CHAPTER 1

Evaluation and Management (E/M)

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The Essential Coding Resource for Doctors of Chiropractic
Evaluation and Management (E/M) Services

Note: The ACA House of Delegates adopted the following statement regarding CPT Audit Requirements for E/M during the 1997 annual meeting:

RESOLVED that ACA adopt as ACA policy the audit requirements used by physicians for the CPT evaluation and management codes. These audit requirements are to be reviewed for updates as appropriate by the insurance committee.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of physician work varies by type of service, place of service, and the patient's status.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, e.g., office consultation. Third, the content of the service is defined, e.g., comprehensive history and comprehensive examination. Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified.

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.
An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

In the instance where a physician is on call for or covering for another physician, the patient’s encounter will be classified as it would have been by the physician who is not available.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

Chief Complaint
A concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient’s words.

Concurrent Care
Concurrent care is the provision of similar services, eg, hospital visits, to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required. Modifier -75 has been deleted.

Counseling
Counseling is a discussion with a patient and/or family concerning one or more of the following areas;
- Diagnostic results, impressions, and/or recommended diagnostic studies;
- Prognosis;
- Risks and benefits of management (treatment) options;
- Instructions for management (treatment) and/or follow-up;
- Importance of compliance with chosen management (treatment) options;
- Patient and family education

Family History
A review of medical events in the patient’s family that includes significant information about:
- The health status or cause of death of parent, siblings and children;
- Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review;
- Diseases of family members which may be hereditary or place the patient at risk.
History of Present Illness
A chronological description of the development of the patient's present illness from
the first sign and/or symptom to the present. This includes a description of location,
quality, severity, timing, context, modifying factors and associated signs and
symptoms significantly related to the presenting problem(s).

Levels of E/M Services
Within each category or subcategory of E/M service, there are three to five levels of
E/M services available for reporting purposes. Levels of E/M services are not
interchangeable among the different categories or subcategories. For example, the
first level of E/M services in the subcategory of office visit, new patient, does not have
the same definition as the first level of E/M services in the subcategory of office visit,
established patient.

The levels of E/M services include examinations, evaluation, treatments, conferences
with or concerning patients, preventive pediatric and adult health supervision, and
similar medical services, such as the determination of the need and/or location for
appropriate care. Medical screening includes the history, examination and medical
decision-making required to determine the need and/or location for appropriate care
and treatment of the patient (e.g., office and other outpatient setting, emergency
department, nursing facility, et.). The levels of E/M services encompass the wide
variations in skill, effort, time, responsibility and medical knowledge required for the
prevention or diagnosis and treatment of illness or injury and the promotion of
optimal health. Each level of E/M services may be used by all physicians.

The descriptors for the levels of E/M services recognize seven components, six of
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 (history, examination, and medical decision
making) are considered the key components in selecting a level of E/M services.

The next three components (counseling, coordination of care, and the nature of the
presenting problem) are considered contributory factors in the majority of encounters.
Although the first two of these contributory factors are important E/M services, it is
not required that these services be provided at every patient encounter.
Coordination of care with other providers or agencies without a patient encounter on that day is reported using the case management codes.

The final component, time, is discussed in detail.

Any specifically identifiable procedure (i.e., identified with a specific CPT code) performed on or subsequent to the date of initial or subsequent “E/M Services” should be reported separately.

The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic test/studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code with modifier -26 appended.

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service above and beyond other services provided or beyond the usual preservice and postservice care associated with the procedure that was performed. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier -25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

Nature of Presenting Problem
A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

Minimal: A problem that may not require the presence of the physician, but service is provided under the physician's supervision.

Self-limited or minor: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance.

Low severity: A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
Moderate severity: A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

High severity: A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

Past History
A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:
- prior major illnesses and injuries;
- prior operations;
- prior hospitalizations;
- current medications;
- allergies (e.g., drug, food);
- age appropriate immunization status;
- age appropriate feeding/dietary status.

Social History
- an age appropriate review of past and current activities that includes significant information about:
  - marital status and/or living arrangements;
  - current employment;
  - occupational history;
  - use of drugs, alcohol, and tobacco;
  - level of education;
  - sexual history;
  - other relevant social factors.

System Review (Review of Systems)
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. For the purposes of CPT the following elements of a system review have been identified:
- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

**Time**

The inclusion of time in the definitions of levels of E/M services is done to assist physicians in selecting the most appropriate level of E/M services. It should be noted that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for physicians to provide accurate estimates of the time spent face-to-face with the patient.

Studies to establish levels of E/M services employed surveys of practicing physicians to obtain data on the amount of time and work associated with typical E/M services. Since “work” is not easily quantifiable, the codes must rely on other objective, verifiable measures that correlate with physicians’ estimates of their “work.” It has been demonstrated that physicians’ estimations of intraservice time (see below), both within and across specialties, is a variable that is predictive of the “work” of E/M services. This same research has shown there is a strong relationship between intraservice time and total time for E/M services. Intraservice time, rather than total time, was chosen for inclusion with the codes because of its relative ease of measurement and because of its direct correlation with measurements of the total amount of time and work associated with typical E/M services.

Intraservice times are defined as face-to-face time for offices and other outpatient visits and as unit/floor time for hospital and other inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of a typical hospital visit takes place during the time spent on the patient’s floor or unit.
Face-to-face time (office and other outpatient visits and office consultations): For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.

Physicians also spend time doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

This non face-to-face time for office services (also called pre-and post-encounter time) is not included in the time component described in the E/M codes. However, the pre- and post-face-to-face work associated with an encounter was included in calculating the total work of typical services in physician surveys.

Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit codes. However, the pre- and post-work performed during the time spent off the floor or unit was included in calculating the total work of typical services in physician surveys. Thus, the unit/floor time associated with the services described by any code is a valid proxy for the total work done before, during and after the visit.

**Unlisted Service**
An E/M service may be provided that is not listed. When reporting such a service, the appropriate “unlisted” code may be used to indicate the service, identifying it by “special report”. The “unlisted services” and accompanying codes for the E/M section are:

- 99429 Unlisted preventive medicine service
- 99499 Unlisted evaluation and management service

**Special Report**
An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort and equipment necessary to provide the service. Additional items which may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.
Clinical Examples (See Chapter 9)
Clinical examples of the codes for E/M services are provided to assist physicians in understanding the meaning of the descriptors and selecting the correct code.

**Instructions for Selecting a Level of E/M Services**
Identify the category and subcategory of service. Review the reporting instructions for the selected category or subcategory. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, e.g., "Inpatient Hospital Care," special instructions will be presented preceding the levels of E/M services.

Review the level of E/M service descriptors and examples in the selected category or subcategory.
The descriptors for the levels of E/M services recognize seven components, six of 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) should be considered the key components in selecting the level of E/M services. An exception to this rule is in the case of visits which consist predominantly of counseling or coordination of care.

The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.

**Determine the Extent of History Obtained**
The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of history that are defined as follows:

- Problem Focused: chief complaint; brief history of present illness or problem.
- Expanded problem focused: chief complaint; brief history of present illness; problem pertinent system review.
Detailed: chief complaint; extended history of present illness; problem pertinent system review extended to included a review of a limited number of additional systems; pertinent past, family, and/or social history directly related to the patient’s problems.

Comprehensive: chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.

The comprehensive history obtained as part of the preventive medicine evaluation and management service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history or pertinent risk factors.

Determine the Extent of Examination Performed
The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize 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 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).

Note: The comprehensive examination performed as part of the preventive medicine evaluation and management service is multisystem, but its extent is based on age and risk factors identified.

For the purposes of these CPT definitions, the following body areas are recognized:
- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity
For the purposes of these CPT definitions the following organ systems are recognized:

- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

Determine the Complexity of Medical Decision Making

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
- 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.

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity and high complexity.

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

Select the Appropriate Level of E/M Services Based on the Following:

1) For the following categories/subcategories, all of the key components, (i.e., history, examination and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient, hospital observation services; initial hospital care, office consultations; initial inpatient consultations; confirmatory consultations; emergency department services; comprehensive nursing facility assessments; domiciliary care, new patient; and home, new patient.
2) For the following categories/subcategories, two of the three key components (i.e., history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; follow-up inpatient consultations; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

3) 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), then time is considered the key or controlling factor to qualify for a particular level of E/M services.

### Complexity of Medical Decision Making

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<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of significant complications, morbidity, and/or mortality</th>
<th>Type of decision</th>
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<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
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<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
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<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
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<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
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### Office or Other Outpatient Services

The following codes are used to report evaluation and management services provided in the physician's office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

#### New Patient

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
1. a problem focused history,
2. a problem focused examination, and
3. straightforward medical decision making.

Counseling and/or coordination of care with other providers 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. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

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| 99202  | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:  
       | 1. an expanded problem focused history;  
       | 2. an expanded problem focused examination; and  
       | 3. straightforward medical decision making.                                                   |

Counseling and/or coordination of care with other providers 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. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

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| 99203  | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:  
       | 1. a detailed history;  
       | 2. a detailed examination; and  
       | 3. medical decision making of low complexity.                                                  |

Counseling and/or coordination of care with other providers 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. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

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| 99204  | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:  
       | 1. a comprehensive history;  
       | 2. a comprehensive examination; and  
       | 3. medical decision making of moderate complexity.                                              |

Counseling and/or coordination of care with other providers 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. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
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| 99205  | Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:  
1. a comprehensive history;  
2. a comprehensive examination; and  
3. medical decision making of high complexity.  
Counseling and/or coordination of care with other providers 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. Physicians typically spend 60 minutes face-to-face with the patient and/or family.  
**Established Patient**  
99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician.  
Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.  
99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:  
1. a problem focused history;  
2. a problem focused examination;  
3. straightforward medical decision making.  
Counseling and/or coordination of care with other providers 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. Physicians typically spend 10 minutes face-to-face with the patient and/or family.  
99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:  
1. an expanded problem focused history;  
2. an expanded problem focused examination;  
3. medical decision making of low complexity.  

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Counseling and coordination of care 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. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
1. a detailed history;
2. a detailed examination;
3. medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers 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. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
1. a comprehensive history;
2. a comprehensive examination;
3. medical decision making of high complexity.

Counseling and/or coordination of care with other providers 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. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

**Hospital Observation Services**

The following codes are used to report evaluation and management services provided to patients designated/admitted as “observation status” in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital.
If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc., these codes are to be utilized if the patient is placed in such an area.

Typical times have not yet been established for this category of service.

**Observation Care Discharge Services**

Observation care discharge of a patient from “observation status” includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see codes 99234-99236 as appropriate.

99217 Observation care discharge day management (This code is utilized by the physician to report all services provided to a patient on discharge from “observation status” if the discharge is on other than the initial date of “observation status.” To report services to “inpatient status” and discharges on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate].)

**Initial Observation Care**

New or Established Patient
The following codes are used to report the encounter(s) by the supervising physician with the patient when designated as “observation status.” This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments. For observation encounters by other physicians, see Office or Other Outpatient Consultation codes (99241-99245).

To report services provided to a patient who is admitted to the hospital after receiving hospital observation care services on the same date, see the notes for initial hospital inpatient care. For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported with the appropriate Initial Hospital Care code (99221-99223). For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate. Do not report observation discharge (99217) in conjunction with a hospital admission.

When “observation status” is initiated in the course of an encounter on another site of service (e.g., hospital emergency department, physician’s office, nursing facility) all evaluation and management services provided by the supervising physician in...
conjunction with initiating “observation status” are considered part of the initial observation care when performed on the same date. The observation care level of service reported by the supervising physician should include the services related to initiating “observation status” provided in the other sites of service as well as in the observation setting.

Evaluation and Management services on the same date provided in sites that are related to initiating “observation status” should NOT be reported separately.

These codes may not be utilized for post-operative recovery if the procedure is considered part of the surgical “package.” These codes apply to all evaluation and management services that are provided on the same date of initiating “observation status.”

99218 Initial observation care, per day, for the evaluation and management of a patient which requires these three key components:
1. A detailed or comprehensive history;
2. A detailed or comprehensive examination; and
3. Medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to “observation status” are of low severity.

99219 Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components:
1. A comprehensive history;
2. A comprehensive examination; and
3. Medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually the problem(s) requiring admission to “observation status” are of moderate severity.

99220 Initial observation care, per day, for the evaluation and management of a patient, which requires these three key components:
1. A comprehensive history;
2. A comprehensive examination; and
3. Medical decision making of high complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to “observation status” are of high severity.

**Hospital Inpatient Services**

The following codes are used to report Evaluation and Management services provided to hospital inpatients. Hospital inpatient services include those services provided to patient in a “partial hospital” setting. These codes are to be used to report these partial hospitalization services.

For definitions of key components and commonly used terms, please see Evaluation and Management Services Guidelines. For Hospital Observation Services, see 99218-99220. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate.

**Initial Hospital Care - New or Established Patient**

The following codes are used to report the first hospital inpatient encounter with the patient by the admitting physician. For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.

When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (e.g., hospital emergency department, observation status in a hospital, physician's office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting. Evaluation and Management services on the same date provided in sites other than the hospital that are related to the admission should not be reported separately.

99221 Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components:
- a detailed or comprehensive history;
- a detailed or comprehensive examination; and
- medical decision making that is straightforward or of low complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

99222 Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:
1. a comprehensive history;
2. a comprehensive examination; and
3. medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

99223 Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:
1. a comprehensive history;
2. a comprehensive examination; and
3. medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

**Subsequent Hospital Care**

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status, (i.e., changes in history, physical condition and response to management) since the last assessment by the physician.
99231 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:
1. a problem focused interval history;
2. a problem focused examination;
3. medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:
1. an expanded problem focused interval history;
2. an expanded problem focused examination;
3. medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:
1. a detailed interval history;
2. a detailed examination;
3. medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.
Observation or Inpatient Care Services (Including Admission and Discharge Services)

The following codes are used to report observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service. When a patient is admitted to the hospital from “observation status” on the same date, the physician should report only the initial hospital care code. The initial hospital care code reported by the admitting physician should include the services related to the observation status services he/she provided on the same date of inpatient admission.

When “observation status” is initiated in the course of an encounter in another site of service (e.g., hospital emergency department, physicians office, nursing facility) all evaluation and management services provided by the supervising physician in conjunction with the initiating “observation status” are considered part of the initial observation care when performed on the same date. The observation care level of service should include the services related to initiating “observation status” provided in the other sites of service as well as in the observation setting when provided by the same physician.

For patients admitted to the observation or inpatient care and discharged on a different date, see codes 99218-99220 and 99217, or 99221-99223 and 99238, 99239.

99234 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:
1. a detailed or comprehensive history;
2. a detailed or comprehensive examination; and
3. medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers 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) requiring admission are of low severity.

99235 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three components:
1. a comprehensive history;
2. a comprehensive examination; and
3. medical decision making of moderate complexity.
Counseling and/or coordination of care with other providers 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) requiring admission are of moderate severity.

99236 Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components:
1. a comprehensive history;
2. a comprehensive examination; and
3. medical decision making of high complexity.

Counseling and/or coordination of care with other providers 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) requiring admission are of high severity.

**Hospital Discharge Services**

The hospital discharge day management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescription and referral forms, even if the time spent by the physician on that date is not continuous.

99238 Hospital discharge day management; 30 minutes or less
99239 more than 30 minutes

(These codes are to be utilized by the physician to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient status.

To report services to a patient who is admitted as an inpatient, and discharged on the same date, see codes 99234-99236 for observation or inpatient hospital care, including the admission and discharge of the patient on the same date.)
Consultations

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician, insurer, employer, or other appropriate source. A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

The written or verbal request for a consult may be made by a physician or other appropriate source and documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

If subsequent to the completion of a consultation the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the follow-up consultation codes should not be used. In the office setting, the appropriate established patient code should be used.

Key Components:
- a physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit;
- the written or verbal request for a consult may be made by a physician or other appropriate source and documented in the patient's medical record;
- the consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.

A “consultation” initiated by a patient and/or family, and not requested by a physician, is not reported using the initial consultation codes but may be reported using the codes for confirmatory consultation or office visits, as appropriate. If a confirmatory consultation is required, e.g., by a third-party payer, the modifier -32, mandated services, should also be reported.

It is inappropriate to bill consultation codes unless the service is requested by another appropriate source. Taking a history and providing a report of findings is considered a standard component of evaluation and management services and therefore should not be considered a separate consultation service.

CPT guidelines do not set restrictions regarding individuals who may be considered an “appropriate source.” Some common examples may include a medical physician, osteopathic physician, physician assistant, nurse practitioner, chiropractic physician, physical therapist, occupational therapist, speech-language therapist, psychologist, social worker, or lawyer.
Office or Other Outpatient Consultations

New or Established Patient

The following codes are used to report consultations provided in the physician’s office or in an outpatient or other ambulatory facility, including hospital observation services, home services, domiciliary, rest home, custodial care, or emergency department (see consultation definition, above). Follow-up visits in the consultant’s office or other outpatient facility that are initiated by the physician consultant are reported using office visit codes for established patients (99211-99215).

If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used again.

99241 Office consultation for a new or established patient, which requires these three key components:
1. problem-focused history;
2. problem-focused examination; and
3. straightforward medical decision making.

Counseling and/or coordination of care with other providers 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. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99242 Office consultation for a new or established patient, which requires these three components:
1. an expanded problem-focused history;
2. an expanded problem-focused examination; and
3. straightforward medical decision making.

Counseling and/or coordination of care with other providers 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 severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99243</td>
<td>Office consultation for a new or established patient, which requires these</td>
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<tr>
<td></td>
<td>three key components:</td>
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<tr>
<td></td>
<td>1. a detailed history;</td>
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<tr>
<td></td>
<td>2. a detailed examination; and</td>
</tr>
<tr>
<td></td>
<td>3. medical decision making of low complexity.</td>
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<tr>
<td></td>
<td>Counseling and/or coordination of care with other providers or agencies are</td>
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<tr>
<td></td>
<td>provided consistent with the nature of the problem(s) and the patient's</td>
</tr>
<tr>
<td></td>
<td>and/or family's needs.</td>
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<tr>
<td></td>
<td>Usually, the presenting problem(s) are of moderate severity. Physicians</td>
</tr>
<tr>
<td></td>
<td>typically spend 40 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>99244</td>
<td>Office consultation for a new or established patient, which requires these</td>
</tr>
<tr>
<td></td>
<td>three key components;</td>
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<tr>
<td></td>
<td>1. a comprehensive history;</td>
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<tr>
<td></td>
<td>2. a comprehensive examination; and</td>
</tr>
<tr>
<td></td>
<td>3. medical decision making of moderate complexity.</td>
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<tr>
<td></td>
<td>Counseling and/or coordination of care with other providers or agencies are</td>
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<tr>
<td></td>
<td>provided consistent with the nature of the problem(s) and the patient's</td>
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<tr>
<td></td>
<td>and/or family's needs.</td>
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<tr>
<td></td>
<td>Usually, the presenting problem(s) are of moderate to high severity.</td>
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<tr>
<td></td>
<td>Physicians typically spend 60 minutes face-to-face with the patient and/or</td>
</tr>
<tr>
<td></td>
<td>family.</td>
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<tr>
<td>99245</td>
<td>Office consultation for a new or established patient, which requires these</td>
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<td></td>
<td>three key components:</td>
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<tr>
<td></td>
<td>1. a comprehensive history;</td>
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<tr>
<td></td>
<td>2. a comprehensive examination; and</td>
</tr>
<tr>
<td></td>
<td>3. medical decision making of high complexity.</td>
</tr>
<tr>
<td></td>
<td>Counseling and/or coordination of care with other providers or agencies are</td>
</tr>
<tr>
<td></td>
<td>provided consistent with the nature of the problem(s) and the patient's</td>
</tr>
<tr>
<td></td>
<td>and/or family's needs.</td>
</tr>
<tr>
<td></td>
<td>Usually, the presenting problem(s) are of moderate to high severity.</td>
</tr>
<tr>
<td></td>
<td>Physicians typically spend 80 minutes face-to-face with the patient and/or</td>
</tr>
<tr>
<td></td>
<td>family.</td>
</tr>
</tbody>
</table>
Initial Inpatient Consultations

New or Established Patient
The following codes are used to report physician consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting. Only one initial consultation should be reported by a consultant per admission.

99251 Initial inpatient consultation for a new or established patient, which requires these three key components:
1. a problem focused history;
2. a problem focused examination; and
3. straightforward medical decision making.

Counseling and/or coordination of care with other providers 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. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor unit.

99252 Initial inpatient consultation for a new or established patient, which requires these three key components:
1. an expanded problem focused history;
2. an expanded problem focused examination; and
3. straightforward medical decision making.

Counseling and/or coordination of care with other providers 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 severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor unit.

99253 Initial inpatient consultation for a new or established patient, which requires these three key components:
1. a detailed history;
2. a detailed examination; and
3. medical decision making of low complexity.

Counseling and/or coordination of care with other providers 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. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor unit.
Initial inpatient consultation for a new or established patient, which requires these three key components:
1. a comprehensive history;
2. a comprehensive examination; and
3. medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers 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. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor unit.

Initial inpatient consultation for a new or established patient, which requires these three key components:
1. a comprehensive history;
2. a comprehensive examination; and
3. medical decision making of high complexity.

Counseling and/or coordination of care with other providers 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. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor unit.

Follow-Up Inpatient Consultations

Established Patient

Codes 99261-99263 have been deleted. For follow-up inpatient consultation, see 99231-99233, 99307-99310.

Rationale

The follow-up inpatient consultation codes 99261-99263 have been deleted with instructions to report the subsequent hospital care codes (99231-99233) or the subsequent nursing facility care codes (99307-99310) depending on the site of services. In consideration of the typical use of these codes, it was found that these codes were redundant, and that other more
specific E/M codes would be more appropriately reported (e.g., Subsequent Hospital Care or Subsequent Nursing Facility codes). The initial inpatient consultation codes (99251-99255), which have been retained, are to be used only once by the reporting physician for an individual hospital or nursing facility patient for a particular episode of care. For example, a subsequent consultation that may be rendered in response to a change in patient's status or availability of new information (e.g., test results) provided after the initial consultation during the same inpatient admission should be reported using the subsequent hospital care codes (99231-99233) and not as an initial inpatient consultation. Follow-up consultations that are performed in order to complete the initial consultation (e.g., certain tests results previously not available are now ready) should also be reported using the subsequent hospital care codes (99231-99233). If the subsequent or follow-up consultation is provided in the nursing facility setting, the subsequent nursing facility care codes (99307-99310) should be reported.

**Confirmatory Consultations**

**New or Established Patient**

Codes 99271-99275 have been deleted. For confirmatory consultation, see the appropriate E/M service code for the setting and type of service (e.g., consultation).

**Rationale**

The confirmatory consultation codes (99271-99275) have been deleted with instructions to report the appropriate E/M service code for the setting and type of service (e.g., consultation). The confirmatory consultation codes were believed to be redundant, as other more specific E/M consultation codes are available (99241-99245, 99251-99255) to report these services. For example, when a confirmatory consultation is provided in the outpatient setting, the office consultation codes (99241-99245) should be reported. Confirmatory consultations may be requested by any number of appropriate individuals or sources including the patient. When a consultation is mandated by a third-party payer, modifier 32 should be appended to the level of consultation code reported.
**Emergency Department Services**

**New or Established Patient**
The following codes are used to report evaluation and management services provided in the emergency department. No distinction is made between new and established patients in the emergency department.

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

For evaluation and management services provided to a patient in an observation area of a hospital, see 99217-99220.

For observation or inpatient care services (including admission and discharge services), see 99234-99236.

99281 Emergency department visit for the evaluation and management of a patient, which requires these three key components:
1. a problem focused history;
2. a problem focused examination; and
3. straightforward medical decision making.

Counseling and/or coordination of care with other providers 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.

99282 Emergency department visit for the evaluation and management of a patient, which requires these three key components:
1. an expanded problem focused history;
2. an expanded problem focused examination; and
3. medical decision making of low complexity.

Counseling and/or coordination of care with other providers 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.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>Emergency department visit for the evaluation and management of a patient, which requires these three key components:</td>
</tr>
<tr>
<td></td>
<td>1. an expanded problem focused history;</td>
</tr>
<tr>
<td></td>
<td>2. an expanded problem focused examination; and</td>
</tr>
<tr>
<td></td>
<td>3. medical decision making of moderate complexity.</td>
</tr>
<tr>
<td></td>
<td>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</td>
</tr>
<tr>
<td></td>
<td>Usually, the presenting problem(s) are of moderate severity.</td>
</tr>
<tr>
<td>99284</td>
<td>Emergency department visit for the evaluation and management of a patient, which requires these three key components:</td>
</tr>
<tr>
<td></td>
<td>1. a detailed history;</td>
</tr>
<tr>
<td></td>
<td>2. a detailed examination; and</td>
</tr>
<tr>
<td></td>
<td>3. medical decision making of moderate complexity.</td>
</tr>
<tr>
<td></td>
<td>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</td>
</tr>
<tr>
<td></td>
<td>Usually, the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.</td>
</tr>
<tr>
<td>99285</td>
<td>Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:</td>
</tr>
<tr>
<td></td>
<td>1. a comprehensive history;</td>
</tr>
<tr>
<td></td>
<td>2. a comprehensive examination; and</td>
</tr>
<tr>
<td></td>
<td>3. medical decision making of high complexity.</td>
</tr>
<tr>
<td></td>
<td>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.</td>
</tr>
<tr>
<td></td>
<td>Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.</td>
</tr>
</tbody>
</table>
Prolonged Physician Service With Direct (Face-to-Face) Patient Contact

Codes 99354-99357 are used when a physician provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. This service is reported in addition to other physician service, including evaluation and management services at any level. Appropriate codes should be selected for supplies provided or procedures performed in the care of the patient during this period.

These codes are used to report the total duration of face-to-face time spent by a physician on a given date providing prolonged service, even if the time spent by the physician on that date is not continuous.

Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service. Either code also may be used to report a total duration of prolonged service of 30-60 minutes on a given date. Either code should be used only once per date, even if the time spent by the physician is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.

Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. Either code may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99354</td>
<td>Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care of an acute asthmatic patient in an outpatient setting); first hour (list separately in addition to code for office or other outpatient Evaluation and Management service)</td>
</tr>
<tr>
<td>99355</td>
<td>each additional 30 minutes (list separately in addition to code for prolonged physician service)</td>
</tr>
<tr>
<td>99356</td>
<td>Prolonged physician service in the inpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); first hour (list separately in addition to code for inpatient Evaluation and Management service)</td>
</tr>
</tbody>
</table>
### Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact

Codes 99358 and 99359 are used when a physician provides prolonged service not involving direct (face-to-face) care that is beyond the usual service in either the inpatient or outpatient setting. This service is to be reported in addition to other physician services, including evaluation and management services at any level.

Codes 99358 and 99359 are used to report the total duration of non face-to-face time spent by a physician on a given date providing prolonged service, even if the time spent by the physician on that date is not continuous. Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service.

It may also be used to report a total duration of prolonged service of 30-60 minutes on a given date. It should be used only once per date even if the time spent by the physician is not continuous on that date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Code 99359 is used to report each additional 30 minutes beyond the first hour regardless of the place of service. It may also be used to report the final 15-30 minutes of prolonged service on a given date.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

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Case Management Services

Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.

### Team Conferences

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>99361</td>
<td>Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes</td>
</tr>
<tr>
<td>99362</td>
<td>approximately 60 minutes</td>
</tr>
</tbody>
</table>

### Telephone Calls

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99371</td>
<td>Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (e.g., to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information for other health professionals into the medical treatment plan or to adjust therapy)</td>
</tr>
<tr>
<td>99372</td>
<td>intermediate (e.g., to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care)</td>
</tr>
<tr>
<td>99373</td>
<td>complex or lengthy (e.g., lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan)</td>
</tr>
</tbody>
</table>
Preventive Medicine Services

The following codes are used to report the preventive medicine evaluation and management of infants, children, adolescents and adults.

The extent and focus of the services will largely depend on the age of the patient. (If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier -25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service. An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine E/M service and which does not require additional work and the performance of the key components of a problem-oriented E/M service, should not be reported.

Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic, comprehensive preventive medicine examination. (Refer to codes 99401-99412 for reporting those counseling/anticipatory guidance/risk factor reduction interventions that are provided at an encounter separate from the preventive medicine examination.)

Immunizations and ancillary studies involving laboratory, radiology, or other procedures are reported separately.

New Patient

99381 Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year)
99382 early childhood (age 1 through 4 years)
99383 late childhood (age 5 through 11 years)
99384 adolescent (age 12 through 17 years)
99385 18-39 years
99386 40-64 years
99387 65 years and over
Established Patient

99391 Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year)
99392 early childhood (age 1 through 4 years)
99393 late childhood (age 5 through 11 years)
99394 adolescent (age 12 through 17 years)
99395 18-39 years
99396 40-64 years
99397 65 years and over

Counseling and/or Risk Factor Reduction Intervention

New or Established Patient

There are six distinct E/M risk reduction intervention counseling service levels appropriate for use in the chiropractic office/clinic (outpatient) setting. There are four levels of preventive medicine, individual counseling services, codes 99401-99404. There are also two levels of preventive medicine, group counseling services, codes 99411 and 99412. Each level of service may be used by the DC.

These codes are used to report services provided to individuals at a separate encounter for the purpose of promoting health and preventing illness or injury.

Preventive medicine counseling and risk factor reduction interventions provided as a separate encounter will vary with age and should address such issues as family problems, diet and exercise, substance abuse, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter.

These codes should not be used to document counseling and risk factor reduction interventions provided to patients with symptoms or established illness. For counseling individual patients with symptoms or established illness, use the appropriate office, hospital or consultation or other E/M codes. For counseling groups of patients with symptoms or established illness, use 99078.

Preventive Medicine, Individual Counseling

99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402 approximately 30 minutes

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Preventive Medicine, Group Counseling

99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412 approximately 60 minutes

Special Evaluation and Management Services

The following codes are used to report evaluations performed to establish baseline information prior to life or disability insurance certificates being issued. This service is performed in the office or other setting, and applies to both new and established patients. When using these codes, no active management of the problem(s) is undertaken during the encounter.

If other evaluation and management services and/or procedures are performed on the same date, the appropriate E/M or procedure code(s) should be reported in addition to these codes.

Basic Life and/or Disability Evaluation Services

99450 Basic life and/or disability examination that includes:
- measurement of height, weight and blood pressure;
- completion of a medical history following a life insurance pro forma;
- collection of blood sample and/or urinalysis complying with “chain of custody” protocols; and
- completion of necessary documentation/certificates.

Work Related or Medical Disability Evaluation Services

99455 Work related or medical disability examination by the treating physician that includes:
- completion of a medical history commensurate with the patient’s condition;
- performance of an examination commensurate with the patient’s condition;
- formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment;
- development of future medical treatment plan; and
- completion of necessary documentation/certificates and report.
99456 Work related or medical disability examination by other than the treating physician that includes:
- completion of a medical history commensurate with the patient's condition;
- performance of an examination commensurate with the patient's condition;
- formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment;
- development of future medical treatment plan; and
- completion of necessary documentation/certificates and report.

Other Appropriate Diagnostic Services

Clinical evaluation of the patient may reveal the need for other diagnostic services to be ordered or performed by the DC. When other diagnostic services are rendered, the nature and extent of those services should be consistent with the evaluation of the complaint, conform to commonly accepted patterns of use, be used in accordance with state regulations and be documented using current CPT descriptor language and identifying codes.

Nutritional Codes

Medical Nutrition Therapy Codes were added to CPT in 2001. The nutritional codes should be used when the doctor of chiropractic is actually performing a specific nutritional work-up to include: consultation, examination, laboratory testing (when appropriate), nutritional and/or dietary recommendations, or follow-up care in relation to nutrition.

- 97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- 97803 Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- 97804 Medical nutrition therapy; group (2 or more individual[s]), each 30 minutes

Testing and Measurement Codes

- 95831 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
- 95832 Hand, with or without comparison with normal side
- 95833 Total evaluation of body, excluding hands
- 95834 Total evaluation of body, including hands
- 95851 Range-of-motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
- 95852 Hand, with or without comparison with normal side

Please see page 344 for clarification of these services.
Questions and Answers for E/M Service Codes

Q: How can I determine when to code an evaluation and management (E/M) service as a consultation?

A: To determine this, you must ask yourself the following questions.

Was a consultation requested? Review the patient's medical record to obtain this information. The request for a consultation may be made in written or verbal form, but the request for the consultation must be documented in the patient's medical record.

If the consultation was requested, did the consulting physician perform the consultation, document his or her opinion in the patient's medical record, and communicate findings/recommendations by written report to the requesting physician or other appropriate source?

When these requirements are met, a consultation code may be reported. The level of E/M service should be selected based upon the key components performed (i.e., history, examination, medical decision making). When counseling and coordination of care dominates (more than 50%) 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), then time may be considered the key or controlling factor to qualify for a particular level of E/M consultation services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents, person acting in locum parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

If these requirements are not met, then the appropriate office or other outpatient (99201 - 99215) E/M service should be reported instead of a consultation code.

Much of the confusion in reporting consultative services begins with terms used to describe the service requested. The terms “consultation” and “referral” may be mistakenly interchanged. However, the CPT book does not recognize these terms as synonymous. Careful documentation of the services requested and provided will alleviate much of this confusion.

When a physician refers a patient to another physician it should not automatically be considered a consultation. A consultation would be appropriate if the E/M service provided meets the above criteria for reporting a consultation. Referral of a patient to another physician (e.g., for treatment of a specific problem) without a written or verbal request for a consultation (documented in the patient's medical record) should be reported using office or other outpatient codes (99201 - 99215). The physician may communicate his or her findings back to the referring physician, but
this is not required for a referral as it is for a consultation.

On occasion, a third-party payer may request a second or third opinion consultation. In this instance, the confirmatory consultation E/M codes (99271 - 99275) should be reported. A physician consultant providing a confirmatory consultation is expected to provide an opinion and/or advice only. Any services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care. Consultations, including confirmatory consultations, may be requested by any appropriate source. Upon reading this, you probably will ask, how is “any appropriate source” defined? CPT guidelines do not set restrictions regarding individuals who may be considered an appropriate source. Some common examples include a physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language therapist, psychologist, social worker, lawyer, or insurance company. At times, confirmatory consultations may be initiated at the request of the patient. If a confirmatory consultation is required, e.g., by a third-party payer, the modifier -32, mandated services, should also be reported.

Q: Is it appropriate to code a consultation when the diagnosis is already known by the requesting physician and/or by the consulting physician?

A: A consultation may be reported regardless of whether the diagnosis is known or unknown, provided the requirements for a consultation are met. The requirements are summarized below:

- CPT guidelines define a consultation as “a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source.”
- The written or verbal request for a consult must be documented in the patient’s medical record.
- The consulting physician may initiate diagnostic or therapeutic services at the consultation or at a subsequent visit.
- The consultant’s opinion and any services ordered or performed must be documented in the medical record and communicated by written report to the requesting physician or other appropriate source.

Clinically, there are many situations where the patient’s physician has already established the patient’s diagnosis or condition, evaluates and/or treats the condition, and subsequently requests a consultation from another physician when the requesting physician determines “it may benefit or be helpful to the patient” to do so. Such a request is generally based on clinical observations considered by the requesting physician to merit consultation with another physician.
The decision to request a consultation rests solely with the requesting physician or other appropriate source. It is the clinical judgment of the requesting physician that establishes the need and medical necessity for a consultation, whether or not the diagnosis is known at the time of the request. The content and nature of the request may vary from case to case, based upon the requesting physician's judgment, the patient's condition, and the scope of service the requesting physician desires of the consulting physician.

Upon receipt of the consultant's findings, the requesting physician either continues to manage the patient's condition or requests the consulting physician to assume management of the patient's condition thereafter.

When the consulting physician assumes management of the patient's condition after the consultation is completed, the appropriate code(s) from the office or other outpatient (99211 - 99215) series should be reported for additional E/M services provided by the physician.

Q: When the physician initiates diagnostic or therapeutic services at the time of the “consultative” service, is the encounter still considered a consultation?

A: The consulting physician may perform the evaluation of the patient, initiate diagnostic services, and then initiate therapy at the same encounter. This activity assumes that the consultation has been requested, the consulting physician provides and documents it, and communicates his/her consulting opinion and any services provided in a written report to the requesting physician. The service may be coded as a consultation.

Q: In the context of the previous question, when does the consultative service end?

A: Once the consulting physician communicates his or her opinion and/or advice back to the requesting physician or other source via written report, the consultation service has ended.

Q: When the physician assumes the responsibility for care at the time of the consultation E/M service, should the service still be coded as a consultation?

A: When a physician assumes the responsibility for care of the patient at the time of a consultation, that E/M service is still considered a consultation if all requirements for a consultation are met. Once the consultation has been completed, the follow-up consultation codes should not be used. In the office setting, the appropriate established patient office or other outpatient services code (99211 - 99215) should be reported.
Q: Does initiation of a diagnostic service constitute assumption of management and terminate the consultation?

A: Initiation of a diagnostic service does not constitute assumption of management and thereby terminate the consultation. A diagnostic service can be initiated during the course of a consultation.

For example, during the consultative encounter, the physician may initiate a diagnostic service (e.g., order a diagnostic test or perform a diagnostic exam/procedure) to evaluate the patient so that a diagnostic impression can be formulated and the consultative opinion or advice can be developed. This action does not constitute assumption of care.

American Medical Association, Centers for Medicare and Medicaid Services, May 1997

Foreword

These guidelines have been developed jointly by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS). In developing and testing the validity of these guidelines, special emphasis was placed on assuring that they:

■ are consistent with the clinical descriptors and definitions contained in CPT,
■ would be widely accepted by clinicians and minimize any changes in record-keeping practices, and
■ would be interpreted and applied uniformly by users across the country.

Documentation Guidelines for Evaluation and Management Services

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 health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time
■ communication and continuity of care among physicians and other health care professionals involved in the patient's care
■ accurate and timely claims review and payment
appropriate utilization review and quality of care evaluations
■ 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
■ that services provided have been accurately reported

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.
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:

1. history;
2. examination;
3. medical decision making;
4. counseling;
5. coordination of care;
6. nature of presenting problem; and
7. 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 (e.g., 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 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 dis-
orders 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.

**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)
- 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 judgement 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.)

<table>
<thead>
<tr>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family, and/or Social History (PFSH)</th>
<th>Type of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>Brief</td>
<td>Problem Focused</td>
<td>N/A</td>
<td>Expanded Focus</td>
</tr>
<tr>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
<td>Detailed</td>
</tr>
<tr>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

• 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 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.

•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.

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, usually stated in the patient's words.

•DG The medical record should clearly reflect the chief complaint.

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
- 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.

**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.

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.

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

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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)
- 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.

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.

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 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 home care, new patient.
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

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 judgement, 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 and described in detail below. In the tables, organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column.

Parenthetical examples, “(e.g., ...)”, 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. (These are minimal standards.)

- **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 Examination

To qualify for a given level of multi-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 (•) 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.
### Content and Documentation Requirements—General Multi-System Examination

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| 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 (e.g., development, nutrition, body habitus, deformities, attention to grooming) |
| Eyes             | - Inspection of conjunctivae and lids  
- Examination of pupils and irises (e.g., reaction to light and accommodation, size and symmetry)  
- Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages) |
| Ears, Nose, Mouth and Throat | - External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses)  
- Otoscopic examination of external auditory canals and tympanic membranes  
- Assessment of hearing (e.g., 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 (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)  
- Examination of thyroid (e.g., enlargement, tenderness, mass) |
| Respiratory      | - Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)  
- Percussion of chest (e.g., dullness, flatness, hyperresonance)  
- Palpation of chest (e.g., tactile fremitus)  
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs) |
### Content and Documentation Requirements—General Multi-System Examination

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular</strong></td>
<td>• Palpation of heart (e.g., location, size, thrills)</td>
</tr>
<tr>
<td></td>
<td>• Auscultation of heart with notation of abnormal sounds and murmurs</td>
</tr>
<tr>
<td></td>
<td>• Examination of:</td>
</tr>
<tr>
<td></td>
<td>* carotid arteries (e.g., pulse amplitude, bruits)</td>
</tr>
<tr>
<td></td>
<td>* abdominal aorta (e.g., size, bruits)</td>
</tr>
<tr>
<td></td>
<td>* femoral arteries (e.g., pulse amplitude, bruits)</td>
</tr>
<tr>
<td></td>
<td>* pedal pulses (e.g., pulse amplitude)</td>
</tr>
<tr>
<td></td>
<td>* extremities for edema and/or varicosities</td>
</tr>
<tr>
<td><strong>Chest (Breasts)</strong></td>
<td>• Inspection of breasts (e.g., symmetry, nipple discharge)</td>
</tr>
<tr>
<td></td>
<td>• Palpation of breasts and axillae (e.g., masses or lumps, tenderness)</td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td>• Examination of abdomen with notation of presence of masses or tenderness</td>
</tr>
<tr>
<td>(Abdomen)</td>
<td>• Examination of liver and spleen</td>
</tr>
<tr>
<td></td>
<td>• Examination for presence or absence of hernia</td>
</tr>
<tr>
<td></td>
<td>• Examination (when indicated) of anus, perineum and rectum, including</td>
</tr>
<tr>
<td></td>
<td>• sphincter tone, presence of hemorrhoids, rectal masses</td>
</tr>
<tr>
<td></td>
<td>• Obtain stool sample for occult blood test when indicated</td>
</tr>
<tr>
<td><strong>Genitourinary</strong></td>
<td>Male:</td>
</tr>
<tr>
<td></td>
<td>• Examination of the scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)</td>
</tr>
<tr>
<td></td>
<td>• Examination of the penis</td>
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<tr>
<td></td>
<td>• Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)</td>
</tr>
<tr>
<td></td>
<td>Female:</td>
</tr>
<tr>
<td></td>
<td>• Pelvic examination (with or without specimen collection for smears and cultures), including</td>
</tr>
<tr>
<td></td>
<td>• Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)</td>
</tr>
<tr>
<td></td>
<td>• Examination of urethra (e.g., masses, tenderness, scarring)</td>
</tr>
</tbody>
</table>
### Content and Documentation Requirements—General Multi-System Examination

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>System/Body Area</strong></td>
<td><strong>Elements of Examination</strong></td>
</tr>
<tr>
<td>Bladder</td>
<td>Examination of bladder (e.g., fullness, masses, tenderness)</td>
</tr>
<tr>
<td></td>
<td>Cervix (e.g., general appearance, lesions, discharge)</td>
</tr>
<tr>
<td></td>
<td>Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)</td>
</tr>
<tr>
<td></td>
<td>Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)</td>
</tr>
<tr>
<td><strong>Lymphatic</strong></td>
<td>Palpation of lymph nodes in two or more areas:</td>
</tr>
<tr>
<td></td>
<td>Neck</td>
</tr>
<tr>
<td></td>
<td>Axillae</td>
</tr>
<tr>
<td></td>
<td>Groin</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td><strong>Musculoskeletal</strong></td>
<td>Examination of gait and station</td>
</tr>
<tr>
<td></td>
<td>Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)</td>
</tr>
<tr>
<td></td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions</td>
</tr>
<tr>
<td></td>
<td>Assessment of range of motion with notation of any pain, crepitation or contracture</td>
</tr>
<tr>
<td></td>
<td>Assessment of stability with notation of any dislocation (luxation), subluxation or laxity</td>
</tr>
<tr>
<td></td>
<td>Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements</td>
</tr>
<tr>
<td><strong>Skin</strong></td>
<td>Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)</td>
</tr>
</tbody>
</table>
### Content and Documentation Requirements—General Multi-System Examination

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Palpation of skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)</td>
</tr>
<tr>
<td>Neurologic</td>
<td>• Test cranial nerves with notation of any deficits</td>
</tr>
<tr>
<td></td>
<td>• Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski)</td>
</tr>
<tr>
<td></td>
<td>• Examination of sensation (e.g., by touch, pin, vibration, proprioception)</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>• Description of patient's judgment and insight</td>
</tr>
<tr>
<td></td>
<td>Brief assessment of mental status including:</td>
</tr>
<tr>
<td></td>
<td>• orientation to time, place and person</td>
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<tr>
<td></td>
<td>• recent and remote memory</td>
</tr>
<tr>
<td></td>
<td>• mood and affect (e.g., depression, anxiety, agitation)</td>
</tr>
</tbody>
</table>

| Problem Focused  | One to five elements identified by a bullet. |
| Expanded         | At least six elements identified by a bullet. |
| Problem Focused  | At least two elements identified by a bullet from each of six systems/areas OR at least twelve elements identified by a bullet in two or more systems/areas. |
| Detailed         | 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 systems/areas. |
Single Organ System Examinations

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.
- **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 each box with an unshaded border is expected.

*Note: These other Single Organ System exams are also available: Cardiovascular; Ear, Nose and Throat; Eye; Genitourinary; Hematologic/Lymphatic/Immunologic; Psychiatric; Respiratory; and Skin.

We are highlighting the musculoskeletal and neurological single organ examinations in the following section. For more information regarding the other system exams, please contact the American Chiropractic Association.

### Musculoskeletal Examination

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| 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 (e.g., development, nutrition, body habitus, deformities, attention to grooming) |
### Musculoskeletal Examination - continued

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular</strong></td>
<td>Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)</td>
</tr>
<tr>
<td><strong>Lymphatic</strong></td>
<td>Palpation of lymph nodes in neck, axillae, groin and/or other location</td>
</tr>
</tbody>
</table>
| **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 (e.g., straight leg raising), crepitation or contracture  
|                   | • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity  
|                   | • Assessment of muscle strength and tone (e.g., 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 (e.g., scars, rashes, lesions, café-au-lait spots, ulcers) in four of the following six areas: 1) head and neck; 2) trunk; 3) right |
### Musculoskeletal Examination - continued

#### Skin - continued
- 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 (e.g., 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 (e.g., Babinski)
- Examination of sensation (e.g., by touch, pin, vibration, proprioception)

Brief assessment of mental status including
- Orientation to time, place and person
- Mood and affect (e.g., depression, anxiety, agitation)

### Summary of Content and Documentation Requirements – Musculoskeletal Examination

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>One to five elements identified by a bullet.</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>At least six elements identified by a bullet.</td>
</tr>
<tr>
<td>Detailed</td>
<td>At least twelve elements identified by a bullet.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>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 and unshaded border.</td>
</tr>
</tbody>
</table>
### Neurological Examination

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| 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 (e.g., development, nutrition, body habitus, deformities, attention to grooming) |
| Eyes             | • Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages) |
| Cardiovascular   | • Examination of carotid arteries (e.g., pulse amplitude, bruits)  
• Auscultation of heart with notation of abnormal sounds and murmurs  
• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness) |
| 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 (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation, tardive dyskinesia) |
| Extremities      | [See musculoskeletal] |
| Neurological     | Evaluation of higher integrative functions including:  
• Orientation to time, place and person  
• Recent and remote memory  
• Attention span and concentration  
• Language (e.g., naming objects, repeating phrases, spontaneous speech)  
• Fund of knowledge (e.g., awareness of current events, past history, vocabulary) |
Neurological Examination - continued

System/Body Area | Elements of Examination
--- | ---
Neurological - continued | Test the following cranial nerves:
| 2nd cranial nerve (e.g., visual acuity, visual fields, fundi)
| 3rd, 4th and 6th cranial nerves (e.g., pupils, eye movements)
| 5th cranial nerve (e.g., facial sensation, corneal reflexes)
| 7th cranial nerve (e.g., facial symmetry, strength)
| 8th cranial nerve (e.g., hearing with tuning fork, whispered voice and/or finger rub)
| 9th cranial nerve (e.g., spontaneous or reflex palate movement)
| 11th cranial nerve (e.g., shoulder shrug strength)
| 12th cranial nerve (e.g., tongue protrusion)
| Examination of sensation (e.g., by touch, pin, vibration, proprioception)
| Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (e.g., Babinski)
| Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

Summary of Content and Documentation Requirements

Neurological Examination

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>One to five elements identified by a bullet.</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>At least six elements identified by a bullet.</td>
</tr>
<tr>
<td>Detailed</td>
<td>At least twelve elements identified by a bullet. 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.</td>
</tr>
</tbody>
</table>

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Documentation of the Complexity of Medical Decision Making

The levels of E/M services recognize four types of medical decision making (straightforward, 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
- 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 following chart 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.

Elements of Medical Decision Making

<table>
<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of significant complications, morbidity, and/or mortality</th>
<th>Type of decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

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, e.g., 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.

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, e.g., 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.

Note: 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 option(s) determines the overall risk.
# Table of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| **Minimal**   | One self-limited or minor problem, e.g., cold, insect bite, tinea capitis | • 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, pneumonia, colitis  
• Acute uncomplicated 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 |
<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>• Cardiovascular imaging studies with contrast with identified risk factors</td>
<td>• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>• Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure</td>
<td>• Cardiac electrophysiological tests</td>
<td>• Emergency major surgery (open, percutaneous or endoscopic)</td>
</tr>
<tr>
<td></td>
<td>• An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss</td>
<td>• Diagnostic endoscopies with identified risk factors</td>
<td>• Parenteral controlled substances</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Discography</td>
<td>• Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Decision not to resuscitate or to de-escalate care because of poor prognosis.</td>
</tr>
</tbody>
</table>