

EVALUATION & MANAGEMENT WORKSHEET

Complete steps one, two, three, and four by selecting the appropriate level of each Key Component to determine the Evaluation & Management examination you have performed.

STEP ONE Determine the **History Level** obtained (Key Component #1).
To qualify for a given level, all elements listed for that level must be met or exceeded.

<input type="checkbox"/> 1. Problem-Focused	<input type="checkbox"/> 2. Expanded Problem-Focused	<input type="checkbox"/> 3. Detailed	<input type="checkbox"/> 4. Comprehensive
<ul style="list-style-type: none"> Chief complaint HPI: 1-3 elements 	<ul style="list-style-type: none"> Chief complaint HPI: 1-3 elements Ocular ROS 	<ul style="list-style-type: none"> Chief complaint HPI: 4 elements Ocular ROS PFSH: 1 specific item from at least 1 element ROS: 2-9 additional systems 	<ul style="list-style-type: none"> Chief complaint HPI: 4 elements Ocular ROS PFSH: <ul style="list-style-type: none"> New: 1 or more specific items from each element Established: 1 or more specific items from at least 2 elements ROS: 10 or more additional systems

STEP TWO Determine the **Examination Level** performed (Key Component #2).
To qualify for a given level, all elements listed for that level must be met or exceeded.

<input type="checkbox"/> 1. Problem-Focused	<input type="checkbox"/> 2. Expanded Problem-Focused	<input type="checkbox"/> 3. Detailed	<input type="checkbox"/> 4. Comprehensive
<ul style="list-style-type: none"> Eye exam: 1-5 elements documented Limited exam of the affected body area or organ system 	<ul style="list-style-type: none"> Eye exam: 6-8 elements documented Limited exam of the affected body area or organ system and/or other symptomatic organ systems 	<ul style="list-style-type: none"> Eye exam: 9-13 elements documented Complete exam of the affected body area or organ system and/or other symptomatic organ systems 	<ul style="list-style-type: none"> Eye exam: 14 elements documented Complete single system specialty exam Mental status documented

STEP THREE Determine the level of **Medical Decision-Making** required (Key Component #3).
To qualify for a given level, all elements listed for that level must be met or exceeded.

	<input type="checkbox"/> 1. Straightforward	<input type="checkbox"/> 2. Low Complexity	<input type="checkbox"/> 3. Moderate Complexity	<input type="checkbox"/> 4. High Complexity
Number of Diagnostic and Treatment Options	Minimal	Limited	Multiple	Extensive
Amount and Complexity of Data	Minimal	Limited	Moderate	Extensive
Risk of Complications and/or Morbidity/Mortality	Minimal	Low	Moderate	High (visual damage or loss of eye)

STEP FOUR: Identify the **LEVEL OF SERVICE**.

New Patient:
Must meet 2 of 3 in the column to bill for that code level.

	99201	99202	99203	99204	99205
History	1	2	3	4	4
Exam	1	2	3	4	4
Decision	1	1	2	3	4

Established Patient:
Must meet 2 of 3 in the column to bill for that code level.

	99211	99212	99213	99214	99215
History	0	1	2	3	4
Exam	0	1	2	3	4
Decision	0	1	2	3	4

Consult Patient:
Must meet or exceed 3 of 3 in the column to bill for that code level.

	99241	99242	99243	99244	99245
History	1	2	3	4	4
Exam	1	2	3	4	4
Decision	1	1	2	3	4

Note: This worksheet is designed only to assist physicians in determining the appropriate level of E/M service. The optometrist is ultimately responsible for understanding and complying with all coding rules.

Elements of History (Step One)

Chief Complaint (CC): A concise statement describing the symptom, problem, or condition usually stated in the patient's own words. A CC is described as:

Disease	Injury	Finding
Condition	Symptom	Complaint
Illness	Sign	Other reason for encounter

HPI (History of Present Illness): A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. The HPI may include a description of the:

Location: where on the body the symptom is occurring

Quality: the character of the symptom (e.g. Burning, throbbing, tingling, stabbing, and dullness)

Severity: ranking of symptom(s)/pain on a scale of 1-10 or with terms such as mild, moderate, severe, slight, or worst ever experienced

Duration: how long the symptom(s)/pain has been present or how long the patient experiences it

Timing: when the symptom(s)/pain occur

Context: the situation associated with the symptom(s)/pain

Modifying Factors: the things done to make the symptom(s)/pain worse or better

Associated Signs/Symptoms: what happens when symptom(s)/pain occur (e.g. headache leads to vision constriction)

Ocular ROS (Ocular Review of Systems): may include past history of eye diseases, surgeries, contact lenses, and solutions.

PFSH (Past, Family, and Social History):

Past History: review of patient's past experiences with illnesses, injuries, and treatment that includes significant information about:

Allergies	Current medications	Age appropriate immunization status and
Prior operations	Recent illnesses/injuries	feeding/diet
Prior hospitalizations		

Family History: review of medical history of patient's family that includes significant information about:

Health status or cause of death of parents, siblings, and children
Specific diseases related to the problem identified in the CC or HPI, including ROS
Diseases of family members that are hereditary or place the patient at risk

Social History: age appropriate review of patient's current activities, includes significant information about:

Marital status/living arrangements	Occupational history
Level of education	Other relevant social factors
Current employment	Use of drugs, alcohol, tobacco
Sexual history	

ROS (Review of Systems): an examination of body systems through a series of questions seeking to identify signs and/or symptoms the patient may be experiencing. The systems for review are:

Constitutional symptoms	Gastrointestinal	Psychiatric
Eyes	Genitourinary	Endocrine
Ears/nose/throat	Musculoskeletal	Hematologic/lymphatic
Cardiovascular	Infectious	Allergic/immunologic
Respiratory	Neurologic	

Elements of Exam (Step Two)

Visual acuity	Intraocular pressure	Neurologic (orientation to person, place, time)
Visual fields (confrontation)	Slit lamp exam, cornea	
Adnexa	Slit lamp exam, lens	
Motility	Slit lamp exam, anterior chamber	Psychiatric (mood & affect: anxiety, depression, agitation)
Pupils & irises	Optic nerve	
Bulbar/palpebral conjunctiva	Posterior segment	

Exam Types (Step Four)

New Patient:	A patient who has not received any professional services from the doctor, or another doctor of the same specialty who belongs to the same group, within the past three years
Existing Patient:	A patient who has received professional services within the past three years
Consultation:	A service provided by the doctor whose opinion/advice, regarding the evaluation and/or management of a specific problem, is required by another physician