

- *Expanded Problem Focused Examination* – should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- *Detailed Examination* – examinations other than the eye and Psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet (•), whether in box with a shaded or unshaded border.

Eye and Psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (•), whether in a box with a shaded or unshaded border.

- *Comprehensive Examination* – should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in each box with an unshaded border is expected.

## Content and Documentation Requirements

### General Multi-System Examination

| System/Body Area                    | Elements of Examination   |
|-------------------------------------|---|
| <b>Constitutional</b>               | <ul style="list-style-type: none"> <li>• Measurement of <b>any three of the following seven</b> 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)</li> <li>• General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)</li> </ul>   |
| <b>Eyes</b>                         | <ul style="list-style-type: none"> <li>• Inspection of conjunctivae and lids</li> <li>• Examination of pupils and irises (e.g., reaction to light and accommodation, size and symmetry)</li> <li>• Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)</li> </ul>   |
| <b>Ears, Nose, Mouth and Throat</b> | <ul style="list-style-type: none"> <li>• External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses)</li> <li>• Otoscopic examination of external auditory canals and tympanic membranes</li> <li>• Assessment of hearing (e.g., whispered voice, finger rub, tuning fork)</li> <li>• Inspection of nasal mucosa, septum and turbinates</li> <li>• Inspection of lips, teeth and gums</li> <li>• Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx</li> </ul> |
| <b>Neck</b>                         | <ul style="list-style-type: none"> <li>• Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)</li> <li>• Examination of thyroid (e.g., enlargement, tenderness, mass)</li> </ul>   |
| <b>Respiratory</b>                  | <ul style="list-style-type: none"> <li>• Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)</li> <li>• Percussion of chest (e.g., dullness, flatness, hyperresonance)</li> <li>• Palpation of chest (e.g., tactile fremitus)</li> <li>• Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)</li> </ul>   |
| <b>Cardiovascular</b>               | <ul style="list-style-type: none"> <li>• Palpation of heart (e.g., location, size, thrills)</li> <li>• Auscultation of heart with notation of abnormal sounds and murmurs</li> </ul> <p>Examination of:</p> <ul style="list-style-type: none"> <li>• carotid arteries (e.g., pulse amplitude, bruits)</li> <li>• abdominal aorta (e.g., size, bruits)</li> <li>• femoral arteries (e.g., pulse amplitude, bruits)</li> <li>• pedal pulses (e.g., pulse amplitude)</li> <li>• extremities for edema and/or varicosities</li> </ul>                             |

## Sample #1

### General Surgery Note, New Patient

This exercise dissects the history, examination and medical decision-making and applies the findings on the completed audit tool that is included at the end.

It is recommended you perform the audit also. You will need to copy pages 1 and 2 from the complete audit tool from Section 5. These two pages will be the audit tool you should complete as we go through this process.

#### History portion of note:

***This 37-year-old male is being seen with a complaint of left inguinal pain. The patient reports a several month history of left inguinal pain with a recent increase in severity. He describes the pain as a dull, aching pain which is moderate in severity and intermittent and seems to increase with activity or early in the morning. No history of prior hernia repair. Patient is diabetic and well controlled at this time. His only medication is insulin. No known allergies. Social history is significant for occasional alcohol use. Family history is negative. Patient denies chest pain or shortness of breath. The remainder of the 10-system review completed by the patient today is entirely negative.***

#### Auditing the History portion:

There is a chief complaint indicated.

#### HPI elements:

*This 37-year-old male is being seen with a complaint of left inguinal (**location**) pain. The patient reports a several month history (**duration**) of left inguinal pain with a recent increase in severity (**severity**). He describes the pain as a dull, aching pain (**quality**) which is moderate in severity (**severity**) and intermittent (**timing**) and seems to increase with activity or early in the morning (**timing**). No history of prior hernia repair. Patient is diabetic and well controlled at this time. His only medication is insulin. No known allergies. Social history is significant for occasional alcohol use. Family history is negative. Patient denies chest pain or shortness of breath. The remainder of the 10-system review completed by the patient today is entirely negative.*

Final HPI Result = > 4 HPI elements = **Extended HPI** (circle the extended farthest to the right)

#### ROS:

- Denies chest pain = cardiovascular
- Denies shortness of breath = respiratory
- Remainder of 10-system review = all others negative
- Note: Auditor must verify that forms are complete, appropriate and reviewed and signed by physician for credit to be given for a complete ROS.
- Final ROS Result = 10 systems for ROS = **Complete ROS** (circle complete)

# Appendix B:

## Mock Examination:

### E/M Auditing

1. In the history of present illness portion of the note, duration refers to the length of time the patient has been on prescription medications.  
 True  
 False
2. If the note reads: “For the past two days, the patient complains of sinus tenderness and a runny nose without fever”, what HPI elements are identified:
  - a. timing and location
  - b. duration and location
  - c. timing, location and severity
  - d. location, duration and associated signs/symptoms
3. “No clubbing, cyanosis or edema” is counted on the 1995 physical exam criteria as the musculoskeletal system:  
 True  
 False
4. Using the 1997 Documentation Guidelines, can the following statement be audited using the status of three chronic illnesses? “Patient returns for follow-up of diabetes, COPD and hypertension”  
 Yes  
 No
5. In auditing the physical exam portion of the note, how many system(s) are documented in the following statement? “Patient is AO x 3 with no focal deficits” \_\_\_\_\_
6. “No JVD” is counted as what organ system on the 1995 exam criteria? \_\_\_\_\_
7. “Examination of the abdomen revealed no tenderness and normal bowel sounds” counts as two bullets on the 1997 general multi-system exam criteria:  
 True  
 False
8. A patient is seen in the office and needs a minor laceration repair. If documentation additionally supports an E/M service, what modifier is needed? \_\_\_\_\_
9. Standing orders can be used for requesting consultations.  
 True  
 False