

Documentation — The Basics

The following are the basic principles of documentation. They apply to all types of medical and surgical services in all settings.

1. The medical record should be first and foremost a tool of clinical care and communication.
2. The medical record should be complete and legible.
3. The documentation of each patient encounter should include or provide reference to:
 - The chief complaint and/or reason for the encounter and, as appropriate, relevant history, examination findings and prior diagnostic test results;
 - ⇒ Assessment, clinical impression or diagnosis;
 - ⇒ Plan for care; and
 - ⇒ Date and legible identity of the health care professional.
4. If not specifically documented, the reason for the encounter and/or chief complaint and the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.
5. To the greatest extent possible, past and present diagnoses and conditions, including those in the prenatal and intrapartum period that affect the newborn, should be accessible to the treating and/or consulting physician.
6. Appropriate health risk factors should be identified.
7. The patient's progress, response to and changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.
8. 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 and be at a level sufficient for a clinical peer to determine whether services have been accurately coded.
9. The confidentiality of the medical record should be fully maintained consistent with the requirements of medical ethics and of law.

Reviewing the level of service assigned

The level of service is intended to reflect the work involved in providing the service. Because CPT definitions and/or documentation guidelines will not always fully reflect work provided, coders and reviewers should view these guidelines as sufficient to satisfy CPT coding criteria but should consider also all pertinent work-related information to determine the correct level of service (eg, patient severity, diagnoses, extent of examination, extraordinary encounter time, work between encounters). Such code assignment would be subject to evaluation by a peer reviewer and documentation should be sufficient to justify the code assigned for a clinically knowledgeable reviewer.

In accordance with the Evaluation and Management Services Guidelines for the selection of the appropriate level of E/M services (see page 8 of *CPT 1999*), **all of the key components** (ie, history, examination, and medical decision making), must meet or exceed the stated requirements to qualify for a particular level of E/M service for the following **new or initial patient** categories/subcategories: office, new patient; hospital observation services; initial hospital care; office consultations; initial inpatient consultations; confirmatory consultations; emergency department services; comprehensive nursing facility assessments; domiciliary care, new patient; and home, new patient.

Two key components (ie, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M service for the following **established or follow-up patient** categories/subcategories: office, established patient; subsequent hospital care; follow-up inpatient consultations; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

History

The extent of the history that is obtained is dependent on the physician's clinical judgment and the nature of the presenting problem(s) or the reason for the encounter.

If the physician is unable to obtain a sufficient history from the patient or other source within a clinically appropriate timeframe, the record should describe the patient's medical condition or other circumstance that precludes obtaining a sufficient history. These may include:

- urgent/emergent condition(s);
- patient's inability to communicate;
- patient is at a very high level of risk, where immediate action is necessary;
- lack of interpreter;
- no medical record available; and/or
- no family/significant other or legal guardian available in person or by telephone

Documentation of the circumstances related to the inability to obtain a sufficient history will be deemed equivalent to a comprehensive history for code selection purposes. This equivalence is only permitted for new patients, emergency department visits, initial hospital care codes, or patients new to the consulting physician. CPT describes four types of history:

- ⇒ Problem focused
- ⇒ Expanded problem focused
- ⇒ Detailed
- ⇒ Comprehensive

Each type of history is made up, to varying degrees, of the following components:

- Chief complaint or reason for the encounter
- History of the present illness (HPI)
- Review of systems (ROS)
- Past, family, and/or social history (PFSH)

Any record format for documenting any component of the history (ie, chief complaint/reason for encounter; history of present illness; review of systems; past, family, and/or social history) is acceptable, including, but not limited to, preprinted history forms completed by the patient, other informant, and/or ancillary staff, with documentation of review by the physician or other health care professional. (There must be a dated notation confirming, or supplementing as necessary, information recorded by others, including, but not limited to, pre-printed history forms.) Components may be identified separately or they may be combined, for example, in the history of present illness. A single item of history should be considered either part of the HPI or the ROS but not both.

Chief Complaint and/or Reason for Encounter

Document

The chief complaint and/or the reason for the encounter for all codes except those that require only an interval history (eg, subsequent inpatient hospital services).

The chief complaint and/or the reason for the encounter can include items such as referral by another physician; lab test performance; specific complaints; physician directed return for follow-up. It must be easily inferred if not explicitly documented.

History of Present Illness

The HPI may include positive and clinically pertinent negative statements describing different aspects of the presenting problem(s) (eg, location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms, and related functional status descriptors).

Document

The history of present illness (HPI) as follows:

Brief HPI — Statements about:

- (1) 1 to 3 items about the present illness(es)/presenting problem(s)
- or**
- (2) 1 or 2 present illness(es)/presenting problem(s), or chronic, or clinically pertinent inactive conditions, in any combination.

Extended HPI — Statements about:

- (1) at least 4 items about the present illness(es)/presenting problem(s)
- or**
- (2) at least 3 present illnesses/presenting problems, or chronic or clinically pertinent inactive conditions, in any combination.

Review of Systems

A review of systems obtained during an earlier encounter does not need to be re-recorded. Any new ROS information should be documented, or alternatively document the lack of change (eg, no change) from previous ROS with notation of date or location of previous ROS.

Document

The review of systems as follows:

Brief ROS — Positive and/or negative responses for 1-4 systems.

Extended ROS — Positive and/or negative responses for at least 5 systems

For CPT coding purposes, the following systems are identified:

- Constitutional symptoms (eg, fever, weight loss)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Past, Family, and/or Social History

Document

The past, family, and/or social history as follows:

Brief PFSH — At least 1 item from any PFSH area

Extended PFSH — At least 1 item from at least 2 of the 3 PFSH areas

Past history — Describes the patient's past experiences or lack thereof with illnesses, operations, injuries and treatments, some examples of which are:

- Listing and/or review of current medication(s)
- Allergies (food, drug, and/or environmental)
- Operations
- Injuries/trauma
- Past illnesses and/or hospitalizations
- Pregnancy history
- Growth history
- Development history
- Immunization history
- Behavioral history
- Functional status history
- Other relevant past history (eg, sexual history, gynecologic history, mother's history, newborns, birth history, school history, treatment/medication compliance)

Family history — A review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk, some examples of which are:

- Cardiovascular disease: stroke, myocardial infarction or other cardiovascular illness
- Cancer
- Drug abuse
- Domestic violence and/or child abuse
- Metabolic/lipid disorders
- Hereditary disorders
- Other relevant family history

Social history — Describes age-appropriate past and current activities, some examples of which are: Status of immediate and/or extended family

- Marital status
- Tobacco, or alcohol, or drug use/ abuse
- Employment status
- Occupational history
- Education
- Housing and/or source of drinking water
- Financial status
- Exercise patterns
- Diet history
- Travel history
- Other relevant social factors

A review of past, family, and/or social history obtained during an earlier encounter **does not** need to be re-recorded. Any new PFSH information should be documented, or “no change” from previous PFSH, with notation of date or location of previous PFSH, should be alternatively documented.

Select the type of history

The chart below shows the progression of the elements required for each type of history. All of the applicable history categories must be met for a given level of history, except that:

- ⇒ Two of the three applicable history categories are sufficient for newborn infants; and
- ⇒ Two of the three applicable history categories are also sufficient for those levels of E/M services requiring a detailed or comprehensive interval history (eg, 99231-99233, 99261-99263, 99301-99302, 99311-99313, 99331-99333, 99347-99350).

The chief complaint and/or the reason for the encounter is required for all codes except those that require only an interval history (eg, subsequent inpatient hospital services).

Type of history	HPI	ROS	PFSH
Problem focused	Brief 1 to 3 items about the present illness(es)/presenting problem(s) or 1 or 2 present illness(es)/ presenting problem(s), or chronic, or clinically pertinent inactive conditions, in any combination.	N/A	N/A
Expanded problem focused	Brief 1 to 3 items about the present illness(es)/presenting problem(s) or 1 or 2 present illness(es)/ presenting problem(s), or chronic, or clinically pertinent inactive conditions, in any combination.	Brief — Positive and/or negative responses for 1 to 4 systems	N/A
Detailed	Extended At least 4 items about the present illness(es)/presenting problem(s) or At least 3 present illnesses/presenting problems, or chronic or clinically pertinent inactive conditions, in any combination.	Brief — Positive and/or negative responses for 1 to 4 systems	Brief — At least 1 item from any of the 3PFSH areas
Comprehensive	Extended at least 4 items about the present illness(es)/presenting problem(s) or at least 3 present illnesses/presenting problems, or chronic or clinically pertinent inactive conditions, in any combination.	Extended — Positive and/or negative responses for at least five systems	Extended — At least 1 item from at least 2 of the 3PFSH areas

Examination

CPT describes four types of examinations:

- ⇒ Problem focused
- ⇒ Expanded problem focused
- ⇒ Detailed
- ⇒ Comprehensive

These examinations may be a general multi-system examination, the examination of a single body area or organ system, or any combination thereof. Any examination may be performed by any physician regardless of specialty. Actual content of the examination is selected by the examining physician in accordance with the needs of the patient.

Determine the Extent of Examination Performed

The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examinations that are defined as follows:

- **Problem focused examination** — a limited examination of the affected body area(s) or organ system, which typically includes 1 to 5 exam items
- **Expanded problem focused examination** — a limited examination of the affected body area(s) or organ system and other clinically relevant or related body area(s) or organ system(s), which typically includes 6 to 11 exam items
- **Detailed examination** — an extended examination of the affected body area(s) and other clinically relevant or related body area(s) or organ system(s), which typically includes 12 to 17 exam items
- **Comprehensive examination** — a general multi-system examination or a complete examination of a single organ system and other clinically relevant body area(s) or organ system(s). **Note:** The comprehensive examination performed as part of the preventive medicine evaluation and management service is multi-system, but its extent is based on age and pertinent risk factors.) Typically includes 18 or more exam items (within the constraints imposed by the urgency of the patient's mental status and/or clinical condition).

Any type of record format is acceptable, including, for example, simple "checklists" to indicate that an item has been performed.

If a checklist or template includes descriptors of distinct elements but also includes an indicator that the entire group was normal or negative, a notation to indicate all indicated elements were examined suffices. In this approach, elements not actually performed should be crossed out or otherwise indicated.

A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings.

Specific abnormal and clinically relevant negative findings should be documented. A notation of “abnormal” without elaboration is insufficient. For subsequent visits, a notation of “unchanged” in a previously abnormal finding is adequate.

An item of examination can be documented by reporting one or more examples listed or other observation(s), examination(s), or special test(s) as pertinent.

Simplified Documentation

“Simplified” documentation of a single body area and/or organ system is acceptable and is equivalent to performance of a **single** examination item. The exception is HEENT, where organ systems are grouped collectively. For example, examination of the head, eyes, ear, nose, and throat will be equivalent to three examinations, as this includes several organ systems. Further **examples** are listed below.

Body area and/or Organ System Examination	“Simplified” Documentation Examples	Number of Examination Items
HEENT	Negative	Counts as three examination items, as it includes the head, face, eyes, ears, nose, neck, and throat
Chest	Clear	Counts as one examination item
Heart	WNL	Counts as one examination item
Abdomen	WNL	Counts as one examination item
Genitourinary	WNL	Counts as one examination item
Neurologic	Negative	Counts as one examination item
Skin	Normal	Counts as one examination item
Musculoskeletal	Normal	Counts as one examination item
Mental status/Psychiatric	Normal	Counts as one examination item
Lymph Nodes	No enlargement	Counts as one examination item
Breasts	No masses	Counts as one examination item

The following examination charts have been organized in an anatomic order. It is recognized that, depending on the physician's specialty, and personal examination techniques, the items listed could be categorized in a different anatomic order of body area location. Accordingly, physicians may choose to create a customized list of these examination items, to more closely follow their typical practice patterns and to document in whatever order is clinically appropriate.

Please note that examples are given for clarification as to the meaning of the examination item. This is not meant to imply that each example must be documented. Other examination items performed but not listed here should be documented if clinically pertinent.

Constitutional											
Examination Item	Examples										
<p>Measurement of at least 3 of the following 10 vital signs (counts as one examination item) (may be measured and recorded by ancillary staff)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1) sitting blood pressure</td> <td style="width: 50%;">6) temperature</td> </tr> <tr> <td>2) standing blood pressure</td> <td>7) weight</td> </tr> <tr> <td>3) supine blood pressure</td> <td>8) height</td> </tr> <tr> <td>4) pulse rate</td> <td>9) head circumference</td> </tr> <tr> <td>5) respiratory rate</td> <td>10) body mass index</td> </tr> </table>		1) sitting blood pressure	6) temperature	2) standing blood pressure	7) weight	3) supine blood pressure	8) height	4) pulse rate	9) head circumference	5) respiratory rate	10) body mass index
1) sitting blood pressure	6) temperature										
2) standing blood pressure	7) weight										
3) supine blood pressure	8) height										
4) pulse rate	9) head circumference										
5) respiratory rate	10) body mass index										
General appearance	Development, nutrition, growth, color, skin type, body habitus, deformities, attention to grooming, Cushingoid features, acromegalic features, behavior (eg, pain, hyperactivity), physical or emotional distress, degree of cooperation, attitude toward examiner										
Assessment of ability to communicate and/or quality of communication	Dysarthria, anomia, language barrier										
Assessment of level of consciousness	Alert, obtunded, fluctuating, unconscious										
Other examination (specify)											

Head, Face, and Neck	
Examination Item	Examples
Inspection of head and/or face	Overall appearance, scars, lesions, masses
Examination of neck	Overall appearance, color, texture, skin lesions, scars, masses, torticollis, webbing, symmetry, tracheal deviation
Palpation and/or percussion of face	Sinus tenderness, bony tenderness, masses
Examination of salivary glands	Masses, tenderness
Examination of thyroid	Goiter, nodule, tenderness
Examination of fontanelles	Presence or absence of fullness
Examination of cranial bones and sutures	Swelling, open/closed sutures
Examination of jugular veins (counts as head, face and neck or cardiovascular, not both)	Distention
Examination of carotid arteries (counts as head, face and neck or cardiovascular, not both)	Presence or absence of bruit
Examination of cervical lymphatics	Enlargement of nodes in the anterior/posterior triangle, submental, supraclavicular
Other examination (specify)	
Temporomandibular Joint	
Range of Motion	Degree of movement
Inspection	Swelling, malalignment on opening
Stability	Dislocation
Palpation	Tenderness, crepitus
Special tests (maximum of three)	Oral aperture
Assessment of masticatory function	
Other examination (specify)	

Eyes	
Examination Item	Examples
Inspection of conjunctivae and sclera	Redness, lesions, symblepharon, scleral thinning, jaundice, color
Examination of orbits	Exophthalmos, enophthalmos (measured forward protrusion)
Test visual acuity (not including determination of refractive error) (may be measured and recorded by ancillary staff)	
Gross visual field testing by confrontation	Hemianopsia
Basic ocular motility	Versions, nystagmus, strabismus
Examination of ocular adnexa including lids, lacrimal glands, lacrimal drainage, and orbits	Ptosis, lagophthalmos, dermatitis, lid lag, epiphora
Examination of pupils and/or irides	Shape, direct and consensual reaction (afferent pupillary defect), size, iris lesions, neovascularization, pigmentation
Measurement of intraocular pressure	
Ophthalmoscopic examination of optic disc(s) and posterior segment or macula through undilated pupils or with pupillary dilation (unless contraindicated)	Retinal hemorrhages, exudates, cotton-wool patches, pigmentation, C/D ratio, size, tumor, elevations, appearance (eg, atrophy, elevation, congenital abnormalities), drusen, exudates, edema, hemorrhage
Ophthalmoscopic examination of the retinal periphery with pupillary dilation (unless contraindicated)	Lattice degeneration, holes, tears, detachments
Examination of the vitreous with pupillary dilation (unless contraindicated)	Inflammation, detachment
Slit lamp [†] examination of the cornea(s)	Epithelium, stroma, endothelium, tear film, lesions, dystrophies
Slit lamp [†] examination of the lenses	Opacification and clarity of anterior capsule, posterior capsule, cortex and nucleus; dislocation
Slit lamp [†] examination of the anterior chambers	Depth, cells, and flare
Other examination (specify)	
[†] In some cases these exams may be completed with other instrumentation because of age of patient and location of exam.	

Ear, Nose, Mouth, and Throat	
Examination Item	Examples
Examination of external ears (auricles)	Overall appearance, scars, lesions, masses, dermatitis
Otoscopic examination of external auditory canal and/or tympanic membranes	Otitis externa, otitis media
Pneumo-otoscopy	Mobility of tympanic membranes
Assessment of hearing and/or clinical speech reception thresholds	Whispered voice, finger rub, tuning fork, acoustic blink reflex
Examination of external nose, nasal mucosa, nasal cavity, septum and/or turbinate(s)	Swelling, redness, pallor, polyps, deviation, perforation
Examination of dentoalveolar structures	Dental caries, tooth loss, gingivitis, periodontal disease
Examination of occlusion	Overbite, underbite, cross-bite, occlusal class
Examination of lips and/or oral mucosa	Cyanosis, pallor, deformities, lesions, hydration, cheilitis
Examination of oropharynx (hard and soft palates, tongue, tonsils, and/or posterior pharynx)	Lesions, torii, glossitis, symmetry, pharyngitis
Examination by mirror of larynx, including epiglottis, pharyngeal walls and/or pyriform sinuses, false vocal cords, true vocal cords, and/or mobility of larynx	Nodules, edema, swelling, mobility
Examination by mirror of nasopharynx (including appearance of the mucosa, adenoids, posterior choanae and/or eustachian tubes)	Adenoidal size
Other examination (specify)	

Respiratory	
Examination Item	Examples
Inspection of chest	Shape, symmetry, expansion, intercostal retractions, use of accessory muscles, assessment of respiratory effort
Percussion of chest	Dullness, flatness, hyperresonance, diaphragmatic movement
Palpation of chest	Tenderness, masses, tactile fremitus, crepitus
Auscultation of lungs	Breath sounds, adventitious sounds, rubs, rales, rhonchi
Other examination (specify)	

Cardiovascular	
Examination Item	Examples
Palpation of heart	Location, size, forcefulness of the point of maximal impact, thrills, lifts, palpable S3 or S4
Auscultation of heart rhythm, sounds, and murmurs	Abnormal sounds, murmurs
Auscultation of heart with maneuvers and/or with patient in multiple positions	
Examination of carotid arteries	Waveform, presence of pulse, pulse amplitude, bruits, apical-carotid delay
Examination of axillary arteries	Presence of pulse, pulse amplitude
Examination of abdominal aorta	Size, bruits
Auscultation of renal arteries	Bruits
Examination of brachial arteries	Presence of pulse, pulse amplitude
Examination of radial arteries	Presence of pulse, pulse amplitude, Allen's test
Examination of ulnar arteries	Presence of pulse, pulse amplitude
Examination of femoral arteries	Presence of pulse, pulse amplitude, bruits
Examination of popliteal arteries	Presence of pulse, pulse amplitude
Examination of dorsalis pedis arteries	Presence of pulse, pulse amplitude
Examination of posterior tibial arteries	Presence of pulse, pulse amplitude
Examination of peripheral venous system by observation and/or palpation	Swelling, varicosities, suitability of lower extremity veins for use as conduit, peripheral edema, lymphedema, pallor, temperature, capillary refill, trophic changes, cyanosis
Examination of jugular veins (Counts as head, face and/or neck OR cardiovascular, not both)	Distention (JVD), A, V or cannon A waves
Examination of peripheral hemodialysis, A-V fistula	Patency, status of insertion site
Examination of bypass graft	Presence of pulse, pulse amplitude, bruits, healing of surgical incisions
Other examination (specify)	

Breasts (Chest)	
Examination Item	Examples
Examination of breast for size and symmetry (unilateral)	Gynecomastia, disparity, Tanner stage (males)
Examination of nipple-areola complex	Bleeding, inversion, discharge
Examination of breast parenchyma, no prior breast operation (unilateral)	Masses, tenderness
Examination of breast parenchyma, previously operated breast (unilateral)	Mass, fibrosis, implant displacement
Other examination (specify)	

Lymphatic	
Examination Item	Examples
Palpate lymph nodes in neck	Lymphadenopathy, submental, cervical (anterior/posterior), supraclavicular, preauricular
Palpate lymph nodes in axillae	Lymphadenopathy
Palpate lymph nodes in groin (bilateral)	Lymphadenopathy
Palpate lymph nodes of each additional lymph node area	Lymphadenopathy, epitrochlear, popliteal
Other examination (specify)	

Gastrointestinal (Abdomen)	
Examination Item	Examples
Inspection of abdomen	Obesity, distention, scars
Palpation of abdomen	Masses, guarding, tenderness, presence or absence of ascites
Percussion of abdomen	Bladder size, liver size, tympany
Palpation of liver	Hepatomegaly, size, tenderness, edge
Palpation of spleen	Splenomegaly
Palpation of kidney	Enlargement, CVA tenderness
Examination for inguinal, femoral hernia	Reducible, incarcerated, strangulated
Examination for epigastric, umbilical, ventral, incisional hernia(s)	Reducible, incarcerated, strangulated
Examination for lumbar, Spigelian or other hernia(s)	Reducible, incarcerated, strangulated
Digital anorectal examination	Hemorrhoids, rectal masses, sphincter tone (including obtaining stool sample for occult blood)
Inspection of anus and/or perineum	Condyloma, skin tags, dermatitis
Auscultation of abdomen	Bowel sounds, bruits, rubs
Other examination (specify)	

Genitourinary (Female)	
Examination Item	Examples
Examination (with or without specimen collection for smears and cultures) of external genitalia	General appearance, estrogen effect, discharge, lesion(s), dermatitis
Examination (with or without specimen collection for smears and cultures) of urethra and/or urethral meatus	Size, location, lesions, discharge, prolapse (masses, tenderness, scarring)
Examination of bladder	Fullness, masses, tenderness
Examination (with or without specimen collection for smears and cultures) of vagina	General appearance, estrogen effect, discharge, lesion(s)
Examination (with or without specimen collection for smears and cultures) of cervix	General appearance, discharge, lesion(s)
Examination of uterus	Size, contour, position, mobility, tenderness, consistency, descent or support
Examination of adnexa/parametria	Masses, tenderness, organomegaly, nodularity
Examination of pelvic support assessment	Cystocele, rectocele, enterocele
Other examination (specify)	

Genitourinary (Male)	
Examination Item	Examples
Examination (with or without specimen collection for smears and cultures) of penis	Lesion(s), presence or absence of foreskin, plaque, masses, deformity(s), discharge, dermatitis
Examination (with or without specimen collection for smears and cultures) of scrotum	Lesion(s), cyst(s), rashes, hydrocele
Examination of epididymides	Size, symmetry, masses
Examination of testes	Size, symmetry, masses, varicocele
Examination (with or without specimen collection for smears and cultures) of urethra and/or urethral meatus	Size, location, lesions, hypospadias, masses, tenderness, scarring
Digital rectal examination of prostate/seminal vesicles	Hyperplasia, enlargement, tenderness
Other examination (specify)	

Integumentary	
Examination Item	Examples
Examination of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and/or extremities	Hair quantity, type, color, distribution, loss pattern
Examination of skin and subcutaneous tissues of the scalp	Color, texture, lesion(s), mole(s), birthmark(s), actinic damage, scar(s), dermatitis
Examination of skin and subcutaneous tissues of face	Color, texture, lesion(s), mole(s), birthmark(s), actinic damage, scar(s), dermatitis
Examination of skin and subcutaneous tissues of chest, including breasts and/or axillae	Color, texture, lesion(s), mole(s), birthmark(s), Hyperhidrosis,
Examination of skin and subcutaneous tissues of abdomen	Color, texture, lesion(s), mole(s), rashes
Examination of skin and subcutaneous tissues of groin, and/or buttocks	Color, texture, lesion(s), mole(s), rashes, hyperhidrosis, chromhidroses, bromhidrosis, pressure sores
Examination of skin and subcutaneous tissues of back	Color, texture, lesion(s), mole(s), rashes
Examination of skin and subcutaneous tissues of right upper extremity	Color, texture, lesion(s), mole(s), birthmark(s), actinic damage, dermatitis, dermatoses, hyperhidrosis
Examination of skin and subcutaneous tissues of left upper extremity	Color, texture, lesion(s), mole(s), birthmark(s), actinic damage, dermatitis, dermatoses, hyperhidrosis
Examination of skin and subcutaneous tissues of right lower extremity	Color, texture, lesion(s), mole(s), birthmark(s), actinic damage, dermatitis, dermatoses, hyperhidrosis, ulcer(s)
Examination of skin and subcutaneous tissues of left lower extremity	Color, texture, lesion(s), mole(s), birthmark(s), actinic damage, dermatitis, dermatoses, hyperhidrosis, ulcer(s)
Inspection and palpation of fingernails and/or toenails	Dystrophies, mycosis, subungual tumor, infection, hematoma, psoriasis, abnormal curvature, separation or splitting
Other examination (specify)	

Musculoskeletal	
Examination Item	Examples
Upper Extremity (all examination items are unilateral unless otherwise noted)	
General (Upper Extremity)	
Coordination (bilateral)	See Neurologic Examination
Reflexes (bilateral)	Biceps, triceps, brachioradialis, radioulnar periosteal
Vascular	Pulses, radial, ulnar, brachial, bruit, Allen's test, capillary filling, ulceration, nail color, skin turgor
Observation of functional abilities/performance of functional tasks (Each observation counts as one exam element)	Ability to don/doff clothing, ability to don/doff orthotic devices, ability to feed, ability to bathe, ability to use cane, ability to use walker, observe transitional movements
Sensation	See Neurologic Examination
Other examination (specify)	
Shoulder (Includes Upper Arm)	
Range of motion	Active/passive: abduction, adduction, forward flexion, external rotation, internal rotation, extension; scapular elevation, scapular retraction, degree movement
Strength	Drop arm test, strength in abduction, strength in adduction, strength in external/internal/mid rotation, deltoid, trapezius, rotator cuff, infraspinatus, pectoralis, sternocleidomastoid, biceps, rhomboids, latissimus, serratus anterior
Stability	Anterior/superior/posterior/inferior directional stability, AC and distal clavicle joint motion/stability, abnormal bony motion,
Palpation	Tenderness, crepitus, clicking, snapping, swelling, effusion, AC joint tenderness, SC joint tenderness, dislocation, masses, bony prominences

Musculoskeletal	
Examination Item	Examples
Upper Extremity (all examination items are unilateral unless otherwise noted)	
Shoulder (Includes Upper Arm)	
Inspection	Drooping, AC joint alignment, biceps tendon configuration, atrophy of shoulder girdle, asymmetry, deformity, posture, discoloration, trophic changes
Special tests (maximum of three)	Provocative testing of the following: AC joint, SC joint, anterior/anterior-inferior glenohumeral joint, posterior glenohumeral joint, generalized laxity, rotator cuff, glenohumeral joint, acromioclavicular joint, biceps tendon, thoracic outlet; dynamic palpation and visual observation, sulcus test, drop test, speed's test, impingement test, Yergason test, apprehension test, scapular winging test, subscapularis lift-off test, adson test, Wright test, Roos test, Ludington's test, Halstead's test, Spurling's test, load and shift test, empty can test, apprehension, Dugas test
Elbow Region	
Range of motion	Active/passive: supination, pronation, flexion, extension, degrees of movement
Strength	Brachioradialis, biceps, triceps, pronator, supinator, wrist extensors, wrist flexors, forearm supinators, forearm pronators
Stability	Varus, valgus, radial head, ulnar collateral, anterior, posterior, medial, lateral
Palpation	Tenderness (location), swelling, mass, crepitation, temperature, defect/edema, clicking, snapping, bony prominences
Inspection	Use pattern, deformity, alignment, mass, swelling, atrophy, dislocation, scars, discoloration, trophic changes, cubitus, varus, valgus
Special tests (maximum of three)	Supplemental, Tinel's, ulnar nerve stability, tennis elbow test, posterolateral rotary pivot shift test, Phalen's test, long finger test, elbow hyperextension test, pronator tunnel test, Lacertus test, Struther's test

Musculoskeletal	
Examination Item	Examples
Upper Extremity (all examination items are unilateral unless otherwise noted)	
Wrist (Includes Forearm)	
Range of motion	Active/passive: flexion, extension, radial deviation, ulnar deviation, pronation, supination, degrees of movement
Strength	Presence or absence of forearm muscle, excursion strength, wrist extensors, wrist flexors, ulnar deviation, radial deviation, forearm supinators, forearm pronators
Stability (maximum of three joints)	Subluxation distal radioulnar joint, stability: lunotriquetral, midcarpal, scapholunate, pisotriquetral, radial carpal stability, midcarpal stability, carpometacarpal stability
Palpation	Temperature, tenderness (location), effusion, edema, crepitation, mass, defects, clicking, snapping, bony prominences
Inspection	Deformity, alignment of tendons, swelling, atrophy, scars, color, posture, use pattern, masses, inflammation, discoloration, trophic changes
Special tests (maximum of three)	Watson-rock test, shuck test, Kleinman test, Tinel's sign, Phalen's sign, Finkelstein's test, Allen's test, carpal tunnel bounce test, Lichtman test
Hand/Fingers	
Range of motion (maximum of three) (unilaterally)	CMC/MP joint of thumb, MP joint (each), PIP joint (each), DIP joint (each), active vs. passive motion, fingertip to palm distance, opposition, triggering/tendon gliding (each finger), abduction/adduction, flexion, extension
Strength	Pinch strength, grip strength, grading individual muscles or muscle, groups of extrinsic/intrinsic muscles (eg, flexor digitorum superficialis, flexor digitorum profundus, abductor pollicis brevis)
Stability (maximum of three)	Radial/ulnar, palm/dorsal (specify each joint), bony fracture, medial/lateral, anterior/posterior
Palpation	Temperature, tenderness (location eg, joint, tendon, bone), crepitation, effusion, edema, mass, sweat, bony prominences, clicking, snapping

Musculoskeletal	
Examination Item	Examples
Upper Extremity (all examination items are unilateral unless otherwise noted)	
Hand/Fingers	
Inspection	Deformity, alignment of tendons, swelling, atrophy, discoloration, nail abnormalities, scars, posture, use patterns, calluses, amputations, inflammation, asymmetry, trophic changes
Special tests (maximum of three)	Finkelstein's test, Allen's test, carpal tunnel tests, Tinel's test, Phalen's test, grind Test, Bunnel's test, Froment's test, Jeanne's test, Wartenberg's test, prune test, tourniquet test, flexor profundus test, sublimus test, gamekeeper's test, redundant extensor test
Lower Extremity (all Examination Items are unilateral unless otherwise noted)	
General	
Gait (bilateral)	Antalgic, Trendelenburg, gait Pattern
Stance (bilateral)	Romberg, Genu valgum/varum, tibial varus, calcaneal eversion, inversion, pes planus, pes cavus, shoulder drop, pelvic tilt
Coordination (bilateral)	See Neurologic Examination
Reflexes (bilateral)	See Neurologic Examination
Vascular	Dorsalis pedis pulse, posterior tibial pulse, popliteal pulse, femoral pulse, varicosities, edema, rubor, pallor, capillary filling time, turgor, telangiectasia, petechiae, hair growth
Sensation	See Neurologic Examination
Other examination (specify)	
Hip (Includes Hemipelvis and Thigh)	
Range of motion	Active/passive: flexion/extension, abduction/adduction, external/internal rotation
Strength	Hip flexion and extension, flexors, extensors
Stability	Dislocated, pistoning, Barlow, Ortolani, Galiazzi

Musculoskeletal	
Examination Item	Examples
Lower Extremity (all Examination Items are unilateral unless otherwise noted)	
Hip (Includes Hemipelvis and Thigh)	
Palpation	Trochanter, pubis, groin, sciatic notch, ilium, crepitus
Inspection	Contracture, position varus/valgus, leg length (apparent or real), masses, atrophy, asymmetry, swelling
Special tests (maximum of three)	Irritability-FABER, Patrick's sign, Thomas test, Ober-Yount
Knee (Includes Leg)	
Range of motion	Active/Passive: flexion, extension
Strength	Flexion, extension
Stability	Medial, lateral, pivot shift, reverse pivot shift, subluxation, dislocation, pat-femoral stability
Palpation	Tenderness, crepitus, masses, temperature, effusion, swelling other than effusion
Inspection	Patellofemoral position/tracking, rotational alignment (torsion), standing/dependent, atrophy, Q angle
Special tests (maximum of three)	Patellofemoral articulation, tibiofemoral articulation, patellar apprehension, patellar tracking, patellar mobility, weight bearing provocative tests, anterior drawer, Lachman, tibiofibular, supplemental anterior, supplemental posterior, McMurray's test, Ober's test, Homan's sign
Ankle	
Range of motion	Active/passive: dorsiflexion, plantar flexion; fixed/supple
Strength	Heel walk, toe walk, inner-outer border, muscle grading (each individual tendon/muscle)
Stability	Subluxation (any joint or tendon)

Musculoskeletal	
Examination Item	Examples
Lower Extremity (all Examination Items are unilateral unless otherwise noted)	
Ankle	
Palpation	Crepitus, tenderness, masses, effusion, temperature, swelling
Inspection	Contracture, leg length, alignment, torsion, varus, valgus, amputation, calcaneus, standing/dependent, atrophy, deformity, skin, scars, masses, inflammation
Special tests (maximum of three)	Anterior drawer sign, Tinel's sign, Vallieux's sign, Abadie's sign, ankle clonus test, Thompson test, weight bearing provocative tests, Coleman block test, inversion stress
Foot and Toes	
Range of motion (maximum of three)	Degrees of movement, active and passive dorsiflexion and plantarflexion, pronation, supination, toes (each)
Strength	Manual muscle testing, dorsiflexors, plantarflexors, abductors, adductors, ant single leg toe rise
Stability (maximum of three joints)	Subluxation, dislocation MPJ, IPJ
Palpation	Crepitus (MPJ, IPJ), turgor, masses, tenderness
Inspection	Cavus, planus, deformity, hallux valgus, hammertoes, callus, corn, ulceration, inflammation, general alignment, masses, length pattern (nails: See Integumentary examination)
Special tests (maximum of three)	Mulder's sign, Kelikian's push-up test, Tinel's sign, Vallieux's sign

Musculoskeletal	
Examination Item	Examples
Spine	
General	
Reflexes	See Neurologic Examination
Sensation	See Neurologic Examination
Vascular	Carotid pulse
Inspection	Lordosis, scoliosis, kyphosis, alignment, scapular elevation, gibbus, head, tilt/torticollis
Other examination (specify)	
Cervical	
Range of motion	Flexion, extension, rotation, lateral tilt
Palpation	Crepitation, spinous process tenderness, paraspinal spasm, trigger points, masses
Cervical Strength/stability	Axial compression, flexion, extension, rotators
Peripheral Motor Skills	See Neurologic Examination
Special tests (maximum of three)	L'Hermitte's, Spurling's, root tension signs
Thoracic	
Range of motion	Side bend, shoulder on pelvis, respiratory excursion, flexion/extension, rotation
Palpation	Spinous process tenderness, paraspinal spasm, trigger points, precussive/CVA, costal tenderness, masses
Strength/stability	Sitting strength, abdominal, extensors, strength on movement

Musculoskeletal	
Examination Item	Examples
Spine	
Costal Cage	
Range of motion	Diaphragmatic motion, inhalation/exhalation excursion, flexion, extension, lateral bending, rotation
Palpation	Costochondral junction, sternum, sternoclavicular and sternochondral joints, body of ribs, spinous and transverse process tenderness, paraspinal and intercostal muscle spasm and tenderness, myofascial trigger points, curvature(s), masses, pectoral girdle
Strength/stability	Torso strength flexion, extension, lateral bending, rotation, accessory muscles of respiration, dislocations, ankylosis
Special tests (maximum of three)	Rib compression, sternum compression, measurement of respiratory excursion
Lumbar	
Range of motion	Shoulder on pelvis, flexion/extension, lateral flexion, rotation, ankylosis, respiratory excursion, gait
Palpation	Spinous process and transverse process tenderness, paraspinal muscle spasm(s), myofascial trigger points, curvature(s), facet pain, percussive/CVA, ligament tenderness, swelling, masses
Strength/stability	Sitting strength: flexors, extensors, abdominal, lateral flexion, active and passive instability, hypo- and hypermobility, gait

Musculoskeletal	
Examination Item	Examples
Spine	
Lumbar	
Special tests (maximum of three)	Root tension signs, straight leg raise, Lesegue, bowstring, femoral stretch, Kernig, Milgram, Naffziger
Sacroiliac (Includes Sacrum and Coccyx)	
Range of motion	Seated and standing flexion, extension, lateral flexion, rotation, ankylosis, respiratory excursion, coccyx, gait
Palpation	Spinous process tenderness, sacroiliac joint swelling and pain, parapsinal muscle spasms, piriformis and gluteal spasm(s) and pain, myofascial trigger points, curvature(s), masses, coccyx and ligament tenderness, ischial tuberosities and ilia
Strength/stability	Sitting strength: flexors, extensors, lower abdominal, lateral flexion; active and passive instability, hypo- and hypermobility, gait
Special tests (maximum of three)	Pelvic rock, Gaineslen's, Beevor's, FABRE, Patrick's, Hoover
Other examination (specify)	

Neurologic	
Examination Item	Examples
General	
Provocative testing	Adson, Laseque, Patrick, Tinel, Phalen, Kernig or Brudzinski
Glasgow coma scale (components may not be counted separately)	Counts as three items
Special tests (maximum of three)	ASIA scale, Rancho level
Mental status	See Psychiatric/Mental Status Examination
Other examination (specify)	
Cranial Nerve	
Test cranial nerve I	Smell
Test visual acuity	See Eye Examination
Test visual fields	See Eye Examination
Test pupillary reflexes	Light and accommodation reflexes, anisocoria, margin irregularity
Ophthalmoscopic examination of optic discs and posterior segments through undilated pupils	See Eye Examination
Test cranial nerves III, IV & VI	Saccades, pursuit, ocular range of motion and dysmetria, visual tracking (neonates), doll's eye maneuver (coma)
Test cranial nerve V	Facial sensation, muscles of mastication, jaw jerk
Test cranial nerve VII	Facial muscle strength and atrophy, taste discrimination
Test cranial nerve VIII	Limits of hearing whispers, soft noises, nystagmus
Test cranial nerve IX	Palate movement and gag reflex, pharyngeal sounds

Neurologic	
Examination Item	Examples
Cranial Nerve	
Test cranial nerve X	Phonation duration and consistency
Test cranial nerve XI	Sternocleidomastoid, trapezius strength and atrophy
Test cranial nerve XII	Lingual atrophy, fasciculations, strength
Motor and Movement	
Upper extremity motor exam (unilateral)	Proximal and distal arm strength, mass, tone, drift test
Lower extremity motor exam (unilateral)	Proximal and distal leg strength, mass, tone
Examine for abnormal movements	Tremor, fasciculations, adventitious movements
Examine upper extremity coordination	Finger-nose-finger, finger-object, rapid alternating movements, rebound
Examine lower extremity coordination	Heel-knee-shin, rapid alternating movements
Examine gait and station	Gait, associated movements, Romberg test, tandem gait-and truncal stability
C5 muscle testing	Strength testing of rhomboids, supraspinatus, deltoid, biceps, or brachioradialis
C6 muscle testing	Strength testing of biceps, brachioradialis, supinator, or extensor carpi radialis longus

Neurologic	
Examination Item	Examples
Motor and Movement	
C7 muscle testing	Strength testing of triceps, latissimus dorsi, extensor carpi radialis longus, or extensor digitorum
C8 muscle testing	Strength testing of triceps, abductor pollicis longus, flexor digitorum profundus, or flexor pollicis longus
L1-3 muscle testing	Strength testing of ilio-psoas, sartorius, adductors, or quadriceps
L4 muscle testing	Strength testing of quadriceps, tibialis anterior, or tibialis posterior
L5 muscle testing	Strength testing of hamstrings, gluteus maximus, tibialis anterior, peroneus longus, extensor digitorum longus, or extensor hallucis longus
S1 muscle testing	Strength testing of gastrocnemius, hamstrings, gluteus maximus, peroneus longus, or extensor digitorum brevis
Test sacral function	Test perineal and/or perianal sensation, or rectal tone
Sensory	
Examine pin prick, pain sensation, temperature sensation	Describe response to pin prick and/or pain sensation, and/or temperature sensation, test one extremity
Examine light touch sensation	Describe response to light touch sensation and/or two point perception, test one extremity
Examine discriminative sensation	Measure vibration, sense, position sense, or two-point discrimination; test one extremity
Examine cortical sensory integration	Extinction, graphaesthesia, or stereognosis

Neurologic	
Examination Item	Examples
Reflexes	
Examine upper extremity deep tendon reflexes	Bilateral biceps, triceps, and brachioradialis deep tendon reflexes
Examine lower extremity deep tendon reflexes	Bilateral patellar, Achilles deep tendon reflexes
Examine plantar reflexes	Bilateral plantar responses (eg, Babinski, Chaddock)
Examine superficial reflexes	Abdominal, cremasteric reflexes, anal wink
Examine frontal release reflexes	Glabellar, snout, palmomentar reflexes, grasp reflex
Pediatric Neurologic	
Developmental Assessment of Infants	
Gross motor function	Head control, rolling over, sitting when placed, sitting on own, crawling, pull to stand, stand with support
Fine motor function	Reaching, taking objects in hand, transfer objects, finger feeding, pincer grasp
Language function	Coo, babble, turns to voice, consonants, words, phrases, responds to commands such as no or stop
Personal — social	Smiles, laughs, plays peek-a-boo, pat-a-cake, waves bye-bye
Developmental Assessment of Reflexes	
Trunk and neck	Moro, Landau, tonic neck, truncal incurvation, shoulder traction, head control
Extremities	Palmer grasp, plantar grasp, weight bearing on legs, vertical suspension, parachute
Oro-motor	Suck, root

Neurologic	
Examination Item	Examples
Developmental assessment of Pre-School Children	
Gross motor function	Opens doors, climb stairs, descend stairs, ride a tricycle, bicycle, stand on one foot, jump, throw ball overhead
Fine motor function	Spoon/fork/cup use, scribble, draw, color, use crayon, stack cubes, copy circle, draw vertical line, draws a man
Language function	Point to body part, name picture, recognize colors, follow simple directions, comprehend prepositions, use sentences
Personal — social	Removes clothes, puts on clothes, washes hands, plays interactive games, helps with simple tasks
Other examination (specify)	

Psychiatric/Mental Status	
Examination Items	Examples
Assessment of characteristics of speech	Rate, volume, articulation, coherence and spontaneity
Assessment of language	Echolalia
Assessment of thought process	Rate of thoughts, content of thoughts (logical tangential, computation)
Assessment of insight	Understanding of situation, understanding that he/she has an illness and needs treatment
Assessment of judgment	Cares for own needs, understands consequences of own behavior
Assessment of reliability	Veracity and/or ability to report on his/her situation accurately
Assessment of abstract reasoning	Proverb interpretation
Assessment of current thoughts and perceptions	Spontaneously expressed worries, concerns, hallucinations, delusions, obsessions, compulsions
Assessment of suicidality	Suicidal thoughts, past history of attempts
Assessment of violence	Violent or homicidal thoughts, triggers, history of violent/assaultive behaviour
Assessment of mood and affect	Depression, anxiety, agitation/ amount and range of expression (eg, lability, flatness)
Assessment of orientation	Time, place, person
Assessment of memory	Recent/remote
Assessment of attention and concentration	Serial sevens, three-step commands
Assessment of intelligence	Awareness of current events, past history, vocabulary
Mini-mental status examination (components may not be counted separately)	Counts as three items
Other examination (specify)	

Medical Decision Making

CPT describes four levels of medical decision making. For purposes of documentation, three levels are considered:

- ⇒ Low complexity (encompasses straightforward complexity)
- ⇒ Moderate complexity
- ⇒ High complexity

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as reflected by:

- The scope of the presenting problem(s), number of diagnoses considered, and/or risk of complications, morbidity or mortality.
- Diagnostic procedures/tests ordered and/or the amount of data to be obtained or reviewed.
- Management options considered.

The following table has been prepared to reflect the differences in physician work associated with common courses of diagnosis, review, and/or treatment decisions. This table is provided to assist physicians in selecting the level of medical decision making that most closely resembles their own, in terms of the physician work involved. By definition, therefore, this table is not all-inclusive.

For physicians to make use of the table, they should choose the level of medical decision making by determining the best analogy between the specific clinical encounter they are coding and the closest generic example described in the table. The table is intended to present a range of examples involving medical decision making. Many examples are not specifically represented. **The highest level of any one of the three aspects of medical decision making will determine the overall complexity level chosen for coding purposes.**

- ⇒ The amount of data to be obtained or reviewed describes the range of information pertaining to the specific encounter being coded and may include old records and charts, patient diaries and old and new diagnostic studies. It includes the time necessary to personally review and summarize such written information and diagnostic studies (imaging, histology etc) and to discuss such information during the encounter with other health care professionals as needed to make the medical decisions.
- ⇒ The assignment of diagnostic tests or management options to low, moderate, or high complexity of medical decision making relates to the E/M service associated with the procedure, not to the inherent physician work of the test or procedure itself. The determination of the risk(s) to the patient of management option risk(s) is an important aspect of medical decision making during E/M services.

If the complexity of a clinical situation is not inclusive of the examples given in the table, then the level of medical decision making should be easily inferred if not explicitly documented in the medical record.

Medical Decision Making — LOW		
Scope of presenting problem, number of diagnoses considered and/or risk of complications, morbidity or mortality	Diagnostic procedures/tests ordered and/or amount of data to be obtained or reviewed	Management options considered
<p>One or two self-limited problem(s) or symptom(s)</p> <p>One stable chronic illness or problem</p> <p>Acute self-limited uncomplicated illness or injury</p> <p>Risk of complications, morbidity, or mortality is low</p>	<p>Non-invasive or minimally invasive lab tests (urinalysis, venipuncture, KOH, etc)</p> <p>Non-invasive diagnostic procedures (EEG, ECG, ultrasound, echocardiogram)</p> <p>Physiologic tests not under stress</p> <p>Non-cardiovascular imaging studies without IV or intrathecal contrast (eg, upper GI, barium enema, voiding cystourethrogram)</p> <p>Skin biopsy</p> <p>Superficial needle biopsy</p> <p>Arterial puncture</p>	<p>Rest or exercise, diet, stress management</p> <p>Medication management with minimal risk</p> <p>Referrals not requiring detailed discussion or detailed care plan</p>

Medical Decision Making — MODERATE		
Scope of presenting problem, number of diagnoses considered and/or risk of complications, morbidity or mortality	Diagnostic procedures/tests ordered and/or amount of data to be obtained or reviewed	Management options considered
<p>Three or more or self-limited problems</p> <p>One or more chronic mild and/or self-limited problem(s) with ongoing activity (active problem) mild to moderate exacerbation, progression, or side effects of treatment</p> <p>Two or three stable chronic illnesses or problems requiring evaluation</p> <p>Undiagnosed new illness, injury, or problem with uncertain prognosis</p> <p>Risk of complications, morbidity or mortality is moderate. There may be an uncertain prognosis or the possibility of prolonged functional impairment with or without treatment.</p>	<p>Physiological tests under stress (eg, exercise, pharmacologic stress)</p> <p>Endoscopy for average risk patient (eg, stable vital signs, non-critical illness)</p> <p>Deep needle/incisional biopsy</p> <p>Interventional cardiovascular or radiologic procedure for average risk patient (eg, stable condition, low risk procedure)</p> <p>Percutaneous removal of body cavity fluid</p> <p>Data to be obtained/reviewed requiring at least 10 minutes of physician time</p> <p>IV contrast imaging</p> <p>Therapeutic or diagnostic spinal/nerve injections</p>	<p>Referrals requiring detailed discussion or detailed care plan</p> <p>Management of medications with moderate risk requiring detailed discussion, detailed assessment for side effects, or limited laboratory monitoring (eg, digoxin, warfarin;IV heparin, IV antiarrhythmics beyond first day)</p> <p>Surgery or procedure with ASA 1 risk status</p> <p>Discussion for psychotherapy and/or counseling</p> <p>Arranging hospitalization for non-critical illness/injury</p> <p>Initiation of total parenteral nutrition</p> <p>Referral for comprehensive pain management rehabilitation</p>

Medical Decision Making — HIGH		
Scope of presenting problem, number of diagnoses considered and/or risk of complications, morbidity or mortality	Diagnostic procedures/tests ordered and/or amount of data to be obtained or reviewed	Management options considered
<p>One or more acute or chronic illnesses or problems with severe exacerbations</p> <p>Four or more stable chronic illnesses or problems requiring evaluation</p> <p>Acute complicated injury with significant risk of morbidity or mortality</p> <p>One or more acute or chronic illnesses or problems that pose imminent threat to life or bodily function</p> <p>Abrupt change in bodily function (eg, seizure, CVA, acute mental status change)</p> <p>The risk of complications, morbidity, or mortality is high. There is a possibility of significant prolonged functional impairment.</p>	<p>Intra-arterial cerebral angiography (excludes MRA)</p> <p>Data to be obtained/reviewed requiring at least 20 minutes of physician time</p> <p>Endoscopy for high risk patient (eg, therapeutic endoscopy for bleeding, unstable vital signs, critical illness)</p> <p>Interventional cardiovascular or radiologic procedure for high risk patient (eg, unstable condition)</p>	<p>Emergency hospitalization</p> <p>Medications requiring intensive monitoring, bearing untoward risks of serious morbidity if adverse effects occur (eg, initiation of IV heparin, IV antiarrhythmics; antineoplastics)</p> <p>Surgery or procedure with ASA 2 or higher risk status</p> <p>Decision not to resuscitate or to de-escalate care because of poor prognosis</p> <p>Mechanical ventilator management</p>

Document

In most instances, medical decision making can be inferred from a properly documented medical record. It is not necessary to note the kind of decision making (ie, low, moderate, high).

If medical decision making complexity cannot readily be inferred from the usual documentation, then other clinically relevant information should be documented or appropriately referenced.

Counseling and/or Coordination of Care/Unusual Methods of Communication or Sources of Information

When more than half of the face-to-face (office or other outpatient) or floor/unit time (hospital or nursing facility) is spent with the patient providing counseling or coordination of care, the CPT code may be selected based on the total time of the face-to-face or floor/unit time of the encounter.

Assessment of certain patients' history may require unusual methods of communication or sources of information. Examples include developmental disability, dementia, language barrier, communication impairment, or prolonged efforts to contact sources of medically necessary information. This situation qualifies for using time as an exception to the usual guidelines for code selection. If the time involved in these efforts exceeds more than half of the face-to-face (office or other outpatient) or floor/unit time (hospital or nursing facility) spent during the encounter, the CPT code may be selected based on the total time of the encounter.

Document

⇒ Length of time of the encounter and/or of the time spent in counseling or coordination of care, or in obtaining historical information for patients with communication barriers

⇒ Situations related to communication barriers that required unusual time (brief notation)

(Relevant history, exam, and medical decision making, if performed, should also be noted in the patient's record.)

Select the code

Select the CPT code based on the total face-to-face (office/outpatient) OR floor/unit time (hospital/nursing facility). The following charts show the total time for the most commonly used categories of codes:

Office or Other Outpatient Services New Patient	Total Time of Face-to-Face Encounter
99201	Typically 10 minutes
99202	Typically 20 minutes
99203	Typically 30 minutes
99204	Typically 45 minutes
99205	Typically 60 minutes

Office or Other Outpatient Services Established Patient	Total Time of Face-to-Face Encounter
99211	Typically 5 minutes
99212	Typically 10 minutes
99213	Typically 15 minutes
99214	Typically 25 minutes
99215	Typically 40 minutes

Initial Hospital Inpatient Service	Total Floor/Unit Time
99221	Typically 30 minutes
99222	Typically 50 minutes
99223	Typically 70 minutes

Subsequent Hospital Care	Total Floor/Unit Time
99231	Typically 15 minutes
99232	Typically 25 minutes
99233	Typically 35 minutes