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

- An detailed history
- An detailed examination
- Medical decision making of moderate complexity

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. Descriptions of present illness may include:

- Location
- Quality
- Severity
- Timing
- Context
- Modifying factors
- Associated signs/symptoms significantly related to the presenting problem(s)

**Chief Complaint:** The Chief Complaint is a concise statement from the patient describing:

- The symptom
- Problem
- Condition
- Diagnosis
- Physician recommended return, or other factor that is the reason for the encounter

**Review of Systems:** An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

For purpose of Review of Systems the following systems are recognized:

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

**Past, Family, And/or Social History (PFSH):** Consists of a review of the following:

- Past history (the patient’s past experiences with illnesses, operations, injuries and treatments)
- Family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk)
- Social History (an age appropriate review of past and current activities)

**Detailed physical exam includes:**

Extended exam of the affected body region or organ system

For the purposes of examination the following body areas are recognized

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

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/OPP_Home/ssaact/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.
Medical Decision Making of MODERATE complexity involves 2 of the 3 below:

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

Moderate amount of data to be reviewed consist of:

- Lab results
- Diagnostic & imaging results
- Other practitioners' notes/charts (e.g., PT, OT, consulting physicians)
- Labs or diagnostics that need to be performed

Moderate risk of complications and/or morbidity or mortality:

- Comorbidities associated with the presenting problem
- Risk(s) of diagnostic procedures(s) performed
- Risk(s) associated with possible management options

Detailed physical exam includes (continued):

Symptomatic/related body systems or organ systems

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

Additional Information:

- Select the code for the service based upon the content of the service
  - Duration of the visit does NOT control the level of the service to be billed unless more than 50% of the face-to-face time (for non-inpatient service) or more than 50% of the floor time (for inpatient service) is spent providing counseling or coordination of care as described in CMS Publication 100-04 (link provided in reference section of this Fact Sheet)

- Practitioner’s choosing to use time as the determining factor:
  - MUST document time in the patient’s medical record.
  - Documentation MUST support in sufficient detail the nature of the counseling

- Code selection based on total time of the face-to-face encounter (floor time), the medical record MUST be documented in sufficient detail to justify the code selection.

- Face-to-face time refers to the time with the physician ONLY. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by other staff is NOT considered in selecting the appropriate level of service

- 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

- Please note that ALL services ordered or rendered to Medicare beneficiaries MUST be signed. Signatures may be handwritten or electronically signed; exceptions for stamped signatures are described in MLN Matters article MM8219. ([http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf)) You should NOT add late signatures to a medical record but instead make use of the signature authentication process outlined in MLN Matters article MM6698. ([http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf)). A sample attestation statement is available on the CGS website

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Guidelines regarding signature requirements are located in CMS Publication 100-08, Chapter 3, section 3.3.2.4.

References:

- American Medical Association CPT (current procedural terminology) Codebook