OB/GYN TOOL BOX

Table of Contents:

OB/GYN TOOL BOX

This guide was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This guide was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This guide is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

MEDICARE LEARNING NETWORK

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *www.cms.hhs.gov/MLNGenInfo* on the CMS website.

ICD-9 NOTICE

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

CPT DISCLAIMER AMERICAN MEDICAL ASSOCIATION (AMA) NOTICE AND DISCLAIMER

This guide is offered as a reference tool and does not replace content found in the *1995 Documentation Guidelines for Evaluation and Management Services* and the *1997 Documentation Guidelines for Evaluation and Management Services*. It is recommended that health care providers refer to the *1995* ***Documentation Guidelines for Evaluation and Management Services*** **in order to identify differences between the two sets of guidelines.**

It is recommended that providers refer to the following publications, which were used to prepare this guide:

- *1995 Documentation Guidelines for Evaluation and Management Services*, available at *www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf* on the Centers for Medicare & Medicaid Services (CMS) website;
- *1997 Documentation Guidelines for Evaluation and Management Services*, available at *www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf* on the CMS website;
- Medicare Claims Processing Manual (Pub. 100-4), available at *www.cms.hhs.gov/Manuals/* on the CMS website; and
- *Current Procedural Terminology* book, available from the American Medical Association (800-621-8335 or *www.amapress.org* on the Web).

OB/GYN TOOL BOX

MEDICAL RECORD DOCUMENTATION

“If it isn’t documented, it hasn’t been done” is a saying that is frequently heard in the health care field.

Background

Succinct medical record documentation is critical to receiving accurate and timely reimbursement as well as providing patients with quality care. Documentation should be chronological and document the care of the patient. It is required to record the facts, findings, and observations about the patient’s health history including past and present illnesses, examinations, tests, treatments, and outcomes. Medical record documentation also assists physicians and other health care professionals in evaluating and planning the patient’s treatment and monitoring his or her health care over time.

Payers may require documentation for services that are consistent with the codes being billed in order to validate:

- The site of service;
- The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- That services furnished have been accurately reported.

To ensure that medical record documentation is accurate, the following principles should be followed:

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results.
  - Assessment, clinical impression, or diagnosis.
  - Medical plan of care.
  - Date and legible identity of the observer.

- If there is no documentation the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Any health risk factors should be identified and noted.
- The patient's changes, response to and progress in treatment, and any revision of diagnosis should be documented.
- The Current Procedural Terminology (CPT) and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

When billing for a patient’s visit, codes are selected that best represent the services furnished during the visit. The two common sets of codes used are:

- Diagnostic or International Classification of Diseases, 9th Revision, Clinical Modification codes; and
- Procedural or American Medical Association Current Procedural Terminology (CPT) codes.

These codes are organized into various categories and levels. It is the physician’s responsibility to ensure that documentation reflects the services furnished and that the codes selected reflect those services. The more work performed by the physician, the higher the level of code he or she may bill within the appropriate category. The billing specialist or alternate source reviews the physician’s documentation of services and assists with selecting codes that best reflect the extent of the physician’s personal work necessary to furnish the services.

Evaluation and management (E/M) services are visits and consultations by physicians. Billing Medicare for a patient visit requires the selection of a CPT code that best represents the level of E/M service performed. For example, there are five CPT codes that may be selected to bill for office or other outpatient visits for a new patient:

KEY ELEMENTS OF SERVICE

To determine the appropriate level of service for a patient’s visit, it is necessary to first determine whether the patient is new or already established. The physician then uses the presenting illness as a guiding factor and his or her clinical judgment about the patient’s condition to determine the extent of key elements of service to be performed. The key elements of service are:

OB/GYN TOOL BOX

- History;
- Examination; and
- Medical decision making.

The key elements of service and documentation of an encounter dominated by counseling and/or coordination of care are discussed below.

I. History

The elements required for each type of history are represented in the table below. Note that each history type requires more information as you read down the left hand column. For example, a problem focused history requires the documentation of the chief complaint (CC) and a brief history of present illness (HPI) and a detailed history requires the documentation of a CC, extended HPI, extended review of systems (ROS), and pertinent past, family and/or social history (PFSH), judgment and the nature of the presenting problem.

Documentation of patient history includes some or all of the following elements:

Elements Required for Each Type of History

TYPE OF HISTORY	CHIEF COMPLAINT	HISTORY OF PRESENT ILLNESS	REVIEW OF SYSTEMS	PAST, FAMILY, AND/OR SOCIAL HISTORY
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

*A. **Chief Complaint***

A CC is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient's own words. For example, patient complains of upset stomach, aching joints, and fatigue.

B. History of Present Illness

HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI elements are:

- Location. I.e.: pain in left leg;
- Quality. I.e.: aching, burning, radiating;
- Severity. I.e.: 10 on a scale of 1 to 10;
- Duration. I.e.: it started three days ago;
- Timing. I.e.: it is constant or it comes and goes;
- Context. I.e.: lifted large object at work;
- Modifying factors. I.e.: it is better when heat is applied; and
- Associated signs and symptoms. I.e.: numbness.

There are two types of HPIs:

1) *Brief*, which includes documentation of one to three HPI elements. In the following example, three HPI elements – location, severity, and duration – are documented:

- CC: A patient seen in the office complains of left ear pain.
- Brief HPI: Patient complains of dull ache in left ear over the past 24 hours.

OB/GYN TOOL BOX

2) *Extended*; includes documentation of at least four HPI elements or the status of at least three chronic or inactive conditions. In the following example, five HPI elements – location, severity, duration, context, and modifying factors – are documented:
    - Extended HPI: Patient complains of dull ache in left ear over the past 24 hours. Patient states he went swimming two days ago. Symptoms somewhat relieved by warm compress and ibuprofen.

Review of Systems (ROS)

ROS is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced. The following systems are recognized:

- Constitutional Symptoms (e.g., fever, weight loss);
- Eyes;
- Ears, Nose, Mouth, Throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Integumentary (skin and/or breast);
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic; and
- Allergic/Immunologic.

There are three types of ROS:

1. *Problem pertinent*; inquires about the system directly related to the problem identified in the HPI. In the following example, one system – the ear – is reviewed:
    - CC: Earache.
    - ROS: Positive for left ear pain. Denies dizziness, tinnitus, fullness, or headache.

2. *Extended*; inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems? In the following example, two systems – cardiovascular and respiratory – are reviewed:
    - CC: Follow up visit in office after cardiac catheterization. Patient states “I feel great.”
    - ROS: Patient states he feels great and denies chest pain, syncope, palpitations, and shortness of breath. Relates occasional unilateral, asymptomatic edema of left leg.

3. *Complete*; inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of 10) body systems. In the following example, 10 signs and symptoms are reviewed:
    - CC: Patient complains of “fainting spell.”
    - ROS:
        - Constitutional: weight stable, + fatigue.
        - Eyes: + loss of peripheral vision.
        - Ear, Nose, Mouth, Throat: no complaints.
        - Cardiovascular: + palpitations; denies chest pain; denies calf pain, pressure, or edema.
        - Respiratory: + shortness of breath on exertion.

- Gastrointestinal: appetite good, denies heartburn and indigestion. episodes of nausea. Bowel movement daily; denies constipation or loose stools.
- Urinary: denies incontinence, frequency, urgency, nocturia, pain, or discomfort.
- Skin: + clammy, moist skin.
- Neurological: + fainting; denies numbness, tingling, and tremors.
- Psychiatric: denies memory loss or depression. Mood pleasant.

Past, Family, and/or Social History

PFSH consists of a review of the patient's:

- Past personal history including experiences with illnesses, operations, injuries, and treatments;
- Family history including a review of medical events, diseases, and hereditary conditions that may place him or her at risk; and
- Social history including an age appropriate review of past and current activities.

The two types of PFSH are:

1. *Pertinent*; is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document one item from any of the three history areas. In the following example, the patient's past surgical history is reviewed as it relates to the current HPI:

   Patient returns to office for follow up of coronary artery bypass graft in 1992. Recent cardiac catheterization demonstrates 50 percent occlusion of vein graft to obtuse marginal artery.

2. *Complete*; is a review of two or all three of the areas, depending on the category of E/M service. A complete PFSH requires a review of all three history areas for services that, by their nature, include a comprehensive assessment or reassessment of the patient. A review of two history areas is sufficient for other services. At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services:
   - Office or other outpatient services, established patient;
   - Emergency department;
   - Domiciliary care, established patient; and
   - Home care, established patient.

At least one specific item from each of the history areas must be documented for the following categories of E/M services:

- Office or other outpatient services, new patient;
- Hospital observation services;
- Hospital inpatient services, initial care;
- Consultations;
- Comprehensive Nursing Facility assessments;
- Domiciliary care, new patient; and
- Home care, new patient.

In the following example, the patient's genetic history is reviewed as it relates to the current HPI:

• Family history reveals the following:
- Maternal grandparents: grandmother - + diabetes, hypertension; grandfather - + heart attack at age 55.
- Paternal grandparents: both + for coronary artery disease; grandfather deceased at age 69; grandmother still living.
- Parents: mother - + obesity, diabetes; father - + heart attack age 51, deceased age 57 of heart attack.
- Siblings: sister - + diabetes, obesity, hypertension, age 39; brother - + heart attack at age 45, living.

II. Examination

OB/GYN TOOL BOX

An examination may involve several organ systems or a single organ system. The extent of the examination performed is based upon clinical judgment, the patient's history, and nature of the presenting problem.

THE CHART BELOW REPRESENTS THE BODY AREAS AND ORGAN SYSTEMS THAT ARE RECOGNIZED ACCORDING TO THE CURRENT PROCEDURAL TERMINOLOGY (CPT) BOOK:

BODY AREAS	ORGAN SYSTEMS
Head, including face Neck Chest, including breasts and axilla Abdomen Genitalia, groin, buttocks Back Each extremity	Eyes Ears, Nose, Mouth, and Throat Cardiovascular Respiratory Gastrointestinal Genitourinary Musculoskeletal Skin Neurologic Hematologic/Lymphatic/Immunologic Psychiatric

OB/GYN TOOL BOX

There are two types of examinations that can be performed during a patient's visit:

1) *General multi-system examination*, which involves the examination of one or more organ systems or body areas. According to the *1997 Documentation Guidelines for Evaluation and Management Services* each body area or organ system contains two or more of the following examination elements:

- Constitutional Symptoms (e.g., fever, weight loss);
- Eyes;
- Ears, Nose, Mouth, Throat;
- Neck;
- Respiratory;
- Cardiovascular;
- Chest (breasts);
- Gastrointestinal;
- Genitourinary;
- Lymphatic;
- Musculoskeletal;
- Integumentary;
- Neurological; and
- Psychiatric.

Single organ system examination, which involves a more extensive examination of a specific organ system.

Both types of examinations may be performed by any physician, regardless of specialty. The chart below compares the elements of the **cardiovascular system/body area** for both a general multi-system and single organ system examination.

SYSTEM/ BODY AREA	GENERAL MULTI-SYSTEM EXAMINATION	SINGLE ORGAN SYSTEM EXAMINATION
Cardiovascular	Palpation of heart (e.g., location, size, thrills). Auscultation of heart with notation of abnormal sounds and murmurs. Examination of: • Carotid arteries (e.g., pulse amplitude, bruits) • Abdominal aorta (e.g., size, bruits); • Femoral arteries (e.g., pulse amplitude, bruits); • Pedal pulses (e.g., pulse amplitude); and • Extremities for edema and/or varicosities.	Palpation of heart (e.g., location, size, and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4). Auscultation of heart including sounds, abnormal sounds, and murmurs. Measurement of blood pressure in two or more extremities when indicated (e.g., aortic dissection, coarctation). Examination of: • Carotid arteries (e.g., waveform, pulse amplitude, bruits, apical-carotid delay); • Abdominal aorta (e.g., size, bruits); • Femoral arteries (e.g., pulse amplitude, bruits); • Pedal pulses (e.g., pulse amplitude); and • Extremities for peripheral edema and/or varicosities.

THE ELEMENTS REQUIRED FOR EACH TYPE OF EXAMINATION ARE REPRESENTED IN THE TABLE BELOW.

Problem Focused	A limited examination of the affected body area or organ system.
Expanded Problem Focused	A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
Detailed	An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body areas(s) or organ system(s).
Comprehensive	A general multi-system examination OR complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).

The elements required for general multi-system examinations are represented in the following chart.

General Multi-System Examinations

TYPE OF EXAMINATION	DESCRIPTION

OB/GYN TOOL BOX

Problem Focused	Include performance and documentation of 1 - 5 elements identified by a bullet in 1 or more organ system(s) or body area(s).
Expanded Problem Focused	Include performance and documentation of at least 6 elements identified by a bullet in 1 or more organ system(s) or body area(s).
Detailed	Include at least 6 organ systems or body areas. For each system/area selected, performance and documentation of at least 2 elements identified by a bullet is expected. Alternatively, may include performance and documentation of at least 12 elements identified by a bullet in 2 or more organ systems or body areas.
Comprehensive	*1997 Documentation Guidelines for Evaluation and Management Services*: Include at least 9 organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least 2 elements identified by bullet is expected. *1995 Documentation Guidelines for Evaluation and Management Services*: Eight organ systems ***must*** be examined. If body areas are examined and counted, they must be over and above the 8 organ systems.

According to the *1997 Documentation Guidelines for Evaluation and Management Services*, the 10 single organ system examinations are:

- Cardiovascular;
- Ear, Nose, and Throat;
- Eye;
- Genitourinary;
- Hematologic/Lymphatic/Immunologic;
- Musculoskeletal;
- Neurological;
- Psychiatric;
- Respiratory; and
- Skin.

OB/GYN TOOL BOX

The elements required for single organ system examinations are depicted in the following chart.

Single Organ System Examinations

TYPE OF EXAMINATION	DESCRIPTION
Problem Focused	Include performance and documentation of 1 - 5 elements identified by a bullet, whether in a box with a shaded or unshaded border.
Expanded Problem Focused	Include performance and documentation of at least 6 elements identified by a bullet, whether in a box with a shaded or unshaded border.
Detailed	Examinations other than the eye and psychiatric examinations should include performance and documentation of at least 12 elements identified by a bullet, whether in a box with a shaded or unshaded border. Eye and psychiatric examinations include the performance and documentation of at least 9 elements identified by a bullet, whether in a box with a shaded or unshaded border.
Comprehensive	Include performance of all elements identified by a bullet, whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least 1 element in a box with an unshaded border is expected.

OB/GYN TOOL BOX

The chart below compares the elements that are required for both general multisystem and single organ system examinations.

Multi-System and Single Organ Examinations

TYPE OF EXAMINATION	MULTI-SYSTEM EXAMINATIONS	SINGLE ORGAN SYSTEM EXAMINATIONS
Problem Focused	1 - 5 elements identified by a bullet in 1 or more organ system(s) or body area(s).	1 - 5 elements identified by a bullet, whether in a box with a shaded or unshaded border.
Expanded Problem Focused	At least 6 elements identified by a bullet in one or more organ system(s) or body area(s).	At least 6 elements identified by a bullet, whether in a box with a shaded or unshaded border.
Detailed	At least 6 organ systems or body areas. For each system/area selected, performance and documentation of at least 2 elements identified by a bullet is expected. **OR** At least 12 elements identified by a bullet in 2 or more organ systems or body areas.	At least 12 elements identified by a bullet, whether in a box with a shaded or unshaded border. Eye and psychiatric: At least 9 elements identified by a bullet, whether in a box with a shaded or unshaded border.
Comprehensive	Include at least 9 organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least 2 elements identified by bullet is expected.	Perform all elements identified by a bullet, whether in a shaded or unshaded box. Document every element in each box with a shaded border and at least 1 element in a box with an unshaded border.

Some important points that should be kept in mind when documenting general multi-system and single organ system examinations are:

- Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is not sufficient;
- Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described; and
- A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s). (However, an entire organ system should not be documented with a statement such as “negative.”)

III. Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The chart below depicts the elements for each level of medical decision making. Note that to qualify for a given type of medical decision making**,** two of the three elements must either be met or exceeded.

Elements of Medical Decision Making

OB/GYN TOOL BOX

TYPE OF DECISION MAKING	NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED	RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Number of Diagnoses or Management Options

The number of possible diagnoses and/or the number of management options that must be considered is based on:

- The number and types of problems addressed during the encounter;
- The complexity of establishing a diagnosis; and
- The management decisions that are made by the physician.

In general, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnosed tests performed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those problems that are worsening or failing to change as expected. Another indicator of the complexity of diagnostic or management problems is the need to seek advice from other health care professionals.

Some important points that should be kept in mind when documenting the number of diagnoses or management options are:

- For each encounter, an assessment, clinical impression, or diagnosis should be documented which may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

- For a presenting problem with an established diagnosis, the record should reflect whether the problem is:

- *Improved, well controlled, resolving, or resolved.*
- *Inadequately controlled, worsening, or failing to change as expected*.

- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a “possible,” “probable,” or “rule out” diagnosis.
    - The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.
    - If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom advice is requested.

Amount and/or Complexity of Data to be reviewed

The amount and/or complexity of data to be reviewed are based on the types of diagnostic testing ordered or reviewed. Indications of the amount and/or complexity of data being reviewed include:

- A decision to obtain and review old medical records and/or obtain history from sources other than the patient (increases the amount and complexity of data to be reviewed);

- Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test (indicates the complexity of data to be reviewed); and
- The physician who ordered a test personally reviews the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation (indicates the complexity of data to be reviewed).

Some important points that should be kept in mind when documenting amount and/or complexity of data to be reviewed include:

- If a diagnostic service is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service should be documented.

OB/GYN TOOL BOX

- The review of laboratory, radiology, and/or other diagnostic tests should be documented. A simple notation such as "White blood count elevated" or "Chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report that contains the test results.
- A decision to obtain old records or obtain additional history from the family, caretaker, or other source to supplement information obtained from the patient should be documented.
- Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement information obtained from the patient should be documented. If there is no relevant information beyond that already obtained, this fact should be documented. A notation of “Old records reviewed” or “Additional history obtained from family” without elaboration is not sufficient.
- Discussion about results of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented.
- The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.

Risk of Significant Complications, Morbidity, and/or Mortality

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the following categories:

- Presenting problem(s);
- Diagnostic procedure(s); and
- Possible management options.

The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category determines the overall risk.

The level of risk of significant complications, morbidity, and/or mortality can be:

- Minimal;
- Low;
- Moderate; or
- High.

OB/GYN TOOL BOX

Some important points that should be kept in mind when documenting level of risk are:

- Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented;
- If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure should be documented;
- If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented; and
- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

OB/GYN TOOL BOX

The table on the following page may be used to assist in determining whether the level of risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Because determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk.

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem, eg, cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, eg, echocardiography KOH prep	Rest, Gargles, Elastic bandages, Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness, eg, well controlled hypertension, 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 laboratory 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
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, eg, lump in breast Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis Acute complicated injury, eg, head injury with brief loss of consciousness	Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and 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) with no identified risk factors, Prescription drug management ,Therapeutic nuclear medicine, IV fluids with additives ,Closed treatment of fracture or dislocation without manipulation
High	One or more chronic illnesses with severe exacerbation, progression, or 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 with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic Endoscopies with identified risk factors Discography	Elective major surgery (open, percutaneous or endoscopic) with 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

IV. Documentation of an Encounter Dominated by Counseling and/or Coordination of Care

When counseling and/or coordination of care dominates (more than 50 percent of) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital, or Nursing Facility), time is considered the key or controlling factor to qualify for a particular level of E/M services. If the level of service is reported based on counseling and/or coordination of care, the total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care. For example, if 25 minutes was spent face-to-face with an established patient in the office and more than half of that time was spent counseling the patient or coordinating his or her care, CPT code 99214® should be selected.

The Level I and Level II CPT books available from the American Medical Association list average time guidelines for a variety of E/M services. These times include work done before, during, and after the encounter. The specific times expressed in the code descriptors are averages and, therefore, represent a range of times that may be higher or lower depending on actual clinical circumstances.

OB/GYN TOOL BOX

Place of Service Codes for Professional Claims

From CMS Database (last updated September 10, 2007)

LISTED BELOW ARE PLACE OF SERVICE CODES AND DESCRIPTIONS. THESE CODES SHOULD BE USED ON PROFESSIONAL CLAIMS TO SPECIFY THE ENTITY WHERE SERVICE(S) WERE RENDERED. CHECK WITH INDIVIDUAL PAYERS (E.G., MEDICARE, MEDICAID, OTHER PRIVATE INSURANCE) FOR REIMBURSEMENT POLICIES REGARDING THESE CODES. IF YOU WOULD LIKE TO COMMENT ON A CODE(S) OR DESCRIPTION(S), PLEASE SEND YOUR REQUEST TO THE ADDRESS GIVEN BELOW.

PLACE OF SERVICE CODE(S)	Place of Service Name	Place of Service Description
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (effective 10/1/05)
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A FACILITY OR LOCATION, OWNED AND OPERATED BY THE INDIAN HEALTH SERVICE, WHICH PROVIDES DIAGNOSTIC, THERAPEUTIC (SURGICAL AND NON-SURGICAL), AND REHABILITATION SERVICES TO AMERICAN INDIANS AND ALASKA NATIVES WHO DO NOT REQUIRE HOSPITALIZATION.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members

OB/GYN TOOL BOX

PLACE OF SERVICE CODE(S)	Place of Service Name	Place of Service Description
09-10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (effective 10/1/03)
14	Group Home *	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. (effective 4/1/08)
17-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency	A portion of a hospital where emergency

OB/GYN TOOL BOX

PLACE OF SERVICE CODE(S)	Place of Service Name	Place of Service Description
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)
50	Federally Qualified Health	A facility located in a medically underserved area that

OB/GYN TOOL BOX

PLACE OF SERVICE CODE(S)	Place of Service Name	Place of Service Description
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)
58-59	Unassigned	N/A
60	Mass	A location where providers administer

OB/GYN TOOL BOX

MODIFIERS

Here is a partial list of Modifiers normally used in the physician office setting.

22 **Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work. (i.e.: increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).

24 **Unrelated Evaluation and Management Service by the Same physician During a Postoperative Period:** They physician may need to indicate that an E/M service service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service**: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M Service above and beyond the other service provided or beyond the usual preoperative and postoperative case associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom of condition of which the procedure and/or service was provided. As such, different diagnosis is not required for reporting of the E/M services on the same date. This circumstance may be reported adding the modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery.

26 **Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

32 **Mandated Services**: Service related to mandated consultation and/or related service (eg, third-party payer, governmental, legislative or regulatory requirement) may be identified by adding to modifier 32 to the basic procedure.

50 **Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.

51 **Multiple Procedures**: When multiple procedures, other than Evaluation and Management Service, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated add-on code.

52 **Reduced Services**: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52 signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note; for hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

53 **Discontinued Procedure:** Under certain circumstances, the physician may elect to terminate the surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances of those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

OB/GYN TOOL BOX

54 **Surgical Care Only**: when one physician performs a surgical procedure and another provide preoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 **Postoperative Management Only:** when on physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier 55 to the usual procedure number.

56 **Preoperative Management Only:** When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 **Decision for surgery:** An evaluation and management service that resulted in the initial decision to perform the surgery maybe identified by adding modifier 57 to the appropriate level of E/M service.

58 **Staged or Related Procedure or Service by the Same Physician during the Postoperative Period;** It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (a) planned or anticipated (staged) (b) more extensive than the original procedure;; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note; for treatment of a problem that requires a return to the operative or procedure room (eg, unanticipated clinical condition).

59 **Distinct Procedural Service:** under certain circumstances, it may by necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same or independent from other non E/M services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session. Different procedure or surgery, different site or organ system, separate incision or excision separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used.

Modifier 59 should be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25

76 **Repeat Procedure or service by Same Physician:** it may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. The circumstance may be reported by adding modifier 76 to the repeated procedure or service.

77 **Repeat Procedure by another Physician**: The physician may be to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 **Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a related procedure during the post Operative Period**: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use of an operating or procedure room it may be reported by adding modifier 78 to the related procedure.

79 **Unrelated Procedure or service by the same Physician during the Postoperative Period**: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79.

80 **Assistant Surgeon**: Surgical assistant service may be identified by adding modifier 80 to the usual procedure number(s)

81 **Minimum Assistant Surgeon:** Minimum surgical assistant service is identified by adding modifier 81 to the usual procedure number.

90 **Reference (outside) Laboratory:** When Laboratory Procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

OB/GYN TOOL BOX

Here is the official summary of the Healthcare Information, Portability and Accountability Act. (HIPAA). If you are interested in the full version here is a link to the CMS website where it is published. http://www.cms.hhs.gov/HIPAAGenInfo/Downloads/HIPAALaw.pdf
HTTP://WWW.HHS.GOV/OCR/PRIVACY/HIPAA/UNDERSTANDING/SUMMARY/INDEX.HTML

Health Insurance Portability and Accountability Act of 1996
Summary of Administrative Simplification Provisions

Standards for electronic health information transactions. Within 18 months of Enactment, the Secretary of HHS is required to adopt standards from among those already approved by private standards developing organizations for certain electronic health transactions, including claims, enrollment, eligibility, payment, and coordination of benefits. These standards also must address the security of electronic health information systems.

Mandate on providers and health plans, and timetable. Providers and health plans are required to use the standards for the specified electronic transactions 24 months after they are adopted. Plans and providers may comply directly, or may use a health care clearinghouse. Certain health plans, in particular workers compensation, are not covered.

Privacy. The Secretary is required to recommend privacy standards for health information to Congress 12 months after enactment. If Congress does not enact privacy legislation within 3 years of enactment, the Secretary shall promulgate privacy regulations for individually identifiable electronic health information.

Pre-emption of State Law. The bill supersedes state laws, except where the Secretary determines that the State law is necessary to prevent fraud and abuse, to ensure appropriate state regulation of insurance or health plans, addresses controlled substances, or for other purposes. If the Secretary promulgates privacy regulations, those regulations do not pre-empt state laws that impose more stringent requirements. These provisions do not limit a State's ability to require health plan reporting or audits.

PENALTIES. The bill imposes civil money penalties and prison for certain violations.

OB/GYN TOOL BOX

BELOW ARE CPT CODES THAT ARE TYPICALLY USED IN FAMILY PRACTICE. KEEP IN MIND THAT EVERY PRACTICE IS DIFFERENT AND SOME PHYSICIAN'S WILL USE OTHER SPECIFIED CODES BASED ON THEIR PRACTICES DEMOGRAPHIC.

Evaluation & Management	Code Fee
☐ New Patient, Minimal	99201
☐ New Patient, Problem	99202
☐ New Patient, Low Complex	99203
☐ New Patient, Mod Complex	99204
☐ New Pat, High Complexity	99205
☐ New Pat, part of surgery*	99025
☐ Established Pt, Minimal	99211
☐ Establish Pat, Problem	99212
☐ Establish Pt, Low Complex	99213
☐ Establish Pat, Detailed	99214
☐ Est Pat, Comprehensive	99215

	New	*Estab*
☐ Well Woman 12-17	99384	99394
☐ Well Woman 18-39	99385	99395
☐ Well Woman 40-64	99386	99396
☐ Well Woman 65+	99387	99397
☐ Antepartum visit		59420
☐ Postpartum visit		59430
☐ Post operative visit		99024
☐ Office Consult, Limited		99241
☐ Off Consult,Straightforward		99242
☐ Off Consult, Low Complex		99243
☐ Off Consult, Mod Complex		99244
☐ Off Consult, High Complex		99245
☐ Inpt Consult,Straightforward		99251
☐ Inpt Consult, Expanded		99252
☐ Inpt Consult, Detailed		99253
☐ Inpt Consult,Comprehensive		99254
☐ Inpt Consult, High Complex		99255
☐ Second Opinion, Problem		99271
☐ Sec Opinion,Straightforward		99272
☐ Sec Opinion, Low Complex		99273
☐ Sec Opinion, Mod Complex		99274
☐ Sec Opinion, High Complex		99275

Laboratory	Code Fee
☐ Pap Smear	88150
☐ Specimen Prep	99000
☐ AFP Triscreen	82105
☐ Antibody Screen	86850
☐ Beta Strep Screen	86403
☐ Beta HCG, Qualitative	84703
☐ Beta HCG, Quantitative	84702
☐ CA 125	86316
☐ CBC w/differential	85022
☐ Chlamydia Culture	87110
☐ Estradiol	82670
☐ Fasting Blood Sugar	82947
☐ FSH	83001
☐ GC Culture	87070
☐ Gestational Glucose	82950
☐ Hemacult	82270
☐ Hematocrit	85014
☐ Hemoglobin	85018
☐ Hepatitis B	87340
☐ Herpes Culture	87274
☐ HIV	86701
☐ LH	83002
☐ Obstetric Profile	80055
☐ Post Coital Test	89300
☐ Prolactin	84146
☐ RPR	86592
☐ Serum Progesterone	84144
☐ Sickle Cell	85660
☐ Three Hour GTT	82951
☐ Thyroid Profile	80091
☐ Tissue Biopsy	88305
☐ UCG	81025
☐ Urinalysis	81000
☐ Urinalysis Dip	81002
☐ Urine Culture	87086
☐ Wet Mount	87210

Surgeries/Procedures	Code Fee
☐ Biopsy of Cervix*	57500
☐ Biopsy, Endometrial*	+58100
☐ Biopsy, Vaginal Mucos*	A 57100
☐ Biopsy, Vulvar,1 lesion	56605
☐ Colposcopy*	57452
☐ Colposcopy /biopsy(ies)*	57454
☐ Cryosurgery of Cervix*	57511
☐ Cryosurgery of Vulva*	56515
☐ Destruct vag lesion,simple	57061
☐ Destruct vulvar lesion,sim	56501
☐ Destruct vulvar lesion,ext	56515
☐ Diaphragm fitting	57170
☐ Endocervical Curettage	57505
☐ Excision skin tag(s) 1-15*	11200
☐ I&D Abscess, Simple	10060
☐ I&D Bartholin Abscess*	56420
☐ I&D Vulvar Abscess*	56405
☐ IUD	J7300
☐ IUD Insertion*	58300
☐ IUD Removal	58301
☐ LEEP +	57460
☐ Surgical Tray +	A4550
☐ Vaginal Painting*	57150
☐ Injection	90782
☐ Depo Provera 150 mg	J1055
☐ Lupron Depot 3.75 mg	J1950
☐ Lupron Depot 11.25 mg	J1950
☐ Rhogam	90742
☐ Rocephin	J0696
☐ Biophysical Profile	76818
☐ Fetal Non-Stress Test	59025
☐ OB Ultrasound, Complete	76805
☐ Multiple Gestation	76810
☐ Follow Up OB Ultrasound	76816
☐ Limited OB Ultrasound	76815
☐ Pelvic GYN Ultrasound	76856
☐ Transvaginal Ultrasound	76830

OB/GYN TOOL BOX

DIAGNOSIS: _____ **(ICD-9 CODES)MATERNAL**

__ **ABSCESS OF BREAST..... 675.1**
__ **ABSCESS OF NIPPLE..... 675.03**
__ **AGALACTIA (NO MILK).....676.44**
__ **CRACKED NIPPLE.....676.1**
__ **CYST.....610.0**
__ **DERMATITIS CONTACT.....692**
__ **ENGORGEMENT OF BREASTS.....676.2**
__ **GALACTORRHEA.....676.6**
__ **INFECTIONS OF NIPPLE.....675.04**
__ **LACTATION TOXICITY.....760.70**
__ **MASTITIS – NON-PURULENT.....675.2**
__ **MASTITIS – PURULENT.....675.1**
__ **OTHER AND UNSPECIFIED DISORDER OF BREAST.....676.3**
__ **OTHER DISORDERS OF LACTATION...676.8**
__ **OTHER SPECIFIED INFECTION OF BREAST AND NIPPLE.....675.8**
__ **RETRACTED NIPPLE.....676.0**
__ **SUPPRESSED LACTATION.....676.5**
__ **TWIN PREGNANCY POST-PARTUM CONDITION OR COMPLICATION.....651.04**
__ **UNSPECIFIED DISORDER OF LACTATION 676.9**
__ **UNSPECIFIED INFECTION OF THE BREAST AND NIPPLE 675.9**
__**OTHER**_____
_____

INFANT

__ **ABDOMINAL PAIN.....789.0**
__ **ABNORMAL LOSS OF WEIGHT.....783.2**
__ **ABNORMAL TONGUE POSITION.....750.1**
__ **BIRTH TRAUMA.....767.9** __ **BREASTMILK JAUNDICE.....774.39**
__ **CLEFT PALATE/LIP.....749**
__ **DOWN'S SYNDROME.....758**
__ **DYSPHAGIA.....787.2**
__ **FACIAL NERVE INJURY.....767.5**
__ **FAILURE TO THRIVE.....783.4**
__ **FEEDING DIFFICULTY – INFANT.....783.3**
__ **FEEDING PROBLEMS IN NEWBORN...779.3**
__ **NEONATAL CANDIDA INFECTION.....771.7**
__ **ORAL ORIFICE INSUFFICIENCY.....750.26**
__ **OTHER TRANSITORY NEONATAL DISTURBANCES.....775.5**
__ **PREMATURE INFANT.....765**
__ **SUCK REFLEX ABNORMAL.....796.1**
__ **OTHER** _____

OB/GYN TOOL BOX

CLAIM CORRECTION FORM

Submitted to:

Plan/Payer name: _____ Date submitted: _____/_____/_____

Plan/Payer address: _____
STREET SUITE CITY STATE ZIP

Telephone: (___)_____ Fax: (___)_____ E-mail: _____

Patient name: _____ Birth date: _____/_____/_____
FIRST M.I. LAST

Subscriber name: _____ Date of service: _____/_____/_____

Policy #: _____ Group #: _____ Original claim #: _____

Submitted by:

Provider: _____ Contact: _____ Telephone: (___)_____ Ext: ___ Fax: (___)_____

E-mail: _____

The following corrections were made on this claim:

- ❍ Patient's policy number/group number was incorrect. The correct number(s) are shown above.
- ❍ Date of service was incorrect. Correct date is: _____/_____/_____.
- ❍ CPT code was incorrect. Correct CPT code is _____ instead of _____.
- ❍ Diagnosis code was incorrect. Correct diagnosis code is _____ instead of _____.
- ❍ Visit was denied as over carrier's utilization limits. Please see attached letter to justify extensions of these limits.
- ❍ Procedure was denied as over carrier's utilization limits. Please see attached letter to justify extensions of these limits.
- ❍ Carrier indicated that the patient is covered by another plan that is primary. Patient indicates you are primary.
- ❍ Secondary carrier is _____. ❍ There is no secondary carrier.
- ❍ Procedure was denied as not medically necessary. Supporting documentation is attached.
- ❍ Carrier's clerk failed to enter correct number of times (units) procedure was performed. Correct units are as follows:
  DOS: _____/_____/_____ Code: _____ Units: _____ Charge total: $ _____

- ❍ We failed to enter correct number of times (units) procedure was performed. Correct units are as follows:
  DOS: _____/_____/_____ Code: _____ Units: _____ Charge total: $ _____

Multiple surgical procedures: ❍ Carrier failed to approve any procedure at 100%.
❍ Carrier approved incorrect procedure at 100%.
Carrier should have approved code _____@ 100%/50% (circle one).
Carrier should have approved code _____@ 100%/50% (circle one).
Carrier should have approved code _____@ 100%/50% (circle one).

- ❍ Modifiers were omitted. Please reconsider as follows:

Code	Code	Code	Code
-50 _____	_____	-51 _____	_____
-58 _____	_____	-59 _____	_____
-79_____	_____	GA_____	_____

- ❍ E/M service was denied as included in the global surgical fee. Please reconsider with attached supporting documentation:

Code: _____ Modifier(s): ❍ -24 ❍ -25 Charge: $ _____

- ❍ UPIN information was omitted.

Code: _____ Physician name: _____ UPIN: _____

- ❍ Plan-specific provider ID#: _____.
- ❍ CLIA number: _____.
- ❍ Place of service: _____.
- ❍ Service was rendered at the physician's physical location listed in Box 32 of the original claim form.
- ❍ EOB from primary carrier is attached.
- ❍ Incorrect information was entered on claim form. Line #: ___ Correct information: _____
- ❍ Other reason for correction: _____
- ❍ Comment: _____

_____

OB/GYN TOOL BOX

☐ **Established Patient – General Multisystem Exam**
Requirements must be met in 2 of 3 areas: (1) Hx (2) PE (3) Decisions

History — 3 OF 3 REQUIRED

	99213/LEVEL III – EXP PROBLEM FOCUSED 99214/LEVEL IV -- DETAILED	
	99213 **>=** 1 99214 **>=**4**:** ☐ **LOCATION** ☐ **QUALITY** ☐ **DURATION** ☐ **TIMING** ☐ **CONTEXT** ☐ **MODIFYING FACTORS** ☐ **ASSOCIATED S/S**	**OR 99214 >=3** ☐ **CHR DZ** ☐ **CHR DZ** ☐ **CHR DZ**
ROS	99213 **>=** 1 99214 >=2 **(PERTINENT SYSTEM)**	
	CONSTITUTIONAL ☐ **EYES** ☐ **ENT/MOUTH** ☐ **CV** ☐ **RESP** ☐ **GI** ☐ **GU** ☐ **MUSC** ☐ **SKIN/BREASTS** ☐ **NEURO** ☐ **PSYCH** ☐ **ENDO** ☐ **HEME/LYMPH** ☐ **ALLERGY/IMMUN** ☐	
PFSH	99213: **NO PFSH** 99214 >=1: **PMH** ☐ **FHX** ☐ **SHX** ☐	

CC/HPI:

Pain: _____ out of 10

TOBACCO:

LAST TD: _____

ALLERGIES:

MEDS:

LMP:

BIRTH CONTROL:

VISION SCREEN:
OD 20/
OS 20/
OU 20/

Exam

99213/LEVEL III: >= 6 **FROM ANY SYSTEMS/AREAS**
99214/LEVEL IV: >=12 **FROM** >=2 **SYSTEMS/AREAS**

HT: **WT:** **T:** **P:** **BP:** / **R:** **O_2 SAT :**

NURSE INITIALS

CONSTITUTIONAL
EYES
ENT
NECK
RESP
CV
CHEST (BREASTS)
GI (ABD)
GU
LYMPH
MUSC
SKIN
NEURO
PSYCH

PATIENT EDUCATION GIVEN: ☐ **VERBAL** ☐ **WRITTEN**

TOPIC: ☐ **MEDS** ☐ **DISEASE** ☐ **OTHER**

☐ **UNDERSTANDS** ☐ **NEEDS REPEAT TEACHING**

CHECK IN TIME:
APPT TIME:
EXAM ROOM:
Dr. Time:
COUNSELING TIME:

DICTACTED

CARDIOLOGY TOOL BOX

ESTABLISHED PATIENT – MULTISYSTEM EXAM

DECISION MAKING

⇑ 2 OF 3 REQUIRED ⇓

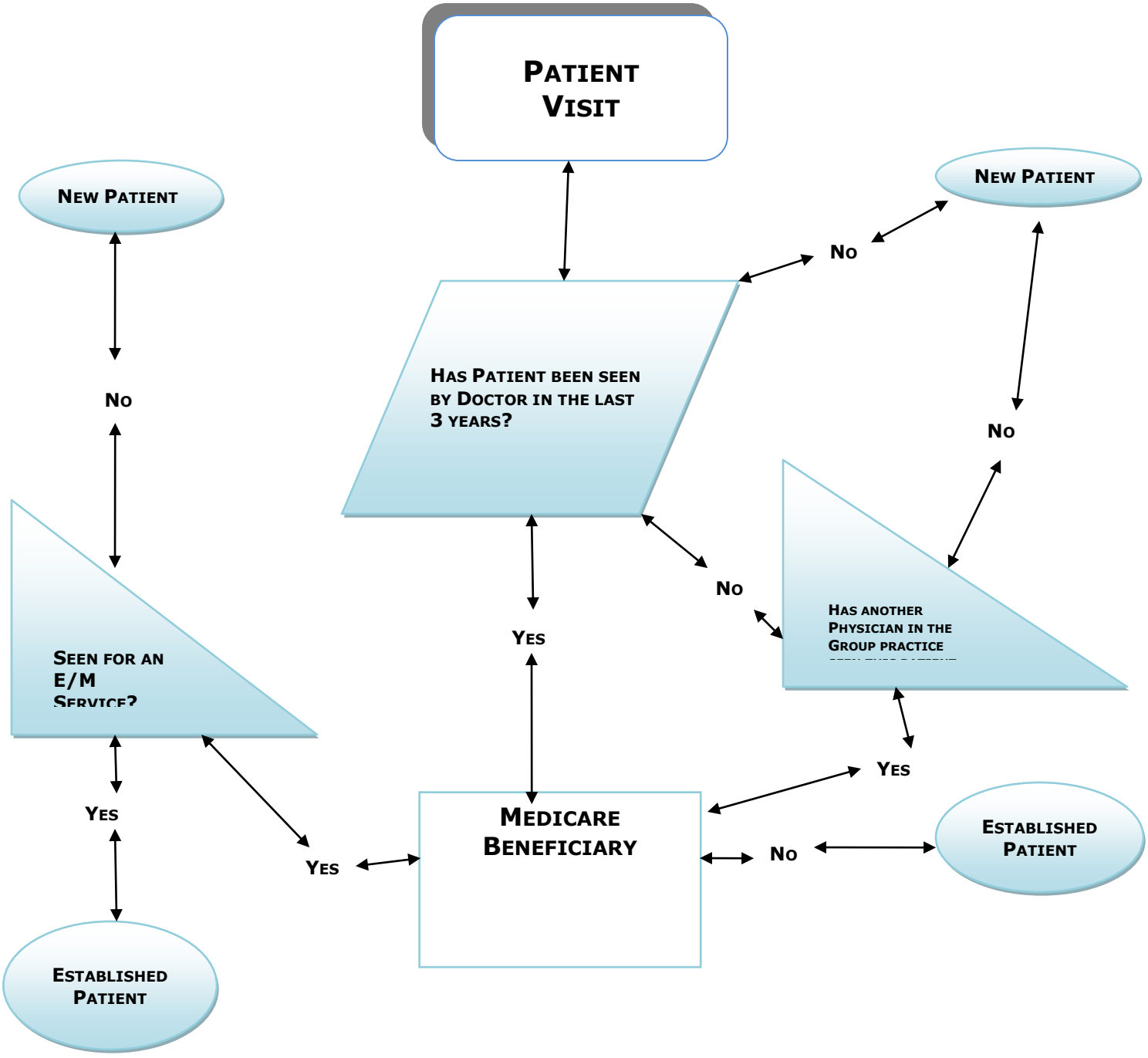
	99211/I	99212/II	99213/III	99214/IV	99215/V
		STRAIGHTFORWARD	**LOW COMPLEXITY**	**MODERATE COMPLEXITY**	**HIGH COMPLEXITY**
DIAGNOSIS		>=1 POINT **(MAX 2 PTS MINOR PROBS)**	>=2 POINTS **(MAX 2 PTS MINOR PROBS)**	>=3 POINTS **(MAX 2 PTS MINOR PROBS)**	>=4 POINTS **(MAX 2 PTS MINOR PROBS)**
		☐ **MINOR PROB** 1 ☐ **MINOR PROB** 1	☐ **MINOR PROB** 1 ☐ **MINOR PROB** 1	☐ **MINOR PROB** 1 ☐ **MINOR PROB** 1	☐ **MINOR PROB** 1 ☐ **MINOR PROB** 1
		☐ **ESTAB PROB-STABLE** 1 ☐ **ESTAB PROB-STABLE** 1	☐ **ESTAB PROB-STABLE** 1 ☐ **ESTAB PROB-STABLE** 1	☐ **ESTAB PROB-STABLE** 1 ☐ **ESTAB PROB-STABLE** 1	☐ **ESTAB PROB-STABLE** 1 ☐ **ESTAB PROB-STABLE** 1
		☐ **ESTAB PROB-WORSE** 2 ☐ **ESTAB PROB-WORSE** 2	☐ **ESTAB PROB-WORSE** 2 ☐ **ESTAB PROB-WORSE** 2	☐ **ESTAB PROB-WORSE** 2 ☐ **ESTAB PROB-WORSE** 2	☐ **ESTAB PROB-WORSE** 2 ☐ **ESTAB PROB-WORSE** 2
		MAX 3 PTS FOR NEW PROBS-STABLE	MAX 3 PTS FOR NEW PROBS-STABLE	MAX 3 PTS FOR NEW PROBS-STABLE	MAX 3 PTS FOR NEW PROBS-STABLE
		☐ **NEW PROB-STABLE** 3 ☐ **NEW PROB-NEED W/U** 4	☐ **NEW PROB-STABLE** 3 ☐ **NEW PROB-NEED W/U** 4	☐ **NEW PROB-STABLE** 3 ☐ **NEW PROB-NEED W/U** 4	☐ **NEW PROB-STABLE** 3 ☐ **NEW PROB-NEED W/U** 4
		TOTAL	TOTAL	TOTAL	TOTAL
DATA		>=1 POINT	>=2 POINTS	>=3 POINTS	>=4 POINTS
		☐ **ORDER/STUDY LABS** 1	☐ **ORDER/STUDY LABS** 1	☐ **ORDER/STUDY LABS** 1	☐ **ORDER/STUDY LABS** 1
		☐ **ORDER/STUDY X-RAYS** 1	☐ **ORDER/STUDY X-RAYS** 1	☐ **ORDER/STUDY X-RAYS** 1	☐ **ORDER/STUDY X-RAYS** 1
		☐ **ORDER/STUDY MED TESTS** 1	☐ **ORDER/STUDY MED TESTS** 1	☐ **ORDER/STUDY MED TESTS** 1	☐ **ORDER/STUDY MED TESTS** 1
		☐ **DISCUSSED RESULTS W/ TESTING DR.** 1	☐ **DISCUSSED RESULTS W/ TESTING DR.** 1	☐ **DISCUSSED RESULTS W/ TESTING DR.** 1	☐ **DISCUSSED RESULTS W/ TESTING DR.** 1
		☐ **ORDER OLD RECS/ADD HX** 1	☐ **ORDER OLD RECS/ADD HX** 1	☐ **ORDER OLD RECS/ADD HX** 1	☐ **ORDER OLD RECS/ADD HX** 1
		☐ **SUMMARY OF REVIEW OF OLD RECS/ADD HX** 2	☐ **SUMMARY OF REVIEW OF OLD RECS/ADD HX** 2	☐ **SUMMARY OF REVIEW OF OLD RECS/ADD HX** 2	☐ **SUMMARY OF REVIEW OF OLD RECS/ADD HX** 2
		☐ **VIEW X-RAY, TRACING OR SLIDE PREV INTERP BY OTHER DR.** 2	☐ **VIEW X-RAY, TRACING OR SLIDE PREV INTERP BY OTHER DR.** 2	☐ **VIEW X-RAY, TRACING OR SLIDE PREV INTERP BY OTHER DR.** 2	☐ **VIEW X-RAY, TRACING OR SLIDE PREV INTERP BY OTHER DR.** 2
		TOTAL	TOTAL	TOTAL	TOTAL
RISK		>=1 POINT	>=1 POINT	>=1 POINT	>=1 POINT
PROBLEMS		☐ **1 MINOR PROB (COLD, BUG BITE)**	☐ **2+ MINOR PROBS**	☐ **1+ CHRONIC PROB-MILD INCR**	☐ **1+ CHRONIC PROB-SEV INCR**
			☐ **1 CHRONIC PROB-STABLE**	☐ **2+ CHRONIC PROBS-STABLE**	☐ **CHRONIC PROB-LIFE THREAT**
			☐ **ACUTE PROB-UNCOMPLICATED (ALLERGY, UTI, SPRAIN)**	☐ **ACUTE PROB-SYSTEMIC (PYELO, PNEUMO)**	☐ **ACUTE PROB-LIFE THREAT**
				☐ **ACUTE INJURY-COMPLICATED (HEAD INJURY W/ BRIEF LOC)**	☐ **ACUTE MENTAL STATUS CHANGE (TIA, SEIZURE, WEAKNESS)**
				☐ **NEW PROB-UNCERT PX (BREAST LUMP)**	
PROCEDURES		☐ **X-RAY**	☐ **NON-CV CONTRAST STUDIES**	☐ **CV CONTRAST STUDIES (NO RISK FACTORS)**	☐ **CV CONTRAST STUDIES (WITH RISK FACTORS)**
		☐ **LABS**	☐ **PFT**	☐ **ENDOSCOPY (NO RISK FACTORS)**	☐ **ENDOSCOPY (WITH RISK FACTORS)**
		☐ **EKG**	☐ **SKIN BX**	☐ **DEEP NEEDLE BX**	
		☐ **UA**	☐ **NEEDLE BX – SUPERFICIAL**	☐ **INCISION BX**	
		☐ **KOH**	☐ **PUNCTURE-ARTERIAL**	☐ **EST**	
				☐ **FST**	
				☐ **BODY CAVITY FLUIDS**	
MANAGEMENT		☐ **REST**	☐ **OTC DRUGS (LIST OTC MEDS)**	☐ **RX DRUGS (LIST MEDS)**	☐ **DRUGS-INTENSIVE MONITOR**
		☐ **GARGLE**	☐ **PT**		☐ **PARENTAL TX**
				☐ **FRACTURE TX-CLOSED (NO MANIP)**	☐ **FRACTURE TX-CLOSED (W/ MANIP)**
		☐ **BANDAGES-ELASTIC**	☐ **OT**		☐ **DNR DECISION OR DEESCALATE CARE DUE TO POOR PX**
		☐ **SUPERFICIAL DRESSINGS**	☐ **IVF (NO ADDITIVES)**	☐ **IVF (W./ ADDITIVES)**	
			☐ **MINOR SURG (NO RISK FACTORS)**	☐ **MINOR SURG (W/ RISK FACTORS)**	
				☐ **MAJOR SURG-ELECTIVE (INCL ENDOSC; NO RISK FACTORS)**	☐ **MAJOR SURG-ELECTIVE (INCL ENDOSC; WITH RISK FACTORS)**
					☐ **MAJOR SURG-EMERGENT (INCL ENDOSC)**

TIME

	5-MIN	10-MIN	15-MIN	25-MIN	40-MIN
DOCUMENTATION MUST INCLUDE: DX, DESCRIPTION OF COUNSELING/COORDINATION, TOTAL TIME, WHO WAS PRESENT. ⇒ **WHEN MORE THAN 50% OF THE FACE-TO-FACE TIME WITH THE PATIENT WAS SPENT IN ADDRESSING COUNSELING COMPONENTS, THE VISIT MAY BE CODED BASED ON TIME IF THE CHART DOCUMENTATION SUPPORTS THE TIME. THE DOCUMENTATION MUST LIST THE TOTAL TIME OF THE ENCOUNTER AND THAT CODING WAS BASED ON COUNSELING REGARDING...**					
☐ **INSTRUCTIONS FOR MANAGEMENT** ☐ **RISK FACTOR REDUCTION** ☐ **IMPORTANCE OF COMPLIANCE W/ CHOSEN TX OPTIONS**		☐ **DIAGNOSTIC RESULTS** ☐ **PROGNOSIS**	☐ **RISKS AND BENEFIT OF TX OPTION** ☐ **PATIENT & FAMILY EDUCATION**	☐ **IMPRESSIONS**	

OB/GYN TOOL BOX

NEW vs. ESTABLISHED PATIENT



OB/GYN TOOL BOX

Below is the legend for the payment indicator box on the next page. To use this grid locate your code and follow the grid across to find out whether a modifier for reimbursement.

To look up a code that is not listed go to this URL:
http://www.cms.hhs.gov/pfslookup/02_PFSsearch.asp?agree=yes&next=Accept

0=Payment restriction applies to this procedure unless supporting documentation is submitted to establish medical necessity.
1=Statutory payment restriction for assistants at surgery applies to this code
2=Payment restrictions for assistants at surgery does not apply to this procedure. Assistant surgery may be paid

Modifier: 0=not allowed: 1=allowed: 9=not applicable

The ZZZ global surgery indicator: Allows payment only when the code is billed in conjunction with another base service. Alternatively, a ZZZ global period service may never be billed alone

OB/GYN TOOL BOX

HCPC	Modifier	Short Description	Proc Stat	PCTC	Global	Asst Surg	Bilt Surg	Mult Surg	Co Surg	Team Surg	Phys Supv	Diag Imaging Family Ind
36410		NON-ROUTINE BL DRAW > 3 YRS	A	0	XXX	1	0	2	0	0	9	99
78465		HEART IMAGE (3D), MULTIPLE	A	1	XXX	0	0	0	0	0	9	99
78465	TC	HEART IMAGE (3D), MULTIPLE	A	1	XXX	0	0	0	0	0	1	99
78465	26	HEART IMAGE (3D), MULTIPLE	A	1	XXX	0	0	0	0	0	9	99
92950		HEART/LUNG RESUSCITATION CPR	A	0	0	0	0	0	0	0	9	99
92960		CARDIOVERSION ELECTRIC, EXT	A	0	0	0	0	0	0	0	9	99
93000		ELECTROCARDIOGRAM, COMPLETE	A	4	XXX	0	0	0	0	0	1	99
93005		ELECTROCARDIOGRAM, TRACING	A	3	XXX	0	0	0	0	0	1	99
93010		ELECTROCARDIOGRAM REPORT	A	2	XXX	0	0	0	0	0	9	99
93012		TRANSMISSION OF ECG	A	3	XXX	0	0	0	0	0	1	99
93014		REPORT ON TRANSMITTED ECG	A	2	XXX	0	0	0	0	0	9	99
93015		CARDIOVASCULAR STRESS TEST	A	4	XXX	0	0	0	0	0	2	99
93040		RHYTHM ECG WITH REPORT	A	4	XXX	0	0	0	0	0	1	99
93224		ECG MONITOR/REPORT, 24 HRS	A	4	XXX	0	0	0	0	0	1	99
93268		ECG RECORD/REVIEW	A	4	XXX	0	0	0	0	0	1	99
93278		ECG/SIGNAL-AVERAGED	A	1	XXX	0	0	0	0	0	9	99
93278	TC	ECG/SIGNAL-AVERAGED	A	1	XXX	0	0	0	0	0	1	99
93278	26	ECG/SIGNAL-AVERAGED	A	1	XXX	0	0	0	0	0	9	99
93307		TTE W/O DOPPLER, COMPLETE	A	1	XXX	0	0	0	0	0	9	99
93307	TC	TTE W/O DOPPLER, COMPLETE	A	1	XXX	0	0	0	0	0	1	99
93307	26	TTE W/O DOPPLER, COMPLETE	A	1	XXX	0	0	0	0	0	9	99
93308		TTE, F-UP OR LMTD	A	1	XXX	0	0	0	0	0	9	99
93308	TC	TTE, F-UP OR LMTD	A	1	XXX	0	0	0	0	0	1	99
93308	26	TTE, F-UP OR LMTD	A	1	XXX	0	0	0	0	0	9	99
93312		ECHO TRANSESOPHAGEAL	A	1	XXX	0	0	0	0	0	9	99
93312	TC	ECHO TRANSESOPHAGEAL	A	1	XXX	0	0	0	0	0	3	99
93312	26	ECHO TRANSESOPHAGEAL	A	1	XXX	0	0	0	0	0	9	99
93313		ECHO TRANSESOPHAGEAL	A	0	XXX	0	0	0	0	0	3	99
93314		ECHO TRANSESOPHAGEAL	A	1	XXX	0	0	0	0	0	9	99
93314	TC	ECHO TRANSESOPHAGEAL	A	1	XXX	0	0	0	0	0	3	99
93314	26	ECHO TRANSESOPHAGEAL	A	1	XXX	0	0	0	0	0	9	99
93320		DOPPLER ECHO EXAM, HEART	A	1	ZZZ	0	0	0	0	0	9	99
93320	TC	DOPPLER ECHO EXAM, HEART	A	1	ZZZ	0	0	0	0	0	1	99

OB/GYN TOOL BOX

93320	26	DOPPLER ECHO EXAM, HEART	A	1	ZZZ	0	0	0	0	0	9	99
93321		DOPPLER ECHO EXAM, HEART	A	1	ZZZ	0	0	0	0	0	9	99
93321	TC	DOPPLER ECHO EXAM, HEART	A	1	ZZZ	0	0	0	0	0	1	99
93321	26	DOPPLER ECHO EXAM, HEART	A	1	ZZZ	0	0	0	0	0	9	99
93325		DOPPLER COLOR FLOW ADD-ON	A	1	ZZZ	0	0	0	0	0	9	99
93325	TC	DOPPLER COLOR FLOW ADD-ON	A	1	ZZZ	0	0	0	0	0	1	99
93325	26	DOPPLER COLOR FLOW ADD-ON	A	1	ZZZ	0	0	0	0	0	9	99
93350		STRESS TTE ONLY	A	1	XXX	0	0	0	0	0	9	99
93350	TC	STRESS TTE ONLY	A	1	XXX	0	0	0	0	0	2	99

CARDIOLOGY TOOL BOX

ACRONYMS

AMA American Medical Association Chief Complaint

CC Chief Complaint

CMS Centers for Medicare & Medicaid Services

CPT Current Procedural Terminology

E/M Evaluation and Management

HPI History of Present Illness

ICD-9-CM International Classification of Diseases, 9th Revision, Clinical Modification

PFSH Past, Family, and/or Social History

ROS Review of Systems