Chief Complaint must be documented.		Exp. Problem Focused	Detailed	Comprehensive
HPI:LocationSeverityTimingModifying FactorQualityDurationContextAssociated sign/symptom	1-3	1-3	4+	4+
Review of Systems: ConstitutionalEyesENMTMusculoNeuroIntegumentaryGIGUCardioRespHem/LymphEndoPsychAllergy/ Immuno	None	1	2-9	10+ or "All others reviewed & negative"
Past History: medications, past illness, surgeries, allergies to medsFamily History: medical events/disease in familySocial History: marital status, education, use of drugs, tobacco, etc.				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

Body AreasHead/FaceChest/BreastAbdomenBack/SpineNeckGenitalia/groin/buttocksExtremities Organ SystemsConstitutionalEyesENMTCVRespGIGUSkinNeuroMusculoskeletalPsychHem/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
Hematologic/Lymphatic/Immunologic Bullets listed on back.	1-5 Bullets	6+ Bullets	12 Bullets	All bullets in shaded borders & 1 in each unshaded

BOX A: Number Of Diagn	osis or Mana	agemen	t Optio	ons (l	N x P = R	2)	
Problems			Numbe	per 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 wo	rk-up planned		Max =	1	3		
New problem: additional work-	up planned				4		
Bring to line A in Final Resul	t for MDM				Tota	ı	
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		
Bring to line B in Final Result for MDM Total				I			
BOX D: Final Result for Complexity of Medical Decision Making: 2 of 3 required							
A Number of diagnoses or management options B Amount and complexity of data to be reviewed C Risk of complications and/or morbidity or mortality	≤ 1 Minimal ≤ 1 Minimal	2 Limit 2 Limit	ted ted	M	3 ultiple 3 ultiple oderate		≥ 4 Extensive ≥ 4 Extensive High
TYPE OF DECISION MAKING	Straight Forward	Lor Compl	••		derate nplexity	0	High Complexity

BOX C: Risk of Complication and/or Morbidity or Mortality					
	Presenting Problems	Diagnostic Procedures ordered	Management Options Selected		
MINIMAL	1 self-limited or minor problem (eg. Cold, insect bite, tinea corporis	Lab tests requiring venipuncture EKG/EEG Urinalysis Ultrasound X-RAYS KOH prep	Rest Gargles Elastic bandages Superficial dressings		
MOT	2 or more self-limited or minor problems 1 stable chronic illness Acute uncomplicated illness or injury	Physiologic test not under stress Non-cardiovascular imaging Superficial needle biopsies Clinical lab test requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery w/ no identified risk factors Physical therapy Occupational therapy IV fluids without additives		
MODERATE	1 or more chronic illnesses w/mild exacerbation, progression or side effects of treatment 2 or more stable chronic illnesses Undiagnosed new problem w/ uncertain prognosis Acute illness with systemic symptoms Acute complicated injury	Physiologic test under stress Diagnostic endoscopies w/no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies w/contrast, no identified risk factors Obtain fluid from body cavity	Minor surgery with identified risk factors Elective major surgery (open, percut, or endoscopic) no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed treatment of fracture or dislocation w/o manipulation		
HIGH	1 or more chronic illnesses w/ severe exacerbation, progression, side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function Abrupt change in neurologic status	Cardiovascular imaging studies w/contrast w/ identified risk factors Cardiac eletrophysiological tests Diagnostic endoscopies w/indentified risk factors Discography	Elective major surgery (open, percut or endoscopic) w/ identified risk factors Emergency major surgery (open, percut, or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis		

System/Body Area	Elements of Examination
Constitutional	 Measurement of any three of the following seven 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) General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Eyes	Palpation and/or percussion of face with notation of presence or absence of sinus tenderness
Eyes	Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	 Otoscopic examination of external auditory canals and tympanic membranes Inspection of nasal mucosa, septum and turbinates Inspection of teeth and gums Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	 Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	 Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	 Auscultation of heart with notation of abnormal sounds and murmurs Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Gastrointestinal (Abdomen)	 Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen
Lymphatic	Palpation of lymph nodes in neck, axillae, groin, and/or other location
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, ecchymoses, bruises)
Neurologic/ Psychiatric	 Brief assessment of mental status including Orientation to time, place and person Mood and affect (eg, depression, anxiety, agitation)
	• wood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	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.