Evaluation and Management Documentation Tips

Chief Complaint (CC)

DO	DON'T
Specify reason for the visit • *"Patient presents for follow-up evaluation of ankle sprain."*	Fail to specify reason for visit • *"Patient presents for follow-up."*
Specify who requested a consult and why • *"Consult requested by Dr. Jones for evaluation of chronic abdominal pain."*	Fail to specify as a consult (who requested and why). Imply referral or transfer of care • *"Patient referred by Dr. Jones."*

History of Present Illness (HPI)

DO	DON'T
Give specific details regarding the presenting illness • *"Patient presents for evaluation of left ankle pain. Slipped on ice yesterday. Felt a pop. Pain currently 6 of 10."*	Fail to give details regarding presenting illness. • *"Ankle pain."*
Document your own HPI	Reference a nurse, clinical tech, or medical student's HPI

Past Medical, Family, Social History (PFSH)

DO	DON'T
Give pertinent details from each history category • *"Patient has previous left ankle fracture." "Family history of type 2 diabetes." "Does not smoke or drink alcohol" "Full time nurse."*	Use terms such as unremarkable or noncontributory • *"Past medical history unremarkable." "Family history is noncontributory."*
Properly reference patient questionnaire or SMH 761 form. Include pertinent findings. • *"PFSH per patient questionnaire. Reviewed and confirmed. Details include previous left ankle fracture."*	Improperly reference patient questionnaire or SMH 761 form. • *"PFSH per patient questionnaire."* • *"See questionnaire."* • *"See 761 for details."*
Ensure patient questionnaire or SMH 761 has been properly completed. Personally complete any missing portions	Fail to review patient questionnaire or SMH 761 form. Fail to personally complete any missing portions
Sign/Initial and date patient questionnaire	Leave signature and date prompts on patient questionnaire blank

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Review of Systems (ROS)

DO	DON'T
Document pertinent findings • *"Recent fever and shortness of breath. No GI or GU issues."*	Use terms such as unremarkable or noncontributory • *"ROS unremarkable."* • *"ROS noncontributory."*
Properly reference patient questionnaire or SMH 761 form. Include pertinent findings. *"ROS per patient questionnaire. Reviewed and confirmed. Details include fever and shortness of breath."*	Improperly reference patient questionnaire or SMH 761 form. • *"ROS per patient questionnaire."* • *"See questionnaire."* • *"See 761 for details."*
When all pertinent findings are individually documented, use *"all other systems negative"* to indicate all remaining systems are negative • *"Recent fever and shortness of breath, all other systems negative."*	Use *"all other systems negative"* without individually documenting all pertinent findings • *"All systems negative."*
Ensure patient questionnaire or SMH 761 has been properly completed. Personally complete any missing portions	Fail to review patient questionnaire or SMH 761 form. Fail to personally complete any missing portions
Check individual box for each system when completing a template ROS category	Draw a single, straight line through multiple boxes for multiple systems
Sign/Initial and date patient questionnaire	Leave signature and date prompts on patient questionnaire blank

Physical Examination (PE)

DO	DON'T
Document the full extent of PE performed • *"Right knee is without effusion, Lachman is negative, and apprehension is negative. There is patellar facet tenderness greater on the left than the right. Forced flexion produces no increased symptoms. Hamstring flexibility is noted to be acceptable and strength is felt to be adequate. There is minimal pain at this point with resistance to extension."*	Only document highlights of PE performed • *"No effusion, some patellar facet tenderness."*
Include documentation of Constitution (e.g. vital signs, general appearance) • *"Well developed male in no apparent distress. Right knee is without…"*	Fail to include documentation of Constitution (e.g. vital signs, general appearance)
Clearly specify when a complete examination of a single organ system has been performed. • *"A complete neurological examination was performed. Details include…"*	Fail to specify when a complete examination of a single organ system has been performed

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Medical Decision Making (MDM)

DO	DON'T
Document the Medical Decision Making process • *"Mr. Doe is a 68 year old male with multiple comorbidities. He has a moderate size aneurysm. This does not currently require treatment but will in the future. Bilateral lower extremity claudication is his major problem which will require surgery. Endovascular intervention is not a good idea because of his aneurysm and total occlusion on the left. Open surgery would treat both of these problems…"*	Simply document the Medical Decision • *"Bilateral claudication. Surgery to be scheduled for next week."*
Include secondary diagnoses that effect MDM • *"Due to the patient's long history of atherosclerosis and high blood pressure, we will get a preoperative cardiac consult to ensure…"* • *"Due to the patient's diabetes, we will refrain from…"*	Fail to include secondary diagnoses that effect MDM
Document all ordered diagnostic procedures • *"Orders for CBC and metabolic profile as well as a chest x-ray were provided and are to be completed prior to next visit."*	Fail to document all ordered diagnostic procedures
Document independent review of image, tracing or specimen • *"Personally reviewed chest x-ray which showed…"*	Fail to specify independent review of image, tracing or specimen • *"Chest x-ray was negative."*
Document the review and summarization of old records • *"Records obtained from Dr. Jones which reveal…"*	Fail to summarize the review or old records • *"Records obtained from Dr. Jones."*
Document all management options selected • *"Patient instructed to use Advil as needed".* • *"Script for Zithromax provided to patient."* • *"Will inject knee today. See separate note for details."* • *"Lesion will be removed under local as an outpatient procedure."* • *"Reconstruction surgery scheduled for next week. Patient instructed that he will be required to stay approximately two days…"*	Fail to clearly document all management options selected • *"Meds discussed with patient."* • *"Surgery."*