In recent months we have published several articles on the critical importance of appropriate documentation for evaluation and management services. However, it has been some time since the actual guidelines have been published in their entirety. For that reason, we are reprinting the 1995 and 1997 Documentation Guidelines (DGs) for Evaluation and Management (E/M) services. Providers may choose either the 1995 or the 1997 version of the guidelines. The carrier must review and adjudicate claims using both the 1995 and the 1997 guidelines.

1995 DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES

I. 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; and
- 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; and/or
- that services provided have been accurately reported.

II. 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 proving 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, physician 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.

III. 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:

- 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) are the **key** components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E/M service.

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 the 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 disorders in the family. In addition, information on growth and development and/or nutrition will be recorded. 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 or present illness (HPI);
- Review of systems (ROS); and
- 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 judgment 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 Pertinent</td>
<td>N/A</td>
<td>Expanded Problem Focused</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.

Definitions and specific documentation guidelines for each of the elements of history are listed below.
**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.

*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, and
- 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 four or more elements of the HPI.

*DG*: The medical record should describe four or more elements of the present illness (HPI) or associated comorbidities.

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

**DG:** *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 treatment);
- family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk); and
- social history (an age appropriate review of past and current activities).

For those categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an “interval” history. It is not necessary to record information about the PFSH.

A **pertinent** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

**DG:** *At least one specific item from any of the three history areas must be documented for a pertinent PFSH.*
A completed PFSH is of 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 that by their nature include a comprehensive assessment of the patient. A review of two of the three history areas is sufficient for other services.

DG: At least one specific item from two of 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; subsequent nursing facility care; domiciliary care, established patient; and home; established patient.

DG: At least one specific item from each of the three 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; subsequent nursing facility care; domiciliary care, established patient; and home; established patient.

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on 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 other symptomatic or related organ system(s).
- **Detailed** - an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- **Comprehensive** - a general multi-system examination or complete examination of a single system.

For purposes of examination, the following body areas are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back. Including spine
- Each extremity

For purposes of examination, the following organ systems are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
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- Psychiatric
- Hematologic/lymphatic/immunologic

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

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 the unaffected or 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).

DG: The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.
C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four types of medical decision making (straight-forward, 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; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The chart below 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.

<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 complications and/or morbidity or mortality</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td><strong>Straightforward</strong></td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td><strong>Low Complexity</strong></td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td><strong>Moderate Complexity</strong></td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td><strong>High Complexity</strong></td>
</tr>
</tbody>
</table>

Each of the elements of medical decision making is described below:

**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 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 a differential diagnosis or as “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 records 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. An entry in 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 containing the status 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 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 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.

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 procedure or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) 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>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>One self-limited or minor problem, e.g. cold, insect bite, tinea corporis</td>
<td>Laboratory tests requiring venipuncture</td>
<td>Rest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chest x-rays</td>
<td>Gargles</td>
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<tr>
<td></td>
<td></td>
<td>EKG/EEG</td>
<td>Elastic bandages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urinalysis</td>
<td>Superficial dressings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ultrasound, e.g., echocardiography</td>
<td>KOH prep</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Two or more self-limited or minor problems</td>
<td>Physiologic tests not under stress, e.g., pulmonary function tests</td>
<td>Over -the-counter drugs</td>
</tr>
<tr>
<td></td>
<td>One stable chronic illness, e.g. well controlled hypertension or non-insulin dependent diabetes, cataract, BPH</td>
<td>non-cardiovascular imaging studies with contrast, e.g., barium enema</td>
<td>Minor surgery with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>Superficial needle biopsies</td>
<td>Physical therapy</td>
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<tr>
<td></td>
<td></td>
<td>clinical laboratory tests requiring arterial puncture</td>
<td>Occupational therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Skin biopsies</td>
<td>IV fluids without additives</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Physiologic tests not under stress, e.g., cardiac stress test, fetal contraction stress test</td>
<td>Minor surgery with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Two or more stable chronic illnesses</td>
<td>Diagnostic endoscopies with no identified risk factors</td>
<td>Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>Deep needle or incisional biopsy</td>
<td>Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram, cardiac catheterization</td>
<td>Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis</td>
<td>IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>Cardiovascular imaging studies with contrast with identified risk factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
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<tr>
<td></td>
<td>Cardiac electrophysiological test</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Diagnostic Endoscopies with identified risk factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discography</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Elective major surgery (open, percutaneous or endoscopic) with identified risk factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency major surgery (open, percutaneous or endoscopic)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Parental; controlled substances</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Drug therapy requiring intensive monitoring for toxicity</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Decisions not to resuscitate or to de-escalate care because of poor prognosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

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

**DG:** If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.
1997 Documentation Guidelines for E/M Services

Changes and additions, as they appear in the 1997 guidelines, include the following:

- the contents of general multi-system examinations have been defined with greater clinical specificity;
- documentation requirements for general multi-system examinations have been changed;
- content and documentation requirements have been defined for examinations pertaining to ten organ systems;
- several editorial changes have been made in the definitions of the four types of exams; and
- the definitions of an extended history of present illness have been expanded to include chronic or inactive conditions.

These criteria are used to review medical records for E/M services and to provide documentation required to support a given level of service. The Centers for Medicare & Medicaid Services’ goal is to provide physicians and claims reviewers with advice about preparing or reviewing documentation for E/M services. 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 Current Procedural Terminology (CPT);
- would be widely accepted by clinicians and would minimize any changes in record-keeping practices; and
- would be interpreted and applied uniformly by users across the country.

Some information and examples have been added for clarity.

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

II. 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 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 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 International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM) codes reported on the health insurance claim form should be supported by the documentation in the medical record.

III. Documentation of E/M Services

This section provides definitions and documentation guidelines for the three key components of E/M services and for visits that consist predominately of counseling and coordination of care. Documentation guidelines are identified by the symbol •DG.

Seven components are used in defining the levels of E/M services:
- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
The first three components (history, examination, and medical decision making) are the key components in selecting the level of E/M services. When visits 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.

A. DOCUMENTATION OF HISTORY

The levels of E/M services are based on four levels 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) and
- Past, family, and/or social history (PFSH)

The extent of the history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart on the following page 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.)

• **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/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
  - 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.

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.
### HISTORY
*(all 3 elements must be met to select a level of history)*

<table>
<thead>
<tr>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS) Past</th>
<th>Family and/or Social History (PFSH)</th>
<th>Type of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief: *1 - 3 elements (below) must be documented</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>Brief: *1 - 3 elements (below) must be documented</td>
<td>Problem Pertinent – System directly related to problem identified in HPI</td>
<td>N/A</td>
<td>Expanded Problem Focused</td>
</tr>
<tr>
<td>Extended: *4 or more elements (below) must be documented</td>
<td>Extended - System directly related to problem identified in HPI and a limited number (2 to 9) of additional systems</td>
<td>Pertinent - At least one specific item from any of the 3 history areas must be documented</td>
<td>Detailed</td>
</tr>
<tr>
<td>Extended: *4 or more elements (below) must be documented</td>
<td>Complete - System directly related to problem identified in HPI plus at least 10 additional systems must be reviewed</td>
<td>Complete - 2 or 3 * specific items from any of the 3 history areas must be documented</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

**Definitions and specific documentation guidelines for each of the elements of history are listed below.**

**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 own 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: (Examples are provided for clarity.)

- Location (e.g., where the problem is located)
- Quality (e.g., sharp, dull, stabbing pain)
- Severity (e.g., measured on a scale of 1 - 10)
- Duration (e.g., how long has this problem existed?)
- Timing (e.g., how long does it last, when does it occur?)
- Context (e.g., it hurts when I swallow)
- Modifying factors (e.g., it feels better when I gargle with salt water)
- Associated signs and symptoms (e.g., swelling, redness)

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 that 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, and 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.

• **DG:** 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); and
- **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.

• **DG:** 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.

• **DG:** 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
- Home Care – Established Patient
• **DG:** 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
  - Home Care – New Patient

**B. DOCUMENTATION OF EXAMINATIONS**

The levels of E/M services are based on **four types of examinations**:
  - **Problem Focused** – Limited examination of the affected body area or organ system
  - **Expanded Problem Focused** – Limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s)
  - **Detailed** – 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** – 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 judgment, 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 below and described in detail in the following tables. In the tables, organ systems and body areas recognized by CPT for purposes of describing examinations are shown in the left column. The content, or individual elements, of the examination pertaining to that body area or organ system are identified by bullets (•) in the right column.

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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.

**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 EXAMINATIONS**
General multi-system examinations are described in detail in the table on the following page. 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.

**SINGLE ORGAN SYSTEM EXAMINATIONS**
The single organ system examinations recognized by CPT are described in detail in the tables on the following pages. 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 examinations* should include performance and documentation of one to five elements identified by a bullet (•), whether in a shaded or unshaded box.
**Expanded problem focused examinations** should include performance and documentation of **at least six elements** identified by a bullet (•), whether in a shaded or unshaded box.

**Detailed examinations** are examinations other than the eye and psychiatric examinations and, 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 an unshaded box.

**Comprehensive examinations** 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 an unshaded box is expected.
# 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 |
| 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 (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses  
• 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) |
| **Genitourinary – 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 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, crepititation, 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 |
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| 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) |

**CONTENT AND DOCUMENTATION REQUIREMENTS FOR GENERAL MULTI-SYSTEM EXAMINATION**

<table>
<thead>
<tr>
<th>Level of Examination</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 from each of six areas/systems or at least twelve elements identified by a bullet in <strong>two or more</strong> areas/systems</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Perform <strong>all elements</strong> identified by a bullet in <strong>at least nine</strong> organ systems or body areas <strong>and document at least two</strong> elements identified by a bullet from each of the nine areas/systems</td>
</tr>
</tbody>
</table>
# CARDIOVASCULAR 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 (e.g., xanthelasma)                                                                                                                                                                  |
| **Ears, Nose, Mouth, and Throat** | • Inspection of teeth, gums, and palate  
• Inspection of oral mucosa with notation of presence of pallor or cyanosis                                                                                                                                          |
| **Neck**                      | • Examination of jugular veins (e.g., distension; a, v, or cannon a waves)  
• Examination of thyroid (e.g., enlargement, tenderness, mass)                                                                                                                                                      |
| **Respiratory**               | • Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)  
• Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)                                                                                                                                             |
| **Cardiovascular**            | • Palpation of heart (e.g., location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4)  
• Auscultation of heart including sounds, abnormal sounds, and murmurs  
• Measurement of blood pressure in two or more extremities when indicated (e.g., aortic dissection, coarctation)  
Examination of:  
  • Carotid arteries (e.g., waveform, pulse amplitude, bruits, apical-carotid delay)  
  • Abdominal aorta (e.g., size, bruits)  
  • Femoral arteries (e.g., pulse amplitude, bruits)  
  • Pedal pulses (e.g., pulse amplitude)  
  • Extremities for peripheral edema and/or varicosities                                                                                                           |
| **Gastrointestinal (abdomen)** | • Examination of abdomen with notation of presence of masses or tenderness  
• Examination of liver and spleen  
• Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy                                                                                     |
| **Musculoskeletal**           | • Examination of the back with notation of kyphosis or scoliosis  
• Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs  
• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements                                                                 |
| **Extremities**               | • Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, |
| **Skin** | • Inspection and/or palpation of skin and subcutaneous tissue (e.g., stasis dermatitis, ulcers, scars, xanthomas) |
| **Neurological/Psychiatric** | Brief assessment of mental status, including:  
• Orientation to time, place, and person  
• Mood and affect (e.g., depression, anxiety, agitation) |

**CONTENT AND DOCUMENTATION REQUIREMENTS FOR CARDIOVASCULAR EXAMINATION**

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<td><strong>One to five</strong> elements identified by a bullet</td>
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<tr>
<td><strong>Expanded Problem Focused</strong></td>
<td><strong>At least six</strong> elements identified by a bullet</td>
</tr>
<tr>
<td><strong>Detailed</strong></td>
<td><strong>At least twelve</strong> elements identified by a bullet</td>
</tr>
<tr>
<td><strong>Comprehensive</strong></td>
<td>Perform <strong>all</strong> elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box</td>
</tr>
</tbody>
</table>
**EAR, NOSE AND THROAT 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)  
• Assessment of ability to communicate (e.g., use of sign language or other communication aids) and quality of voice |

| Head and Face                          | • Inspection of head and face (e.g., overall appearance, scars, lesions, and masses)  
• Palpation and/or percussion of face with notation of presence or absence of sinus tenderness  
• Examination of salivary glands  
• Assessment of facial strength                                                     |

| Eyes                                   | • Test ocular motility, including primary gaze alignment                                                                                                                                  |

| Ears, Nose, Mouth, and Throat          | • Otoscopic examination of external auditory canals and tympanic membranes including pneumootoscopy with notation of mobility of membranes  
• Assessment of hearing with tuning forks and clinical speech reception thresholds (e.g., whispered voice, finger rub)  
• External inspection of ears and nose (e.g., overall appearance, scars, lesions, and masses)  
• 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 (e.g., asymmetry, lesions, hydration of mucosal surfaces)  
• Inspection of pharyngeal walls and pyriform sinuses (e.g., pooling of saliva, asymmetry, lesions)  
• Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords, and mobility of larynx (use of mirror not required in children)  
• Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae, and eustachian tubes (use of mirror not required in children) |

| Neck                                   | • Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)  
• Examination of thyroid (e.g., enlargement, tenderness, mass)                          |
### Respiratory
- Inspection of chest including symmetry, expansion, and/or assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

### Cardiovascular
- 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)

### Lymphatic
- Palpation of lymph nodes in neck, axillae, groin, and/or other location

### Neurological/Psychiatric
- Test cranial nerves with notation of any deficits
- Brief assessment of mental status, including:
  - Orientation to time, place, and person
  - Mood and affect (e.g., depression, anxiety, agitation)

## CONTENT AND DOCUMENTATION REQUIREMENTS FOR EAR, NOSE AND THROAT EXAMINATION

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<tr>
<td><strong>Problem Focused</strong></td>
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<tr>
<td><strong>Expanded Problem Focused</strong></td>
<td>At least six elements identified by a bullet</td>
</tr>
<tr>
<td><strong>Detailed</strong></td>
<td>At least twelve elements identified by a bullet</td>
</tr>
<tr>
<td><strong>Comprehensive</strong></td>
<td>Perform all elements identified by a bullet; document every element in each shaded box and at least new element in each unshaded box</td>
</tr>
</tbody>
</table>
## EYE EXAMINATION

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| **Eyes**         | • Test visual acuity (does not include determination of refractive error)  
                     • Gross visual field testing by confrontation  
                     • Test ocular motility including primary gaze alignment  
                     • Inspection of bulbar and palpebral conjunctivae  
                     • Examination of ocular adnexae including lids (e.g., ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits, and preauricular lymph nodes  
                     • Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size (e.g., anisocoria), and morphology  
                     • Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film  
                     • Slit lamp examination of the anterior chambers including depth, cells, and flare  
                     • Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus  
                     • Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)  
                     Ophthalmoscopic examination through dilated pupils (unless contraindicated) of:  
                     • Optic discs including size, C/D ratio, appearance, (e.g., atrophy, cupping, tumor elevation) and nerve fiber layer  
                     • Posterior segments including retina and vessels (e.g., exudates and hemorrhages) |
| **Neurological/Psychiatric** | Brief assessment of mental status, including:  
                     • Orientation to time, place, and person  
                     • Mood and affect (e.g., depression, anxiety, agitation) |

### CONTENT AND DOCUMENTATION REQUIREMENTS FOR EYE EXAMINATION

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</table>
## GENITOURINARY EXAMINATION (MALE OR FEMALE)

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
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</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) |
| 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)  
                          • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs) |
| Cardiovascular         | • 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) |
| Chest (breasts)        | See Genitourinary – FEMALE |
| Gastrointestinal (abdomen) | • Examination of abdomen with notation of presence of masses or tenderness  
                             • Examination for presence or absence of hernia  
                             • Examination of liver and spleen  
                             • Obtain stool sample for occult blood test when indicated |
| Genitourinary - MALE   | • Inspection of anus and perineum  
                          Examination (with or without specimen collection for smears and cultures) of genitalia, including:  
                          • Scrotum (e.g., lesions, cysts, rashes)  
                          • Epididymides (e.g., size, symmetry, masses)  
                          • Testes (e.g., size, symmetry, masses)  
                          • Urethral meatus (e.g., size, location, lesions, discharge)  
                          • Penis (e.g., lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities)  
                          Digital rectal examination including:  
                          • Prostate gland (e.g., size, symmetry, nodularity, tenderness)  
                          • Seminal vesicles (e.g., symmetry, tenderness, masses, enlargement)  
                          • Sphincter tone, presence of hemorrhoids, rectal masses |
| Genitourinary - FEMALE  | Includes at **least seven of the following eleven** elements identified by bullets:  
                          • Inspection and palpation of breasts (e.g., masses or lumps, tenderness, symmetry, nipple discharge)  
                          • Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses  
                          Pelvic examination (with or without specimen collection for smears and cultures) |
including:
- External genitalia (e.g., general appearance, hair distribution, lesions)
- Urethral meatus (e.g., size, location, lesions, prolapse)
- Urethra (e.g., masses, tenderness, scarring)
- Bladder (e.g., fullness, masses, tenderness)
- Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
- 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)
- Anus and perineum

<table>
<thead>
<tr>
<th>Lymphatic</th>
<th>Palpation of lymph nodes in neck, axillae, groin, and/or other location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)</td>
</tr>
</tbody>
</table>
| Neurological/Psychiatric | Brief assessment of mental status, including  
|                  | - Orientation (e.g., time, place, and person)  
|                  | - Mood and affect (e.g., depression, anxiety, agitation) |

### CONTENT AND DOCUMENTATION REQUIREMENTS FOR GENITOURINARY EXAMINATION

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## HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC EXAMINATION

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<td><strong>Constitutional</strong></td>
<td>• Measurement of <strong>any three of the following seven</strong> vital signs:</td>
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|                           | 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)                                                                                                       |
| **Head and Face**         | • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness                                                                                                                        |
| **Eyes**                  | • Inspection of conjunctivae and lids                                                                                                                                                                                    |
| **Ears, Nose, Mouth, and Throat** | • Otoscopic examination of external auditory canals and tympanic membranes  
• Inspection of nasal mucosa, septum, and turbinates  
• Inspection of teeth and gums  
• Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, 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)  
• Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)                                                                                                                                             |
| **Cardiovascular**        | • 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)                                                      |
| **Gastrointestinal (abdomen)** | • Examination of abdomen with notation of presence of masses or tenderness  
• Examination of liver and spleen                                                                                                                                                                             |
| **Lymphatic**             | • Palpation of lymph nodes in neck, axillae, groin, and/or other location                                                                                                                                               |
| **Extremities**           | • Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)                                                                                               |
| **Skin**                  | • Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, ecchymoses, bruises)                                                                                                         |
| **Neurological/Psychiatric** | Brief assessment of mental status, including:  
• Orientation to time, place, and person  
• Mood and affect (e.g., depression, anxiety, agitation)                                                                                                       |
## CONTENT AND DOCUMENTATION REQUIREMENTS
FOR HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC EXAMINATION

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## MUSCULOSKELETAL EXAMINATION

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| **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)                                                                                      |
| **Cardiovascular**   | • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)                                                                    |
| **Lymphatic**        | • Palpation of lymph nodes in neck, axillae, groin, and/or other location                                                                                                                                                |
| **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  
  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 upper extremity  
  4. left upper extremity |
5. right lower extremity  
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 constitute two elements.

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<td>• 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)</td>
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<td>• Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)</td>
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<tr>
<td>• Examination of sensation (e.g., by touch, pin, vibration, proprioception)</td>
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<tr>
<td>Brief assessment of mental status including:</td>
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<tr>
<td>• Orientation to time, place, and person</td>
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<td>• Mood and affect (e.g., depression, anxiety, agitation)</td>
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## CONTENT AND DOCUMENTATION REQUIREMENTS FOR MUSCULOSKELETAL EXAMINATION

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## UROLOGICAL EXAMINATION

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| **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)  
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)

CONTENT AND DOCUMENTATION REQUIREMENTS FOR NEUROLOGICAL EXAMINATION

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# PSYCHIATRIC EXAMINATION

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  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** | • Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements  
  • Examination of gait and station |
| **Psychiatric** | • Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language)  
  • Description of thought processes including: rate of thoughts; content of thoughts (e.g., logical vs. illogical, tangential); abstract reasoning; and computation  
  • Description of associations (e.g., loose, tangential, circumstantial, intact)  
  • Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions  
  • Description of the patient’s judgment (e.g., concerning everyday activities and social situations) and insight (e.g., concerning psychiatric condition)  
  Complete mental status examination including:  
  • Orientation to time, place, and person  
  • Recent and remote memory  
  • Attention span and concentration  
  • Language (e.g., naming objects, repeating phrases)  
  • Fund of knowledge (e.g., awareness of current events, past history, vocabulary)  
  • Mood and affect (e.g., depression, anxiety, agitation, hypomania, lability) |
CONTENT AND DOCUMENTATION REQUIREMENTS FOR PSYCHIATRIC EXAMINATION

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### RESPIRATORY EXAMINATION

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<td>• supine blood pressure</td>
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<td>• respiration</td>
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<td>• temperature</td>
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<tr>
<td></td>
<td>• height</td>
</tr>
<tr>
<td></td>
<td>• weight (may be measured and recorded by ancillary staff)</td>
</tr>
<tr>
<td></td>
<td>• General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)</td>
</tr>
<tr>
<td><strong>Ears, Nose, Mouth, and Throat</strong></td>
<td>• Inspection of nasal mucosa, septum, and turbinates</td>
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<tr>
<td></td>
<td>• Inspection of teeth and gums</td>
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<tr>
<td></td>
<td>• Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, and posterior pharynx)</td>
</tr>
<tr>
<td><strong>Neck</strong></td>
<td>• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)</td>
</tr>
<tr>
<td></td>
<td>• Examination of thyroid (e.g., enlargement, tenderness, mass)</td>
</tr>
<tr>
<td></td>
<td>• Examination of jugular veins (e.g., distension; a, v, or cannon a waves)</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>• Inspection of chest with notation of symmetry and expansion</td>
</tr>
<tr>
<td></td>
<td>• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)</td>
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<tr>
<td></td>
<td>• Percussion of chest (e.g., dullness, flatness, hyperresonance)</td>
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<td></td>
<td>• Palpation of chest (e.g., tactile fremitus)</td>
</tr>
<tr>
<td></td>
<td>• Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)</td>
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<tr>
<td><strong>Cardiovascular</strong></td>
<td>• Auscultation of heart including sounds, abnormal sounds and murmurs</td>
</tr>
<tr>
<td></td>
<td>• Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)</td>
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<tr>
<td><strong>Gastrointestinal (abdomen)</strong></td>
<td>• Examination of abdomen with notation of presence of masses or tenderness</td>
</tr>
<tr>
<td></td>
<td>• Examination of liver and spleen</td>
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<tr>
<td><strong>Lymphatic</strong></td>
<td>• Palpation of lymph nodes in neck, axillae, groin and/or other location</td>
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<tr>
<td><strong>Musculoskeletal</strong></td>
<td>• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic)</td>
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<td></td>
<td>with notation of any atrophy and abnormal movements</td>
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<td>• Examination of gait and station</td>
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<tr>
<td><strong>Extremities</strong></td>
<td>• Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)</td>
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<tr>
<td><strong>Skin</strong></td>
<td>• Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)</td>
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<tr>
<td><strong>Neurological/Psychiatric</strong></td>
<td>• Brief assessment of mental status including:</td>
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## CONTENT AND DOCUMENTATION REQUIREMENTS FOR RESPIRATORY EXAMINATION

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# Skin Examination

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| **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                                                                                                                                                                                     |
| **Ears, Nose, Mouth and Throat** | • Inspection of lips, teeth, and gums  
 • Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)                                                                                                   |
| **Neck**              | • Examination of thyroid (e.g., enlargement, tenderness, mass)                                                                                                                                                           |
| **Cardiovascular**    | • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)                                                                  |
| **Gastrointestinal (abdomen)** | • Examination of liver and spleen  
 • Examination of anus for condyloma and other lesions                                                                                                               |
| **Lymphatic**         | • Palpation of lymph nodes in neck, axillae, groin, and/or other location                                                                                                                                                 |
| **Extremities**       | • Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)                                                                                           |
| **Skin**              | • Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area, (when indicated) and extremities  
 • Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, susceptibility to and presence of photo damage) in **eight of the following ten** areas:  
  • Head, including the face  
  • Neck  
  • Chest, including breasts and axillae  
  • Abdomen  
  • Genitalia, groin, buttocks  
  • Back  
  • Right upper extremity  
  • Left upper extremity  
  • Right lower extremity  
  • Left lower extremity  
 **Note:** For the comprehensive level, the examination of at least eight 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 the right upper extremity and the left upper extremity constitute two elements. |
• Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses, or bromhidrosis

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

### CONTENT AND DOCUMENTATION REQUIREMENTS FOR SKIN EXAMINATION

<table>
<thead>
<tr>
<th>Level of Examination</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 twelve</strong> elements identified by a bullet</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Perform <strong>all</strong> elements identified by a bullet; document every element in each shaded box and at least one element in each unshaded box</td>
</tr>
</tbody>
</table>
C. DOCUMENTING THE COMPLEXITY OF MEDICAL DECISION MAKING

The levels of E/M services recognize four levels of medical decision making:

- Straightforward
- Low complexity
- Moderate complexity
- 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;
- Amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- Risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

The table below 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**.

<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 complications and/or morbidity or mortality</th>
<th>Type of medical decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td><strong>Straightforward</strong></td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td><strong>Low Complexity</strong></td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td><strong>Moderate Complexity</strong></td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td><strong>High Complexity</strong></td>
</tr>
</tbody>
</table>

The following sections describe each of the elements of medical decision making.

**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 that are improving or resolving are less complex than those that 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: Co-morbidities/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.

The Table of Risk on the following page 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>
<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 corporis) | • 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)  
• Noncardiovascular 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, pneumonitis, 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 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 |
### High
- One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
- Acute or chronic illnesses or injuries that pose a threat to life or bodily function (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 neurologic status (e.g., seizure,
  - TIA, weakness, sensory loss)

### Lower
- Cardiovascular imaging studies with contrast with identified risk factors
- Cardiac electrophysiological tests
- Diagnostic endoscopies with identified risk factors
- Discography

### Lower Lower
- Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors
- Emergency major surgery (open, percutaneous, or endoscopic)
- Parenteral controlled substances
- Drug therapy requiring intensive monitoring for toxicity
- Decision not to resuscitate or to de-escalate care because of poor prognosis
D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE

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, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

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

### PROGRESSION OF LEVELS

**Progression of Elements Required for Each Level of Medical Decision Making**

*(two of the three elements in the table must be either met or exceeded)*

<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 Complications And/Or Morbidity or Mortality</th>
<th>Type of Decision Making</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>

### EXAMPLES

The following tables reflect an initial and an established office encounter. Use the information provided in this chapter to select the appropriate level of coding for the following three key components of the service:

- *History* — Expanded problem focused
- *Examination* — Detailed
- *Medical decision making* — Moderate complexity
INITIAL PATIENT — OFFICE OR OTHER OUTPATIENT VISIT  
(3 of 3 elements must be met or exceeded)

<table>
<thead>
<tr>
<th>Level</th>
<th>History</th>
<th>Examination</th>
<th>Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Problem focused</td>
<td>Problem focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>II</td>
<td>Expanded problem</td>
<td>Expanded problem focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td></td>
<td>focused</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low complexity</td>
</tr>
<tr>
<td>IV</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate complexity</td>
</tr>
<tr>
<td>V</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High complexity</td>
</tr>
</tbody>
</table>

LEVEL II is the correct selection. All three key components must be met or exceeded to select a given level.

The following is an example of an established patient encounter using the following three key components:

- History — Problem focused
- Examination — Expanded problem focused
- Medical decision making — Moderate complexity

ESTABLISHED PATIENT — OFFICE OR OTHER OUTPATIENT CONSULTATION  
(2 of 3 elements must be met or exceeded)

<table>
<thead>
<tr>
<th>Level</th>
<th>History</th>
<th>Examination</th>
<th>Medical Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>II</td>
<td>Problem focused</td>
<td>Problem focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td></td>
<td>expanded problem</td>
<td>expanded problem focused</td>
<td>Low complexity</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>IV</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High complexity</td>
</tr>
</tbody>
</table>

LEVEL III is the correct selection. Only two of the three key components must be met or exceeded

This bulletin should be shared with all Health Care Practitioners and management members of the Provider/Supplier Staff.