Evaluation and Management (E/M) Services

The Seven Components of E/M Services

The descriptions for the levels of most E/M services recognize seven components, three of which are used in defining the level of E/M services.

Key Components

- History
- Examination
- Medical Decision Making

Contributory Components

- Counselling
- Coordination of care
- Nature of presenting problem (illness)
- Time

Most often, the E/M codes are selected based on the documentation of the key components. Information regarding at least two of the three key components (sometimes all three) must be documented in the patient's medical record to substantiate certain levels of E/M codes. The key component requirements for specific categories of E/M codes will be discussed later.

Time is the determining factor for certain E/M codes when counseling and/or coordination of care takes up more than 50 percent of the total visit (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility). Time also is the controlling factor in certain E/M codes, such as critical care and discharge day management.

A. Key Components

The Key components in selecting the level of E/M services are History, Examination, and Medical Decision Making. These three key components appear in the descriptors for office or other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services.
1. History

The extent of history documented is dependent upon the physician's clinical judgment and the nature of the presenting illness or problem. The types of history are defined BELOW:

**Problem-Focused**
- Chief Complaint;
- Brief History of Present Illness (HPI) or Problem

**Expanded Problem-Focused**
- Chief Complaint;
- Brief History of Present Illness (HPI) or Problem,
- Problem-Pertinent System Review

**Detailed**
- Chief Complaint;
- Extended History of Present Illness (HPI) or Problem;
- Extended System Review;
- Pertinent Past, Family and/or Social History

**Comprehensive**
- Chief Complaint;
- Extended History of Present Illness (HPI) or Problem;
- Complete System Review;
- Complete Past, Family and Social History

**Differences in 1995 vs 1997 criteria:**

The only difference is in the history of presenting illness criteria. The 1997 criteria allow inclusion of **the status of at least three chronic or inactive conditions or at least four current elements to establish an extended history of presenting illness.**

Each type of history includes some or all of the following elements:
a. Chief Complaint is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter. To qualify for a given type of history, a chief complaint must be indicated at all levels.

b. History of Present Illness (HPI) is a chronological description of the development of the patient's presenting illness or problem from the first sign and/or symptom, or from the previous encounter to the present. There are two types of HPIs (brief and extended) which are distinguished by the amount of detail included in the documentation for the following elements:

- **Location** - place, whereabouts, site, position. Where on the body is the patient experiencing signs or symptoms? (e.g., pain in groin)
- **Quality** - A description, characteristics, or statement to identify the type of sign or symptom. (e.g., burning pain in groin).
- **Severity** - Degree, intensity, ability to endure. The patient may describe the severity of their signs or symptoms by using a self-assessment scale to measure subjective levels. (e.g., History of mild burning pain in groin that has become more intense)
- **Duration** - Length of time. How long has patient been experiencing the signs or symptoms? (e.g., History of intermittent mild burning pain in groin that has become more intense and frequent for the last two weeks)
- **Timing** - Regulation of occurrence. A description of when the patient experiences signs or symptoms (e.g., history of intermittent mild burning pain in groin that has become more intense and frequent for the last two weeks).
- **Context** - Circumstances, cause, precursor, outside factors. A description of where the patient is or what the patient does when the signs or symptoms are experienced (e.g., history of intermittent mild burning pain in groin that has become more intense and frequent for the last two weeks since the patient bent down to pick up son and continues to feel intense pain when bending).
- **Modifying Factors** - Elements that change, alter or have some effect on the complaint or symptoms (e.g., history of intermittent mild burning pain in groin that has become more intense and frequent for last two weeks since the patient bent down to pick up son; continues to feel intense pain when bending. (Patient currently on Motrin 800 mg BID for past 3 weeks without relief)
- **Associated Signs and Symptoms** - Factors or symptoms that accompany the main symptoms. What other factors does patient
experience in addition to this discomfort/pain? (e.g., Shortness of breath, lightheadedness, nausea/vomiting)

A brief HPI consists of one to three (1 to 3) elements. An extended HPI consists of four or more (at least four) elements, or the status of at least three chronic or inactive conditions (1997 criteria only).

c. Review of Systems (ROS) is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. The three types of ROS (problem pertinent, extended, and complete) are differentiated by the amount of information included in the documentation for the following systems:

- constitutional symptoms (fever, weight loss, etc.)
- 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. 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. The patient's positive and pertinent negative responses for two to nine systems should be documented.

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

d. Past, Family and Social History (PFSH)

The PFSH consists of a review of three history areas:

- **past history** includes recording of prior major illnesses and injuries; operations; hospitalizations; current medications; allergies; age-appropriate immunization status; and/or age-appropriate feeding/dietary status.

- **family history** involves the recording of the health status or cause of death of parents, siblings and children; specific diseases related to problems identified in the chief complaint or history of presenting illness and/or system review; and/or diseases of family members that may be hereditary or place the patient at risk.

- **social history** contains marital status and/or living arrangements; current employment; occupational history; use of drugs, alcohol and tobacco; level of education; sexual history; or other relevant social factors.

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 for any of the three history areas must be documented.

A **complete** PFSH is a review of two or all three of the history area(s), depending on the category of the E/M service.

- At least one specific item from **two of the three history** areas must be documented for the following categories of E/M services: office or other outpatient services (established patient); emergency department; subsequent nursing facility care; domiciliary care (established patient); and home care (established patient).

- at least one specific item from **each of the three** history areas must be documented for the following categories of E/M services: office or other outpatient services (new patient); hospital observation services; hospital inpatient services (initial care); consultations; comprehensive nursing facility assessments; domiciliary care (new patient); and home care (new patient).

- Categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, domiciliary care (established patient); and home care (established patient) require only an "interval"
history. It is necessary to record only the changes in the PFSH that have occurred since the previous documentation of the history areas.

**Note:** All three elements (HPI, ROS and PFSH) must be documented to qualify for a detailed or comprehensive history.

e. Additional Guidelines for Documenting History Component

- The chief complaint, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the HPI.
- A ROS and/or PFSH obtained during an earlier encounter does not need to be recorded again if there is evidence that the physician reviewed and updated the previous information. This update may be documented by: describing any new ROS and/or PFSH information or noting any changes in the information; and noting the date and location of the earlier ROS and/or PFSH either on the list form or in the documentation itself. This form must be signed by the physician.
- 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. For example, using a checklist as an alternative method of documentation is acceptable when the physician: indicates his/her review of the information; details all abnormal (or positive) findings; and references the checklist in the progress note.
- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a history and should note the inability to obtain the history from the patient.
- If ROS/PFSH are non-contributory or negative after assessment, the physician should document these areas accordingly.
SUMMARY OF HISTORY COMPONENTS AND DOCUMENTATION REQUIREMENTS

<table>
<thead>
<tr>
<th>LEVEL OF HISTORY</th>
<th>PROBLEM FOCUSED</th>
<th>EXPANDED PROBLEM FOCUSED</th>
<th>DETAILED</th>
<th>COMPREHENSIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI</td>
<td>1-3 elements</td>
<td>1-3 elements</td>
<td>4 or more elements</td>
<td>4 or more elements</td>
</tr>
<tr>
<td>ROS</td>
<td>0</td>
<td>1 element</td>
<td>2-9 elements</td>
<td>10 or more elements</td>
</tr>
<tr>
<td>PFSH</td>
<td>0</td>
<td>0</td>
<td>1 element</td>
<td>2 or 3 elements</td>
</tr>
</tbody>
</table>

A. Comparison of 1995 E/M Documentation Requirements to 1997 E/M Documentation Requirements

**History Examination**
(3 out of 3 components must be met or exceeded)

<table>
<thead>
<tr>
<th>1995 Requirements</th>
<th>1997 Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint: (required)</td>
<td>Chief Complaint: (required)</td>
</tr>
<tr>
<td>• Concise statement of reason for treatment must</td>
<td>• Concise statement of reason for treatment must</td>
</tr>
<tr>
<td>be documented for all levels of service</td>
<td>be documented for all levels of service</td>
</tr>
<tr>
<td>(1) History of Presenting Illness:</td>
<td>(1) History of Presenting Illness:</td>
</tr>
<tr>
<td>• Chronological description of patient's present</td>
<td>• Chronological description of patient's present</td>
</tr>
<tr>
<td>illness from first sign/symptom or from previous encounter to present.</td>
<td>present illness from first sign/symptom or from previous encounter to present.</td>
</tr>
<tr>
<td><em>Brief: 1-3 elements</em></td>
<td><em>Brief: 1-3 elements</em></td>
</tr>
<tr>
<td><em>Extended: 4 or more elements</em></td>
<td><em>Extended: 4 or more elements or the status of at least three chronic or inactive conditions</em></td>
</tr>
<tr>
<td>(2) Review of Systems:</td>
<td>(2) Review of Systems:</td>
</tr>
<tr>
<td>• Inventory of body systems by questioner to identify signs/symptoms patient is</td>
<td>• Inventory of body systems by questioner to identify signs/symptoms patient is</td>
</tr>
<tr>
<td>experiencing or may have experienced.</td>
<td>experiencing or may have experienced.</td>
</tr>
</tbody>
</table>
**Problem pertinent:** 1 element  
**Extended:** 2-9 elements  
**Complete:** 10 or more elements or documentation of positive or pertinent negative responses with additional documentation of "all other systems are negative"

<table>
<thead>
<tr>
<th>Problem pertinent: 1 element</th>
<th>Problem pertinent: 1 element</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Extended:</strong> 2-9 elements</td>
<td><strong>Extended:</strong> 2-9 elements</td>
</tr>
<tr>
<td><strong>Complete:</strong> 10 or more elements or documentation of positive or pertinent negative responses with additional documentation of &quot;all other systems are negative&quot;</td>
<td><strong>Complete:</strong> 10 or more elements or documentation of positive or pertinent negative responses with additional documentation of &quot;all other systems are negative&quot;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(3) Past, Family &amp; Social History:</th>
<th>(3) Past, Family &amp; Social History:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review of three areas: past medical history, family</td>
<td>• Review of three areas: past medical history, family</td>
</tr>
<tr>
<td>history including hereditary diseases or place the patient at risk and age appropriate social history.</td>
<td>history including hereditary diseases or place the patient at risk and age appropriate social history.</td>
</tr>
</tbody>
</table>

**Pertinent:** 1 element  
**Complete:** 3 elements must be documented for new patients; 2/3 elements must be documented for established or ER patients

**Pertinent:** 1 element  
**Complete:** 3 elements must be documented for new patients; 2/3 elements must be documented for established or ER patients

*The only difference between the 1995 vs. 1997 history criteria is in the history of presenting illness. The 1997 criteria allows inclusion of the status of at least three chronic or inactive conditions or at least four current elements to establish an extended history of presenting illness.*

2. Physical Examination

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

**Differences in 1995 vs 1997 criteria:**

The 1995 criteria allows use of both a general multi-system exam or single specialty exam criteria but does not define documentation elements for the single specialty exam. General multi-system exam criteria defines the number of elements which must be documented in each type of examination but the content and performance elements are left to the clinical judgement of the physician.

Using the 1997 criteria, documentation elements for a general multi-system examination or a single organ system examination are clearly defined by "bullets." Any physician regardless of specialty may use the general multi-system criteria or a single organ system examination. The 1997 criteria requires performance of all elements in a body area/organ system but documentation of only 2 bullets to "count" in level of service determination.

**a. Types of Examinations**
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).

b. The Body Areas and Organ Systems

The AMA and HCFA define body areas as:

- head, including the face;
- neck;
- chest, including breasts and axilla;
- abdomen;
- genitalia, groin and buttocks;
- back; and
- each extremity.

The AMA and HCFA define organ systems as:

- eyes;
- ears, nose, mouth, throat;
- cardiovascular;
- respiratory;
- gastrointestinal;
- genitourinary;
- musculoskeletal;
- skin;
- neurologic;
- psychiatric;
- hematologic/lymphatic/imunologic.

*Note:* Medicare recognizes "constitutional (e.g., vital signs, general appearance)" as an organ system for the physical examination.

c. GENERAL MULTI-SYSTEM EXAMINATIONS (1997 criteria)
General multi-system examinations are described in detail below. 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 (1997 criteria)**

<table>
<thead>
<tr>
<th>Organ 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                   | • Eyes Inspection of conjunctivae and lids  
  • Examination of pupils and irises (e.g., reaction to light and... |
<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ears, Nose, Mouth and Throat</td>
<td>• Accommodation, size and symmetry</td>
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<tr>
<td></td>
<td>• Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)</td>
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<tr>
<td></td>
<td>• Ears, Nose, Mouth and Throat External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses)</td>
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<tr>
<td></td>
<td>• Otoscopic examination of external auditory canals and tympanic membranes</td>
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<td></td>
<td>• Assessment of hearing (e.g., whispered voice, finger rub, tuning fork)</td>
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<tr>
<td></td>
<td>• Inspection of nasal mucosa, septum and turbinates</td>
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<td></td>
<td>• Inspection of lips, teeth and gums</td>
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<td></td>
<td>• Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx</td>
</tr>
<tr>
<td>Neck</td>
<td>• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)</td>
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<td></td>
<td>• Examination of thyroid (e.g., enlargement, tenderness, mass)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)</td>
</tr>
<tr>
<td></td>
<td>• Percussion of chest (e.g., dullness; flatness, hyperresonance)</td>
</tr>
</tbody>
</table>
- Palpation of chest (e.g., tactile fremitus)
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

<table>
<thead>
<tr>
<th>Organ System/Body Area</th>
<th>Elements of Examination</th>
</tr>
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<tbody>
<tr>
<td><strong>Cardiovascular</strong></td>
<td></td>
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<tr>
<td></td>
<td>- Palpation of heart (e.g., location, size, thrills)</td>
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<tr>
<td></td>
<td>- Auscultation of heart with notation of abnormal sounds and murmurs</td>
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<td></td>
<td>Examination of:</td>
</tr>
<tr>
<td></td>
<td>- carotid arteries (e.g., pulse amplitude, bruits)</td>
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<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>
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<tr>
<td></td>
<td>- extremities for edema and/or varicosities</td>
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<tr>
<td><strong>Chest (Breasts)</strong></td>
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<tr>
<td></td>
<td>- Inspection of breasts (e.g., symmetry, nipple discharge)</td>
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<tr>
<td></td>
<td>- Palpation of breasts and axillae (e.g., masses or lumps, tenderness)</td>
</tr>
<tr>
<td>Organ System/Body Area</td>
<td>Elements of Examination</td>
</tr>
<tr>
<td>------------------------</td>
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</tr>
</tbody>
</table>
| **Gastrointestinal (Abdomen)** | • Examination of abdomen with notation of presence of masses or tenderness  
• Examination of liver and spleen  
• Examination for presence or absence of hernia  
• Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses  
• Obtain stool sample for occult blood test when indicated |
| **Lymphatic** | Palpation of lymph nodes in two or more areas:  
• Neck  
• Axillae  
• Groin  
• Other |
| Musculoskeletal | • Examination of gait and station  
|                | • Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)  
|                | Examination of joints, bones and muscles of one or more of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:  
|                | • Inspection and/or palpation with notation of presence of any misalignment, 
|                | asymmetry, crepitation, defects, tenderness, masses, effusions  
|                | • Assessment of range of motion with notation of any pain, crepitation or contracture  
|                | • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity  
|                | • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with 
|                | notation of any atrophy or abnormal movements  
| Skin           | • Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)  
|                | • Palpation of skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)  

Test cranial nerves with notation of any deficits

Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski)

Examination of sensation (e.g., by touch, pin, vibration, proprioception)

Description of patient's judgment and insight

Brief assessment of mental status including:

Orientation to time, place and person

Recent and remote memory

Mood and affect (e.g., depression, anxiety, agitation)

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td><strong>One to five</strong> elements identified by a bullet.</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td><strong>At least six</strong> elements identified by a bullet.</td>
</tr>
<tr>
<td>Detailed</td>
<td><strong>At least two</strong> elements identified by a bullet <strong>from each of six areas/systems OR at least twelve</strong> elements identified by a bullet <strong>in two or more areas/systems.</strong></td>
</tr>
</tbody>
</table>
Perform all elements identified by a bullet in **at least nine** organ systems or body areas. **Document** at least two elements identified by a bullet from each of nine areas/systems.

### d. SINGLE-ORGAN SYSTEM EXAMINATIONS (See Appendix B)

The AMA and HCFA have identified the following single organ systems:

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

The single organ system examinations recognized by CPT are described in detail below. 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 shaded or unshaded box.
- **Expanded Problem Focused Examination**—should include performance and documentation of **at least six elements** identified by a bullet (·), whether in a shaded or unshaded box.
- **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 shaded or unshaded box.
- **Eye and Psychiatric** examinations should include the performance and documentation of **at least nine elements** identified by a bullet (·), whether in a shaded or unshaded box.
- **Comprehensive Examination**—should include performance of all elements identified by a bullet (·), whether in a shaded or unshaded box. Documentation of every element in a shaded box and at least one element in each unshaded box is expected.

**e. Additional Documentation Guidelines**

- Specific abnormal and relevant 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 documentation.
- Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.
- A brief statement or notation indicating "negative" or "normal" is sufficient to document findings that have been determined as being within normal limits. However, "exam normal" or "exam negative" is unacceptable documentation. The normal or negative findings must be listed by body area or organ system.*
- Recent clarification from HCFA indicates that stating "Cardiovascular, negative" is not considered sufficient documentation to meet the criteria for the higher level examinations. The physician needs to be more specific by indicating the elements which are negative.

**Physical Examination**

<table>
<thead>
<tr>
<th>1995 Requirements*</th>
<th>1997 Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem Focused Examination:</strong></td>
<td><strong>Problem Focused Examination:</strong></td>
</tr>
<tr>
<td>Limited to affected body area or organ system.</td>
<td>One to five element(s) in one or more organ system(s) or body area(s).</td>
</tr>
<tr>
<td><strong>Expanded Problem Focused Examination:</strong></td>
<td><strong>Expanded Problem Focused Examination:</strong></td>
</tr>
<tr>
<td>A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).</td>
<td>Six elements in one or more organ system(s) or body area(s).</td>
</tr>
<tr>
<td>Two to seven body areas or organ systems.</td>
<td></td>
</tr>
<tr>
<td><strong>Detailed Examination:</strong></td>
<td><strong>Detailed Examination:</strong></td>
</tr>
<tr>
<td>An extended examination of the affected body area(s) and</td>
<td>At least six organ systems or body area(s).</td>
</tr>
</tbody>
</table>
Other symptomatic or related organ system(s).
Two to seven body areas or organ systems.

For each of the six organ systems or body areas, at least two elements identified by a bullet is expected; OR
At least twelve elements identified by a bullet in two or more organ systems or body areas.

**Comprehensive Examination:**
A general multi-system examination or a complete examination of a single organ system *.
Eight or more organ systems.

**Comprehensive Examination:**
At least nine organ systems or body areas.
For each organ system/body area, ALL elements identified by a bullet should be performed.
For each organ system/body area, documentation of at least two elements identified by a bullet is expected.

* 1995 criteria do not define documentation elements for a single organ system exam.

3. Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option. **No differences in documentation requirements are noted between 1995 and 1997 criteria.** The levels of E/M services recognize four types of medical decision making:

**Straightforward**
- minimal number of diagnoses or management options considered
- little, if any, amount or complexity of data reviewed
- minimal risk of complications or morbidity or mortality (expectation of full recovery without functional impairment)

**Low Complexity**
- limited number of diagnoses or management options considered
- limited amount and complexity of data reviewed
- low risk of complications or morbidity or mortality (uncertain outcome or increased probability of prolonged functional impairment)
**Moderate Complexity**

- multiple number of diagnoses or management options considered
- moderate amount and complexity of data reviewed
- moderate risk of complications or morbidity or mortality (uncertain outcome or increased probability of prolonged functional impairment or high probability of severe prolonged functional impairment)

**High Complexity**

- extensive number of diagnoses or management options considered
- extensive amount and complexity of data reviewed
- high risk of complications or morbidity or mortality (uncertain outcome or increased probability of prolonged functional impairment or high probability of severe prolonged functional impairment)

**a. 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.

The **types of presenting problems** (the fourth component) are:

1. **minimal**: problem not requiring presence of physician but service is provided under the physician's supervision.

2. **self-limited or minor**: problem that runs a definite and prescribed course, is transient in nature, not likely to permanently alter patient's health status, has good prognosis with management and compliance.

3. **low severity**: problem where risk of morbidity without treatment is low; little or no risk of mortality without treatment, full recovery without functional impairment.

4. **moderate severity**: problem where risk of morbidity without treatment is moderate; moderate risk of mortality without treatment; uncertain prognosis or increased probability of functional impairment.

5. **high severity**: problem where risk of morbidity without treatment is high to extreme; there is a moderate risk of mortality without treatment or high probability of severe, prolonged functional impairment.
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 evaluations.

- For a presenting problem with an established diagnosis the record should reflect whether the problem is:
  a) improved, well controlled, resolving or resolved; or
  b) inadequately controlled, worsening or failing to change as expected.
- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnosis or as "possible," "probable" or "rule out" (R/O) diagnoses.
- The initiation of changes in treatment should be documented. Treatment includes a wide range of management options, including patient instructions, nursing instructions, therapies and medications.
- If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.

b. 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 of complexity of data to be reviewed.

- Data should be documented as follows:
  - 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.
  - The review of lab, radiology and/or other diagnostic tests should be documented. An entry in the progress note, such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report that contains the test results.
  - A decision to obtain old records or decision to obtain additional history from the family, caregiver, or other source to supplement information obtained from the patient should be documented.
  - Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source 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.
  - The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.
  - The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician, should be documented.
c. 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. Information to include:

- Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.
- If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure (e.g., laparoscopy), should be documented.
- If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.
- The referral for, or decision to perform, a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is minimal, low, moderate or high. Because the determination of risk is complex and not readily quantifiable, the table includes some 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.

E/M TABLE OF RISK

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s)</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>one self-limited or minor problem, e.g., cold, insect bite, tinea corporis</td>
<td>laboratory tests requiring, venipuncture, chest x-rays, EKG/EEG, urinalysis, ultrasound e.g., echocardiography, KOH prep</td>
<td>rest, gargles, elastic bandages, superficial dressings</td>
</tr>
<tr>
<td>Level</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>-------</td>
<td>-----</td>
<td>----------</td>
<td>------</td>
</tr>
</tbody>
</table>
|       | - 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 | - 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 systematic symptoms, e.g., pyelonephritis, pneumonitis, colitis  
       | - acute complicated injury, e.g., head injury with brief loss of consciousness | - one or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
       | - cardiovascular imaging studies with contrast with identified risk factors  
       | - 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  
       | - cardiovascular imaging studies with contrast with identified risk factors  
       | - elective major surgery (open, percutaneous, endoscopic) with no identified risk factors  
       | - minor surgery with identified risk factors  
       | - elective major surgery (open, percutaneous, endoscopic) with no identified risk factors  
       | - prescription drug management  
       | - therapeutic nuclear medicine  
       | - IV fluids with additives  
       | - closed treatment of fracture or dislocation without manipulation  
       | - over-the-counter drugs  
       | - minor surgery with no identified risk factors  
       | - physical therapy occupational therapy  
       | - IV fluids without additives  
       | - skin biopsies  
       | - 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  
       | - physiologic test 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  
       | - cardiovascular imaging studies with contrast with identified risk factors  
       | - elective major surgery (open, percutaneous, endoscopic) with no identified risk factors  
       | - prescription drug management  
       | - therapeutic nuclear medicine  
       | - IV fluids with additives  
       | - closed treatment of fracture or dislocation without manipulation  |
treatment
- acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure
- an abrupt change in neurological status, e.g., seizure, TIA, weakness, or sensory loss

risk factors
- cardio electrophysiological tests
- diagnostic endoscopies with identified risk factors
- discography

or endoscopic) with identified risk factors
- emergency major surgery (open, percutaneous, or endoscopic)
- parenteral controlled substances
- drug therapy requiring intensive monitoring for toxicity
- decision not to resuscitate or to de-escalate care because of poor prognosis

**SUMMARY OF MEDICAL DECISION MAKING**

<table>
<thead>
<tr>
<th>MEDICAL DECISION MAKING</th>
<th>STRAIGHT-FORWARD</th>
<th>LOW</th>
<th>MODERATE</th>
<th>HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dx/Mgmt</td>
<td>0-1 elements</td>
<td>2 elements</td>
<td>3 elements</td>
<td>&gt;3 elements</td>
</tr>
<tr>
<td>Data</td>
<td>0-1 elements</td>
<td>2 elements</td>
<td>3 elements</td>
<td>&gt;3 elements</td>
</tr>
<tr>
<td>Risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>

**Medical Decision Making**
(requires 2/3 elements to be met or exceeded)**

<p>| 1995 Requirements* | 1997 Requirements |</p>
<table>
<thead>
<tr>
<th>Number of Diagnoses/Management Options</th>
<th>Number of Diagnoses/Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong>: self-limited or minor problem or stable, improving established problem</td>
<td><strong>Minimal</strong>: self-limited or minor problem or stable, improving established problem</td>
</tr>
<tr>
<td><strong>Limited</strong>: Worsening established problem</td>
<td><strong>Limited</strong>: Worsening established problem</td>
</tr>
<tr>
<td><strong>Multiple</strong>: New problem with no additional work up required</td>
<td><strong>Multiple</strong>: New problem with no additional work up required</td>
</tr>
<tr>
<td><strong>Extensive</strong>: New problem with additional work up planned</td>
<td><strong>Extensive</strong>: New problem with additional work up planned</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount of Data Reviewed</th>
<th>Amount of Data Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six elements of consideration: (1) ordering of diagnostic service, (2) review of test results, (3) decision to obtain old records/additional history information from family or other source, (4) documentation of relevant elements from review of old records/other source, (5) discussion with physician performing diagnostic tests or (6) direct visualization / independent interpretation of test results.</td>
<td>Six elements of consideration: (1) ordering of diagnostic service, (2) review of test results, (3) decision to obtain old records/additional history information from family or other source, (4) documentation of relevant elements from review of old records/other source, (5) discussion with physician performing diagnostic tests or (6) direct visualization / independent interpretation of test results.</td>
</tr>
<tr>
<td><strong>Minimal or None</strong>: only one element</td>
<td><strong>Minimal or None</strong>: only one element</td>
</tr>
<tr>
<td><strong>Limited</strong>: 2 elements</td>
<td><strong>Limited</strong>: 2 elements</td>
</tr>
<tr>
<td><strong>Moderate</strong>: 3 elements</td>
<td><strong>Moderate</strong>: 3 elements</td>
</tr>
<tr>
<td><strong>Extensive</strong>: 4 or more elements</td>
<td><strong>Extensive</strong>: 4 or more elements</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk of Complication/Comorbidity</th>
<th>Risk of Complication/Comorbity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's risk of significant complications, morbidity or mortality using Table of Risk as a guide. This table delineates presenting problem(s), diagnostic procedure(s) ordered and management options selected as: <strong>minimal</strong>,</td>
<td>Patient's risk of significant complications, morbidity or mortality using Table of Risk as a guide. This table delineates presenting problem(s), diagnostic procedure(s) ordered and management options selected as: <strong>minimal</strong>,</td>
</tr>
</tbody>
</table>
The highest level of risk in any one category in the Table of Risk determines the overall risk.

** There is no difference in the medical decision making component between 1995 and 1997 criteria.

B. Time and Counseling and/or Coordination of Care

*In the case where counselling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.* This includes time spent with parties who have assumed responsibility for the care or decision making of the patient, whether or not they are family members (eg foster parents, legal guardians, locum parentis).

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

Counselling is defined as 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;
- Risk factor reduction; and
- Patient and family education.

*Time is the explicit factor in selecting the following level of E/M service codes: hospital discharge day management, critical care services, prolonged physician services, physician standby service, care plan oversight services, and preventive medicine counselling.*

The inclusion of time in certain E/M service codes (e.g., new and established patient, office or other outpatient services) are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.