EVALUATION AND MANAGEMENT CHART REQUIREMENTS

Per CMS & AMA, Evaluation and Management Visits need the following elements documented in the patient's chart:

CC: HPI: Chronic Illness(s): ROS: PFSH: PE: MDM: A&P: SIGNATURE & DATE:

1) Chief Complaint (CC) – Clinical reason for visit

2) History of Present Illness (HPI)
   a. Location – Where the injury or pain is
   b. Duration – 3 days ago, Started, Since, Happened, Acute/Chronic, PTA
   c. Context – How it happened, what patient was doing prior
   d. Severity – Mild, moderate, Severe, 8 out 10 pain scale, Slightly, Extremely, Hurts a lot, degree of temp
   e. Quality – Pressure, Weakness, Tightness, Dull, Aching, Sharp, Pain, Congestion, Cramping, Burning, Dull, Radiating, Numbness, Wheezing, Like Prior
   f. Timing – Still present, Gone now, resolved, constant, waxing & waning, intermittent, off & on, Persistent
   g. Modifying Factors – Relieved by, Hx of, Exacerbated by, Seen previously, Took (meds) prior, Sick contacts (sibling sick), Homeless, Able to take po, TD up to date
   h. Signs & Symptoms – Any symptom not related to complaint
   i. Chronic problems – Risk Factors

3) Review of Systems (ROS) – As stated by the patient
   a. Constitutional
   b. Eyes
   c. ENT
   d. Cardiovascular
   e. Respiratory
   f. GI
   g. GU
   h. Musculoskeletal
   i. Skin/Hair/Nails
   j. Neurologic
   k. Psych
   l. Heme/Lymph/Immuno
   m. All other pertinent systems reviewed and are negative

4) Past/Family/Social History (PFSH)
   a. Past – Operations, Illness, Meds
   b. Family – Hereditary illness/death
   c. Social – Marital, Work, ETOH, Tobacco, Drugs

5) Physical Exam (PE) – as identified by the provider
   a. Constitutional: Conversant, well developed, in NAD
   b. Vitals: BP is 130/72, HR 72, RR 18
   c. Eyes: Anicteric sclerae: no lid-lag or proptosis
   d. ENT
   e. Cardiovascular: No peripheral edema
   f. Respiratory: Normal respiratory effort
   g. GI
   h. GU
   i. Musculoskeletal: No digital cyanosis. Normal gait and station.
   j. Skin/Hair/Nails: No rash, lesions or ulcers
   k. Neurologic: Cranial nerves II-XII grossly intact.
   l. Psych: Intact judgment and insight. A&OX3 with a cordial affect.
   m. Heme/Lymph/Immuno

6) Medical Decision Making (MDM)
   a. Current Problem List (diagnosis/signs/symptoms being addressed or that effect todays visit)
   b. Treatments and Therapeutic Options
      i. Prescriptions (medication management), changes in dosing, new RX, etc.
      ii. Referrals to other providers
      iii. Patient educated on self or home care
      iv. If continuing same or ongoing plan or treatment, document plan or treatment
   c. Data Reviewed or Ordered
      i. Order and/or review of Lab, Radiology, Medical section tests
      ii. Discuss case and or discuss test results with other providers
      iii. Document findings of other medical records reviewed or that they were ordered
      iv. Obtain history from someone other than the patient
      v. Independently visualize and report findings from images, tracings, pathologies

7. Assessment and Plan (A&P)

8. Sign and date chart to complete

a. Management Options

b. Time Based Visits require documenting what was counseled and/or coordinated. For example, test results and options. Chart must show " >50% of 40 minute visit was spent discussing.....

New Patient Visit	Typical Time (minutes)	Established Patient Visit	Typical Time (minutes)
99201	10	**99211**	5
99202	20	**99212**	10
99203	30	**99213**	15
99204	45	**99214**	25
99205	60	**99215**	40