DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®

Official CMS Information for
Medicare Fee-For-Service Providers

Evaluation and Management Services Guide

December 2010 / ICN: 006764

PREFACE

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." These publications are available in the Reference Section of this guide and at ***http://www.cms.gov/MLNProducts/Downloads/1995dg.pdf*** and ***http://www.cms.gov/MLNProducts/Downloads/MASTER1.pdf*** on the Centers for Medicare & Medicaid Services website.

Note: Either version of the documentation guidelines, not a combination of the two, may be used by the provider for a patient encounter.

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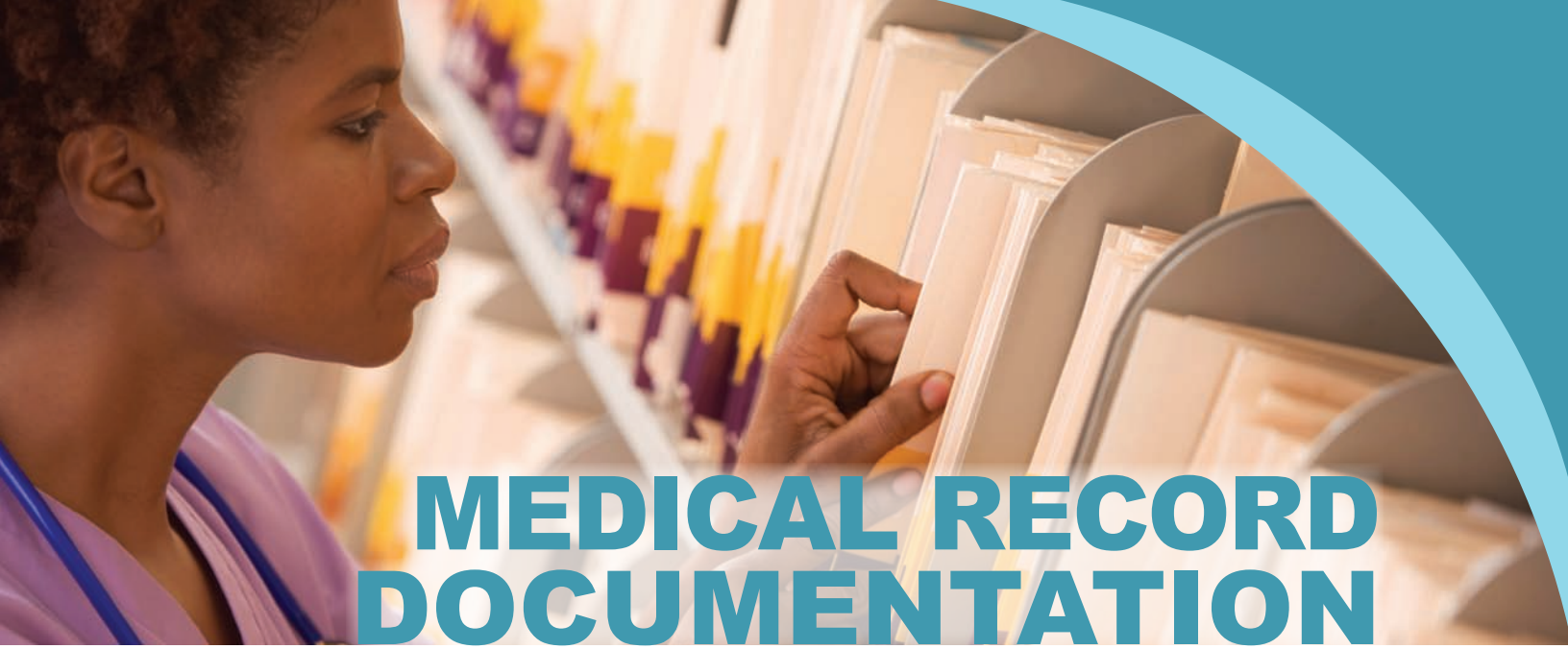


MEDICAL RECORD DOCUMENTATION

This chapter provides information about the general principles of evaluation and management (E/M) documentation, common sets of codes used to bill for E/M services, and E/M service providers.

GENERAL PRINCIPLES OF EVALUATION AND MANAGEMENT DOCUMENTATION

"If it isn't documented, it hasn't been done" is an adage that is frequently heard in the health care setting.

Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and are used to record pertinent facts, findings, and observations about the patient's health history. Medical record documentation assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring the patient's health care over time.

Health care payers may require reasonable documentation to ensure that a service is consistent with the patient's insurance coverage and 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.

There are general principles of medical record documentation that are applicable to all types of medical and surgical services in all settings. While E/M services vary in several ways, such as the nature and amount of physician work required, the following general

principles help ensure that medical record documentation for all E/M services is appropriate:

- 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; and
  - Date and legible identity of the observer.
- If not documented, 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;
- Appropriate health risk factors should be identified;
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented; and
- The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

In order to maintain an accurate medical record, services should be documented during the encounter or as soon as practicable after the encounter.

COMMON SETS OF CODES USED TO BILL FOR EVALUATION AND MANAGEMENT SERVICES

When billing for a patient's visit, select codes that best represent the services furnished during the visit. A billing specialist or alternate source may review the provider's documented services before the claim is submitted to a payer. These reviewers may assist with selecting codes that best reflect the provider's furnished services. However, it is the provider's responsibility to ensure that the submitted claim accurately reflects the services provided.

The provider must ensure that medical record documentation supports the level of service reported to a payer. The volume of documentation should not be used to determine which specific level of service is billed.

In addition to the individual requirements associated with the billing of a selected E/M

code, in order to receive payment from Medicare for a service, the service must also be considered reasonable and necessary. Therefore, the service must be:

- Furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition (i.e., not provided mainly for the convenience of the beneficiary, provider, or supplier); and
- Compliant with the standards of good medical practice.

The two common sets of codes that are currently used for billing are: Current Procedural Terminology (CPT) codes and International Classification of Diseases (ICD) diagnosis and procedure codes.

CURRENT PROCEDURAL TERMINOLOGY CODES

Physicians, qualified non-physician practitioners (NPP), outpatient facilities, and hospital outpatient departments report CPT codes to identify procedures furnished in an encounter. CPT codes are used to bill for services furnished to patients other than inpatients and for services being billed on claims other than inpatient claims. Therefore, CPT codes should be used to bill for E/M services provided in the outpatient facility setting and in the office setting.

INTERNATIONAL CLASSIFICATION OF DISEASES DIAGNOSIS AND PROCEDURE CODES

The use of ICD-9-Clinical Modification (CM) diagnosis and procedure codes is limited to billing for inpatient E/M services on inpatient claims. All other provider types should continue to use CPT codes to bill for E/M services.

The compliance date for implementation of the International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) is for services provided on or after October 1, 2013, for all Health Insurance Portability and Accountability Act covered entities. ICD-10-CM/PCS is a replacement for ICD-9-CM diagnosis and procedure codes. The implementation of ICD-10-CM/PCS will not impact the use of CPT and alpha-numeric Healthcare Common Procedure Coding System codes.

All providers billing for inpatient services provided to inpatient beneficiaries will use ICD-10-CM diagnosis codes instead of ICD-9-CM diagnosis codes for services furnished on or after October 1, 2013.

ICD-10-CM/PCS will enhance accurate payment for services rendered and facilitate evaluation of medical processes and outcomes. The new classification system provides significant improvements through greater detailed information and the ability to expand in order to capture additional advancements in clinical medicine.

ICD-10-CM/PCS consists of two parts:

- ICD-10-CM – The diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all U.S. health care treatment settings. Diagnosis coding under this system uses 3 – 7 alpha and numeric digits and full code titles, but the format is very much the same as ICD-9-CM; and
- ICD-10-PCS – The procedure classification system developed by the Centers for Medicare & Medicaid Services for use in the U.S. for billing inpatient hospital claims for inpatient services ONLY. The new procedure coding system uses 7 alpha or numeric digits while the ICD-9-CM coding system uses 3 or 4 numeric digits.

EVALUATION AND MANAGEMENT SERVICE PROVIDERS

E/M services refer to visits and consultations furnished by physicians and the following qualified NPPs:

- Nurse practitioners;
- Clinical nurse specialists;
- Certified nurse midwives; and
- Physician assistants.

A NPP's Medicare benefit must permit him or her to bill for E/M services, and the services must be furnished within the scope of practice in the State in which the NPP practices in order to receive payment from Medicare.

EVALUATION AND MANAGEMENT BILLING AND CODING CONSIDERATIONS

This chapter discusses selecting the code that best represents the service furnished and other evaluation and management (E/M) considerations.

SELECTING THE CODE THAT BEST REPRESENTS THE SERVICE FURNISHED

Billing Medicare for an E/M service requires the selection of a Current Procedural Terminology (CPT) code that best represents:

- Patient type;
- Setting of service; and
- Level of E/M service performed.

PATIENT TYPE

For purposes of billing for E/M services, patients are identified as either new or established, depending on previous encounters with the provider.

A **new patient** is defined as an individual who has not received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous three years.

An **established patient** is an individual who has received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous three years.

SETTING OF SERVICE

E/M services are categorized into different settings depending on where the service is furnished. Examples of settings include:

- Office or other outpatient setting;
- Hospital inpatient;

- Emergency department (ED); and
- Nursing facility (NF).

LEVEL OF EVALUATION AND MANAGEMENT SERVICE PERFORMED

The code sets used to bill for E/M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code the physician or NPP may bill within the appropriate category. In order to bill any code, the services furnished must meet the definition of the code. It is the physician's or NPP's responsibility to ensure that the codes selected reflect the services furnished.

There are three key components when selecting the appropriate level of E/M service provided: history, examination, and medical decision making. Visits that consist predominately of counseling and/or coordination of care are an exception to this rule. For these visits, time is the key or controlling factor to qualify for a particular level of E/M services.

History

The elements required for each type of history are depicted in the table below. Further discussion of the activities comprising each of these elements is included below the table. To qualify for a given type of history, all four elements indicated in the row must be met. Note that as the type of history becomes more intensive, the elements required to perform that type of history also increase in intensity. For example, a problem focused history requires the documentation of the chief complaint (CC) and a brief history of present illness (HPI) while a detailed history requires the documentation of a CC, an extended HPI, plus an extended review of systems (ROS), and pertinent past, family, and/or social history (PFSH).

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

While documentation of the CC is required for all levels, the extent of information gathered for the remaining elements related to a patient's history is dependent upon clinical judgment and the nature of the presenting problem.

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. The medical record should clearly reflect the CC.

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

There are two types of HPIs: brief and extended.

A **brief HPI** includes documentation of one to three HPI elements.

In the following example, three HPI elements – location, quality, and duration – are documented:

- CC: Patient complains of earache.
- Brief HPI: Dull ache in left ear over the past 24 hours.

An **extended HPI**:

- 1995 documentation guidelines – Should describe four or more elements of the present HPI or associated comorbidities.
- 1997 documentation guidelines – Should describe at least four elements of the present HPI or the status of at least three chronic or inactive conditions.

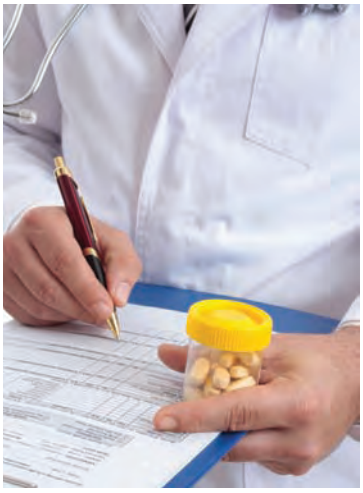
In the following example, five HPI elements – location, quality, duration, context, and modifying factors – are documented:

- CC: Patient complains of earache.
- 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 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 for ROS purposes:

- 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: problem pertinent, extended, and complete.

A **problem pertinent ROS** 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.

An **extended ROS** 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.

A **complete ROS** inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of ten) organ systems. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.

In the following example, ten 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 three areas:

- Past history including experiences with illnesses, operations, injuries, and treatments;
- Family history including a review of medical events, diseases, and hereditary conditions that may place the patient at risk; and

- Social history including an age appropriate review of past and current activities.

The two types of PFSH are: pertinent and complete.

A **pertinent PFSH** is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document at least 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 identified HPI:

- HPI: Coronary artery disease.
- PFSH: 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.

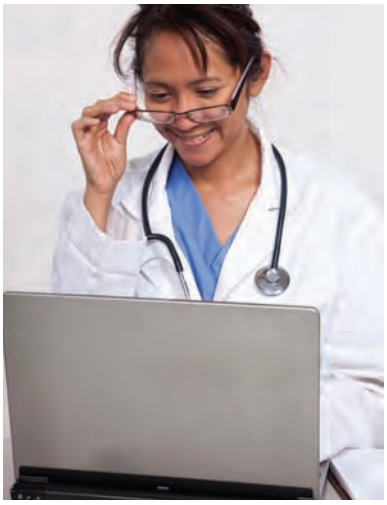
A **complete PFSH** is a review of two or all three of the areas, depending on the category of E/M service. A complete PFSH requires a review of all three history areas for services that, by their nature, include a comprehensive assessment or reassessment of the patient. A review of two history areas 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;
- ED;
- Domiciliary care, established patient;
- Subsequent NF care (if following the 1995 documentation guidelines); 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;
- Comprehensive NF 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:

- HPI: Coronary artery disease.
- PFSH: Family history reveals the following:
  - Maternal grandparents – Both + for coronary artery disease; grandfather: deceased at age 69; grandmother: still living.
  - Paternal grandparents – Grandmother: + diabetes, hypertension; grandfather: + heart attack at age 55.
  - Parents – Mother: + obesity, diabetes; father: + heart attack at age 51, deceased at age 57 of heart attack.
  - Siblings – Sister: + diabetes, obesity, hypertension, age 39; brother: + heart attack at age 45, living.

Notes on the Documentation of History

- The CC, ROS, and PFSH may be listed as separate elements of history or they may be included in the description of the history of the present illness.
- A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:
  - Describing any new ROS and/or PFSH information or noting there has been no change in the information; and
  - Noting the date and location of the earlier ROS and/or PFSH.
- The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.

Examination

As stated previously, there are two versions of the documentation guidelines – the 1995 version and the 1997 version. The most substantial differences between the two versions occur in the examination documentation section. Either version of the documentation guidelines, not a combination of the two, may be used by the provider for a patient encounter.

The levels of E/M services are based on four types of examination:

- **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 area(s) or organ system(s); and
- **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) – 1997 documentation guidelines).

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

The 1997 documentation guidelines describe two types of comprehensive examinations that can be performed during a patient's visit: general multi-system examination and single organ examination.

A **general multi-system examination** involves the examination of one or more organ systems or body areas, as depicted in the chart below.

TYPE OF EXAMINATION	DESCRIPTION
Problem Focused	Include performance and documentation of one to five elements identified by a bullet in one or more organ system(s) or body area(s).
Expanded Problem Focused	Include performance and documentation of at least six elements identified by a bullet in one or more organ system(s) or body area(s).
Detailed	Include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet is expected. Alternatively, may include performance and documentation of at least twelve elements identified by a bullet in two or more organ systems or body areas.
Comprehensive	Include at least nine 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 two elements identified by bullet is expected.*

* The 1995 documentation guidelines state that the medical record for a general multi-system examination should include findings about eight or more organ systems.

A **single organ system examination** involves a more extensive examination of a specific organ system, as depicted in the chart below.

TYPE OF EXAMINATION	DESCRIPTION
Problem Focused	Include performance and documentation of one to five 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 six 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 twelve 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 nine 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 one element in a box with an unshaded border is expected.

Both types of examinations may be performed by any physician, regardless of specialty.

Some important points that should be kept in mind when documenting general multi-system and single organ system examinations (in both the 1995 and the 1997 documentation guidelines) 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.
- 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).

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.

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 and/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; or
        - 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 is 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.
- The review of laboratory, radiology, and/or other diagnostic tests should be documented. A simple notation such as “WBC 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.

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.

The table on the next 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.

Table of Risk

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., echocardiography) • 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, 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 • 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 (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 catheterization) • 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 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 (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, 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

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 NF), 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.

The Level I and Level II CPT® books, which are 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.

OTHER CONSIDERATIONS

SPLIT/SHARED SERVICES

A split/shared service is an encounter where a physician and a NPP each personally perform a portion of an E/M visit. Below are the rules for reporting split/shared E/M services between physicians and NPPs:

- Office/clinic setting:
  - For encounters with established patients that meet incident to requirements, report the using the physician's National Provider Identifier (NPI); and
  - For encounters that do not meet incident to requirements, report using the NPP's NPI.
- Hospital inpatient, outpatient, and ED setting encounters shared between a physician and a NPP from the same group practice:
  - When the physician provides any face-to-face portion of the encounter, report using either provider's NPI; and
  - When the physician does not provide a face-to-face encounter, report using the NPP's NPI.

CONSULTATION SERVICES

Effective for services furnished on or after January 1, 2010, inpatient consultation codes (CPT codes 99251 – 99255) and office and other outpatient consultation codes (CPT codes 99241 – 99245) are no longer recognized by Medicare for Part B payment purposes. However, telehealth consultation codes (Healthcare Common Procedure Coding System G0406 – G0408 and G0425 – G0427) continue to be recognized for Medicare payment. Physicians and NPPs who furnish services that, prior to January 1, 2010, would have been reported as CPT consultation codes should report the appropriate E/M visit code in order to bill for these services beginning January 1, 2010.

REFERENCE SECTION

RESOURCES

Additional information about evaluation and management services is available as follows:

- The publication titled “1995 Documentation Guidelines for Evaluation and Management Services” can be accessed beginning on page 23 of this guide and at ***http://www.cms.gov/MLNProducts/Downloads/1995dg.pdf*** on the Centers for Medicare & Medicaid Services (CMS) website;
- The publication titled “1997 Documentation Guidelines for Evaluation and Management Services” can be accessed beginning on page 39 of this guide and at ***http://www.cms.gov/MLNProducts/Downloads/MASTER1.pdf*** on the CMS website;
- The “Medicare Benefit Policy Manual” (Pub. 100-02) and the “Medicare Claims Processing Manual” (Pub. 100-04) can be accessed at ***http://www.cms.gov/Manuals/IOM/list.asp*** on the CMS website;
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) resources are available at ***http://www.cms.gov/ICD9ProviderDiagnosticCodes*** and International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) resources are available at ***http://www.cms.gov/ICD10*** on the CMS website; and
- CPT® books are available from the American Medical Association at ***https://catalog.ama-assn.org/Catalog/home.jsp*** on the Internet.

1995 DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time;
- communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- the site of service;

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- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or

- that services provided have been accurately reported.

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.

2. 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;

    - plan for care; and

    - date and legible identity of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

4. Past and present diagnoses should be accessible to the treating and/or consulting physician.

5. Appropriate health risk factors should be identified.

6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

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II. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three ***key*** components of E/M services and for visits which consist predominately of counseling or coordination of care. The three key components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. **Documentation guidelines are identified by the symbol • DG.**

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (i.e., history, examination and medical decision making) are the ***key*** components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E/M service.

For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

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As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, information on growth and development and/or nutrition will be recorded. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four types of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC);
- History of present illness (HPI);
- Review of systems (ROS); and
- Past, family and/or social history (PFSH).

The extent of history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history, **all three elements in the table must be met.** (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	***Problem Focused***
Brief	Problem Pertinent	N/A	***Expanded Problem Focused***
Extended	Extended	Pertinent	***Detailed***
Extended	Complete	Complete	***Comprehensive***

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- *DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.*

- *DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:*

    - *describing any new ROS and/or PFSH information or noting there has been no change in the information; and*

    - *noting the date and location of the earlier ROS and/or PFSH.*

- *DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*

- *DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.*

Definitions and specific documentation guidelines for each of the elements of history are listed below.

CHIEF COMPLAINT (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

- *DG: The medical record should clearly reflect the chief complaint.*

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HISTORY OF PRESENT ILLNESS (HPI)

The 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. It includes the following elements:

- location;
- quality;
- severity;
- duration;
- timing;
- context;
- modifying factors; and
- associated signs and symptoms.

Brief and ***extended*** HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A ***brief*** HPI consists of one to three elements of the HPI.

- *DG: The medical record should describe one to three elements of the present illness (HPI).*

An ***extended*** HPI consists of four or more elements of the HPI.

- *DG: The medical record should describe four or more elements of the present illness (HPI) or associated comorbidities.*

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

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For purposes of ROS, 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
- Allergic/Immunologic

A ***problem pertinent*** ROS inquires about the system directly related to the problem(s) identified in the HPI.

- *DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.*

An ***extended*** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

- *DG: The patient's positive responses and pertinent negatives for two to nine systems should be documented.*

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A ***complete*** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

- *DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.*

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- past history (the patient's past experiences with illnesses, operations, 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); and
- social history (an age appropriate review of past and current activities).

For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an "interval" history. It is not necessary to record information about the PFSH.

A ***pertinent*** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- *DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.*

A ***complete*** PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- *DG: 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; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.*

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- *DG: At least one specific item from each 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, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and homecare, new patient.*

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on four types of examination that are defined as follows:

- ***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 other symptomatic or related organ system(s).
- ***Detailed*** -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- ***Comprehensive*** -- a general multi-system examination or complete examination of a single organ system.

For purposes of examination, the following ***body areas*** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

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For purposes of examination, the following ***organ systems*** are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

- *DG: 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 insufficient.*
- *DG: Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.*
- *DG: 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).*
- *DG: The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.*

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C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straight-forward, low complexity, moderate complexity, and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- 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 shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	***Straightforward***
Limited	Limited	Low	***Low Complexity***
Multiple	Moderate	Moderate	***Moderate Complexity***
Extensive	Extensive	High	***High Complexity***

Each of the elements of medical decision making is described on the following page.

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.

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

- *DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It 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: a) improved, well controlled, resolving or resolved; or, b) 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 a differential diagnoses or as "possible," "probable," or "rule out" (R/O) diagnoses.*

- *DG: 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.*

- *DG: 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 the advice is requested.*

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. 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 is an indication of the complexity of data being reviewed. On

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occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who
prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- *DG: If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray, should be documented.*

- *DG: The review of lab, radiology and/or other diagnostic tests should be documented. An entry in a progress note such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

- *DG: A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.*

- *DG: Relevant finding from the review of old records, and/or the receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*

- *DG: The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

- *DG: The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.*

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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 presenting problem(s), the diagnostic procedure(s), and the possible management options.

- *DG: 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.*

- *DG: If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure eg, laparoscopy, should be documented.*

- *DG: If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*

- *DG: The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is **minimal**, **low**, **moderate**, or **high**. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. 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 one. 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 (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

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Table 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

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or 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.

- *DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

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TABLE OF CONTENTS

I. INTRODUCTION

WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- **the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time.**
- **communication and continuity of care among physicians and other healthcare professionals involved in the patient's care;**
- **accurate and timely claims review and payment;**
- **appropriate utilization review and quality of care evaluations; and**
- **collection of data that may be useful for research and education.**

An appropriately documented medical record can reduce many of the hassles associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

WHAT DO PAYERS WANT AND WHY?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

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

II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. **The medical record should be complete and legible.**

2. **The documentation of each patient encounter should include:**

   - **reason for encounter and relevant history, physical examination findings, and prior diagnostic test results;**

   - **assessment, clinical impression, or diagnosis;**

   - **plan for care; and**

   - **date and legible identity of the observer.**

3. **If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.**

4. **Past and present diagnoses should be accessible to the treating and/or consulting physician.**

5. **Appropriate health risk factors should be identified.**

6. **The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.**

7. **The CPT and ICD-9-CM codes reported on the health insurance claim form should be supported by the documentation in the medical record.**

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III. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits which consist predominately of counseling or coordination of care. The three *key* components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. Documentation guidelines are identified by the symbol • DG.

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- **history;**
- **examination;**
- **medical decision making;**
- **counseling;**
- **coordination of care;**
- **nature of presenting problem; and**
- **time.**

The first three of these components (i.e., history, examination and medical decision making) are the key components in selecting the level of E/M services. In the case of visits which consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.

Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (eg, examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

These Documentation Guidelines for E/M services reflect the needs of the typical adult population. For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants,

children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, the content of a pediatric examination will vary with the age and development of the child. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four levels of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- **Chief complaint (CC)**
- **History of present illness (HPI)**
- **Review of systems (ROS) and**
- **Past, family, and/or social history (PFSH).**

The extent of the history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history all three elements in the table must be met. (A chief complaint is indicated at all levels.)

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief	N/A	N/A	*Problem Focused*
Brief Problem	Problem Pertinent	N/A	*Focused Expanded Problem*
Extended	Extended	Pertinent	*Detailed*
Extended	Complete	Complete	*Comprehensive*

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- ***DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.***

- ***DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:***

    - ***describing any new ROS and/or PFSH information or noting there has been no change in the information; and***

    - ***noting the date and location of the earlier ROS and/or PFSH.***

- ***DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.***

- ***DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a history.***

Definitions and specific documentation guidelines for each of the elements of history are listed below.

<u>CHIEF COMPLAINT (CC)</u>
The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's own words.

- ***DG: The medical record should clearly reflect the chief complaint.***

6

HISTORY OF PRESENT ILLNESS (HPI)

The 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. It includes the following elements:

- **location ,**
- **quality ,**
- **severity,**
- **duration,**
- **timing,**
- **context ,**
- **modifying factors, and**
- **associated signs and symptoms.**

***Brief* and *extended* HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).**

A *brief* HPI consists of one to three elements of the HPI.

- ***DG: The medical record should describe one to three elements of the present illness (HPI).***

An *extended* HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

- ***DG: The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions*.**

7

REVIEW OF SYSTEMS (ROS)

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized:

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

A *problem pertinent* ROS inquires about the system directly related to the problem(s) identified in the HPI.

- ***DG: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.***

An *extended* ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

- ***DG: The patient's positive responses and pertinent negatives for two to nine systems should be documented.***

A *complete* ROS inquires about the system(s) directly related to the problem(s) identified in the HPI, *plus* all additional body systems.

- ***DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.***

8

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three areas:

- **past history (the patient's past experiences with illnesses, operations, injuries and treatments);**
- **family history (a review of medical events in the patient's family, including diseases which maybe hereditary or place the patient at risk); and**
- **social history (an age appropriate review of past and current activities).**

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care.

A *pertinent* PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- ***DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.***

A *complete* PFSH is a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- ***DG: 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.***

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- ***DG: At least one specific item from each 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, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; home care, new patient.***

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on four types of examination:

- ***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 area(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).**

These types of examinations have been defined for general multi-system and the following single organ systems:

- **Cardiovascular**
- **Ears, Nose, Mouth, and Throat**
- **Eyes**
- **Genitourinary (Female)**
- **Genitourinary (Male)**
- **Hematologic/Lymphatic/Immunologic**
- **Musculoskeletal**
- **Neurological**
- **Psychiatric**
- **Respiratory**
- **Skin**

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A general multi-system examination or a single organ system examination may be performed by any physician, regardless of specialty. The type (general multi-system or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s).

The content and documentation requirements for each type and level of examination are summarized below and described in detail in tables beginning on page 13. In the tables, organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (•) in the right column.

Parenthetical examples "(eg,…)", have been used for clarification and to provide guidance regarding documentation. Documentation for each element must satisfy any numeric requirements (such as "Measurement of *any three of the following seven*...") included in the description of the element. Elements with multiple components but with no specific numeric requirement (such as "Examination of *liver* and *spleen*") require documentation of at least one component. It is possible for a given examination to be expanded beyond what is defined here. When that occurs, findings related to the additional systems and/or areas should be documented.

- ***DG: 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 insufficient.***

- ***DG: Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.***

- ***DG: 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).***

GENERAL MULTI-SYSTEM EXAMINATIONS

General multi-system examinations are described in detail beginning on page 13. To qualify for a given level of multi-system examination, the following content and documentation requirements should be met:

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- ***Problem Focused Examination*** **– should include performance and documentation of one to five elements identified by a bullet (•) in one or more organ system(s) or body area(s).**
- ***Expanded Problem Focused Examination*** **– should include performance and documentation of at least six elements identified by a bullet (•) in one or more organ system(s) or body area(s).**
- ***Detailed Examination*** **– should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet (•) is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet (•) in two or more organ systems or body areas.**
- ***Comprehensive Examination*** **– should include at least nine 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 two elements identified by a bullet is expected.**

SINGLE ORGAN SYSTEM EXAMINATIONS

The single organ system examinations recognized by CPT are described in detail beginning on page 18. Variations among these examinations in the organ systems and body areas identified in the left columns and in the elements of the examinations described in the right columns reflect differing emphases among specialties. To qualify for a given level of single organ system examination, the following content and documentation requirements should be met:

- ***Problem Focused Examination*** **– should include performance and documentation of one to five elements identified by a bullet (•), whether in a box with a shaded or unshaded border.**
- ***Expanded Problem Focused Examination*** **– should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.**
- ***Detailed Examination*** **– examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet (•), whether in a box with a shaded or unshaded border.**

  Eye and psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

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- ***Comprehensive Examination*** **– should 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 one element in a box with an unshaded border is expected**.

CONTENT AND DOCUMENTATION REQUIREMENTS

General Multi-System Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Inspection of conjunctivae and lids • Examination of pupils and irises (eg, reaction to light and accommodation, size and symmetry) • Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	• External inspection of ears and nose (eg, overall appearance, scars, lesions, masses) • Otoscopic examination of external auditory canals and tympanic membranes • Assessment of hearing (eg, whispered voice, finger rub, tuning fork) • Inspection of nasal mucosa, septum and turbinates • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)

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System/Body Area	Elements of Examination
Respiratory	• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (eg, dullness, flatness, hyperresonance) • Palpation of chest (eg, tactile fremitus) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Palpation of heart (eg, location, size, thrills) • Auscultation of heart with notation of abnormal sounds and murmurs Examination of: • carotid arteries (eg, pulse amplitude, bruits) • abdominal aorta (eg, size, bruits) • femoral arteries (eg, pulse amplitude, bruits) • pedal pulses (eg, pulse amplitude) • extremities for edema and/or varicosities
Chest (Breasts)	• Inspection of breasts (eg, symmetry, nipple discharge) • Palpation of breasts and axillae (eg, masses or lumps, tenderness)
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Examination for presence or absence of hernia • Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses • Obtain stool sample for occult blood test when indicated

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System/Body Area	Elements of Examination
Genitourinary	**MALE:** • Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass) • Examination of the penis • Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness) **FEMALE:** Pelvic examination (with or without specimen collection for smears and cultures), including • Examination of external genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Examination of urethra (eg, masses, tenderness, scarring) • Examination of bladder (eg, fullness, masses, tenderness) • Cervix (eg, general appearance, lesions, discharge) • Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) • Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)
Lymphatic	Palpation of lymph nodes in **two or more** areas: • Neck • Axillae • Groin • Other

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System/Body Area	Elements of Examination
Musculoskeletal	• Examination of gait and station • Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) Examination of joints, bones and muscles of **one or more of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions • Assessment of range of motion with notation of any pain, crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
Skin	• Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers) • Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)
Neurologic	• Test cranial nerves with notation of any deficits • Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski) • Examination of sensation (eg, by touch, pin, vibration, proprioception)
Psychiatric	• Description of patient's judgment and insight Brief assessment of mental status including: • orientation to time, place and person • recent and remote memory • mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least two** elements identified by a bullet **from each of six areas/systems** OR **at least twelve** elements identified by a bullet **in two or more areas/systems**.
Comprehensive	Perform **all elements** identified by a bullet in **at least nine** organ systems or body areas and document **at least two** elements identified by a bullet **from each of nine areas/systems.**

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Cardiovascular Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	• Inspection of conjunctivae and lids (eg, xanthelasma)
Ears, Nose, Mouth and Throat	• Inspection of teeth, gums and palate • Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	• Examination of jugular veins (eg, distension; a, v or cannon a waves) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Palpation of heart (eg, 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 (eg, aortic dissection, coarctation) Examination of: • Carotid arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay) • Abdominal aorta (eg, size, bruits) • Femoral arteries (eg, pulse amplitude, bruits) • Pedal pulses (eg, pulse amplitude) • Extremities for peripheral edema and/or varicosities

System/Body Area	Elements of Examination
Chest (Breasts)	
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy
Genitourinary (Abdomen)	
Lymphatic	
Musculoskeletal	• Examination of the back with notation of kyphosis or scoliosis • Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, stasis dermatitis, ulcers, scars, xanthomas)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person, • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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Ear, Nose and Throat Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming) • Assessment of ability to communicate (eg, use of sign language or other communication aids) and quality of voice
Head and Face	• Inspection of head and face (eg, overall appearance, scars, lesions and masses) • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness • Examination of salivary glands • Assessment of facial strength
Eyes	• Test ocular motility including primary gaze alignment
Ears, Nose, Mouth and Throat	• Otoscopic examination of external auditory canals and tympanic membranes including pneumo-otoscopy with notation of mobility of membranes • Assessment of hearing with tuning forks and clinical speech reception thresholds (eg, whispered voice, finger rub) • External inspection of ears and nose (eg, overall appearance, scars, lesions and masses) • Inspection of nasal mucosa, septum and turbinates • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx (eg, asymmetry, lesions, hydration of mucosal surfaces) • Inspection of pharyngeal walls and pyriform sinuses (eg, pooling of saliva, asymmetry, lesions) • Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords and mobility of larynx (Use of mirror not required in children) • Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae and eustachian tubes (Use of mirror not required in children)

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System/Body Area	Elements of Examination
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	• Inspection of chest including symmetry, expansion and/or assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	
Skin	
Neurological/ Psychiatric	• Test cranial nerves with notation of any deficits Brief assessment of mental status including • Orientation to time, place and person, • Mood and affect (eg, depression, anxiety, agitation)

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Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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Eye Examination

System/Body Area	Elements of Examination
Constitutional	
Head and Face	
Eyes	• Test visual acuity (Does not include determination of refractive error) • Gross visual field testing by confrontation • Test ocular motility including primary gaze alignment • Inspection of bulbar and palpebral conjunctivae • Examination of ocular adnexae including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes • Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology • Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film • Slit lamp examination of the anterior chambers including depth, cells, and flare • Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus • Measurement of intraocular pressures (except in children and patients with trauma or infectious disease) Ophthalmoscopic examination through dilated pupils (unless contraindicated) of • Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer • Posterior segments including retina and vessels (eg, exudates and hemorrhages)
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	

System/Body Area	Elements of Examination
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	
Extremities	
Skin	
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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Genitourinary Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (e.g. pulses, temperature, edema, tenderness)
Chest (Breasts)	[See genitourinary (female)]
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination for presence or absence of hernia • Examination of liver and spleen • Obtain stool sample for occult blood when indicated

System/Body Area	Elements of Examination
Genitourinary	**MALE:** • Inspection of anus and perineum Examination (with or without specimen collection for smears and cultures) of genitalia including: • Scrotum (eg, lesions, cysts, rashes) • Epididymides (eg, size, symmetry, masses) • Testes (eg, size, symmetry, masses) • Urethral meatus (eg, size, location, lesions, discharge) • Penis (eg, lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities) Digital rectal examination including: • Prostate gland (eg, size, symmetry, nodularity, tenderness) • Seminal vesicles (eg, symmetry, tenderness, masses, enlargement) • Sphincter tone, presence of hemorrhoids, rectal masses

System/Body Area	Elements of Examination
Genitourinary (Cont'd)	**FEMALE:** Includes **at least seven of the following eleven** elements identified by bullets: • Inspection and palpation of breasts (eg, masses or lumps, tenderness, symmetry, nipple discharge) • Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses Pelvic examination (with or without specimen collection for smears and cultures) including: • External genitalia (eg, general appearance, hair distribution, lesions) • Urethral meatus (eg, size, location, lesions, prolapse) • Urethra (eg, masses, tenderness, scarring) • Bladder (eg, fullness, masses, tenderness) • Vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Cervix (eg, general appearance, lesions, discharge) • Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) • Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity) • Anus and perineum
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation (eg, time, place and person) and • Mood and affect (eg, depression, anxiety, agitation)

	Content and Documentation Requirements
Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Hematologic/Lymphatic/Immunologic Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	• Palpation and/or percussion of face with notation of presence or absence of sinus tenderness
Eyes	• Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	• Otoscopic examination of external auditory canals and tympanic membranes • Inspection of nasal mucosa, septum and turbinates • Inspection of teeth and gums • Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx)
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
Genitourinary	

System/Body Area	Elements of Examination
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Musculoskeletal	
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, ecchymoses, bruises)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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Musculoskeletal Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	• Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location

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System/Body Area	Elements of Examination
Musculoskeletal	• Examination of gait and station Examination of joint(s), bone(s) and muscle(s)/ tendon(s) of **four of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions • Assessment of range of motion with notation of any pain (eg, straight leg raising), crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements NOTE: For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.
Extremities	[See musculoskeletal and skin]
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, scars, rashes, lesions, cafe-au-lait spots, ulcers) in **four of the following six** areas: 1) head and neck; 2) trunk; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. NOTE: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitutes two elements.
Neurological/ Psychiatric	• Test coordination (eg, finger/nose, heel/ knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children) • Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (eg, Babinski) • Examination of sensation (eg, by touch, pin, vibration, proprioception) Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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Neurological Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	• Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	• Examination of carotid arteries (eg, pulse amplitude, bruits) • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	

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System/Body Area	Elements of Examination
Musculoskeletal	• Examination of gait and station Assessment of motor function including: • Muscle strength in upper and lower extremities • Muscle tone in upper and lower extremities (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (eg, fasciculation, tardive dyskinesia)
Extremities	[See musculoskeletal]
Skin	
Neurological	Evaluation of higher integrative functions including: • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases, spontaneous speech) • Fund of knowledge (eg, awareness of current events, past history, vocabulary) Test the following cranial nerves: • 2nd cranial nerve (eg, visual acuity, visual fields, fundi) • 3rd, 4th and 6th cranial nerves (eg, pupils, eye movements) • 5th cranial nerve (eg, facial sensation, corneal reflexes) • 7th cranial nerve (eg, facial symmetry, strength) • 8th cranial nerve (eg, hearing with tuning fork, whispered voice and/or finger rub) • 9th cranial nerve (eg, spontaneous or reflex palate movement) • 11th cranial nerve (eg, shoulder shrug strength) • 12th cranial nerve (eg, tongue protrusion) • Examination of sensation (eg, by touch, pin, vibration, proprioception) • Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (eg, Babinski) • Test coordination (eg, finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)
Psychiatric	

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	Content and Documentation Requirements
Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Psychiatric Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	• Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	
Skin	
Neurological	

System/Body Area	Elements of Examination
Psychiatric	• Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language) • Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (eg, loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions • Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition) Complete mental status examination including • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases) • Fund of knowledge (eg, awareness of current events, past history, vocabulary) • Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

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Respiratory Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	• Inspection of nasal mucosa, septum and turbinates • Inspection of teeth and gums • Examination of oropharynx (eg, oral mucosa, hard and soft palate, tongue, tonsils and posterior pharynx)
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass) • Examination of jugular veins (eg, distention, a, v or cannon a waves)
Respiratory	• Inspection of chest with notation of symmetry and expansion • Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (eg, dullness, flatness, hyperresonance) • Palpation of chest (eg, tactile fremitus) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	

System/Body Area	Elements of Examination
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
Genitourinary	
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	• Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

Skin Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	• Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	• Inspection of teeth and gums • Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)
Neck	• Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	
Cardiovascular	• Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	• Examination of liver and spleen • Examination of anus for condyloma and other lesions
Genitourinary	
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Musculoskeletal	
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)

System/Body Area	Elements of Examination
Skin	• Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities • Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, susceptibility to and presence of photo damage) in **eight of the following ten** areas: • Head, including the face and • Neck • Chest, including breasts and axillae • Abdomen • Genitalia, groin, buttocks • Back • Right upper extremity • Left upper extremity • Right lower extremity • Left upper extremity NOTE: For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and the left upper extremity constitutes two elements. • Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses or bromhidrosis
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least twelve** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straight-forward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- 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 shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	***Straightforward***
Limited	Limited	Low	***Low Complexity***
Multiple	Moderate	Moderate	***Moderate Complexity***
Extensive	Extensive	High	***High Complexity***

Each of the elements of medical decision making is described below.

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.

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

DG: *For each encounter, an assessment, clinical impression, or diagnosis should be documented. It 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: a) improved, well controlled, resolving or resolved; or, b) 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" (R/O) diagnosis.*

DG: *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.*

DG: *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 the advice is requested.*

AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. 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 is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

DG: *If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, eg, lab or x-ray, should be documented.*

DG: *The review of lab, radiology and/or other diagnostic tests should be documented. A simple notation such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

DG: *A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.*

DG: *Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of “Old records reviewed” or “additional history obtained from family” without elaboration is insufficient.*

DG: *The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

DG: *The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.*

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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 presenting problem(s), the diagnostic procedure(s), and the possible management options.

DG: *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.*

DG: *If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, eg, laparoscopy, should be documented.*

DG: *If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.*

DG: *The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.*

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is *minimal*, *low*, *moderate*, or *high*. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. 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 one. 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 (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.**

TABLE 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

D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other or 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.

DG: *If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

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