Office or other outpatient visit for the evaluation and management of an established patient, which requires two of these three key components:

- An expanded problem focused history
- An expanded problem focused examination
- Medical decision making of low complexity

Documentation to support this service should include, but is not limited to the following: Medicare allows only the medically necessary portion of the visit. Even if a complete note is generated, only the necessary services for the condition of the patient at the time of the visit can be considered in determining the level of an E/M code.

**HPI – History of Present Illness**

A chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present.

- It should include the following elements: Location, Severity, Context Modifying Factors, Quality, Timing, Associated signs/symptoms
- Brief and extended HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problems.
- A brief HPI consists of one to three elements of the HPI; the medical record should describe one to three elements of the present illness (HPI)
- An extended HPI consists of:
  - Four or more elements of the HPI; the medical record should describe four or more elements of the present illness (HPI) or associated comorbidities, or
  - The status of at least three chronic or inactive conditions

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<th>Expanded problem focused history includes:</th>
<th>Expanded problem focused physical exam includes:</th>
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<tr>
<td>• Chief complaint</td>
<td>• Limited exam of the affected body region or organ system</td>
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<tr>
<td>• Brief history of present illness</td>
<td>• Symptomatic/related body systems or organ systems</td>
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<td>• Problem pertinent review of systems</td>
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**Medical Decision Making of LOW Complexity**

Medical Decision Making of LOW complexity involves 2 of the 3 below:

1. Limited management options for diagnosis or treatment
2. Limited amount of data to be reviewed
3. Low risk of complications and/or morbidity

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<th>Limited amount of data to be reviewed consist of:</th>
<th>Low risk of complications and/or morbidity or mortality:</th>
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<tr>
<td>• Lab results</td>
<td>• Comorbidities associated with the presenting problem</td>
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<tr>
<td>• Diagnostic &amp; imaging results</td>
<td>• Risk(s) of diagnostic procedures(s) performed</td>
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<tr>
<td>• Other practitioners’ notes/charts</td>
<td>• Risk(s) associated with possible management options</td>
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<td>(e.g. PT, OT, consulting physicians)</td>
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This Fact Sheet is for informational purposes only and is not intended to guarantee payment for services, all services billed to Medicare must meet Medical Necessity. The definition of “medically necessary” for Medicare purposes is located in Section 1862(a)(1)(A) of the Social Security Act – Medical necessity (http://www.ssa.gov/OP_Home/ssact/title18/1862.htm). CPT only copyright 2018 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use.
Additional Information:

- When choosing CPT code 99213 as the appropriate E/M code for the patient’s visit, two of the above three key components must be met and MEDICALLY NECESSARY for the presenting problem.
- Comorbidities and other underlying diseases in and of themselves are not considered when selecting the E/M codes UNLESS their presence significantly increases the complexity of the medical decision making.
- Time criteria for each E/M are average/guidelines and NOT considered determining factors of E/M selection UNLESS counseling and coordination of care consist of GREATER than 50% of the visit – then time may be considered the key or controlling factor when selecting the level of service. If the practitioner chooses to use time as the determining factor: DOCUMENTATION OF TIME MUST BE PRESENT in the patient’s medical record.
- Always remember when sending records ALL entries must be dated and have a legible signature. When a signature is illegible, please provide a signature log or attestation. A missing or illegible signature will result in claim delays and possibly service denials.

References:

- CMS Medicare Program Integrity Manual (Pub 100-08), chapter 3, section 3.3.2.4: Signature Requirements (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf)