	Chief Complaint must be documented.	Problem Focused	Exp. Problem Focused	Detailed	Comprehensive
HISTORY	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

95 EXAM	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**
97 EXAM	**Genitourinary - Male** 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	
Bring to line A in Final Result for MDM		**Total**	

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**	

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	• 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
LOW	• 2 or more self-limited or minor problems • 1 staple 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)
Neck	• Exam of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Exam 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 • Exam of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Gastrointestinal	• Examination of abdomen with notation of presence of masses or tenderness • Examination for presence or absence of hernia • Examination of liver and spleen • Obtain stool sample for occult blood test when indicated
Genitourinary **MALE:**	• Inspection of anus and perineum Examination (with or without specimen collection for smears and cultures) of genitalia including: • Scrotum (eg, lesions, cysts, rashes) • Epididymides (eg, size, symmetry, masses) • Testes (eg, size, symmetry, masses) • Urethral meatus (eg, size, location, lesions, discharge) • Penis (eg, lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities) Digital rectal examination including: • Prostate gland (eg, size, symmetry, nodularity, tenderness) • Seminal vesicles (eg, symmetry, tenderness, masses, enlargement) • Sphincter tone, presence of hemorrhoids, rectal masses
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin and/or other location
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)
Neurological/ Psychiatric	Brief assessment of mental status including • Orientation (eg, time, place and person) and • Mood 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 12** 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.