

ADOLESCENT MEDICINE

IS THIS A CHDP CHECK? <input type="checkbox"/> Yes <input type="checkbox"/> No	Billing Area: <input type="checkbox"/>	Provider Name and #: <input type="checkbox"/>
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• ALL SHADED DATA ELEMENTS MUST BE COMPLETED BY ATTENDING PHYSICIAN
• CIRCLE ONE OF THE E/M CODES FOR NEW PATIENT, CONSULTS OR ESTABLISHED PATIENT

Addressograph

LOCATION <input type="checkbox"/>	HOSP <input type="checkbox"/>	Date of Injury	W/C Claim/Case #	Full Name of Referring Physician (#)	Full Name of Requesting Physician (#)
INSURANCE AUTHORIZATION: Authorization # _____ Authorized By: _____ Authorization Phone: _____				Patient Agreement for Non Covered Services Signed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Billing Instructions <input type="checkbox"/> Financial Hardship <input type="checkbox"/> Courtesy <input type="checkbox"/> Other

Include modifier -25 (separate service on same day as procedure) even if procedure is at a different location.

E/M DX # _____

NEW OUTPATIENTS & OUTPATIENT CONSULTS: When selecting a code, all 3 sections under the code (history, exam, medical decision making) must be met & documented.

	Level 1			Level 2			Level 3			Level 4			Level 5		
	New 99201	Consult 99241	Confirm 99271	New 99202	Consult 99242	Confirm 99272	New 99203	Consult 99243	Confirm 99273	New 99204	Consult 99244	Confirm 99274	New 99205	Consult 99245	Confirm 99275
H X E X A M	HPI: 1- 3 Components All Req'd			HPI: 1- 3 Components All Req'd ROS: 1 System			HPI: 4+ Components* All Req'd ROS: 2 - 9 Systems PFSH: 1			HPI: 4+ Components* All Req'd ROS: 10+ Systems PFSH: 3			HPI: 4+ Components* All Req'd ROS: 10+ Systems PFSH: 3		
M D M	Problem focused 1 - 5 bullets			Expanded Problem Focused At least 6 bullets			Detailed At least 12 bullets			Comprehensive General Multi-System vs Single System exam see specialty req. card			Comprehensive General Multi-System vs Single System exam see specialty req. card		
	Straightforward Dx: ≤ 1 Data: ≤ 1 Req'd Risk: Minimal			Straightforward Dx: ≤ 1 Data: ≤ 1 Req'd Risk: Minimal			Low Complexity Dx: 2 Data: 2 Req'd Risk: Low			Moderate Complexity Dx: 3 Data: 3 Req'd Risk: Moderate			High Complexity Dx: 4 Data: 4 Req'd Risk: High		

ESTABLISHED OUTPATIENTS: When selecting a code, 2 of 3 sections under the code (history, exam, medical decision making) must be met & documented.

	99211		99212		99213		99214		99215	
	New	Consult	New	Consult	New	Consult	New	Consult	New	Consult
H X E X A M	None		HPI: 1- 3 Components All Req'd		HPI: 1- 3 Components All Req'd ROS: 1 System		HPI: 4+ Components* All Req'd ROS: 2 - 9 Systems PFSH: 1		HPI: 4+ Components* All Req'd ROS: 10+ Systems PFSH: 2	
M D M	None		Problem focused 1 - 5 bullets		Expanded Problem Focused At least 6 bullets		Detailed At least 12 bullets		Comprehensive General Multi-System vs Single System exam see specialty req. card	
	None		Straightforward Dx: ≤ 1 Data: ≤ 1 Req'd Risk: Minimal		Low Complexity Dx: 2 Data: 2 Req'd Risk: Low		Moderate Complexity Dx: 3 Data: 3 Req'd Risk: Moderate		High Complexity Dx: 4 Data: 4 Req'd Risk: High	

NEW PATIENT - PREVENTIVE MEDICINE		ESTABLISHED PATIENT - PREVENTIVE MEDICINE		# PROCEDURE CODES: Link procedure with diagnosis code by using 1, 2, 3, etc.					
99384	99385	99394	99395	#	DESCRIPTION	CPT	#	DESCRIPTION	CPT
12 - 17 years old	18 - 39 years old	12 - 17 years old	18 - 39 years old		Norplant	11975		Norplant Removal	11976

HISTORY OF PRESENT ILLNESS (HPI) COMPONENTS:				SELECT E/M CODE BASED ON TIME ONLY when over 50% of the Attending Physician face to face encounter was spent in counseling and/or coordination of patient care.								
Location	Quality	Severity	Duration	Timing	Document the following times:							
Context Modifying factors Associated signs/symptoms					Total Face-Face time with patient: _____ minutes.		NEW		CONSULT		ESTABLISHED	
* Or the status of at least three chronic or inactive conditions					Counseling/Coordination time: _____ minutes.		CODE	TIME	CODE	TIME	CODE	TIME
REVIEW OF SYSTEMS (ROS): Constitutional Eyes ENT/Mouth					(Circle code based on total face to face time)							
Respiratory CV GI GU Neuro Integumentary												
Psych Musculoskeletal Endo Allergic/Immune Hem/Lymph												
PFSH = Past, Family, Social History MDM = Medical Decision Making							99201	10 min	99241	15 min	99211	5 min
							99202	20 min	99242	30 min	99212	10 min
							99203	30 min	99243	40 min	99213	15 min
							99204	45 min	99244	60 min	99214	25 min
							99205	60 min	99245	80 min	99215	40 min

Write In Procedure:	#	CPT CODE	PROCEDURE	MODIFIER
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Indicate Priority of Diagnoses by 1, 2, 3, etc.					
PR	Diagnosis/ICD-9 Code	PR	Diagnosis/ICD-9 Code	PR	Diagnosis/ICD-9 Code
	Abdominal pain 789.0		Bronchitis 490		Fibrocystic disease 277.00
	Acne 706.1		Cerclitis 616.0		Gonorrhea 098.0
	Acute pharyngitis 462		Chest pain 789.50		Headache 784.0
	Acute viral syndrome 079.99		Chlamydia 079.98		Menorrhagia 626.3
	Allergic rhinitis 477.9		Conjunctivitis 372.30		Monilia 112.9
	Adolescent exam (CHDP) V70.0		Dermatitis atopic 691.8		Musculoskeletal disorders 729.9
	Amenorrhea 626.0		Dysfunct. uterine bleeding 626.8		Psychosocial issues 309.9
	Anemia 285.9		Dysmenorrhea 625.3		Pregnancy v22.22
	Asthma 493.90		Family planning v25.09		Rash 782.1

SEE ABOVE FOR DIAGNOSES/ICD-9 CODE				DX #	ICD-9 CODE	DX #	ICD-9 CODE
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CHECK ONE BOX FOR E/M CODE SELECTED: I was physically present and directly participating **with** the resident/fellow in the patient's care. (Use -GC Modifier)
 I personally provided the services indicated **without** resident/fellow involvement.

CHECK ONE BOX FOR PROCEDURE CODE SELECTED: I was physically present and directly participating **with** the resident/fellow in the patient's care. (Use -GC Modifier)
 I personally provided the services indicated **without** resident/fellow involvement.

"I certify that (1) all services on this form were rendered and are hereby approved for billing (2) the medical record documentation will support the services provided and (3) the rendering of the services and the documentation in the medical record are in accordance with our teaching physician guidelines."

Provider Signature: _____ Date: _____