

HISTORY - 1st KEY Component (MUST meet or exceed 3/3 history areas for a level of service) →	PROBLEM FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPREHENSIVE
HPI (History of Present Illness) elements: <input checked="" type="checkbox"/> Location <input type="checkbox"/> Severity <input checked="" type="checkbox"/> Timing <input checked="" type="checkbox"/> Modifying Factors <input type="checkbox"/> Quality <input type="checkbox"/> Duration <input checked="" type="checkbox"/> Context <input checked="" type="checkbox"/> Associated Signs & Symptoms	Brief 1-3 elements	Brief 1-3 elements	Extended ≥ 4 elements or status 3 + chronic/inactive conditions	Extended ≥ 4 elements or status 3 + chronic or inactive conditions
ROS (Review Of Systems): <input checked="" type="checkbox"/> Constitutional (wt. loss, etc.) <input type="checkbox"/> Ears, nose, mouth, throat <input type="checkbox"/> Eyes <input type="checkbox"/> GI <input type="checkbox"/> Integ. (skin, breast) <input type="checkbox"/> Endo <input type="checkbox"/> Hem/Lymph <input type="checkbox"/> GU <input checked="" type="checkbox"/> All/Imm <input checked="" type="checkbox"/> Card/Vas <input type="checkbox"/> Resp <input checked="" type="checkbox"/> Musc <input checked="" type="checkbox"/> Neuro <input type="checkbox"/> Psych <input type="checkbox"/> All others negative	None	Pertinent to problem 1 system	Extended 2-9 systems	Complete ≥ 10 systems OR 10+ systems with statement "all others negative"
PFSH (Past Medical, Family, Social History) areas: <input checked="" type="checkbox"/> Past history (the patient's past experiences with illnesses, operations, injuries and treatments) <input checked="" type="checkbox"/> Family history (a review of medical events in a patient's family, including diseases which may be hereditary or place the patient at risk) <input checked="" type="checkbox"/> Social history (an age appropriate review of past and current activities)	None	None	Pertinent 1 history area	Complete* 2 OR 3 history areas

If physician is unable to obtain history, the record should describe circumstances which identify the reason "why" it can NOT be obtained.

NO PFSH is required for: a) subsequent hospital care; b) follow-up in patient consults; c) Subsequent nursing facility care; d) Est. pts - Domiciliary, rest home & home

*Complete PFSH: 2 history areas: a) Established patient office (outpatient) care; domiciliary care; home care; b) Emergency department

3 history areas: a) New pt. office (outpatient) care; domiciliary care; home care; b) Consults; c) Initial hosp care; d) Hosp Observ. e) Comprehensive Nrsng facility Assessments

General Multi-system Exam::	← EXAMINATION → 2 nd KEY Component	Single Organ System Exams:
1-5 elements identified by •	PROBLEM FOCUSED	1-5 elements identified by •
≥ 6 elements identified by •	EXPANDED PROBLEM FOCUSED	≥ 6 elements identified by •
≥ 2 elements identified by • from 6 areas/systems OR ≥ 12 elements identified by • from at least 2+ areas/systems	DETAILED	≥ 12 elements identified by • EXCEPT..... Eye and Psychiatric exams ≥ 9 elements identified by •
≥ 2 elements identified by • from 9 areas/systems	COMPREHENSIVE	Perform all elements identified by • document all elements in shaded boxes; document ≥ 1 element in unshaded boxes

C) Risk of Complications and/or Morbidity/Mortality (Bring result to Line C in Final Result of MDM)

Medical Decision Making - 3rd KEY Component

A) Number of Diagnoses or Treatment Options

Number of Problems to Examiner	Number X Points=Result		
Self-limited or minor (stable, improved or worsening)	1		Max=2
Established problem (to examiner); stable, improved	1		
Established problem (to examiner); worsening	2		
New problem (to examiner); NO additional workup planned	2	3	3 Max = 3
New problem (to examiner); additional workup planned	4		

Bring total to Line A in Final Result for MDM TOTAL = 1

B) Amount and/or Complexity of Data to be Reviewed

Data to Be Reviewed and/or Ordered	Points
Review and/or order of clinical lab tests	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 obtain 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 of image, tracing or specimen itself (not simply review of report)	2

Bring total to Line B in Final Result of MDM TOTAL 2

FINAL RESULT OF MEDICAL DECISION MAKING

A	Number diagnosis or management options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Amount and Complexity of Data	≤ 1 Minimal or low	2 Limited	3 Moderate	≥ 4 Extensive
C	Highest Risk	Minimal	Low	Moderate	High
	Type of Decision Making	Straight-Forward	Low Complex	Moderate Complex	High Complex

(MUST meet or exceed 2/3 MDM areas for a level of service)

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
MINIMAL	• One self-limited or minor problem, e.g. cold, insect bite, tinea corporis	• Laboratory test requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g. echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW	• Two or more self-limited or minor problems • One stable chronic illness, e.g. well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress e.g. pulm. function tests • Non-cardiovascular imaging studies with contrast, e.g. barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
MODERATE	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • 2 or > stable chronic illnesses • Undiagnosed new prob. with uncertain prog. e.g. breast lump • Acute illness with systemic symptoms e.g. pneumonitis, pyelonephritis, colitis • Acute complicated injury e.g. head injury with brief loss of consciousness	• Physiologic tests under stress e.g. cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovasc. imaging studies with contrast and no identified risk factors, e.g. arteriogram, cardiac cath. • Obtain fluid from body cavity e.g. lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous, endoscopic) with no identified risk factor • Prescription drug management • Therapeutic nuclear medicine. • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
HIGH	• One or more chronic illnesses with severe exacerbation, progression, or side effects of tx • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g. multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to others, acute renal failure, peritonitis • An abrupt change in neurologic status, e.g. seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological test • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous 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

