NOVITAS SOLUTIONS

Medicare Part B

A CMS CONTRACTOR

NOVITAS SOLUTIONS DOCUMENTATION WORKSHEET

Beneficiary HIC #

_____

Provider Number

_____

Date of Service

_____

Procedure Code Reported

_____

Check one: ❑ Agree ❑ Disagree

Documented Procedure Code Level

_____

1. History

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

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

HISTORY				
HPI: Status of chronic conditions: ❑ 1 condition ❑ 2 conditions ❑ 3 conditions OR **HPI (history of present illness) elements:** ❑ Location ❑ Severity ❑ Timing ❑ Modifying factors ❑ Quality ❑ Duration ❑ Context ❑ Associated signs and symptoms		❑ Status of 1-2 chronic conditions ❑ Brief (1-3)		❑ Status of 3 chronic conditions ❑ Extended (4 or more)
ROS (review of systems): ❑ Constitutional (wt loss, etc) ❑ Eyes ❑ Ears,nose, mouth, throat ❑ Card/vasc ❑ Resp ❑ GI ❑ GU ❑ Musculo ❑ Integumentary (skin, breast) ❑ Neuro ❑ Psych ❑ Endo ❑ Hem/lymph ❑ All/immuno ❑ All others negative	❑ None	❑ Pertinent to problem (1 system)	❑ Extended (2-9 systems)	❑ *Complete
PFSH (past medical, family, social history) areas: ❑ Past history (the patient's past experiences with illnesses, operation, injuries and treatments) ❑ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk) ❑ Social history (an age appropriate review of past and current activities)		❑ None	❑ Pertinent (1 history area)	❑ **Complete (2 or 3 history areas)
	PROBLEM FOCUSED	**EXP.PROB. FOCUSED**	**DETAILED**	**COMPRE-HENSIVE**
	12	02 13	03 14	04/05 15

***Complete ROS:** 10 or more systems or the pertinent positives and/or negatives of some systems with a statement "all others negative".

****Complete PFSH:** 2 history areas: a) Established Patients - Office (Outpatient) Care; b) Emergency Department.

3 history areas: a) New Patients - Office (Outpatient) Care, Domiciliary Care, Home Care; b) Initial Hospital Care; c) Initial Hospital Observation; d) Initial Nursing Facility Care.

NOTE: For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Please refer to procedure code descriptions.

2. Examination

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

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

EXAM				
Body areas: ❑ Head, including face ❑ Chest, including breasts and axillae ❑ Abdomen ❑ Neck ❑ Back, including spine ❑ Genitalia, groin, buttocks ❑ Each extremity **Organ systems:** ❑ Constitutional (e.g., vitals, gen app) ❑ Eyes ❑ Ears,nose, mouth, throat ❑ Cardiovascular ❑ Resp ❑ GI ❑ GU ❑ Musculo ❑ Skin ❑ Neuro ❑ Psych ❑ Hem/lymph/imm	❑ 1 body area or system <6	❑ Up to 7 systems 6-11	❑ Up to 7 systems 12-17	❑ 8 or more systems 18+
	PROBLEM FOCUSED	**EXP.PROB. FOCUSED**	**DETAILED**	**COMPRE-HENSIVE**
	12	02 13	03 14	04,05 15

3. Medical Decision Making

MEDICAL DECISION MAKING

Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.)

Number of Diagnoses or Treatment Options				
A	B	X	C	= D
Problem(s) Status	**Number**		**Points**	**Result**
Self-limited or minor (stable, improved or worsening)	*Max = 2*		1	
Est. problem (to examiner); stable, improved			1	
Est. problem (to examiner); worsening			2	
New problem (to examiner); no additional workup planned	*Max = 1*		3	
New prob. (to examiner); add. workup planned			4	
			TOTAL	3

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.

Bring total to **line A** in Final Result for Complexity (table below)

Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the points column. Total the points.

Amount and/or Complexity of Data Reviewed	
Reviewed Data	**Points**
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
TOTAL	3

Bring total to **line C** in Final Result for Complexity (table below)

Risk of Complications and/or Morbidity or Mortality

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below).

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g.,pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clincal 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, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• Physiologic tests under stress, e.g., 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, e.g., arteriogram cardiac cath • Obtain fluid from body cavity, e.g., 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 addititives • 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 may pose a threat to life or bodily function, e.g., 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, e.g., seizure, TIA, weakness or 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

Final Result for Complexity

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

Final Result for Complexity					
A	Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making		**STRAIGHT-FORWARD**	**LOW COMPLEX.**	**MODERATE COMPLEX.**	**HIGH COMPLEX.**
		02 12	03 13	04 14	05 15

4. Time

If the physician documents total time *and* suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

Does documentation reveal total time? Time: Face-to-face in outpatient setting / Unit/floor in inpatient setting	Yes	No
Does documentation describe the content of counseling or coordinating care?	Yes	No
Does documentation reveal that more than half of the time was counseling or coordinating care?	Yes	No

If all answers are "yes", select level based on time.

5. LEVEL OF SERVICE

New Office, Outpatient and Emergency Room

	New Office / Outpatient / ER					Established Office / Outpatient				
	Requires 3 components within shaded area					Requires 2 components within shaded area				
History	PF **ER:** PF	EPF **ER:** EPF	D **ER:** EPF	C **ER:** D	C **ER:** C	*Minimal problem that may not require presence of physician*	**PF**	**EPF**	**D**	**C**
Examination	PF **ER:** PF	EPF **ER:** EPF	D **ER:** EPF	C **ER:** D	C **ER:** C		**PF**	**EPF**	**D**	**C**
Complexity of medical decision	SF **ER:** SF	SF **ER:** L	L **ER:** M	M **ER:** M	H **ER:** H		**SF**	**L**	**M**	**H**
Average time (minutes)	10 New (99201)	20 New (99202)	30 New (99203)	45 New (99204)	60 New (99205)	5	10	15	25	40
ER has no average time	ER (99281)	ER (99282)	ER (99283)	ER (99284)	ER (99285)	(99211)	(99212)	(99213)	(99214)	(99215)
Level	**I**	**II**	**III**	**IV**	**V**	**I**	**II**	**III**	**IV**	**V**

Hospital Care

	Initial Hospital/Observation			Subsequent Hospital/Observation		
	Requires 3 components within shaded area			Requires 2 components within shaded area		
History	D/C	C	C	PF interval	EPF interval	D interval
Examination	D/C	C	C	PF	EPF	D
Complexity of medical decision	SF/L	M	H	SF/L	M	H
Average time (minutes)	30 Init hosp (99221) 30 Init observ Care (99218)	50 Init hosp (99222) 50 Init observ Care (99219)	70 Init hosp (99223) 70 Init observ Care (99220)	15 Sub hosp (99231) 15 Sub observ care (99224)	25 Sub hosp (99232) 25 Sub observ care (99225)	35 Sub hosp (99233) 35 Sub observ care (99226)
Level	**I**	**II**	**III**	**I**	**II**	**III**

Nursing Facility Care

	Initial Nursing Facility			Subsequent Nursing Facility				Other Nursing Facility (Annual Assessment)
	Requires 3 components within shaded area			Requires 2 components within shaded area				Requires 3 components within shaded area
History	D/C	C	C	PF interval	EPF interval	D interval	C interval	D interval
Examination	D/C	C	C	PF	EPF	D	C	C
Complexity of medical decision	SF/L	M	H	SF	L	M	H	L/M
Average time (minutes)	25 99304	35 99305	45 99306	10 99307	15 99308	25 99309	35 99310	30 99318
Level	**I**	**II**	**III**	**I**	**II**	**III**	**IV**	

Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services and Home Care

	Requires 3 components within shaded area					Requires 2 components within shaded area			
History	PF	EPF	D	C	C	PF interval	EPF interval	D interval	C interval
Examination	PF	EPF	D	C	C	PF	EPF	D	C
Complexity of medical decision	SF	L	M	M	H	SF	L	M	M/H
Average time (minutes)	20 Domiciliary (99324) Home care (99341)	30 Domiciliary (99325) Home care (99342)	45 Domiciliary (99326) Home care (99343)	60 Domiciliary (99327) Home care (99344)	75 Domiciliary (99328) Home care (99345)	15 Domiciliary (99334) Home care (99347)	25 Domiciliary (99335) Home care (99348)	40 Domiciliary (99336) Home care (99349)	60 Domiciliary (99337) Home care (99350)
Level	**I**	**II**	**III**	**IV**	**V**	**I**	**II**	**III**	**IV**

PF = Problem focused EPF = Expanded problem focused D = Detailed C = Comprehensive SF = Straightforward L = Low M = Moderate H = High

SKIN CARE ENCOUNTER FORM

Family Practice Management®

Patient Name _____ Patient ID # _____ D.O.B. _____ Date _____

CPT		DESCRIPTION
		OFFICE VISITS
		Established patient
99212		Problem focused
99213		Expanded problem focused
99214		Detailed
99215		Comprehensive [ ] Procedure only
99024		Post-op care
		New patient
99201		Problem focused
99202		Expanded problem focused
99203		Detailed
99204		Comprehensive (moderate MDM)
99205		Comprehensive (high MDM)
		CONSULTATIONS
		Requesting Dr. _____
99241		Problem focused
99242		Expanded problem focused
99243		Detailed
99244		Comprehensive (moderate MDM)

CPT		DESCRIPTION
		OFFICE PROCEDURES
10040		Acne surgery
11000		Debridement
10060		I & D abscess, single
10061		I & D abscess, complex or multiple
11900		Intralesional injection, ≤ 7 lesions
11901		Intralesional injection, > 7 lesions
95044		Patch tests _____# of tests
11100		Skin biopsy, single
+11101		Skin biopsy, each add'l (#) _____
11200		Skin tags, up to 15
+11201		Skin tags, each additional 10 lesions
		Destruction premalignant lesions – AKs
17000		First lesion
+17003		2-14 lesions each Total: 1+ _____
17004		15 or more lesions
		Destruct benign lesions warts/molluscum/milia
17110		Up to 14 lesions
17111		15 or more lesions
87177		Scabies mount
87220		KOH prep

ICD-10		DESCRIPTION
L83		Acanthosis nigricans
L70.0		**Acne vulgaris**
L70.9		Acne, unspecified
L56.8		Actinic cheilitis (sun)
L57.0		Actinic keratosis
T50.905A		Adverse effect of drug, unspec, initial encounter
L63.9		Alopecia areata, unspecified
L63.8		Alopecia areata, other
K13.0		Diseases of lips
L20.89		Atopic dermatitis, other
D23. ____		**Benign neoplasm skin, other, site: _____**
L13.9		Bullous disorder, unspecified
L03.90		Cellulitis, unspecified
H61.00 ___		Chondrodermatitis nodularis helicis
L23.5		Contact dermatitis, chemicals
L23.0		Contact dermatitis, metals
L23.7		Contact dermatitis, plants/poison ivy
L23.81		Contact dermatitis, animal
L23.89		Contact dermatitis, other
L23.9		Contact dermatitis, other cause
L84		Corns and callosities
L50.3		Dermatographic urticaria
L98.9		**Disorder of the skin, unspecified**
L81.9		Disorder of pigmentation, unspecified
L30.1		**Dyshidrotic eczema**
L30.9		**Eczema, NOS**
L72.0		**Epidermoid cyst**
L51.9		Erythema multiforme, unspecified
L30.3		Infective dermatitis
B08.4		Hand, foot, and mouth disease
L98.1		Factitial dermatitis
K62.0		**Fibroepithelial polyp (anal)**
L73.9		Folliculitis/follicular disease
L02. _____		Furuncle or carbuncle, site: _____
L92.0		Granuloma annulare
L11.1		Grover's
D18.01		Hemangioma/cherry angioma
B00.9		Herpes simplex, NOS
L73.2		Hidradenitis suppurativa

ICD-10		DESCRIPTION
L74.511		Hyperhidrosis, face
L85.9		Hyperkeratosis
L01.00		Impetigo, unspecified
L30.4		Erythema intertrigo
L91.0		Hypertrophic scar, keloid
L85.1		Keratoderma, acquired
L85.8		Keratosis pilaris
L81.4		Lentigo/Lentigo maligna
L43.9		Lichen planus
L90.0		Lichen sclerosus et atrophicus
L28.0		**Lichen simplex chronicus**
D17._____		Lipomatous neoplasm, benign, site: ____
L93.0		Lupus erythematous, discoid
C43.___		Malignant melanoma of skin, site: _____
C44.___		Malignant neoplasm, skin, site/type: ___
B08.1		Molluscum contagiosum
L60.9		Nail disorder, unspecified
D48.5		**Neoplasm, uncert. behavior of skin, verify by pathology**
B35.1		Onychomycosis
L56.9		Photodermatitis
L42		Pityriasis rosea
L28.1		Prurigo nodularis
L29.9		**Pruritus, unspecified**
L40.9		**Psoriasis, unspecified**
L98.0		Pyogenic granuloma
L71.9		Rosacea, unspecified
B86		Scabies
L90.5		Scar
L73.8		**Sebaceous hyperplasia**
L21.0		**Seborrheic capititis**
L82.1		**Seborrheic keratosis, other**
L82.0		Seborrheic keratosis, inflamed
L57.8		Solar elastosis
I87.2		Stasis dermatitis
L90.6		Striae atrophicae
T81.89XA		Surgical wound, nonhealing, active care episode
I78.1		Telangiectasia (spider)

	≤ 0.5 cm	0.6-1.0	1.1-2.0	2.1-3.0	3.1-4.0	> 4.0
Destruction malignant lesion (curettage, ED&C, cryotherapy)						
Trunk, arms, legs	17260	17261	17262	17263	17264	17266
Scalp, neck, hands, feet, genitals	17270	17271	17272	17273	17274	17276
Face, ears, eyelids, nose, lips	17280	17281	17282	17283	17284	17286
Excision benign lesion						
Trunk, arms, legs	11400	11401	11402	11403	11404	11406
Scalp, neck, hands, feet, genitals	11420	11421	11422	11423	11424	11426
Face, ears, eyelids, nose, lips, mucous membrane	11440	11441	11442	11443	11444	11446
Excision malignant lesion						
Trunk, arms, legs	11600	11601	11602	11603	11604	11606
Scalp, neck, hands, feet, genitals	11620	11621	11622	11623	11624	11626
Face, ears, eyelids, nose, lips, mucous membrane	11640	11641	11642	11643	11644	11646
Shave lesion	**≤ 0.5 cm**	**0.6-1.0**	**1.1-2.0**	**>2.000**		
Trunk, arms, legs	11300	11301	11302	11303		
Scalp, neck, hands, feet, genitals	11305	11306	11307	11308		
Face, ears, eyelids, nose, lips, mucous membrane	11310	11311	11312	11313		
Simple closure * For each site, each type of closure, report the sum as one code	2.5 cm or <	2.6 - 7.5 cm	7.6 - 12.5 cm	12.6 - 20.0 cm		
Scalp, neck, axillae, ext. genitalia, truck, and /or ext. (including feet and hands)	12001	12002	12004	12005		
Face, ears, eyelids, nose, lips, and/or mucous membranes	12011	12013	12014	12015		
Complex closure * For lengths greater than those listed, consult CPT	1.1 - 2.5 cm	2.6 - 7.5 cm	Each add'l 5 cm or <			
Trunk	13100	13101	+ 13102			
Scalp, arms, and/or legs	13120	13121	+ 13122			
Forehead, cheek, chin, mouth, neck, axillae, genitalia, hands and/or feet	13131	13132	+ 13133			
Eyelids, nose, ears, and/or lips	13151	13152	+ 13153			
Two layer closure				**≤2.5 cm**		**2.6-7.5**
Scalp, axilla, trunk, extremities excluding hand and foot				12031		12032
Neck, hand, foot, genitals				12041		12042
				≤2.5 cm	**2.6-5.0**	**5.1-7.5**
Face, ear, eyelid, nose, lip, mucous membrane				12051	12052	12053

ICD-10		DESCRIPTION
B35.0/.4 /.6		Tinea capitis/corporis/cruris
B35.3 /.2		Tinea pedis/tinea manuum
B36.0		Tinea versicolor
L98. 4___		Ulcer, non-pressure, chronic (specify site: _____, depth:_____)
L50.0		Urticaria, allergic
L50.1		Urticaria, idiopathic
B07.9		**Verruca (viral wart)**
L80		Vitiligo
K68.11		Postprocedural retroperitoneal abscess
L85.3		**Xerosis cutis**
Z80.8		Family history of melanoma
Z85.820		Personal history of melanoma
Z85.828		**Personal history of other malignant neoplasm (BCC/SCC)**

DIAGNOSIS:

AMERICAN ACADEMY OF FAMILY PHYSICIANS

***FPM* Toolbox** To find more practice resources, visit http://www.aafp.org/fpm/toolbox.