DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®

Official CMS Information for
Medicare Fee-For-Service Providers

Evaluation and Management Services Guide

December 2010 / ICN: 006764

- Emergency department (ED); and
- Nursing facility (NF).

LEVEL OF EVALUATION AND MANAGEMENT SERVICE PERFORMED

The code sets used to bill for E/M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code the physician or NPP may bill within the appropriate category. In order to bill any code, the services furnished must meet the definition of the code. It is the physician's or NPP's responsibility to ensure that the codes selected reflect the services furnished.

There are three key components when selecting the appropriate level of E/M service provided: history, examination, and medical decision making. Visits that consist predominately of counseling and/or coordination of care are an exception to this rule. For these visits, time is the key or controlling factor to qualify for a particular level of E/M services.

History

The elements required for each type of history are depicted in the table below. Further discussion of the activities comprising each of these elements is included below the table. To qualify for a given type of history, all four elements indicated in the row must be met. Note that as the type of history becomes more intensive, the elements required to perform that type of history also increase in intensity. For example, a problem focused history requires the documentation of the chief complaint (CC) and a brief history of present illness (HPI) while a detailed history requires the documentation of a CC, an extended HPI, plus an extended review of systems (ROS), and pertinent past, family, and/or social history (PFSH).

TYPE OF HISTORY	CHIEF COMPLAINT	HISTORY OF PRESENT ILLNESS	REVIEW OF SYSTEMS	PAST, FAMILY, AND/OR SOCIAL HISTORY
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

While documentation of the CC is required for all levels, the extent of information gathered for the remaining elements related to a patient's history is dependent upon clinical judgment and the nature of the presenting problem.

Chief Complaint

A CC is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient's own words. For example, patient complains of upset stomach, aching joints, and fatigue. The medical record should clearly reflect the CC.

History of Present Illness

HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI elements are:

- Location (example: left leg);
- Quality (example: aching, burning, radiating pain);
- Severity (example: 10 on a scale of 1 to 10);
- Duration (example: started three days ago);
- Timing (example: constant or comes and goes);
- Context (example: lifted large object at work);
- Modifying factors (example: better when heat is applied); and
- Associated signs and symptoms (example: numbness in toes).

There are two types of HPIs: brief and extended.

A **brief HPI** includes documentation of one to three HPI elements.

In the following example, three HPI elements – location, quality, and duration – are documented:

- CC: Patient complains of earache.
- Brief HPI: Dull ache in left ear over the past 24 hours.

An **extended HPI**:

- 1995 documentation guidelines – Should describe four or more elements of the present HPI or associated comorbidities.
- 1997 documentation guidelines – Should describe at least four elements of the present HPI or the status of at least three chronic or inactive conditions.

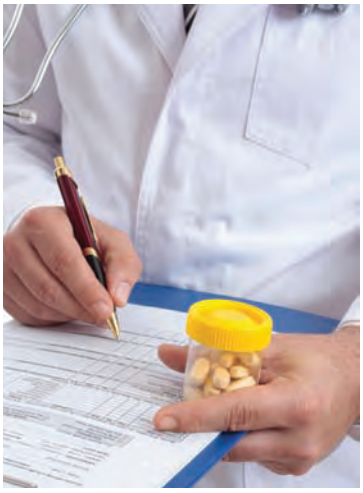
In the following example, five HPI elements – location, quality, duration, context, and modifying factors – are documented:

- CC: Patient complains of earache.
- Extended HPI: Patient complains of dull ache in left ear over the past 24 hours. Patient states he went swimming two days ago. Symptoms somewhat relieved by warm compress and ibuprofen.

Review of Systems

ROS is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced. The following systems are recognized for ROS purposes:

- Constitutional Symptoms (e.g., fever, weight loss);
- Eyes;
- Ears, Nose, Mouth, Throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Integumentary (skin and/or breast);
- Neurological;
- Psychiatric;
- Endocrine;
- Hematologic/Lymphatic; and
- Allergic/Immunologic.



There are three types of ROS: problem pertinent, extended, and complete.

A **problem pertinent ROS** inquires about the system directly related to the problem identified in the HPI.

In the following example, one system – the ear – is reviewed:

- CC: Earache.
- ROS: Positive for left ear pain. Denies dizziness, tinnitus, fullness, or headache.

An **extended ROS** inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems.

In the following example, two systems – cardiovascular and respiratory – are reviewed:

- CC: Follow up visit in office after cardiac catheterization. Patient states "I feel great."
- ROS: Patient states he feels great and denies chest pain, syncope, palpitations, and shortness of breath. Relates occasional unilateral, asymptomatic edema of left leg.

A **complete ROS** inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of ten) organ systems. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.

In the following example, ten signs and symptoms are reviewed:

- CC: Patient complains of "fainting spell."
- ROS:
  - Constitutional: Weight stable, + fatigue.
  - Eyes: + loss of peripheral vision.
  - Ear, Nose, Mouth, Throat: No complaints.
  - Cardiovascular: + palpitations; denies chest pain; denies calf pain, pressure, or edema.
  - Respiratory: + shortness of breath on exertion.
  - Gastrointestinal: Appetite good, denies heartburn and indigestion. + episodes of nausea. Bowel movement daily; denies constipation or loose stools.
  - Urinary: Denies incontinence, frequency, urgency, nocturia, pain, or discomfort.
  - Skin: + clammy, moist skin.
  - Neurological: + fainting; denies numbness, tingling, and tremors.
  - Psychiatric: Denies memory loss or depression. Mood pleasant.

Past, Family, and/or Social History

PFSH consists of a review of three areas:

- Past history including experiences with illnesses, operations, injuries, and treatments;
- Family history including a review of medical events, diseases, and hereditary conditions that may place the patient at risk; and

- Social history including an age appropriate review of past and current activities.

The two types of PFSH are: pertinent and complete.

A **pertinent PFSH** is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document at least one item from any of the three history areas.

In the following example, the patient's past surgical history is reviewed as it relates to the identified HPI:

- HPI: Coronary artery disease.
- PFSH: Patient returns to office for follow up of coronary artery bypass graft in 1992. Recent cardiac catheterization demonstrates 50 percent occlusion of vein graft to obtuse marginal artery.

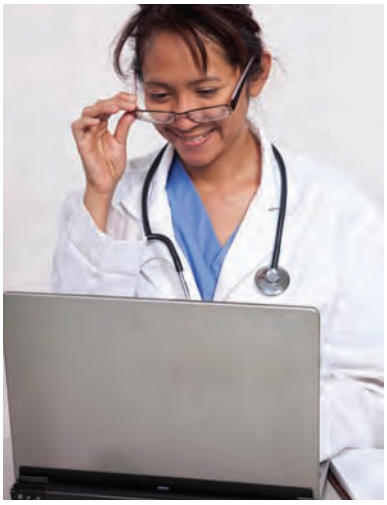
A **complete PFSH** is a review of two or all three of the areas, depending on the category of E/M service. A complete PFSH requires a review of all three history areas for services that, by their nature, include a comprehensive assessment or reassessment of the patient. A review of two history areas is sufficient for other services.

At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services:

- Office or other outpatient services, established patient;
- ED;
- Domiciliary care, established patient;
- Subsequent NF care (if following the 1995 documentation guidelines); and
- Home care, established patient.

At least one specific item from each of the history areas must be documented for the following categories of E/M services:

- Office or other outpatient services, new patient;
- Hospital observation services;
- Hospital inpatient services, initial care;
- Comprehensive NF assessments;
- Domiciliary care, new patient; and
- Home care, new patient.



In the following example, the patient's genetic history is reviewed as it relates to the current HPI:

- HPI: Coronary artery disease.
- PFSH: Family history reveals the following:
  - Maternal grandparents – Both + for coronary artery disease; grandfather: deceased at age 69; grandmother: still living.
  - Paternal grandparents – Grandmother: + diabetes, hypertension; grandfather: + heart attack at age 55.
  - Parents – Mother: + obesity, diabetes; father: + heart attack at age 51, deceased at age 57 of heart attack.
  - Siblings – Sister: + diabetes, obesity, hypertension, age 39; brother: + heart attack at age 45, living.

Notes on the Documentation of History

- The CC, ROS, and PFSH may be listed as separate elements of history or they may be included in the description of the history of the present illness.
- A ROS and/or a PFSH obtained during an earlier encounter does not need to be 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.
- 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 which precludes obtaining a history.

Examination

As stated previously, there are two versions of the documentation guidelines – the 1995 version and the 1997 version. The most substantial differences between the two versions occur in the examination documentation section. Either version of the documentation guidelines, not a combination of the two, may be used by the provider for a patient encounter.

The levels of E/M services are based on four types of examination:

- **Problem Focused** – A limited examination of the affected body area or organ system;
- **Expanded Problem Focused** – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s);
- **Detailed** – An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s); and
- **Comprehensive** – A general multi-system examination or complete examination of a single organ system (and other symptomatic or related body area(s) or organ system(s) – 1997 documentation guidelines).

An examination may involve several organ systems or a single organ system. The type and extent of the examination performed is based upon clinical judgment, the patient's history, and nature of the presenting problem(s).

The 1997 documentation guidelines describe two types of comprehensive examinations that can be performed during a patient's visit: general multi-system examination and single organ examination.

A **general multi-system examination** involves the examination of one or more organ systems or body areas, as depicted in the chart below.

TYPE OF EXAMINATION	DESCRIPTION
Problem Focused	Include performance and documentation of one to five elements identified by a bullet in one or more organ system(s) or body area(s).
Expanded Problem Focused	Include performance and documentation of at least six elements identified by a bullet in one or more organ system(s) or body area(s).
Detailed	Include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet is expected. Alternatively, may include performance and documentation of at least twelve elements identified by a bullet in two or more organ systems or body areas.
Comprehensive	Include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by bullet is expected.*

* The 1995 documentation guidelines state that the medical record for a general multi-system examination should include findings about eight or more organ systems.

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.*

16

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 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.***

7

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 maybe 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; and home care, established patient.***

9

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 tables beginning on page 13. 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.

Parenthetical examples "(eg,…)", 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 beginning on page 13. To qualify for a given level of multi-system examination, the following content and documentation requirements should be met:

11

- ***Comprehensive Examination*** **– should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in a box with an unshaded border is expected**.

CONTENT AND DOCUMENTATION REQUIREMENTS

General Multi-System Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Eyes	• Inspection of conjunctivae and lids • Examination of pupils and irises (eg, reaction to light and accommodation, size and symmetry) • Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	• External inspection of ears and nose (eg, overall appearance, scars, lesions, masses) • Otoscopic examination of external auditory canals and tympanic membranes • Assessment of hearing (eg, whispered voice, finger rub, tuning fork) • Inspection of nasal mucosa, septum and turbinates • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)

13

System/Body Area	Elements of Examination
Respiratory	• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (eg, dullness, flatness, hyperresonance) • Palpation of chest (eg, tactile fremitus) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Palpation of heart (eg, location, size, thrills) • Auscultation of heart with notation of abnormal sounds and murmurs Examination of: • carotid arteries (eg, pulse amplitude, bruits) • abdominal aorta (eg, size, bruits) • femoral arteries (eg, pulse amplitude, bruits) • pedal pulses (eg, pulse amplitude) • extremities for edema and/or varicosities
Chest (Breasts)	• Inspection of breasts (eg, symmetry, nipple discharge) • Palpation of breasts and axillae (eg, masses or lumps, tenderness)
Gastrointestinal (Abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Examination for presence or absence of hernia • Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses • Obtain stool sample for occult blood test when indicated

System/Body Area	Elements of Examination
Genitourinary	**MALE:** • Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass) • Examination of the penis • Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness) **FEMALE:** Pelvic examination (with or without specimen collection for smears and cultures), including • Examination of external genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) • Examination of urethra (eg, masses, tenderness, scarring) • Examination of bladder (eg, fullness, masses, tenderness) • Cervix (eg, general appearance, lesions, discharge) • Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) • Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)
Lymphatic	Palpation of lymph nodes in **two or more** areas: • Neck • Axillae • Groin • Other

15

System/Body Area	Elements of Examination
Musculoskeletal	• Examination of gait and station • Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) Examination of joints, bones and muscles of **one or more of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions • Assessment of range of motion with notation of any pain, crepitation or contracture • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
Skin	• Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers) • Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)
Neurologic	• Test cranial nerves with notation of any deficits • Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski) • Examination of sensation (eg, by touch, pin, vibration, proprioception)
Psychiatric	• Description of patient's judgment and insight Brief assessment of mental status including: • orientation to time, place and person • recent and remote memory • mood and affect (eg, depression, anxiety, agitation)

GENERAL MULTISYSTEM EXAM FOR ESTABLISHED PATIENTS

Content and Documentation Requirements

	Level of Exam	Perform and Document:
Level 2	Problem Focused	**One to five** elements identified by a bullet.
Level 3	Expanded Problem Focused	**At least six** elements identified by a bullet.
Level 4	Detailed	**At least two** elements identified by a bullet **from each of six areas/systems** OR **at least twelve** elements identified by a bullet **in two or more areas/systems**.
Level 5	Comprehensive	Perform **all elements** identified by a bullet in **at least nine** organ systems or body areas and document **at least two** elements identified by a bullet **from each of nine areas/systems.**

17