

E&M AUDIT FORM

Patient Name	MR#	DOS
Provider	Insurance	Dept.

Type of Service			
INPATIENT		OUTPATIENT	
<input type="checkbox"/> Initial Hospital Care	99221-99223	<input type="checkbox"/> New	99201-99205
<input type="checkbox"/> Subsequent Hosp Care	99231-99233	<input type="checkbox"/> Established	99211-99215
<input type="checkbox"/> Initial Consult	99251-99255	<input type="checkbox"/> Consultation	99241-99245
<input type="checkbox"/> Discharge Services	99238-99239	<input type="checkbox"/> Emergency Care	99281-99285
<input type="checkbox"/> Critical Care	99291-99292 (time-based)	<input type="checkbox"/> Observation	99218-99220
<input type="checkbox"/> Nursing Home	99304-99316	<input type="checkbox"/> Observation Discharge	99217
OUTPT DIAGNOSIS:			

HISTORY (the column containing a circle farthest to the LEFT identifies the type of history)	PROBLEM FOCUSED	EXP. PROB. FOCUSED	DETAILED	COMPREHENSIV E
HPI (history of present illness) elements: <input type="checkbox"/> Location <input type="checkbox"/> Severity <input type="checkbox"/> Timing <input type="checkbox"/> Modifying factors <input type="checkbox"/> Quality <input type="checkbox"/> Duration <input type="checkbox"/> Context <input type="checkbox"/> Assoc. signs/symptoms		<input type="checkbox"/> Brief (1-3)	<input type="checkbox"/> Extended (4 or more or 3 chronic conditions)	
ROS (review of systems): <input type="checkbox"/> Constitutional (wt loss, etc) <input type="checkbox"/> Ears, nose, mouth, throat <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> Integumentary (skin, breast) <input type="checkbox"/> Endo Heme/lymph <input type="checkbox"/> Eyes <input type="checkbox"/> Card/vasc <input type="checkbox"/> Musculo <input type="checkbox"/> Neuro <input type="checkbox"/> Allergy/Immuno <input type="checkbox"/> Resp <input type="checkbox"/> Psych <input type="checkbox"/> All others negative	<input type="checkbox"/> None	<input type="checkbox"/> Problem Pertinent (1 system)	<input type="checkbox"/> Extended (2-9 systems)	<input type="checkbox"/> Complete (10+ systems)
PFSH (past medical, family, social history) areas: <input type="checkbox"/> Past history (past illnesses, operations, injuries, and treatments) <input type="checkbox"/> Family history (a review of medical events in patient's family, including diseases which may be hereditary or place the patient at risk) <input type="checkbox"/> Social history (an age appropriate review of past and current activities)	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Pertinent (At least 1 history area)*	<input type="checkbox"/> Complete (2 or 3 history areas)*
*Complete PFSH: 2 hx areas: Established patient, outpatient; emergency dept 3 hx areas: New patient and consultations				

PHYSICAL EXAMINATION:

- Problem Focused Exam** - Limited to affected body area or organ system (*one body area or system related to problem*)
- Expanded Problem Focused Exam** - Affected body area or organ system and other symptomatic or related organ system(s) (*additional systems up to a total of 7*)
- Detailed Exam** - Extended exam of affected body area(s) and other symptomatic or related organ system(s) (*additional systems up to a total of 7 - in more depth than Exp.*)
- Comprehensive Exam** - General multi-system exam (*8 or more systems*) or complete exam of a single organ system

Comments on History and Exam: _____

Miscellaneous Questions:

1. Is the encounter form signed by the provider? Y N
2. Does the diagnoses on the encounter form match the diagnoses in the note? Y N add'l dx
3. Are the labs ordered on the encounter form substantiated in the documentation? Y N
4. Specify the type of dictation (eg, solely by MD, fellow's note with MD Addendum, etc.) _____

MEDICAL DECISION MAKING:

Table 1 - **Number of Diagnoses and/or Management Options**

PROBLEM CATEGORIES	NUMBER X	POINTS =	SCORE
Self-limited or minor (stable, improved, or worsening)	Max = 2	1	
Established problem; stable improved		1	
Established problem, worsening		2	
New problem, no additional work up planned	Max = 1	3	
New problem, additional work up planned		4	
		TOTAL	

Table 2 - **Amount and/or Complexity of Data to be Reviewed**

POINTS	TYPE OF DATA (Amount and complexity)
1	Review and/or order of clinical lab tests
1	Review and/or order of tests in the radiology section of CPT (nuclear medicine and all imaging except echocardiography and cardiac cath)
1	Review and/or order of tests in the medicine section of CPT (EEG,EKG, echocardiography, cardiac cath, non-invasive vascular studies, pulmonary function studies)
1	Discussion of test results with the performing physician
2	Independent review of image, tracing, or specimen
1	Decision to obtain old records and/or obtain history from someone other than the patient
2	Review and summarization of old records and/or obtaining history from someone other than the patient and/or discussion of case with another health provider
	TOTAL

Table 3 - **Overall Risk** – choose the highest level of overall risk.

Presenting Problem(s)	Minimal	Low	Moderate	High
Diagnostic Procedure(s)	Minimal	Low	Moderate	High
Management Options	Minimal	Low	Moderate	High
Overall Risk	1 Minimal	2 Low	3 Moderate	4 High

Use the data obtained from Tables 1, 2, & 3 to determine the level of decision making

No of Diagnoses or Management Options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
Amount and Complexity of Data	≤ 1 Minimal/Low	2 Limited	3 Moderate	≥ 4 Extensive
Overall Risk	1 Minimal	2 Low	3 Moderate	4 High
Level of Decision Making	Straight-forward	Low Complexity	Moderate Complexity	High Complexity

Comments about Medical Decision Making: _____

MD Assigned Code _____ Reviewer Code _____ Reviewer _____

Review Date _____ Time: _____(minutes)

Hx - PE - MDM -