SMFM White Paper on Taxonomy Codes

The purpose of this White Paper is to advise members of the definition of a Taxonomy Code, clarification of “specialty” and “sub-specialty” and proper usage.

General Obstetrician-Gynecologists are considered as “Specialists” and Maternal-Fetal Medicine fellowship graduates as “Sub-specialists”, and are defined by a distinct Healthcare Provider Taxonomy Code (HPTC):

- Maternal-Fetal Medicine, Specialty Code =112, Taxonomy Code = 207VM0101X
- OB-GYN, Specialty Code = 015 , Taxonomy Code = 207V00000X

Taxonomy codes are 10-character federally established alpha-numeric codes which health care professionals use to identify unique specialty or sub-specialty areas. They are a combination of Provider Type and Provider Specialty that are self-declared by health care providers during the National Provider Identifier (NPI) enumeration process. The Health Care Provider Taxonomy code set is developed by the Centers for Medicare and Medicaid Services (CMS) and is published twice a year in July and January.

When contracting with payers, it is important that you are listed in their systems under the correct sub-specialty of Maternal-Fetal Medicine and corresponding Taxonomy Code for optimal reimbursement.

Example:

A patient is being cared for by the Obstetrician for her routine pregnancy. At 28 weeks gestation she develops Gestational Diabetes. The Obstetrician requests an office consultation by a Maternal-Fetal Medicine Specialist, who happens to belongs to the same hospital organization.

In this example, as long as the requirements for a consultation are met (see below), it would be appropriate to report the consultation codes (99241-99245). If the requirements for a consultation were not met, and the Maternal-Fetal Medicine Physician had never seen the patient, the new patient outpatient/office visit codes (99201-99205) would be reported accordingly.

New/Established Patient Guidelines:

For 2012, the new and established patient definitions in the E&M Guidelines have been revised providing further clarification of professional services rendered by physicians in regards to specialties and subspecialties.

The revision includes the addition of the terms **“exact”** and **“subspecialty”** to specifically indicate that the professional services must be from a physician of the “exact” same specialty “and subspecialty” who belongs to the same group practice within the past three years to be considered an established patient.

In other words, differences among subspecialties often require significant additional work, and should therefore be considered a new patient rather than an established patient service. Again, if a General OB-GYN requests a consultation by Maternal-Fetal Medicine, even within the same organization, that patient would **not** be considered an established patient. The same applies for consultation requests from Reproductive Endocrinologists or Gynecologic Oncologists.

A ***new patient*** is one who has not received any professional services from the physician or another physician of the **exact same specialty and subspecialty** who belongs to the same group practice, within the past three years.

Consultation Guidelines:

In order to report a consultation you must meet the three (3) R's:

- A consultation must be requested by a physician or other appropriate source (i.e. Nurse Practitioner, Certified Nurse Midwife, etc.).
  Note: The request can be written or verbal.

- A record of the physicians' opinion and any services ordered or performed must be documented in the chart.

- A written report must be sent back to the physician or appropriate source who requested the consultation.