EVALUATION AND MANAGEMENT GUIDELINES

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"If it isn't documented, it hasn't been done"

Basic Principles of Medical Record Documentation

1. There is no specific format required for documenting the components of an E&M service.

2. The medical record should be complete and legible.

3. The documentation of each patient encounter should include:

a. The patient's name and appropriate demographic information

b. The chief complaint and/or reason for the encounter and relevant history, physical examination findings and prior diagnostic results,

c. Assessment, clinical impression or diagnosis,

d. Plan for care,

e. Date and a verifiable legible identity of the health care professional who provided the service.

4. If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.

5. To the greatest extent possible, past and present diagnoses and conditions should be accessible to the treating and/or consulting physician. This should include those diagnoses and conditions from the prenatal and intrapartum period that affect the newborn.

6. Appropriate health risk factors, including allergies, should be identified

7. The patient's progress, response to and changes in treatment, planned follow-up care, and instructions and diagnosis should be documented.

8. The Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes reported on the health insurance claim form (CMS 1500) or billing statement should be supported by the documentation in the medical record.

9. Any addendum to the medical record should be dated the day the information is added to the medical record and not dated for the date the service was provided.

10. Documentation should be timely. A service should be documented during the visit, or soon after it is provided, in order to maintain an accurate medical record.

11. The confidentiality of the medical record should be fully maintained, consistent with the requirements of medical ethics and of law.

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

1. The site of service;
2. The medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
3. 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:

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;
    - Medical plan of 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; and
7. 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.

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 Evaluation and Management Services Guide 5 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:

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

Billing 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).

CPT/HCPCS Codes included in Range 99201 - 99205

CPT/HCPCS CODE	CPT/HCPCS CODE DESCRIPTION
99201 ***Usually done by a non-physician***	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR. TYPICALLY, 10 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99202 ***Problem Focused***	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. TYPICALLY, 20 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99203 **Expanded Problem Focused**	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY. TYPICALLY, 30 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99204 **Detailed**	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. TYPICALLY, 45 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99205 **Comprehensive**	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING

	PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. TYPICALLY, 60 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.

NOTE: Although time is a key element in deciding the correct E/M code, it is not the ultimate arbiter. There are multiple variables, with time as 1 part of a variable equation, meaning that more or less time should not sway your decision. The content of the evaluation is deciding factor.

99202: Physicians typically spend 20 minutes face to face with a patient
99203: Physicians typically spend 30 minutes face to face with a patient
99204: Physicians typically spend 45 minutes face to face with a patient
99205: Physicians typically spend 60 minutes face to face with a patient

Again…This is typical, but not the arbiter. The arbiter is what was done AND documented. Just performing the required elements do not count. IF… it isn't written… it doesn't exist!

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:

1. History
2. Examination
3. 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 pain the neck that radiates into the arms 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:

1. Location (example: left leg);
2. Quality (example: aching, burning, radiating pain);
3. Severity (example: 10 on a scale of 1 to 10);
4. Duration (example: started three days ago);
5. Timing (example: constant or comes and goes);
6. Context (example: lifted large object at work);
7. Modifying factors (example: better when heat is applied); and
8. 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.

1. Earache
2. Dull in left ear
3. Past 24 hours

An **extended HPI**:

Note: You have 2 choices to follow and both are acceptable. I recommend the first as associated comorbidities are more impactful in a biomechanical environment

- 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.

1. Earache
2. Dull in left ear
3. Past 24 hours
4. Went swimming 2 days ago
5. Relieved by warm compresses & ibuprofen

Review of Systems

Note: As chiropractors, we are considered both specialists in neuro-musculoskeletal biomechanical treatment and primary care provider concurrently. In addition, there are a myriad of comorbidities that can affect the diagnosis, prognosis and treatment plan in the neuro-musculoskeletal biomechanical / chiropractic environment. As a result, this is why we are trained as primary care providers, to ensure the safety of the public. As a result, it is my strongest recommendation to ALWAYS do a complete 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:

1. Constitutional Symptoms (for example, fever, weight loss);
2. Eyes;
3. Ears, Nose, Mouth, Throat;
4. Cardiovascular;
5. Respiratory;
6. Gastrointestinal;
7. Genitourinary;
8. Musculoskeletal;
9. Integumentary (skin and/or breast);
10. Neurological;
11. Psychiatric;
12. Endocrine;
13. Hematologic/Lymphatic; and
14. 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 – musculoskeletal and respiratory – are reviewed:

- CC: Follow up visit in office after chiropractic spinal adjustments as sequella to motor vehicle accident. Patient states “I feel the neck pain has gone form an 8/10 to a 4/10.”
- ROS: Patient states he feels the neck pain has gone form an 8/10 to a 4/10 and denies chest pain, syncope, palpitations, and shortness of breath. Relates occasional unilateral, mild paraesthesia of the left upper outer arm.

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.”

Systems:

1. Constitutional: Weight stable, + fatigue.
2. Eyes: + loss of peripheral vision.
3. Ear, Nose, Mouth, Throat: No complaints.
4. Cardiovascular: + palpitations; denies chest pain; denies calf pain, pressure, or edema.
5. Respiratory: + shortness of breath on exertion.
6. Gastrointestinal: Appetite good, denies heartburn and indigestion + episodes of nausea. Bowel movement daily; denies constipation or loose stools.
7. Urinary: Denies incontinence, frequency, urgency, nocturia, pain, or discomfort.
8. Skin: + clammy, moist skin.
9. Neurological: + fainting; denies numbness, tingling, and tremors.
10. 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;**

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;**

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 rerecorded 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.

NOTE: ***Therefore you may, to the letter of the interpretation, document that you reviewed the patient's intake forms in your evaluation and initial the form. HOWEVER... I do not support that short cut as I have never seen any other specialist take that route. In order to win at the highest level, you must take extraordinary measures to be the best with every detail. Not display shortcuts that are accommodated by an "*" with what is acceptable.***

- 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).

CONTENT AND DOCUMENTATION REQUIREMENTS

Problem Focused 99202	**One to five** elements identified by a bullet.
Expanded Problem Focused 99203	**At least six** elements identified by a bullet.
Detailed 99204	**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 99205	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.**

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)

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

nitourinary	**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

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: 1. orientation to time, place and person 2. recent and remote memory 3. mood and affect (eg, depression, anxiety, agitation)

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.

    NOTE: You may only diagnose what is present. If you suspect other pathology, but have not yet concluded the diagnosis, discuss it, but do not use "possible, probable or rule out diagnosis" in your diagnosis section. Limit those to discussion only with an explanation sad to why you are ordering more tests to conclude an accurate 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.

NOTE: Include the test and results in your report as to supporting the foundation of your medical decision making

- 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.

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

References:

1. A Guide to Evaluation and Management Coding and Documentation, Retrieved from: http://www.connecticare.com/provider/PDFs/CCIOvercodingGuideFINAL.pdf
2. Evaluation and Management Services Guide, Retrieved from: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf
3. CPT/HCPC Codes, Retrieved from: https://www.cms.gov/medicare-coverage-database/staticpages/cpt-hcpcs-code-range.aspx?DocType=LCD&DocID=32007&Group=1&RangeStart=99201&RangeEnd=99205