination	Decision-Making
Domiciliary / Rest Home Visit (3 out of 3)				
99324	20	Problem Focused • CC • 1HPI	*Problem Focused* *1995 –(1)* *1997 – (1 check)*	*Straightforward* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99325	30	Exp. Problem Focused • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 7)* *1997 – (6 checks)*	*Low* • Diagnosis – Limited • Data – Limited • Risk – Low
99326	45	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (2-7 – need 4x2)*** *1997 – (12 checks)*	*Moderate / High* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99327	60	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Social and Family 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
99328	75	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Social, Family 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
Domiciliary / Rest Home Visit (2 out of 3)				
99334	15	Problem Focused • CC • 1HPI	*Problem Focused* *1995 –(1)* *1997 – (1 check)*	*Straightforward* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99335	25	Exp. Problem Focused • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 7)* *1997 – (6 checks)*	*Low* • Diagnosis – Limited • Data – Limited • Risk – Low
99336	40	Detailed • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (2-7 – need 4x2)*** *1997 – (12 checks)*	*Moderate / High* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99337	60	Comprehensive • CC • 4 HPI or status of 3 chronic conditions • 10 ROS • Medical, Social, Family 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

Definitions	
99334	Usually, the patient is stable, recovering, or improving.
99335	Usually, the patient is responding inadequately to therapy or has minor complication
99336	Usually, the patient has developed a significant complication or sig. new problem
99337	Pt. is unstable or developed significant new problem requiring immediate attention.

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Evaluation & Management Coding Summary – Home Services

Initial Home Visits 3 out of 3				
Code	Minutes	History	Examination	Decision-Making
99341	20	Problem Focused • CC • 1HPI	*Problem Focused* 1995 –(1) 1997 – (1 check)	*Straightforward* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99342	30	*Exp. Problem Focused* • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 7)* *1997 – (6 checks)*	*Low* • Diagnosis – Limited • Data – Limited • Risk – Low
99343	45	*Detailed* • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (2-7 – need 4x2)*** *1997 – (12 checks)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99344	60	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
99345	75	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 Home Visits (2 out of 3)				
99347	15	*Problem Focused* • CC • 1HPI	*Problem Focused* 1995 –(1) 1997 – (1 check)	*Straightforward* • Diagnosis – Minimal • Data – Minimal or None • Risk – Minimal
99348	25	*Exp. Problem Focused* • CC • 1 HPI • 1 ROS	*Exp. Problem Focused* *1995 – (2 – 7)* *1997 – (6 checks)*	*Low* • Diagnosis – Limited • Data – Limited • Risk – Low
99349	40	*Detailed* • CC • 4 HPI or status of 3 chronic conditions • 2 ROS • Medical or Family or Social History	*Detailed* ***1995 – (2-7 – need 4x2)*** *1997 – (12 checks)*	*Moderate* • Diagnosis – Multiple • Data – Moderate • Risk – Moderate
99350	60	*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 to High* • Diagnosis – Extensive • Data – Extensive • Risk – High

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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

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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									
Hemoccult (1 yr.) G0107									

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

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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.*

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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*. $80

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. $70

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

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Care Plan Oversight

o G0181 – Home Health Agency – Greater than 30 Minutes - $115
Name of Home Health Agency:___________________________________

o G0182 – Hospice Care – Greater than 30 Minutes - $125
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													
Other (Define)													
Other (Define)													
Total Time													

Physician Signature: ____

Form must be signed by physician!

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Top Primary Code / ObGyn 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

2009 Modifiers

Surgery Only

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E&M MODIFIERS ONLY

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25
57

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E&M Credit Cards

History	Exam	MDM
99232 can also be billed on time – 25 min		
Cc,1 HPI, 1 ROS	2-7	Moderate
History	**Exam**	**MDM**
99233 can also be billed on time – 35 min		
Cc, 4 HPI, 2 ROS, Med Hx	2-7 (4x2)	High

High Risk: Severe Exacerbation, Acute or Chronic Illness that poses a threat to life or bodily function, Abrupt change in neurologic status, Parenteral controlled substances, DNR
Counseling: I spent _____ min. on the floor. Greater than 50% of that time was counseling/coordinating care:
99239 – Discharge > 30 min
99406 – Tobacco Cessation 3-10 min // 99407 > 10 min

History	Exam	MDM
99244 or 99254		
Cc, 4 HPI, 10 ROS, M, F, S Hx	8	Moderate
99245 or 99255		
Cc, 4 HPI, 10 ROS, M, F, S Hx	8	High
History	**Exam**	**MDM**
99222		
Cc, 4 HPI, 10 ROS, M, F, S Hx	8	Moderate
99223		
Cc, 4 HPI, 10 ROS, M, F, S Hx	8	High

EXAM - (8): CONST, EYE, ENT, CV, RESP, LYMPH, MUSK, GI, GU, SKIN, NEURO, PSYCH
ROS - (10): "all other systems reviewed negative"

History	Exam	MDM
99204 or 99244 or 99254		
Cc, 4 HPI, 10 ROS, M, F, S Hx	8	Moderate
99205 or 99245 or 99255		
Cc, 4 HPI, 10 ROS, M, F, S Hx	8	**High**
History	**Exam**	**MDM**
99213 can also be billed on time – 15 min		
Cc, 1 HPI, 1 ROS (Hx **OR** exam)	2-7	Low
99214 can also be billed on time – 25 min		
Cc, 4 HPI, 2 ROS, Meds (Hx **OR** exam)	2-7 (4x2)	**Moderate**

High Risk: Severe Exacerbation, Acute or Chronic Illness that poses a threat to life or bodily function
Moderate Risk: Three or more chronic problems on Rx **OR** new problem to you with Rx
Consultation: Pt being seen in consult at the request of Dr.__ for:

History	Exam	MDM
99222		
Cc, 4 HPI, 10 ROS, M, F, S Hx	8	Moderate
99223		
Cc, 4 HPI, 10 ROS, M, F, S Hx	8	**High**
History	**Exam**	**MDM**
99232 can also be billed on time – 25 min		
Cc, 1 HPI, 1 ROS (Hx **OR** exam)	2-7	Moderate
99233 can also be billed on time – 35 min		
Cc, 4 HPI, 2 ROS, Meds (Hx **OR** exam)	2-7 (4x2)	**High**

EXAM - (8): CONST, EYE, ENT, CV, RESP, LYMPH, MUSK, GI, GU, SKIN, NEURO, PSYCH
ROS - (10): "all other systems reviewed negative"
Counseling: I spent _____ min. face to face. Greater than 50% of that time was counseling/coordinating care:

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Dermatological Sheet

DATE: _____/_____/_____

Patient Name: _______________________________________ M / F DOB: _____/_____/_____

Skin Tags
Up to 15 tags: 11200
16-25 tags: 11200, 11201
26-35 tags: 11200, 11201 (x2)

Destruction Premalignant Lesion(s)
1 lesion: 17000
2 lesions 17000, 17003
3 lesions 17000, 17003 (x2)
15 or more lesions: 17004

Excision & Repair
Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm: 11403 *– includes simple closure*

Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm: 12032

Code: 12032
11403 - 51

FRONT

BACK

Removal - o Skin Tag o Pre-Malignant Lesion Destruction - (Cryo)
o Shave o Biopsy o Lesion Excision

- ❑ 1% Xylocaine
- ❑ 1% Xylocaine w/Epi
- ❑ Plain
- ❑ Silk
- ❑ Vicryl
- ❑ Chromic

Location of Lesion(s) and Number Per Location:

Size of Lesion(s) Plus Narrowest Margin(s) in cm:

Type of Closure: o Simple o Intermediate o Complex

Length of Closure in cm:

Path Results: o Benign o Malignant o Other:

Signature: ________________________________ Date: ____/____/____

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