Office Visits and Consults

Office/Outpatient—New Patient

New or initial: 3 of 3 key components (history, physical, decision-making) must be met or exceeded.

Office/OP, New	*99201*	*99202*	*99203*	*99204*	*99205*
Consults, Office	*99241*	*99242*	*99243*	*99244*	*99245*
Consults, Init. IP	*99251*	*99252*	*99253*	*99254*	*99255*
History					
History	*Problem-Focused*	*Exp. Prob.-Focused*	*Detailed*	*Compre-hensive*	*Compre-hensive*
Chief Complaint	Required	Required	Required	Required	Required
History (HPI)	Brief (1-3)	Brief (1-3)	Ext. (4+)	Ext. (4+)	Ext. (4+)
System Review		Prob. Pert.	Ext. (2-9)	Comp (10+)	Comp (10+)
Past History			Pertinent*	Complete†	Complete†
Family History			Pertinent*	Complete†	Complete†
Social History			Pertinent*	Complete†	Complete†
Physical					
Exam	*Problem-Focused*	*Exp. Prob.-Focused*	*Detailed*	*Compre-hensive*	*Compre-hensive*
Medical Decision-Making					
Decision-Making	*Stfrwd*	*Stfrwd*	*Low Comp*	*Mod Comp*	*High Comp*
Number of diag-noses or manage-ment options	Minimal	Minimal	Limited	Multiple	Extensive
Amt and/or com-plex of data to be reviewed	None-Min.	None-Min.	Limited	Moderate	Extensive
Risk of compl and/or morbidi-ty/mortality	Minimal	Minimal	Low	Moderate	High

• At least 1 item of 1 PFSH area must be documented

† At least 1 item from each PFSH area must be documented

For Medical Decision-Making, 2 of 3 elements in the table must be met or exceeded; choose the type of decision-making based on the two highest elements.

Selecting the E/M level: The code associated with the lowest component (history, physical, decision making) determines the level of service

Contributory Components					
Time—Face to Face (Overrides other components if >50% of time is counseling)					
Office/OP	10	20	30	45	60
OP Consults	15	30	40	60	80
IP Consults	20	40	55	80	110
Severity of Presenting Problem (Problem must justify treatment)					
Risk of Morb/Mort	Self-Limited	Low	Moderate	Mod-High	Mod-High

NOTE: A "consultation" initiated by a patient and/or family, and not requested by a physician, is not reported using the consultation codes but may be reported using the office visit codes, as appropriate.

If subsequent to the completion of a consultation, the consultant assumes responsibility for the management of a portion or all of the patient's condition(s), the appropriate Evaluation and Management services code for the site of service should be reported. In the hospital setting, the consulting physician should use the appropriate hospital consultation code for the initial encounter and then subsequent hospital care codes. In the office setting the appropriate established patient code should be used.

Office/Outpatient—Established Patient

Established patient: 2 of 3 key components (history, physical, decision-making) must be met or exceeded.

Office/OP, Est.	*99211*	*99212*	*99213*	*99214*	*99215*
History					
History		*Problem-Focused*	*Exp. Prob.-Focused*	*Detailed*	*Compre-hensive*
Chief Complaint	Required	Required	Required	Required	Required
History (HPI)		Brief (1-3)	Brief (1-3)	Ext. (4+)	Ext. (4+)
System Review			Prob.-Pert.	Ext. (2-9)	Comp (10+)
Past History				Pertinent*	Complete†
Family History				Pertinent*	Complete†
Social History				Pertinent*	Complete†
Physical					
Exam		*Problem-Focused*	*Exp. Prob.-Focused*	*Detailed*	*Compre-hensive*
Medical Decision-Making					
Decision-Making		*Stfrwd*	*Low Comp*	*Mod Comp*	*High Comp*
Number of diag-noses or manage-ment options		Minimal	Limited	Multiple	Extensive
Amt and/or com-plex of data to be reviewed		None-Min.	Limited	Moderate	Extensive
Risk of compl and/or morbidi-ty/mortality		Minimal	Low	Moderate	High

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• At least 1 item of 1 PFSH area must be documented

† At least 1 item of 2 PFSH areas must be documented

For Medical Decision-Making, 2 of 3 elements in the table must be met or exceeded; choose the type of decision-making based on the two highest elements.

To select the E/M level, find the 2 highest components (history, physical, medical decision-making).

Contributory Components					
Time—Face to Face (Overrides other components if >50% of time is counseling)					
Office/OP	5	10	15	25	40
Severity of Presenting Problem (Problem must justify treatment)					
Risk of Morb/Mort	None-Min.	Self-Limited	Low-Mod	Mod-High	Mod-High

Office or Other Outpatient Prolonged (face-to-face) Services	
Total time spent face-to-face must be documented	
Must exceed E/M time thresholds above by at least 30 minutes	
+ 99354	Prolonged physician, requiring direct (face-to-face); first hour
+ 99355	Prolonged physician, requiring direct (face-to-face); each additional 30 min

3M

POCKET E/M

The *history*, *examination*, and *medical decision making* are the *key* components in selecting the level of E/M services. The suggested times 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.

In the case where counseling and/or coordination of care dominates more than 50% of the physician/patient and/or family encounter, then time is considered the key or controlling factor to qualify for a particular level of E/M service.

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.

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
   - 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 codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

HISTORY

- *Problem-focused:* CC; brief HPI
- *Expanded problem-focused:* CC; brief HPI; pertinent ROS EL3
- *Detailed:* CC; extended HPI; extended ROS; pertinent PFSH EL4
- *Comprehensive:* CC; extended HPI; complete ROS; complete PFSH

History of Present Illness	*Review of Systems*	*Elements of Past History*
Brief = 1-3 elements Extended = 4+ elements or the status of 3 chronic or inactive conditions	Problem-pertinent = 1 system Extended = 2-9 systems Complete = 10+ systems	Pertinent = 1 element Complete = 2-3 elements
Location Quality Severity Timing Duration Context Modifying Factors Assoc. Signs & Symptoms	Constitutional Eyes Ears, Nose, Mouth, Throat Hematologic/Lymphatic Cardiovascular Gastrointestinal Genitourinary Integumentary Neurologic Psychiatric Endocrine Allergic/Immunologic Respiratory Musculoskeletal	Past Medical History Family History Social History For comprehensive history, all three elements of Past History must be reviewed for new outpatient visits, initial inpatient visits, and for consultations (except follow-up inpatient consults)

DOCUMENTATION GUIDELINES FOR HISTORY

- The *chief complaint (CC)*, *review of systems (ROS)*, and *past, family, social history (PFSH)* may be listed as separate elements of history, or they may be included in the description of the history of the present illness.
- An ROS and/or 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, *and*
  - Noting the date and location of the earlier ROS and/or PFSH
- The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, *there must be a notation* supplementing or confirming the information recorded by others.
- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or circumstance which precludes obtaining a history.

All of the elements for a given type of history must be met to achieve that level of service. A chief complaint must always be present.

DOCUMENTATION GUIDELINES FOR EXAMINATION

- 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.
- Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.
- A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

MEDICAL DECISION MAKING

Four types of medical decision making are recognized: 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

Two of these elements must be met or exceeded:

Number of Possible Diagnoses or Management Options	*Amount and/or Complexity of Data To Be Reviewed*	*Risk of Complications and/or Morbidity or Mortality*	*Type of Decision Making*
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low complexity
Multiple	Moderate	Moderate	Moderate complexity
Extensive	Extensive	High	High complexity

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.

DOCUMENTATION GUIDELINES TO INCLUDE FOR MEDICAL DECISION MAKING

- Assessment, clinical impression, or diagnosis
- Whether or not problem is diagnosed or undiagnosed
- Established problem resolving, improving, worsening or failing to change as expected
- Undiagnosed problem as "possible," "probable," or "rule out"
- The need to seek a consultation or referral and/or discussion of test results with performing/interpreting physician
- Diagnostic tests ordered, planned, or scheduled (document findings or initial and date report)
- Independent review of tests such as an image, tracing, or specimen previously or subsequently interpreted by another physician
- Decision to obtain old records and/or history obtained from source in addition to patient
- Relevant findings from review of old records and/or other source
- Risk of presenting problem between present encounter and the next scheduled encounter
- Comorbidities/underlying diseases which increase risk of complications, morbidity, mortality
- Plan for surgical or invasive diagnostic procedures (document urgency)

Physical

DOCUMENTATION REQUIREMENTS

1997 General Multisystem Examination

Level of Exam	Perform and Document
Problem-Focused	*One to five* elements identified by a bullet
EL3 Expanded Problem-Focused	*At least six* elements identified by a bullet
EL4 Detailed	*At least two* elements identified by a bullet *from each of six areas/systems* or *at least 12* elements identified by a bullet *in two or more areas/systems.*
Comprehensive	Perform *all* elements identified by a bullet in at least nine organ systems or body areas; document *at least two from each of nine areas/systems.*

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, 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).

Cardiovascular

- Palpation of heart (e.g., location, size, thrills).
- Auscultation of heart with notation of abnormal sounds and murmurs.

Examination of:

- Carotid arteries (e.g., pulse, amplitude, bruits).
- Abdominal aorta (e.g., size, bruits).
- Femoral arteries (e.g., pulse amplitude, bruits).
- Pedal pulses (e.g., pulse amplitude).
- Extremities for edema and/or varicosities.

Chest (Breasts)

- Inspection of breasts (e.g., symmetry, nipple discharge).
- Palpation of breasts and axillae (e.g., masses or lumps, tenderness).

Gastrointestinal (Abdomen)

- Examination of abdomen with notation of presence of masses or tenderness.
- Examination of liver and spleen.
- Examination for presence or absence of hernia.
- Examination of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses, when indicated.
- Obtain stool sample for occult blood test when indicated.

Genitourinary

Male:

- Examination of the scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass).
- Examination of the penis.
- Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness).

Female:

Pelvic examination (with or without specimen collection for smears and cultures), including:

- 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).
- Examination of urethra (e.g., masses, tenderness scarring).
- Examination of bladder (e.g., fullness, masses, tenderness).
- Cervix (e.g., general appearance, lesions, discharge).
- Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support).
- Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity).

Lymphatic

Palpation of lymph nodes ***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 motions 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).

Neurologic

- 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).

Psychiatric

- Description of patient's judgment and insight.

Brief assessment of mental status, including:

- Orientation to time, place, and person.
- Recent and remote memory.

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

3M
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Medical Decision Making – 3rd KEY Component

A) Number of Diagnoses or Treatment Options

Number of Problems to Examiner	Number	X Points	=Result
Self-limited or minor (stable, improved or worsening)		1	Max=2
Established problem (to examiner), stable, improved		1	
Established problem (to examiner), worsening		2	
New problem (to examiner); NO additional workup planned		3	Max = 3
New problem (to examiner), additional workup planned		4	

Bring total to Line A in Final Result for MDM TOTAL =_____

B) Amount and/or Complexity of Data to be Reviewed

Data to Be Reviewed and/or Ordered	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2

Bring total to Line B in Final Result of MDM TOTAL =_____

FINAL RESULT OF MEDICAL DECISION MAKING

A	Number diagnosis or management options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Amount and Complexity of Data	≤ 1 Minimal or low	2 Limited	3 Moderate	≥ 4 Extensive
C	Highest Risk	Minimal	Low	Moderate	High
	Type of Decision Making	Straight-Forward	Low Complex	Moderate Complex	High Complex

(MUST meet or exceed 2/3 MDM areas for a level of service)

C) Risk of Complications and/or Morbidity/Mortality (Bring result to Line C in Final Result of MDM)

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
MINIMAL	• One self-limited or minor problem, e.g. cold, insect bite, tinea corporis	• Laboratory test requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g. echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW EL3	• Two or more self-limited or minor problems • One stable chronic illness, eg. well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress e.g. pulm. 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 EL4	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • 2 or > stable chronic illnesses • Undiagnosed new prob. with uncertain prog. e.g. breast lump • Acute illness with systemic symptoms e.g. pneumonitis pyelonephritis, colitis • Acute complicated injury e.g. head injury with brief loss of consciousness	• Physiologic tests under stress e.g. cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular, imaging studi with contrast and no identified risk factors, e.g. arteriogram, cardiac cath. • Obtain fluid from body cavity e.g. lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous, endoscopic) with no identified risk factor • Prescription drug management • Therapeutic nuclear medicine. • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
HIGH	• One or more chronic illnesses with severe exacerbation, progression, or side effects of tr • 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 others, acute renal failure, peritonitis • An abrupt change in neurologic status, e.g. seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological test • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors • Emergency major surgery (open, percutan. 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