

Evaluation and Management (E/M) Training

Module 5



AMA Disclaimer

CPT® copyright 2011 American Medical Association. All rights reserved.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT® is a registered trademark of the American Medical Association.

© 2012 AAPC

2480 South 3850 West, Suite B, Salt Lake City, Utah 84120
800-626-CODE (2633), Fax 801-236-2258, www.aapc.com

All rights reserved.

CPC®, CPC-H®, CPC-P®, CIRCC®, CPMA®, CPCO™, and CPPM™ are trademarks of AAPC.



Module 5

Leveling Evaluation and Management Services: Putting it all together

Totaling the Level of Visit

When the level of each key component (History, Exam, and Medical Decision Making) has been determined, the overall level of the visit can be calculated. To determine the level of visit based on the key components, you will need to read the requirements for the category or subcategory for the level of codes. Some codes require two of three key components to be met while others require all three key components to be met.

Again, a table is used to help us determine the overall level of E/M. Refer to the Evaluation and

Management Tables provided prior to the E/M section in your CPT® codebook. Some coders find it helpful to use an audit sheet to determine the level of an E/M service. An audit sheet has been provided for you at the end of this chapter.

Throughout this module, we have dissected each E/M key component (History, Exam, Medical Decision Making) for three E/M visits (Hospital admit, Consultation, and Emergency Department visit). For this documentation dissection, we will refer back to the tables for these notes and add them together to calculate the level of E/M.

Calculating the EM Level: Hospital Admit

2.12.2012—Admission History & Physical examination, 19:45, Attending Physician: J. Shoe, MD

Admission diagnosis: Pelvic pain, probable pelvic inflammatory disease; rule out ectopic; rule out appendicitis.

History: This established patient is a 37 y.o. G3 P1012 white female seen in the office this afternoon for recent onset of a foul discharge and pelvic pain. LMP was 5 weeks ago, she is often irregular. She reports 7 days ago having relations with her former partner on consecutive days. 3 to 4 days following the weekend, she noted the gradual onset of a foul smelling yellow-green discharge and cramping. Over the subsequent 3 days this discharge has increased requiring a Peri-Pad. She has had to change the pad q hour. She has also noted the increase in pelvic and lower abdominal pain and cramping. The pain is worse than her normal menstrual cramps, not helped with the application of heat. There was initially a small improvement with oral Ibuprofen; it has not helped today. Upon questioning her partner, he reports some mild burning with urination for 5 days, otherwise no symptoms. She does not have a thermometer, has not taken her temperature. She has felt uncomfortably warm the last 2 days and today has had occasional chills.

ROS: She denies any N/V, diarrhea, or changes in her bowels or bladder function. She denies any SOB or palpitations. She denies headache or visual disturbance.

PMH: Prozac for depression x 3 years; 3 pregnancies, 1 spontaneous Ab, 2 SVDs, 1 at term, 1 at 35 weeks, living male age 8 years, female age 5 years. Postpartum BTL for contraception 5 years ago. No chronic illnesses.

SH & FH: single parent, lives with children age 5 and 8 years. Currently works as a medical record auditor. Parents are living and healthy. Mother has type II diabetes. Is the oldest with 3 living siblings in good health.

Physical examination:

Patient is a healthy white female in mild distress, crying quietly, sitting slumped over in bed.

VS- 19:00 – T: 102.1; BP: 118/70; p: 92; RR: 24

Skin: face is flushed, moist with hair damp

HEENT: nose & throat clear

Neck: supple, no masses

Lungs: clear bilaterally

Cardiac: normal S1, S2, no murmur or gallop; RRR

Abdomen: +BS, soft, no masses; bilateral tenderness in lower quadrants. Negative rebound, 1+/4 guarding. - CVAT

Pelvic: per office, foul discharge, no masses. 3+/4+ tenderness bilaterally

Extremities: normal gait

Assessment/Differential Diagnosis: 1) pelvic pain; 2) pelvic inflammatory disease; 3) rule out ectopic; 4) rule out appendicitis

Plan: 1) Admit for observation, begin IV antibiotics; 2) IV fluids & NPO, bed rest; 3) pain control; 4) labs ordered: CBC with diff tonight and in am, pregnancy test STAT; 3) ultrasound in am; 4) cultures from office pending; blood cultures tonight before IV antibiotics begun; 5) Prozac qd with sip.

J. Shoe, MD, attending OB/GYN physician

Initial Hospital Care (requires 3 of 3 key components)				
Table A	History	Detailed or Comprehensive	Comprehensive	Comprehensive
Table B1	Exam	Detailed or Comprehensive	Comprehensive	Comprehensive
Table F	Medical Decision Making	Straightforward or Low	Moderate	High
E/M Level		99221	99222	99223

All three key components are required to be met for a hospital admission. The history is a detailed level causing the highest level of E/M code possible to be 99221. If this were a Medicare patient, modifier -AI would have been appended to indicate this is the principal physician of record.

When the requirements for the lowest level of initial hospital care are not met (eg, problem focused exam instead which is lower than the required level of detailed), check with your payer on how to report the service. Options may include 99221 with modifier 52, reporting 99499 (Unlisted evaluation and management service), or reporting a code from a different subcategory. This will be determined by your payer.

The MCM Pub. 100-04, Medicare Claims Processing Manual Chapter 12 --Physicians/ Non-physician Practitioners 30.6.9.1 F gives the following advice when an admit is performed after a Level 5 office visit: “When a physician performs a visit that meets the definition of a Level 5 office visit several days prior to an admission and on the day of admission performs less than a comprehensive history and physical, he or she should report the office visit that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code 99221) for the initial hospital admission. Contractors pay the office visit as billed and the Level 1 initial hospital care code.”

Calculating the EM Level: Consultation

Example: Consultation

REASON FOR CONSULT: Atrial flutter

HISTORY OF PRESENT ILLNESS: The patient is a 60-year-old male who comes today at the request of Dr. Y for a consultation of his atrial flutter. ¹ He was originally diagnosed this in January of 2011. At that time he developed extensive palpitations as well as chest tightness. He was subsequently found to be in atrial flutter and was admitted to St. Francis Hospital. He spontaneously converted to sinus rhythm. He underwent echo showing normal LV function and left heart catheterization showing no significant CAD. Since that time the patient has been taking aspirin and Multaq. His Multaq was stopped December 2011 secondary to patient preference. He subsequently had an episode when he was working out in which he had a fast irregular heartbeat. He also felt short of breath, fatigue, and dizzy during this episode. He restarted his Multaq and the symptoms improved. Since that time he does not feel that he has had further episodes of palpitations.

The patient reports that he is quite active. He exercises 4 days a week and is able to perform cardio workout up to 30 minutes. He denies chest pain, chest tightness, or syncope.

PAST MEDICAL HISTORY:

1. Atrial flutter, diagnosed 1/2011—EKG appears consistent with right atrial flutter, negative in inferior leads and slightly positive in VI; perhaps clockwise atrial flutter
2. Hypertension
3. Hyperlipidemia
4. Minimal CAD-1/2011 left heart catheterization only demonstrating luminal irregularities

PAST SURGICAL HISTORY:

1. Tonsillectomy
2. Right inguinal hernia repair
3. Left knee arthroscopic surgery

¹ Documentation of the request for consult.

PREVIOUS CARDIAC EVALUATION:

1/2011 LHC: Minimal CAD, normal LV systolic function

1/2011 TTE: EF greater than 55%, moderate LVH, left atrium mildly dilated, mild TR

ALLERGIES: No history of contrast or iodine allergy

CURRENT ALLERGY LIST: NKDA

CURRENT MEDICATION LIST:

DAILY VITAMIN FORMULA ORAL TABLET, daily

ASPIRIN BUFFERED ORAL TABLET 325 MG, daily

SIMVASTATIN ORAL TABLET 40 MG, daily

LISINOPRIL ORAL TABLET 10 MG, 1/2 daily

MULTAQ ORAL TABLET 400 MG, 1 Every Day

MEDICATION INFORMATION SOURCE: Medication information source comes from the patient's memory.

SOCIAL HISTORY:

The patient is married. He works as a principal at a local school. No tobacco use ever, he drinks 8–10 alcoholic beverages per week, no history of illicit drug use.

FAMILY HISTORY: The patient has no family history of sudden death or significant arrhythmias. No family history of premature coronary artery disease.

REVIEW OF SYSTEMS: Please see HPI above for relevant cardiac ROS. Otherwise, a full review of systems including constitutional, neurologic, ENT, pulmonary, gastrointestinal, genitourinary, musculoskeletal, endocrine, and psychiatric systems was reviewed. These were all negative except as noted in the HPI above and urinary frequency at night.

PHYSICAL EXAM:

VITAL SIGNS: PULSE: 40 Right Radial, Regular, BP: 150/90 Left Arm Sitting, HEIGHT: 6 ft 5 in, VS-WEIGHT: 234 lbs 8 oz, BMI: 27.8

General: alert and oriented x3. No acute distress

HEENT: normocephalic, clear oropharynx, mucus membranes moist

Neck: supple; no carotid bruits; no thyromegaly; JVD normal

Chest: normal respiratory effort; lungs clear to auscultation

CV: normal S1, S2; no audible murmurs, rubs, or gallops

Abdomen: soft, non-tender, non-distended, NABS; no hepatosplenomegaly

EXT: warm, well perfused, no cyanosis, no LE edema

Neuro: CN II-XII intact, no major motor or sensory deficits

LABS: 3/2011 TSH3.6, Cr 1.1

ECG: A 12-lead electrocardiogram obtained today in clinic reveals sinus rhythm with a rate of 40. There is normal P wave morphology with a PR interval of 190. There are no pathologic Q waves or evidence of ventricular preexcitation noted. There are no significant ST-T wave changes. The adjusted QT interval is 439 msec.

IMPRESSION/RECOMMENDATION:

1. Paroxysmal atrial flutter: The patient has documented atrial flutter from 1/2011. I suspect that he had an additional episode very recently after stopping his Multaq. His previous EKG is suggestive to me of a right atrial flutter. P waves are negative in the inferior leads and positive in VI. There is a somewhat atypical appearance of this which may suggest that it is a clockwise atrial flutter. Furthermore, we've discussed stroke prevention. He has a CHADS risk score of one considering his hypertension. After discussion of the risks and benefits, he is interested in anticoagulation with Pradaxa. I do think this is reasonable for the most optimal stroke prevention in him. At this point therapeutic options include continuing current medical therapy versus considering an ablation procedure. The advantage of him having an ablation procedure would be that in the long term he might not need antiarrhythmic medication and might not need anticoagulation. Regardless, prior to consideration of an ablation procedure, I would like to make sure that he is not having any atrial fibrillation.

- check a one month CardioNet monitor
- hold Multaq in anticipation of diagnosis of atrial flutter versus atrial fibrillation
- with another episode he will try to immediately come to our office for an EKG
- re-start Multaq vs. start flecainide at the time of recurrent atrial flutter or a fib
- start Pradaxa 150mg bid and stop ASA

2. Hypertension: He will continue his current lisinopril.
3. Hyperlipidemia: He is currently taking simvastatin. If his Multaq is restarted then we will need to decrease his simvastatin dose to 10 mg p.o. q.h.s.
4. Sinus bradycardia: The patient reports that he chronically has a heart rate in the 40s. He does not appear to have any significant symptoms from this.

RETURN VISIT: 6 weeks.

Thank you very much for the opportunity to participate in the care of this patient. Please feel free to contact me with any questions or concerns. ²

Tim Smith, M.D.

Electrophysiology/Cardiology

² Indicating the note is a written report back to the provider.

Office or Other Outpatient Consultations (requires 3 of 3 key components)						
Table A	History	Problem focused	Expanded problem focused	Detailed	Comprehensive	Comprehensive
Table B1	Exam	Problem focused	Expanded problem focused	Detailed	Comprehensive	Comprehensive
Table F	Medical Decision Making	Straightforward	Straightforward	Low	Moderate	High
E/M Level		99241	99242	99243	99244	99245

All three key components are required to be met for a consultation. The MDM is a moderate level causing the highest level of E/M code possible to be 99224. This case does not specify the insurance carrier. If this were a Medicare patient, the visit would be reported using codes from the New Office or Other Outpatient subcategory of E/M (if the patient is new to the examiner, it is not clear in this documentation). The code component requirements are the same for the New Office or Other Outpatient subcategory as they are for the Office or Other Outpatient Consultation codes. If this were a Medicare patient, the code reported would be 99204.

Calculating the EM Level: Emergency Department Visit

Example: Emergency Department

CHIEF COMPLAINT: Left elbow injury.

HISTORY OF PRESENT ILLNESS: This is a 19-year-old female who presents with pain in her left elbow. She states that this morning, around 8 o'clock in the morning, she tripped over a vacuum, fell, landing on an outstretched arm. It felt like her left arm was stuck in place straightened, so she bent it and now it feels worse than before like she cannot bend or straighten her elbow. Went to an urgent care around 5 o'clock. X-rays were done which were normal. She was told that she might need an MRI to look for a ligamentous injury. She was referred to the ED. She presents at midnight tonight complaining of elbow pain and is requesting an MRI of her elbow. No numbness or tingling in the fingers. No pain into the wrist or into the shoulder joint. Never injured this elbow before. She is wearing a sling upon presentation. She took ibuprofen earlier in the day.

REVIEW OF SYSTEMS: All systems reviewed and negative except for those stated in HPI.

PAST MEDICAL HISTORY: She denies.

PAST SURGICAL HISTORY: She denies.

SOCIAL HISTORY: She is a smoker.

ALLERGIES: Allergic to erythromycin.

MEDICATIONS: She is on Zyrtec.

PHYSICAL EXAMINATION

This is a 19-year-old female who appears in no acute distress. Temperature 97.1, heart rate is 89, blood pressure 116/64, respirations are 20, she is 99% on room air. She is awake, alert, and oriented x3. Her head is atraumatic, normocephalic. Pupils are equally reactive to light. Extraocular motions are intact. Her neck is supple. Chest wall is nontender. Heart is a regular rate and rhythm Lungs: Clear to auscultation bilaterally. Abdomen is soft, nondistended, nontender, no guarding, mass or rebound.

Skin is warm and dry, without any rashes. She has full range of motion of the wrists to bilateral upper extremities. She is mildly tender along the left radius, into the radial head and ulna. However, she can supinate, pronate, flex and extend her arm with assistance. No pain into the left shoulder with full range of motion of that shoulder.

In the emergency room, X-rays were done of the elbow showing no acute abnormalities, no fractures noted. She already has a sling. She is going to be discharged.

IMPRESSION: Elbow sprain.

PLAN: Given a prescription for Naprosyn, Vicodin, two weeks off work. Told to wear the sling for the next 5–7 days as needed for comfort. Return to the ED with any new concerns. Follow up with her doctor this week.

Emergency Department Services (requires 3 of 3 key components)						
Table A	History	Problem focused	Expanded Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Table B1	Exam	Problem focused	Expanded Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Table C	Medical Decision Making	Straightforward	Low	Moderate	Moderate	High
Level of E/M		99281	99282	99283	99284	99285

All three key components are required to be met for an ED visit. The MDM is a moderate level causing the highest level of E/M code possible to be 99284.

In the code description for a level 5 emergency department visit (99285), there is a caveat to the key component requirement. The descriptor for 99285 states, “Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient’s clinical condition and/or mental status.” This allows for an ED visit to be leveled at 99285 based on the severity of the patient’s condition without necessarily meeting all of the key component requirements for a 99285. 99285 should be reported when the patient’s condition poses an immediate significant threat to life or physiologic function.

Contributory Factors to E/M Service Leveling

Contributory factors for selecting an E/M service include counseling, coordination of care, and nature of the presenting problem. The first two factors are important in E/M, but are not required for each visit. Nature of the presenting problem is considered as the disease, illness, condition, injury, symptom, signs, finding, complaint, or other with or without a diagnosis.

Counseling

Counseling may be included during the visit of a patient and reflect conversations with the patient and/or family regarding risk reduction, treatment options, benefits and risks associated with differing treatment options and other education given to the patient and/or family. This often occurs when a patient has a complicated illness or injury with different treatment options to consider. It is also common when a patient is newly diagnosed with an acute or chronic illness posing a threat to life.

Example

I had an extremely extensive 60+ minute examination, and series of discussions, with the patient and her family members. Over half of the time was spent on counseling the patient and family members.

At great length, with the patient and her daughter, and later with her son-in-law who arrived secondarily, and later again with her husband, who arrived at the end of my visit, I discussed how with diabetic injury, especially with neuropathy, she would be at risk, over time, of valvular dysfunction in the leg veins. I discussed the anatomy and physiology of orthostatic hypotension, and how this can be very pronounced, especially in long-term diabetics, and this would be made even worse with respect to her gait and balance, with her underlying peripheral neuropathy. Superimposing orthostatic hypotension on top of the neuropathy could certainly make her at risk for falling, to greater degree.

Nature of Presenting Problems

The Nature of a Presenting Problem is the reason for the visit: the sign, symptom, illness, or disease being treated. Nature of a presenting problem includes five types which are defined in the E/M guidelines of your CPT® codebook.

Appendix C: Clinical Examples in your CPT® coding manual can be used as a good indication when determining the nature of the presenting problem. Keep in mind the level of visit is still dependent on the key components documented in the medical record.

Time

In some cases, the encounter does not require the provider to perform a history, exam, and MDM. Examples of time based codes include critical care, care plan oversight, etc.

Example

In Module 1, we looked at an example of a patient coming through the emergency department in critical care.

EMERGENCY DEPARTMENT

CHIEF COMPLAINT: Unresponsiveness.

HISTORY OF PRESENT ILLNESS

The patient is a 77-year-old female with a seizure disorder. She has also had a stroke with persistent left hemiparesis and right gaze preference. She was found unresponsive in her bed today. She has snoring respirations. She does not respond to painful stimulus. Family also arrived with the patient; however, from the nursing home no other information is available. Patient's family had nothing else to add.

REVIEW OF SYSTEMS: No review of systems is available due to patient unresponsive.

PAST MEDICAL HISTORY: Seizure disorder, stroke, left hemiparesis.

MEDICATIONS: List reviewed.

ALLERGIES: Reviewed.

SOCIAL HISTORY: Nursing home resident. Multiple family members are here, but no other history is available.

FAMILY HISTORY: Not known.

PHYSICAL EXAMINATION

The patient is unresponsive, snoring respirations and no response to painful stimulus. She has a right gaze preference and does not respond to any verbal stimulus. Head and neck exam: No evidence of trauma, no ecchymosis. Skin: Pale, but warm and dry. No rashes or edema. Oral mucosa well hydrated. Pupils: Equal, round and reactive to light, stay deviated to the right. No nystagmus identified. Ears: Clear. Neck: Stays predominantly turned towards the right. She resists movement back to the left. Lungs: Clear. No wheezes. Heart: Regular. There is no murmur. There are loud referred upper airway noises. Abdomen: Soft, not grossly distended. No mass or pulsations. Back: No ecchymosis or skin breakdown. Pelvis is stable. Hips are mobile passively.

The left lower extremity is flaccid; the right lower extremity is held in extension and somewhat stiffly. Upper extremities are both flaccid; however, the right upper extremity does somewhat resist passive range of motion. There is no response to painful stimulus on either side. There is an upgoing Babinski on the right. The lower extremities have good peripheral pulses. There is no edema, no ecchymosis. Neuro exam: As noted, no response to painful stimulus, snoring respirations with gurgling and upper airway noises. There is a right gaze preference, flaccid left upper extremity and left lower extremity. The right upper extremity: No withdrawal to pain. Right lower extremity: Upward-going Babinski.

DIAGNOSTIC STUDIES

Cardiogram: Atrial fibrillation, rate of 167, narrow complexes, left axis deviation. Study reviewed by me. Chest X-ray shows worsened interstitial prominence consistent with mild congestive heart failure. CT scan of the brain showed no acute findings. CBC: White count 17, hemoglobin 14.5, BNP400. Electrolytes: BUN and creatinine normal, glucose 136. Liver functions are normal. Cardiac enzymes are negative. INR 2.2.

EMERGENCY DEPARTMENT COURSE

The patient developed generalized seizure activity. This carried on for a couple of minutes, and after

Ativan intravenously, the seizure activity stopped. The patient had IV Dilantin following that. She had no further seizure activity, was much more calm. Her stiff right lower extremity resolved and was now mobile. She still does not respond to any verbal or painful stimulus. She was given IV Cardizem, both bolus and infusion. Her heart rate promptly dropped to 80, remained in atrial fibrillation. Her blood pressure stabilized. Initially, blood pressure was 190 systolic and subsequently was 120 systolic. She does seem to be more stable. She required 90 minutes of critical care time in the emergency room, excluding time for procedures. **1** Nasopharyngeal airway was placed, and her snoring respirations improved. She is maintained on supplemental oxygen with good oxygen saturations.

IMPRESSION

1. Status epilepticus.
2. Atrial fibrillation with rapid ventricular response.

DISPOSITION

The patient is from Whetstone Nursing Home, and the patient will be admitted to the COPC service to the intensive care unit.

In this example, critical care time is stated as 90 minutes. It is also stated this does not include time for any procedures performed. According to the Critical Care table in the CPT® codebook, 90 minutes is reported with 99291 and 99292. 99291 reports the first 74 minutes and 99292 reports the remaining 16 minutes.

1 Indication for Critical Care.

Time may be considered the controlling factor to qualify for a particular E/M service level, “When counseling and/or coordination of care dominates (more than 50 percent) the physician/patient and/or family encounter...,” according to CPT® guidelines. The E/M category selected must include a time reference. As an example, the descriptor for level 5 established patient outpatient service 99215 specifies, “Physicians typically spend 40 minutes at the bedside and on the patient’s hospital floor or unit.” By contrast, Observation

services 99234–99236 do not include a stated time component; these services may not be reported with time as the deciding component.

Time may include face-to-face time in the office or other outpatient setting, or floor/unit time in the hospital or nursing facility, and includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether they are family members.

Time the physician spends taking the patient's history or performing an examination does not count as counseling time. The physician must look at the entire patient encounter and decide if he or she spent the majority of time in counseling and/or coordinating care or if the key components of history, exam, and MDM should be the deciding factor when choosing an E/M level.

Counseling and coordinating care could include discussion with the patient (or his or her family) about one or more of the following, according to CPT® guidelines:

- diagnostic results
- impressions and/or recommended diagnostic studies
- prognosis
- risks and benefits of treatment options
- instructions for treatment and/or follow-up
- importance of compliance with chosen treatment options
- risk-factor reduction
- patient/family education

The provider's documentation should support the content and extent of the patient counseling. The most important part of coding by time is complete and adequate documentation of the visit—including documentation of the total visit time and the total time the physician spends counseling.

Chart #: _____

E/M Audit Form

Patient Name: _____ Date of service: ____/____/____ Provider: _____ MR #: _____

Place of Service: _____ Service Type: _____ Insurance Carrier: _____

Code (s) selected: _____ Code(s) audited: _____ ☐ Over ☐ Under ☐ Correct ☐ Miscoded

History

History of Present Illness

- ☐ Location
- ☐ Quality
- ☐ Severity
- ☐ Duration
- ☐ Timing
- ☐ Context
- ☐ Modifying factors
- ☐ Associated signs and symptoms
- ☐ No. of chronic diseases

Review of Systems

- ☐ Constitutional symptoms
- ☐ Eyes
- ☐ Ears, nose, mouth, throat
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Gastrointestinal
- ☐ Genitourinary
- ☐ Integumentary
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Psychiatric
- ☐ Endocrine
- ☐ Hematologic/lymphatic
- ☐ Allergic/immunologic

Past, Family & Social History

PAST MEDICAL

- ☐ Current medication
- ☐ Prior illnesses and injuries
- ☐ Operations and hospitalizations
- ☐ Age-appropriate immunizations
- ☐ Allergies ☐ Dietary status

FAMILY

- ☐ Health status or cause of death of parents, siblings, and children
- ☐ Hereditary or high risk diseases
- ☐ Diseases related to CC, HPI, ROS

SOCIAL

- ☐ Living arrangements
- ☐ Marital status ☐ Sexual history
- ☐ Occupational history
- ☐ Use of drugs, alcohol, or tobacco
- ☐ Extent of education
- ☐ Current employment ☐ Other

History _____

PF=Brief HPI

EPF=Brief HPI, ROS (Pertinent=1)

Detailed= Extended HPI (4+) + ROS=(2-9) PFSH=1

Comprehensive= Extended HPI + ROS (10 + systems) PFSH=2 Established, 3 New Patient

☐ PFSH Form reviewed, no change ☐ PFSH form reviewed, updated ☐ PFSH form new

**Extended HPI=Status of 3 chronic illnesses with 1997 DG. Some allow for 1995 as well.

General Multi-System Examination

Constitutional

- ☐ 3 of 7 (BP,pulse,respir,tmp,hgt,wgt)
- ☐ General Appearance

Eyes

- ☐ Conjunctivae, Lids
- ☐ Eyes: Pupils, Irises
- ☐ Ophthalm exam -Optic discs, Pos Seg

ENT

- ☐ Ears, Nose
- ☐ Oto exam -Aud canals,Tymp membr
- ☐ Hearing
- ☐ Nasal mucosa, Septum, Turbinates
- ☐ ENTM: Lips, Teeth, Gums
- ☐ Oropharynx -oral mucosa,palates

Neck

- ☐ Neck
- ☐ Thyroid

Respiratory

- ☐ Respiratory effort
- ☐ Percussion of chest
- ☐ Palpation of chest
- ☐ Auscultation of lungs

Cardiovascular

- ☐ Palpation of heart
- ☐ Auscultation of heart (& sounds)
- ☐ Carotid arteries
- ☐ Abdominal aorta
- ☐ Femoral arteries
- ☐ Pedal pulses
- ☐ Extrem for periph edema/varicosities

Chest

- ☐ Inspect Breasts
- ☐ Palpation of Breasts & Axillae

Gastrointestinal

- ☐ Abd (+/- masses or tenderness)
- ☐ Liver, Spleen
- ☐ Hernia (+/-)
- ☐ Anus, Perineum, Rectum
- ☐ Stool for occult blood

GU/Female

- ☐ Female: Genitalia, Vagina
- ☐ Female Urethra
- ☐ Bladder
- ☐ Cervix
- ☐ Uterus
- ☐ Adnexa/parametria

GU/Male

- ☐ Scrotal Contents
- ☐ Penis
- ☐ Digital rectal of Prostate

Lymphatic

- ☐ Lymph: Neck
- ☐ Lymph: Axillae
- ☐ Lymph: Groin
- ☐ Lymph: Other

Musculoskeletal

- ☐ Gait (...ability to exercise)
- ☐ Palpation Digits, Nails
- ☐ Head/Neck: Inspect, Palp
- ☐ Head/Neck: Motion (+/-pain,crepit)
- ☐ Head/Neck: Stability (+/- lux,sublux)
- ☐ Head/Neck: Muscle strength & tone
- ☐ Spine/Rib/Pelv: Inspect, Palp
- ☐ Spine/Rib/Pelv: Motion
- ☐ Spine/Rib/Pelv: Stability
- ☐ Spine/Rib/Pelv: Strength and tone
- ☐ R.Up Extrem: Inspect, Palp

- ☐ R.Up Extrem: Motion (+/- pain, crepit)
- ☐ R.Up Extrem: Stability (+/- lux, sublux)
- ☐ R.Up Extrem: Muscle strength & tone
- ☐ L.Up Extrem: Inspect, Palp
- ☐ L.Up Extrem: Motion (+/- pain, crepit)
- ☐ L.Up Extrem: Muscle strength & tone
- ☐ R.Low Extrem: Inspect, Palp
- ☐ R.Low Extrem: Motion (+/-pain, crepit)
- ☐ R.Low Extrem: Stability (+/- lux, laxity)
- ☐ R.Low Extrem: Muscle strength & tone
- ☐ L.Low Extrem: Inspect, Palp
- ☐ L.Low Extrem: Motion (+/-pain, crepit)
- ☐ L.Low Extrem: Stability (+/- lux, sublux)
- ☐ L.Low Extrem: Muscle strength & tone

Skin

- ☐ Skin: Inspect Skin & Subcut tissues
- ☐ Skin: Palpation Skin & Subcut tissues

Neuro

- ☐ Neuro: Cranial nerves (+/- deficits)
- ☐ Neuro: DTRs (+/- pathological reflexes)
- ☐ Neuro: Sensations

Psychiatry

- ☐ Psych: Judgement, Insight
- ☐ Psych: Orientation time, place, person
- ☐ Psych: Recent, Remote memory
- ☐ Psych: Mood, Affect (depression, anxiety)

Exam: _____

1995-1=PF, limited 2-7=EPF, extended
2-7=Detailed, 8+ organ systems=Comprehensive
1997-1-5=PF, 6-11=EPF, 2x6 systems=D
2 from 9 systems=Comp.

Number of Diagnoses/Management Options	Points
Self-limited or minor (Stable, improved or worsening) → Maximum 2 points in this category.	1
Established problem (to examining MD); stable or improved	1
Established problem (to examining MD); worsening	2
New problem (to examining MD); no additional work-up planned →	3
New problem (to examining MD); additional work-up (e.g. admit/transfer)	4
Total	

Amount and/or Complexity of Data Reviewed	Points
Lab ordered and/or reviewed (regardless of # ordered)	1
X-ray ordered and/or reviewed (regardless of # ordered)	1
Medicine section (90701-99199) ordered and/or reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old record and/or obtain hx from someone other than patient	1
Review and summary of old records and/or obtaining hx from someone other than patient and/or discussion with other health provider	2
Independent visualization of image, tracing, or specimen (not simply review of report)	2
Total	

TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
<i>Minimal</i>	• One self-limited or minor problem, eg, cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, eg, echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
<i>Low</i>	• Two or more self-limited or minor problems • One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, eg, pulmonary function tests • Non-cardiovascular imaging studies with contrast, eg, 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
<i>Moderate</i>	• 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, eg, lump in breast • Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis • Acute complicated injury, eg, head injury with brief loss of consciousness	• Physiologic tests under stress, eg, 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, eg, arteriogram, cardiac catheterization • Obtain fluid from body cavity, eg 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
<i>High</i>	• 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, eg, 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, eg, seizure, TIA, weakness, sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic Endoscopies with identified risk factors • Discography	• 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

Medical Decision Making	SF	LOW	MOD	HIGH
Number of Diagnoses or Treatment Options	1	2	3	4
Amount and/or Complexity of Data to be Reviewed	1	2	3	4
Risk of Complications, Morbidity, Mortality	Minimal	Low	Moderate	High
MDM Level=2 out of 3				

MDM _____

Chart Note

Comments

- ☐ Dictated ☐ Handwritten
☐ Form ☐ Illegible
☐ Note signed
☐ Signature missing

Other Services or Modalities:

Auditor's Signature