Evaluation & Management Services Guide

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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*. It is recommended that health care providers refer to the *1995 Documentation Guidelines for Evaluation and Management Services* in order to identify differences between the two sets of guidelines.

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

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

TABLE OF CONTENTS

Medical Record Documentation……………………………………………………….5

International Classification of Diseases, 9th Revision, Clinical Modification and American Medical Association Current Procedural Terminology Codes …………7

Key Elements of Service………………………………………………………….....9

Acronyms…………………………………………………………………………….26

Reference Materials……………………………………………………………...27

MEDICAL RECORD DOCUMENTATION

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

Background

Concise medical record documentation is critical to providing patients with quality care as well as to receiving accurate and timely reimbursement for furnished services. It chronologically documents the care of the patient and is required to record pertinent facts, findings, and observations about the patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes. Medical record documentation also assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring his or her health care over time.

Payers may require reasonable documentation that services are consistent with the insurance coverage provided in order to validate:

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

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

- The medical record should be complete and legible.
- The documentation of each patient encounter should include:
    - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results.
    - Assessment, clinical impression, or diagnosis.
    - Medical plan of care.
    - Date and legible identity of the observer.
- If 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.
- The Current Procedural Terminology (CPT) and International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Documentation guidelines for teaching physicians, interns, and residents can be found in the Medicare Learning Network (MLN) publication titled *Guidelines for Teaching Physicians, Interns, and Residents*. This and other MLN publications are available at [*http://www.cms.hhs.gov/MLNGenInfo*](http://www.cms.hhs.gov/MLNGenInfo) on the CMS website.

INTERNATIONAL CLASSIFICATION OF DISEASES, 9th REVISION, CLINICAL MODIFICATION AND AMERICAN MEDICAL ASSOCIATION CURRENT PROCEDURAL TERMINOLOGY CODES

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

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

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

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

- 99201 – Usually the presenting problem(s) are self limited or minor and the physician typically spends 10 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
  - Problem focused history.
  - Problem focused examination.
  - Straightforward medical decision making.
- 99202 – Usually the presenting problem(s) are of low to moderate severity and the physician typically spends 20 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
  - Expanded problem focused history.
  - Expanded problem focused examination.
  - Straightforward medical decision making.
- 99203 – Usually the presenting problem(s) are of moderate severity and the physician typically spends 30 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
  - Detailed history.
  - Detailed examination.
  - Medical decision making of low complexity.

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- 99204 – Usually the presenting problem(s) are of moderate to high severity and the physician typically spends 45 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Comprehensive history.
    - Comprehensive examination.
    - Medical decision making of moderate complexity.
- 99205 – Usually the presenting problem(s) are of moderate to high severity and the physician typically spends 60 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Comprehensive history.
    - Comprehensive examination.
    - Medical decision making of high complexity.

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KEY ELEMENTS OF SERVICE

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

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

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

I. History

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

Elements Required for Each Type of History

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

The extent of information gathered for history is dependent upon clinical judgment and the nature of the presenting problem. Documentation of patient history includes some or all of the following elements:

A. Chief Complaint

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

B. History of Present Illness

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

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

There are two types of HPIs:

1) Brief, which includes documentation of one to three HPI elements. In the following example, three HPI elements – location, severity, and duration – are documented:
    - CC: A patient seen in the office complains of left ear pain.
    - Brief HPI: Patient complains of dull ache in left ear over the past 24 hours.

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

C. 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:

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

There are three types of ROS:

1) Problem pertinent, which inquires about the system directly related to the problem identified in the HPI. In the following example, one system – the ear – is reviewed:

- CC: Earache.
- ROS: Positive for left ear pain. Denies dizziness, tinnitus, fullness, or headache.

2) Extended, which inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems. In the following example, two systems – cardiovascular and respiratory – are reviewed:

- CC: Follow up visit in office after cardiac catheterization. Patient states “I feel great.”
- ROS: Patient states he feels great and denies chest pain, syncope, palpitations, and shortness of breath. Relates occasional unilateral, asymptomatic edema of left leg.

3) Complete, which inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of 10) body systems. In the following example, 10 signs and symptoms are reviewed:

- CC: Patient complains of “fainting spell.”
- ROS:
  - Constitutional: weight stable, + fatigue.
  - Eyes: + loss of peripheral vision.
  - Ear, Nose, Mouth, Throat: no complaints.
  - Cardiovascular: + palpitations; denies chest pain; denies calf pain, pressure, or edema.
  - Respiratory: + shortness of breath on exertion.
  - Gastrointestinal: appetite good, denies heartburn and indigestion. + episodes of nausea. Bowel movement daily; denies constipation or loose stools.
  - Urinary: denies incontinence, frequency, urgency, nocturia, pain, or discomfort.
  - Skin: + clammy, moist skin.
  - Neurological: + fainting; denies numbness, tingling, and tremors.
  - Psychiatric: denies memory loss or depression. Mood pleasant.

D. Past, Family, and/or Social History

PFSH consists of a review of the patient’s:

- 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 him or her at risk; and
- Social history including an age appropriate review of past and current activities.

The two types of PFSH are:

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

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

2) Complete, which is a review of two or all three of the areas, depending on the category of E/M service. A complete PFSH requires a review of all three history areas for services that, by their nature, include a comprehensive assessment or reassessment of the patient. A review of two history areas is sufficient for other services. At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services:

- Office or other outpatient services, established patient;
- Emergency department;
- Domiciliary care, established patient; and
- Home care, established patient.

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

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

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

- Family history reveals the following:
  - Maternal grandparents: 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 age 51, deceased age 57 of heart attack.
  - Siblings: sister - + diabetes, obesity, hypertension, age 39; brother - + heart attack at age 45, living.

II. Examination

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

The chart below depicts the body areas and organ systems that are recognized according to the Current Procedural Terminology (CPT) book:

Recognized Body Areas and Organ Systems

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

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

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

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

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

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

Cardiovascular System/Body Area

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

The elements required for each type of examination are depicted in the table below.

Elements Required for Each Type of Examination

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

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

General Multi-System Examinations

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

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

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

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

Single Organ System Examinations

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

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

Multi-System and Single Organ Examinations

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

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

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

III. Medical Decision Making

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

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

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

Elements of Medical Decision Making

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

Number of Diagnoses or Management Options

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

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

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

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

- For each encounter, an assessment, clinical impression, or diagnosis should be documented which may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.
    - For a presenting problem with an established diagnosis, the record should reflect whether the problem is:
        - Improved, well controlled, resolving, or resolved.
        - Inadequately controlled, worsening, or failing to change as expected.
    - For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a “possible,” “probable,” or “rule out” diagnosis
- The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.
- If referrals are made, consultations requested, or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom advice is requested.

Amount and/or Complexity of Data to be Reviewed

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

Risk of Significant Complications, Morbidity, and/or Mortality

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

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

The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter. The assessment of risk of selecting diagnostic procedures and

management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category determines the overall risk.

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

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

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

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

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

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

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

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ACRONYMS

AMA	American Medical Association
CC	Chief Complaint
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
E/M	Evaluation and Management
HPI	History of Present Illness
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
PFSH	Past, Family, and/or Social History
ROS	Review of Systems

REFERENCE MATERIALS

Documentation Guidelines for E&M Services
Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

CMS Internet-Only Manuals
Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov/Manuals/IOM/list.asp

Medicare Learning Network
Centers for Medicare & Medicaid Services
http://www.cms.hhs.gov/MLNGenInfo

Level I and Level II CPT Books
American Medical Association
(800) 621-8335
http://www.amapress.org

ICD-9-CM Book
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(800) 621-8335
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