Evaluation and Management
Documentation Detail – Key Components

K1. History
• Chief Complaint
• History of Present Illness
• Past, Family, and Social History
• Review of Systems

Chief Complaint
• Only 1 level, but all levels of history require
• CC states the reason for the encounter
– May be from the provider perspective, e.g.,
• Main symptom(s)
• Follow up visit for …
– May be from the patient perspective, e.g.,
• "I cry too much."
• "My mother told me to come."

HPI
Description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present.
Elements:
• Location
• Quality
• Severity
• Duration
• Timing
• Context
• Modifying factors
• Associated signs and symptoms

HPI Example
The patient reports intermittent-1 emotional-2 problems of moderate -3 sadness -4 starting with a romantic breakup -5 six months ago -6, now more so when alone -7 and associated with poor sleep and appetite -8.
1. Timing
2. Location
3. Severity
4. Quality
5. Context
6. Duration
7. Modifying factors
8. Associated signs and symptoms

HPI Levels

• Brief
– 1-3 elements OR
– Status of 1-2 chronic or inactive conditions
• Extended
– 4 or more elements OR
– Status of at least 3 chronic or inactive conditions

Past, Family and/or Social History (PFSH)

1. Past history
   – Illnesses and/or Operations
   – Injuries
   – Treatments
2. Family history
   –Medical events in patient's family
3. Social history
   – Past and current activities
   Measure:

- Pertinent
  – Item from 1 area
- Complete
  – Item each from 2 areas (established patient)
  – Item each from all 3 areas (new patient)

Review of Systems

• Constitutional
• Eyes
• Ears, Nose, Mouth, and Throat
• Cardiovascular
• Respiratory
• Genitourinary
• Musculoskeletal
• Gastrointestinal
• Integumentary (skin and/or breast)
• Neurological
• Psychiatric
• Endocrine
• Hematologic and Lymphatic
• Allergic/Immunologic

Review of Systems

• Measure:

- *Problem pertinent*: System directly related to the problem(s) identified in the
HPI
- E*xtended*: 2-9 systems
- C*omplete*: 10 or more systems

– Document individually systems with positive or pertinent negative responses
– "All other systems reviewed and are negative" is permissible
– In the absence of such a notation, at least 10 systems must be individually documented

K2. Physical Examination

• Cardiovascular
• Ears, nose, mouth and throat
• Eyes
• Genitourinary (female)
• Genitourinary (male)
• Hematologic, Lymphatic, Immunologic
• Musculoskeletal
• Neurological
• Psychiatric
• Respiratory
• Skin

Psychiatric Exam
Constitutional (shaded box)

• Three vital signs:
– Sitting or standing blood pressure
– Supine blood pressure
– Pulse rate and regularity
– Respiration
– Temperature
– Height
– Weight
• General appearance of patient, e.g.:
– Development
– Nutrition
– Body habitus, deformities
– Attention to grooming

Psychiatric Exam
Musculoskeletal (unshaded box)

• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
• Examination of gait and station

Psychiatric Exam
Mental Status (shaded box)
• Speech
• Thought process
• Associations
• Abnormal or psychotic thoughts
• Judgment and insight
• Orientation
• Recent and remote memory
• Attention span and concentration
• Language
• Fund of knowledge
• Mood and affect

K3. Medical Decision Making
• Number of diagnoses or management options
• Amount and/or complexity of data to be reviewed
• Risk of complications and/or morbidity or mortality
2/3 elements must be met or exceeded

Number of Diagnoses or Management Options
• Based on
– Number or types of problems addressed during the encounter
– Complexity of establishing a diagnosis
– The management decisions that were made
• Other indicators
– Problem undiagnosed
– Number or types of tests ordered
– Need for consultation
– Problem worsening

Number of Diagnoses or Management Options

• Minimal
• Limited
• Multiple
• Extensive

Amount and/or Complexity of Data to be Reviewed
- Types of diagnostic tests ordered
- Review of old medical records
  - – Document the relevant findings
- History from other sources
  - – Document the relevant findings
- Discussion of test results with physician who interpreted the test

Amount and/or Complexity of Data to be Reviewed
- Minimal or None
- Limited
- Moderate
- Extensive

Risk of Significant Complications, Morbidity, and/or Mortality
- Based on risks associated with the presenting problem, diagnostic procedure, and the possible management options
- The highest level of risk in any one of these categories determines the overall risk.

T1. and T2. Counseling and/or Coordination of Care Exception
- Counseling and/or coordination of care is more than 50% of the time of the encounter
- Time becomes the controlling factor

– Face-to-face time for office visits
– Unit time for facility visits
- Document

– Length of time of the encounter and of the time spent in counseling and coordination of care
– The counseling and/or coordination of care activities