		Problem Focused	Exp. Problem Focused	Detailed	Comprehensive
HISTORY	Chief Complaint must be documented.				
	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	**Skin** 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 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)
Eyes	• Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	• Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	• Examination of thyroid (eg, enlargement, tenderness, mass)
Cardiovascular	• Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)
Gastrointestinal (Abdomen)	• Examination of liver and spleen • Examination of anus for condyloma and other lesions
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	• Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities • Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, susceptibility to and presence of photo damage) in eight of the following ten areas: ◦ Head, including the face and ◦ Neck ◦ Chest, including breasts and axillae ◦ Abdomen ◦ Genitalia, groin, buttocks ◦ Back ◦ Right upper extremity ◦ Left upper extremity ◦ Right lower extremity ◦ Left lower extremity NOTE: For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and the left upper extremity constitutes two elements. • Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses or bromhidrosis
Neurologic/ Psychiatric	Brief assessment of mental status including • Orientation to time, place and person • 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 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.