

<b>HISTORY</b>	Chief Complaint must be documented.	Problem Focused	Exp. Problem Focused	Detailed	Comprehensive
	HPI: __ Location __ Severity __ Timing __ Modifying Factor __ Quality __ Duration __ Context __ Associated sign/symptom	1-3	1-3	4+	4+
	Review of Systems: __ Constitutional __ Eyes __ ENMT __ Musculo __ Neuro __ Integumentary __ GI __ GU __ Cardio __ Resp __ Hem/Lymph __ Endo __ Psych __ Allergy/ Immuno	None	1	2-9	10+ or "All others reviewed & negative"
	__ Past History: medications, past illness, surgeries, allergies to meds __ Family History: medical events/disease in family __ Social History: marital status, education, use of drugs, tobacco, etc.	None	None	1	3*

\*Complete PFSH: 2 HX areas for Est pts. Office, Domiciliary, Home, Emergency Dept, Subseq Nursing Facility  
3 HX areas for New pts. Office, Consultation, Initial Hospital, Hospital Obs, Comp Nursing facility assessment

<b>95 EXAM</b>	Body Areas __Head/Face __Chest/Breast __Abdomen __Back/Spine __Neck __Genitalia/groin/buttocks __Extremities Organ Systems __Constitutional __Eyes __ENMT __CV __Resp __GI __GU __Skin __Neuro __Musculoskeletal __Psych __Hem/Lymph/Immuno	1 Area or Organ system	2-7 Areas &/or Organ systems	2-7 Areas &/or Organ Systems; 1 in Detail	8+ Organ Systems Only
	<b>97 EXAM</b> <b>ENMT</b> Bullets listed on back.	1-5 bullets	6+ bullets	12 bullets	All bullets in shaded borders & 1 in each unshaded

BOX A: Number Of Diagnosis or Management Options (N x P = R)				
Problems	Number	Points	Results	
Self-limited or minor (stable, improved or worsening)	Max = 2	1		
Est. problem: stable or improving		1		
Est problem: worsening		2		
New problem: no additional work-up planned	Max = 1	3		
New problem: additional work-up planned		4		
<b>Bring to line A in Final Result for MDM</b>			<b>Total</b>	
BOX B: Amount and/or Complexity of Data to be reviewed				Points
Review and/or order of clinical lab test				1
Review and/or order of tests in the radiology section of CPT				1
Review and/or order of tests in the medicine section of CPT				1
Discussion of test results with performing physician				1
Decision to obtain old records and/or obtaining history from someone other than patient				1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider				2
Independent visualization, tracing or specimen itself (not simply review of report)				2
<b>Bring to line B in Final Result for MDM</b>			<b>Total</b>	
BOX D: Final Result for Complexity of Medical Decision Making: 2 of 3 required				
A Number of diagnoses or management options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B Amount and complexity of data to be reviewed	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
C Risk of complications and/or morbidity or mortality	Minimal	Low	Moderate	High
TYPE OF DECISION MAKING	Straight Forward	Low Complexity	Moderate Complexity	High Complexity

BOX C: Risk of Complication and/or Morbidity or Mortality			
	Presenting Problems	Diagnostic Procedures ordered	Management Options Selected
MINIMAL	<ul style="list-style-type: none"> <li>1 self-limited or minor problem (eg. Cold, insect bite, tinea corporis)</li> </ul>	<ul style="list-style-type: none"> <li>Lab tests requiring venipuncture</li> <li>EKG/EEG</li> <li>Urinalysis</li> <li>Ultrasound</li> <li>X-RAYS</li> <li>KOH prep</li> </ul>	<ul style="list-style-type: none"> <li>Rest</li> <li>Gargles</li> <li>Elastic bandages</li> <li>Superficial dressings</li> </ul>
LOW	<ul style="list-style-type: none"> <li>2 or more self-limited or minor problems</li> <li>1 stable chronic illness</li> <li>Acute uncomplicated illness or injury</li> </ul>	<ul style="list-style-type: none"> <li>Physiologic test not under stress</li> <li>Non-cardiovascular imaging</li> <li>Superficial needle biopsies</li> <li>Clinical lab test requiring arterial puncture</li> <li>Skin biopsies</li> </ul>	<ul style="list-style-type: none"> <li>Over-the-counter drugs</li> <li>Minor surgery w/ no identified risk factors</li> <li>Physical therapy</li> <li>Occupational therapy</li> <li>IV fluids without additives</li> </ul>
MODERATE	<ul style="list-style-type: none"> <li>1 or more chronic illnesses w/mild exacerbation, progression or side effects of treatment</li> <li>2 or more stable chronic illnesses</li> <li>Undiagnosed new problem w/ uncertain prognosis</li> <li>Acute illness with systemic symptoms</li> <li>Acute complicated injury</li> </ul>	<ul style="list-style-type: none"> <li>Physiologic test under stress</li> <li>Diagnostic endoscopies w/no identified risk factors</li> <li>Deep needle or incisional biopsy</li> <li>Cardiovascular imaging studies w/contrast, no identified risk factors</li> <li>Obtain fluid from body cavity</li> </ul>	<ul style="list-style-type: none"> <li>Minor surgery with identified risk factors</li> <li>Elective major surgery w/o identified risk factors (any approach)</li> <li>Prescription drug management</li> <li>Therapeutic nuclear medicine</li> <li>IV fluids with additives</li> <li>Closed treatment of fracture or dislocation w/o manipulation</li> </ul>
HIGH	<ul style="list-style-type: none"> <li>1 or more chronic illnesses w/ severe exacerbation, progression, side effects of treatment</li> <li>Acute or chronic illnesses or injuries that pose a threat to life or bodily function</li> <li>Abrupt change in neurologic status</li> </ul>	<ul style="list-style-type: none"> <li>Cardiovascular imaging studies w/contrast w/ identified risk factors</li> <li>Cardiac electrophysiological tests</li> <li>Diagnostic endoscopies w/identified risk factors</li> <li>Discography</li> </ul>	<ul style="list-style-type: none"> <li>Elective major surgery w/ risk factors (any approach)</li> <li>Emergency major surgery (open, percutaneous or endoscopic)</li> <li>Parenteral controlled substances</li> <li>Drug therapy requiring intensive monitoring for toxicity</li> <li>Decision not to resuscitate or to de-escalate care because of poor prognosis</li> </ul>

System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> <li>• Measurement of <b>any three of the following seven</b> vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)</li> <li>• General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)</li> <li>• Assessment of ability to communicate (eg, use of sign language or other communication aids) and quality of voice</li> </ul>
Head and Face	<ul style="list-style-type: none"> <li>• Inspection of head and face (eg, overall appearance, scars, lesions and masses)</li> <li>• Palpation and/or percussion of face with notation of presence or absence of sinus tenderness</li> <li>• Examination of salivary glands</li> <li>• Assessment of facial strength</li> </ul>
Eyes	<ul style="list-style-type: none"> <li>• Test ocular motility including primary gaze alignment</li> </ul>
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> <li>• Otoscopic examination of external auditory canals and tympanic membranes including pneumotoscopy with notation of mobility of membranes</li> <li>• Assessment of hearing with tuning forks and clinical speech reception thresholds (eg, whispered voice, finger rub)</li> <li>• External inspection of ears and nose (eg, overall appearance, scars, lesions and masses)</li> <li>• Inspection of nasal mucosa, septum and turbinates</li> <li>• Inspection of lips, teeth and gums</li> <li>• Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx (eg, asymmetry, lesions, hydration of mucosal surfaces)</li> <li>• Inspection of pharyngeal walls and pyriform sinuses (eg, pooling of saliva, asymmetry, lesions)</li> <li>• Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords and mobility of larynx (Use of mirror not required in children)</li> <li>• Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae and eustachian tubes (Use of mirror not required in children)</li> </ul>
Neck	<ul style="list-style-type: none"> <li>• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)</li> <li>• Examination of thyroid (eg, enlargement, tenderness, mass)</li> </ul>
Respiratory	<ul style="list-style-type: none"> <li>• Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)</li> <li>• Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)</li> </ul>
Cardiovascular	<ul style="list-style-type: none"> <li>• Auscultation of heart with notation of abnormal sounds and murmurs</li> <li>• Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)</li> </ul>
Lymphatic	<ul style="list-style-type: none"> <li>• Palpation of lymph nodes in neck, axillae, groin and/or other location</li> </ul>
Neurologic/ Psychiatric	<ul style="list-style-type: none"> <li>• Test cranial nerves with notation of any deficits</li> </ul> <p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> <li>• Orientation to time, place and person,</li> <li>• Mood and affect (eg, depression, anxiety, agitation)</li> </ul>

### Content and Documentation Requirements

#### Level of Exam

Problem Focused

#### Perform and Document:

**One to five** elements identified by a bullet.

Expanded Problem Focused

**At least six** elements identified by a bullet.

Detailed

**At least twelve** elements identified by a bullet.

Comprehensive

Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.