1997 Physical Exam Bullets

Constitutional

- Three vital signs
- General appearance

Eyes

- Inspection of conjunctivae and lids
- Examination of pupils and irises (PERRLA)
- Ophthalmoscopic examination of discs and posterior segments

Ears, Nose, Mouth, and Throat

- External appearance of the ears and nose
- Otoscopic exam of the external auditory canals and TMs
- Assessment of hearing
- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx

Neck

- Exam of neck (masses, symmetry, tracheal position, crepitus)
- Examination of thyroid (masses, nodules, tenderness)

Respiratory

- Assessment of respiratory effort
- Percussion of chest
- Palpation of chest (tactile fremitus)
- Auscultation of the lungs

Chest (Breasts)

- Inspection of the breasts
- Palpation of the breasts and axillae

Cardiovascular

- Palpation of the heart (PMI)
- Auscultation of the heart
- Assessment of lower extremity edema
- Examination of the carotid arteries
- Examination of abdominal aorta
- Examination of the femoral pulses
- Examination of the pedal pulses

Gastrointestinal (Abdomen)

- Examination of the abdomen (masses or tenderness)
- Examination of the liver and spleen
- Examination for the presence or absence of hernias
- Examination of anus, perineum, and rectum
- Obtain stool for occult blood testing if indicated

Genitourinary (Male)

- Examination of the scrotal contents (tenderness of cord, testicular mass)
- Examination of the penis
- Digital rectal examination of the prostate

Genitourinary (Female)

- Examination of the external genitalia
- Examination of the urethra
- Examination of the bladder (fullness, masses, tenderness)
- Examination of the cervix
- Examination of the uterus (size, contour, position, mobility)
- Examination of the adnexa (masses, tenderness, nodularity)

Lymphatic: Palpation of lymph nodes in **two** or more areas:

- Neck
- Groin
- Axillae
- Other (e.g., extremities)

Skin

- Inspection of skin and subcutaneous tissue (rashes, lesions, ulcers)
- Palpation of the skin and subcutaneous tissue (induration, subcutaneous nodules, tightening)

Musculoskeletal

- Examination of gait and station
- Inspection and/or palpation of digits and nails (clubbing, cyanosis, ischemia)

Examination of the joints, bones, and muscles of one or more of the following six areas:

1) Head and neck
2) Spine, ribs, and pelvis
3) Right upper extremity
4) Left upper extremity
5) Right lower extremity
6) Left lower extremity

The examination of a given area may include:

- Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
- Assessment of range of motion with notation of any pain, crepitation or contracture
- Assessment of stability with notation of any dislocation, subluxation, or laxity
- Assessment of muscle strength and tone with notation of any atrophy or abnormal movements

Neurologic

- Test cranial nerves with notation of any deficits
- Examination of DTRs with notation of abnormal reflexes
- Examination of sensation (touch, pin-prick, vibration, proprioception)

Psychiatric

- Description of patient's judgment and insight

Brief assessment of mental status, which may include:

- Orientation to time, place, and person
- Recent and remote memory
- Mood and affect

Coding Based on Time

*When coding based on TIME, you MUST spend the entire allotted time face-to-face with the patient AND over half of that time must have been devoted to counseling and/or coordination of care. Time spent must be documented.

Critical Care Services

Critical care is the direct delivery by a physician of medical care for any critical illness which acutely impairs one or more vital organ systems. Time spent on critical care services must be documented. Add up time spent within each calendar date in the unit or discussing care issues with the designated surrogate decision-maker or other treating physicians. Time spent does NOT need to be continuous.

Code 99291 for the first 30 minutes to 1 hour of critical care
Code 99292 for each additional 30 minutes of critical care

A 30 minute threshold is required for the first hour of critical care. A 15 minute threshold is required for each successive half hour of critical care beyond the first hour.

Prolonged Services

Prolonged services are billed separately when a physician spends over 30 minutes above and beyond the time allotted for any E/M encounter. Time must be spent face-to-face with the patient but does NOT need to continuous within any calendar date. Time must be documented. These codes are reported *in addition* to standard E/M codes.

Code 99354 for the first 30 minutes to one hour of prolonged services in the outpatient setting. Code 99355 for each additional 30 minutes beyond the first hour.

Code 99356 for the first 30 minutes to one hour of prolonged services in the inpatient setting. Code 99357 for each additional 30 minutes beyond the first hour.

Observation/Observation & D/C

MDM	E/M	Hx	Exam	Time*
SF/Low	99218/99234	Det	Det	NA
Mod	99219/99235	Comp	Comp	NA
High	99220/99236	Comp	Comp	NA
Requires 3/3 key components				

Office (9924x) & Inpatient (9925x) Consults

MDM	E/M	Hx	Exam	Time*
SF	99241/99251	PF	PF	15/20
SF	99242/99252	EPF	EPF	30/40
Low	99243/99253	Det	Det	40/55
Mod	99244/99254	Comp	Comp	60/80
High	99245/99255	Comp	Comp	80/110
Requires 3/3 key components				

E/M UNIVERSITY

E/M Coding Guide

Rational Physician Coding Steps

1. Calculate Medical Decision-Making (MDM)
2. Identify target E/M code supported by MDM
3. Confirm medical necessity of history/exam
4. Perform and document required elements

For clinically-driven E/M coding education, visit us at www.EMuniversity.com or call us at 1-888-U-EM-CODE

New Office Patients

MDM	E/M	Hx	Exam	Time*
SF	99201	PF	PF	10
SF	99202	EPF	EPF	20
Low	99203	Det	Det	30
Mod	99204	Comp	Comp	45
High	99205	Comp	Comp	60
Requires 3/3 key components				

Established Office Patients

MDM	E/M	Hx	Exam	Time*
None	99211	None	None	5
SF	99212	PF	PF	10
Low	99213	EPF	EPF	15
Mod	99214	Det	Det	25
High	99215	Comp	Comp	40
Requires 2/3 key components				

Admission H&Ps

MDM	E/M	Hx	Exam	Time*
SF/Low	99221	Det	Det	30
Mod	99222	Comp	Comp	50
High	99223	Comp	Comp	70
Requires 3/3 key components				

Hospital Progress Notes

MDM	E/M	Hx	Exam	Time*
SF/Low	99231	PF	PF	15
Mod	99232	EPF	EPF	25
High	99233	Det	Det	35
Requires 2/3 key components				

Table of Risk

Stratify risk based on the presenting problems, diagnostic procedures or management options selected

Minimal Risk	Low Risk	Moderate Risk	High Risk
♦One self-limited or minor problem (e.g., cold, insect bite, tinea corporis) ♦Labs ♦EKG ♦EEG ♦CXR ♦UA ♦Ultrasound ♦Echo ♦KOH prep ♦Rest ♦Gargles ♦Elastic bandages ♦Superficial dressings	♦Two or more self-limited or minor problems ♦One stable chronic illness, (e.g., well controlled HTN, DM2) ♦Acute uncomplicated illness or injury (e.g., cystitis/rhinitis) ♦Physiologic tests without stress ♦Non-cardiovascular imaging with contrast ♦Skin or superficial needle biopsy ♦ABG ♦Over the counter drugs ♦Minor surgery without risk factors ♦PT/OT ♦IV fluids without additives	♦One or more chronic illness, with mild exacerbation or progression ♦Two or more stable chronic illnesses ♦Undiagnosed new problem with uncertain prognosis (e.g., lump in breast) ♦Acute illness with systemic symptoms (e.g., pyelonephritis, colitis) ♦Physiologic tests with stress ♦Endoscopy without known risk factors ♦Deep needle/incisional biopsy ♦Cardiovascular imaging with contrast without risk factors (arteriogram/cath) ♦Fluid from body cavity (LP, thoracentesis, paracentesis, etc.) ♦Prescription drug management ♦Minor surgery with risk factors ♦Elective major surgery without risk factors ♦IV fluids with additives ♦Closed treatment of fracture or dislocation	♦Chronic illness with severe exacerbation or progression ♦Illness with threat to life or bodily function (MI, ARF, PE) ♦Abrupt change in neurological status (TIA, weakness) ♦Cardiovascular imaging with contrast (arteriogram, cardiac cath) with risk factors ♦EP studies ♦Endoscopy with risk factors ♦Discography ♦Elective major surgery with risk factors ♦ Emergency surgery ♦Parenteral controlled substances ♦Drugs requiring intensive monitoring for toxicity ♦Decision for DNR or to de-escalate care

It only takes **ONE** item from the above table to qualify for any level of risk. Use highest risk present.

Medical Decision-Making Points

Problem Points	Pts
Self-limited or minor (maximum of 2)	1
Established problem, stable or improving	1
Established problem, worsening	2
New problem, no work-up planned (max of 1)	3
New problem, with additional work-up planned	4

Data Reviewed Points	Pts
Review/order clinical lab tests	1
Review/order X-rays (except heart cath or echo)	1
Review/order medical test (PFTs, EKG, echo, cath)	1
Discuss test with performing physician	1
Independent review of image, tracing, or specimen	2
Decision to obtain old records	1
Review and summation of old records	2

Overall Complexity of MDM

After determining Problem Points, Data Points and level of Risk, calculate complexity of MDM by referring to the following table:

MDM	Problem Pts	Data Pts	Risk
SF	1	1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4	4	High

Only **TWO** out of **THREE** qualifying components required for any given level of MDM complexity

MDM = medical decision-making, SF = straightforward, Mod = moderate, PF = problem focused, EPF = expanded problem focused, Det = detailed, E/M = evaluation and management code, D/C = discharge, Pts = points, PFSH = past medical, family and social history, ROS = review of systems, HENT = head, ears, nose, throat

History

Comprehensive: 4 elements of HPI* or the status of 3 chronic medical problems**, 10 system ROS, and complete PFSH (only 2/3 PFSH needed for office follow-up and ER visits)

Detailed: 4 elements of HPI* or the status of 3 chronic medical problems**, 2 - 9 ROS, plus **one** *pertinent* PFSH (PFSH NOT required for hospital progress notes)

Expanded Problem Focused: 1 - 3 elements of HPI* or status of 1 - 2 chronic medical problems**, plus 1 ROS

Problem Focused: 1 - 3 elements of HPI* or status of 1 – 2 chronic medical problems**

*HPI elements: location, quality, severity, duration, timing, context, modifying factors, associated signs or symptoms (use for ’95 OR ’97 E/M guidelines)
**For 1997 E/M guidelines only (NOT for ’95 rules)

Review of Systems

Constitutional	Eyes	Ears/Nose/Throat
Cardiovascular	Respiratory	Gastrointestinal
Genitourinary	Integumentary	Musculoskeletal
Psychiatric	Endocrine	Neurological
Hematologic/Lymphatic		Allergic/Immunologic

Physical Exam

1995 Exam Rules

Body Areas

♦Head/face
♦Neck
♦Chest/breast/axillae
♦Abdomen
♦Genitalia/groin/buttocks
♦Back/spine
♦Each extremity

Organ Systems

♦Constitutional
♦Eyes
♦ENMT
♦Cardiovascular
♦Respiratory
♦GI
♦GU
♦Musculo-skeletal
♦Skin
♦Neuro
♦Psychiatric
♦Hem-lymphatic

Problem Focused: a limited exam of affected body area or organ system
Expanded Problem Focused: a limited exam of the affected body area or organ system and other symptomatic or related organ systems
Detailed: an extended exam of the affected body area or organ system and other symptomatic or related organ systems
Comprehensive: a general multi-system exam or complete exam of a single organ system

1997 Exam Rules

Problem Focused: 1 to 5 bullets from any organ systems
Expanded Problem Focused: 6 to 11 bullets from any organ systems
Detailed: 12 bullets from any organ systems
Comprehensive: 2 bullets from EACH of 9 organ systems

See reverse side for bullets and organ systems

History Tips

1) A chief complaint is required for every encounter. It may be a symptom or a statement such as “follow-up HTN.”

2) The physician must always complete the HPI. However, it is acceptable to have the patient or a member of your staff fill out a questionnaire for the past medical, family, and social history (PFSH). However, to ensure credit for this information, you should initial the intake form and include any pertinent positive and negative items in the body of your note. You should also mention that you reviewed the form in its entirety. Finally, you must keep the questionnaire as a permanent part of the medical record.

3) You don’t have to list out the ROS; it is acceptable to have the patient fill out a form and then initial it, but that form must remain in the chart and you must refer to it in the body of your note. For example, “Complete 10 system ROS performed and documented, with pertinent findings included in the interval history.”

4) A Complete ROS requires that at least 10 systems be documented. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating “all other systems are negative” is permissible. *(Warning: Some Medicare carriers do NOT accept this shortcut.)*

5) When doing a comprehensive history on a follow-up patient in the office, you do not need to re-dictate a previous PFSH if one is already in the chart. It is acceptable to refer to the earlier PFSH and make any additions as needed. For example: “The comprehensive past medical, family, and social history obtained during our initial encounter was re-examined and reviewed with the patient. For details, please refer to my dictated note in this chart, dated September 23, 2003. Nothing more to add at this time.” Be sure to record the both the date and location of the previous note.

6) If the patient is too ill or confused to give a reliable history or ROS , you do not need to include this information in the documentation, but you must explain why the data is missing, e.g., “Unable to obtain ROS or PFSH due to patient’s mental status”

7) Only **2** out of **3** elements of PFSH are required to qualify for a Comprehensive History for established office patients, ER visits, and established domiciliary or home patients.

8) PFSH Exemption: hospital progress notes require only an interval history. These encounters are officially exempt from the requirement for any elements of PFSH. Therefore a level 3 hospital progress note (99233)--which requires a Detailed History--*does not* require documentation of any elements of PFSH