

	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 ____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	1	2-9	10+ or "All others reviewed & negative"
		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	General Multi-System Bullets listed on back.	1-5 Bullets	6+ Bullets	2 bullets from 6 systems or 12 bullets in 2 or more systems	2 bullets in 9 systems

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

	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 • Obtain fluid from body cavity	• Physiologic test under stress • Diagnostic endoscopies w/o identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies w/contrast, no identified risk factors	• 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 electrophysiological tests • Diagnostic endoscopies w/identified 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Inspection of conjunctivae and lids Examination of pupils and irises (eg, reaction to light and accommodation, size and symmetry) Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> External inspection of ears and nose (eg, overall appearance, scars, lesions, masses) Otoscopic examination of external auditory canals and tympanic membranes Assessment of hearing (eg, whispered voice, finger rub, tuning fork) 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	<ul style="list-style-type: none"> Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	<ul style="list-style-type: none"> Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) Percussion of chest (eg, dullness, flatness, hyperresonance) Palpation of chest (eg, tactile fremitus) Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	<ul style="list-style-type: none"> Palpation of heart (eg, location, size, thrills) Auscultation of heart with notation of abnormal sounds and murmurs <p>Examination of:</p> <ul style="list-style-type: none"> carotid arteries (eg, pulse amplitude, bruits) abdominal aorta (eg, size, bruits) femoral arteries (eg, pulse amplitude, bruits) pedal pulses (eg, pulse amplitude) extremities for edema and/or varicosities
Chest (Breasts)	<ul style="list-style-type: none"> Inspection of breasts (eg, symmetry, nipple discharge) Palpation of breasts and axillae (eg, masses or lumps, tenderness)
Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> Examination of abdomen with notation of presence of masses or tenderness Examination of liver and spleen Examination for presence or absence of hernia Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses Obtain stool sample for occult blood test when indicated
Genitourinary	<p>MALE:</p> <ul style="list-style-type: none"> Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass) Examination of the penis Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness) <p>FEMALE:</p> <p>Pelvic examination (with or without specimen collection for smears and cultures), including:</p> <ul style="list-style-type: none"> Examination of external genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele) Examination of urethra (eg, masses, tenderness, scarring) Examination of bladder (eg, fullness, masses, tenderness) Cervix (eg, general appearance, lesions, discharge) Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)
Lymphatic	Palpation of lymph nodes in two or more areas: <ul style="list-style-type: none"> Neck Axillae Groin Other
Musculoskeletal	<ul style="list-style-type: none"> Examination of gait and station Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) <p>Examination of 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; and 6) left lower extremity. The examination of a given area includes:</p> <ul style="list-style-type: none"> Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions Assessment of range of motion with notation of any pain, crepitation or contracture Assessment of stability with notation of any dislocation (luxation), subluxation or laxity Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements
Skin	<ul style="list-style-type: none"> Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers) Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)
Neurologic	<ul style="list-style-type: none"> Test cranial nerves with notation of any deficits Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski) Examination of sensation (eg, by touch, pin, vibration, proprioception)
Psychiatric	<ul style="list-style-type: none"> Description of patient's judgment and insight <p>Brief assessment of mental status including:</p> <ul style="list-style-type: none"> orientation to time, place and person recent and remote memory mood and affect (eg, depression, anxiety, agitation)