E/M Audit Strategies

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E/M Audit Strategies

• **Overview:**
  – This webinar will:
    • Cover the differences between 1995 and 1997 Guidelines;
    • Cover how to prepare for an audit;
    • Show you how to conduct the audit using various tools;
    • Show you how to prepare the post audit analysis;
    • Provide tips to communicate and provide education for the physician/provider.
E/M Audit Strategies

• **You Will Learn**
  – Attendees will learn how to use audit tools adhering to both 1995 and 1997 Guidelines;
  – Attendees will learn how to sample/prepare for the audit;
  – Attendees will learn how to comply and analyze the findings and present them to the provider with recommendations for education.

Choosing an E/M Code

• What type of service was performed?
• What is the place of service?
• Is this a new patient or established?
• What is the extent of the history and exam and the complexity of the MDM?
• Any modifying factors (eg, time)?
Components of an E/M Service

• *History
• *Exam
• *Medical Decision Making
• Counseling
• Coordination of Care
• Time
• Nature of the presenting problem
  – Medical necessity

*Key components

E/M Audit Strategies

• E/M levels are chosen based on the three key components:
  – History (extent)
  – Exam (extent)
  – Medical Decision Making (complexity)
• E/M levels may be chosen based on time if more than 50% of the visit was spent in counseling and coordination of care
• The nature of the presenting problem is used to assist the provider in determining how much history and exam is needed to treat the patient
Nature of the Presenting Problem

- How sick was the patient?
- How much work was done?
- Does the documentation support both?

Medicare’s Overarching Criteria

- Medical necessity of a service is the overarching criterion not simply the individual requirements of a CPT® code
- It would not be medically necessary or appropriate to bill a higher level of E/M when a lower level is warranted
- Although the documentation should support the level of service reported, the volume of documentation should not be the primary influence upon which a specific level of service is billed
History

- 4 Subcomponents:
  - Chief Complaint (CC)
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past, Family and Social History (PFSH)

Chief Complaint

- The chief complaint is the diagnosis, condition, problem, symptom or reason for the encounter
- Explains why patient is being seen
- Must be documented for every encounter
- Can be inferred
History Of Present Illness

• The History of Present Illness is a chronological description of the development of the patient’s present illness from the first sign and symptom to the present
• Use of 8 descriptors

- Location: where it hurts (rt arm, chest)
- Quality: descriptive (throbbing, productive, red)
- Severity: level of pain (pain scale, temps to 102, extremely)
- Duration: how long it’s been hurting (for 3 days)
- Timing: when it hurts (in the am, intermittent, worse in pm)
- Context: how you got hurt/sick (falling, exposure at school)
- Modifying factors: what helps (Tylenol reduced fever, ice, heat)
- Associated Signs and Symptoms: (cough, fever, runny nose)
History Of Present Illness

- **Must be** documented by the billing provider
- **Brief:** 1-3 descriptors
- **Extended:** 4 or more descriptors
  - An extended HPI can also be met if the documentation shows the status of at least three chronic or inactive conditions
    - The documentation should show what actions the physician is taking concerning these conditions and how they affect the chief complaint
    - This DG is in the 1997 version, but can be used for either the 1995 or 1997 guidelines
      Depends on the MAC/carrier

Review of Systems

- The Review of Systems is an inventory of body systems obtained through a series of questions seeking to identify signs and symptoms which the patient may be experiencing or has experienced
Review of Systems

• Series of questions relating to 14 body systems:
  - Constitutional
  - Musculoskeletal
  - Eyes
  - Integumentary
  - ENT/Mouth
  - Neurological
  - Cardiovascular
  - Psych
  - Respiratory
  - Endocrine
  - Gastrointestinal
  - Hem/Lymph
  - Genitourinary
  - Allergy/Immunology

• Problem pertinent: 1 system
• Extended: 2-9 systems
• Complete: 10 systems

Review of Systems

• Series of questions asked of the patient or parent relating to body systems
• Can be taken using: intake form, support staff, etc.
• At least 1 system needs to be documented in order to report beyond a level 1 new patient visit (99201)
• Documentation should show that the provider has posed a question to the patient
• Words such as “Denies headache” or symbols such as “- pain” or “+ cough” would indicate that the patient responded to questions posed by the provider
Past, Family & Social History

**PFSH**

- **Past Medical History**
- **Family History**
- **Social History**
- Pertinent PFSH: 1 item from any 3 PFSH areas
- Complete PFSH: a review of 2 or 3 PFSH areas
  - Examples of E/Ms with 2 areas needed: Established patient, ER Visits
  - Examples of E/Ms with 3 areas needed: New patient, Initial Inpt, Consultations

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**Past, Family & Social History**

- Past History - a review of the patient’s past experiences with illnesses/injuries/treatments that includes significant information about:
  - prior major illnesses and injuries
  - prior operations and hospitalizations
  - current medications
  - allergies
    - If more detail is given, for example- “patient has allergy to penicillin causing hives” this can be counted as ROS
    - If simply stated as “NKDA” or “Latex allergy”, then count as PFSH
  - age appropriate
  - immunization status
  - age appropriate feeding/dietary status
Past, Family & Social History

• Family History - a review of the medical events in the patient’s family that includes significant information about:
  – the health and status or cause of death of parents, siblings, and children
  – specific diseases in the family related to problems identified in the chief complaint or HPI and/or ROS
  – A notation that the patient is adopted would satisfy the documentation requirement for family history

Past, Family & Social History

• Social History - an age appropriate review of past and current activities that includes significant information about:
  – marital status and/or living arrangements
  – current employment and occupational history
  – level of education
  – school activities
  – use of drugs, alcohol and tobacco
  – sexual history
  – other relevant social factors
History Documentation Tips

- **CC**: Should be clear in every note
- **HPI**: Billing provider must document
- **PFSH**: In addition to past medical history, family and social history are both required for a comprehensive history for new patients, consultations and initial inpatient visits

History Caveat: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.

- However, neither the 1995 or 1997 DG indicate any level of history is automatic if unable to obtain a history.
History Documentation Tips

- **ROS**: Can be documented by ancillary personnel (nursing) or referred to (intake form or questionnaire)
  - Preferred: include a separate ROS section
  - A complete ROS (10 or more systems) is required for a comprehensive history – needed for 99204 or 99205 (level 4 or 5 New pt clinic visit) and for 99222 or 99223 (highest 2 levels of Initial Hosp H&Ps)
  - Documentation requirements can be met for a complete ROS if all positive responses, pertinent negatives and a statement including the words “Complete”, “All”, or “Remainder” is documented
    Examples: “Complete ROS otherwise negative”, “All systems negative other than above”, “Remainder of systems negative”

Exam

- There are two sets of guidelines developed by CMS for use and adopted by major carriers
  - 1995 Guidelines
  - 1997 Guidelines
  - Difference primarily lies with the exam component
    - The 1997 guidelines require more detail in the documentation, but allow for comprehensive levels for specialty specific exams
  - Either set of guidelines can be used
Exam

• The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s)

• There are 4 types of examinations
  – Problem Focused
  – Expanded Problem Focused
  – Detailed
  – Comprehensive

Exam

• ‘95 Guidelines
  – Consist of 7 Body Areas:
    - Head, including face
    - Abdomen
    - Chest, including breasts/axillae
    - Each extremity
    - Neck
    - Genitalia, groin, buttocks
    - Back, including spine
  – Consist of 12 Organ Systems:
    - Constitutional (vitals, gen app)
    - Ears, nose, mouth, throat
    - Cardiovascular
    - GI
    - Musculoskeletal
    - Hem/Lymph/Immuno
    - Eyes
    - Respiratory
    - Skin
    - GU
    - Neuro
    - Psych
Exam

‘95 Guidelines

- **Problem Focused** - a limited exam of the affected area or organ system (1 area/system)
- **Expanded Problem Focused** - a limited exam of the affected area or organ system and other symptomatic or related organ system(s) (2-4 areas/systems depending on MAC)
- **Detailed** - an extended exam of the affected area(s) and other symptomatic/related organ system(s) (5-7 areas/systems depending on MAC)
- **Comprehensive** - a general or multi-system exam or a complete exam of a single organ system (8 or more systems)

Exam

‘97 Guidelines – General Multi-System Exam

- **Problem Focused** - a limited exam of affected area or organ system
  - 1-5 elements identified by a bullet in one or more organ system(s) or body area(s)
- **Expanded Problem Focused** - a limited exam of affected area or organ system and other symptomatic or related organ system(s)
  - 6 elements identified by a bullet in one or more organ system(s) or body area(s)
Exam

‘97 Guidelines – General Multi-System Exam

- **Detailed** - an extended examination of the affected area(s) and other symptomatic or related organ system(s)
  - Should include at least six organ systems or body areas
  - For each system/area selected, performance and documentation of at least two elements identified by a bullet is expected
  - Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet in two or more organ systems or body areas

Exam

‘97 Guidelines – General Multi-System Exam

- **Comprehensive** - a general or multi-system examination or a complete examination of a single organ system
  - Should include at least nine organ systems or body areas
  - For each system/area selected, all elements of the examination identified by a bullet should be performed, unless specific directions limit the content of the exam
  - For each area/system, documentation of at least two elements identified by a bullet is expected
Exam

‘97 Guidelines – Single Organ System Exam

• **Problem Focused:** Should include performance and documentation of 1-5 elements identified by a bullet, shaded or unshaded box

• **Expanded Problem Focused:** Should include performance and documentation of at least 6 elements identified by a bullet, shaded or unshaded box

• **Detailed:** Exams other than eye and psych exams should include performance and documentation of at least 12 elements identified by a bullet, shaded or unshaded box
  - Eye and Psych exams should include the performance and documentation of at least 9 elements identified by a bullet, shaded or unshaded box

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Exam

‘97 Guidelines – Single Organ System Exam

• **Comprehensive**
  - Should include performance and documentation of all elements identified by a bullet, whether in a box with a shaded or unshaded border
  - Documentation of every element in each box with a shaded border and at least one element in each box with an unshaded border is expected
Exam Documentation Tips

• OK to use check boxes on a preprinted encounter form or EMR system
• Be specific and don’t leave out elements of the exam if performed
• Additional documentation is needed if a notation of “abnormal” or an abnormal box for the exam on a form is checked
• An abnormal notation without elaboration is insufficient

Medical Decision Making

• The Medical Decision Making refers to the complexity of establishing and/or selecting a management option as measured by:
  • The number of possible diagnoses and/or the number of management options that must be considered
  • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
  • The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options
Medical Decision Making

- Determined based on 2 of the 3 subcomponents:
  1. Number of diagnoses or treatment options
     - New vs. established problems, with or without work-up
  2. Amount/complexity of the data to be reviewed
     - Ordering or reviewing of labs, X-rays, other diag tests
  3. Risk of complications and/or morbidity or mortality based on:
     - Presenting problem(s)
     - Diagnostic procedure(s) ordered
     - Management/treatment options

- Four levels of medical decision making are recognized:
  - Straightforward
  - Low Complexity
  - Moderate Complexity
  - High Complexity

- Comorbidities/underlying diseases are not considered in selecting a level of E/M services, unless their presence significantly increases the complexity of the medical decision making
Medical Decision Making

TABLE OF NUMBER OF DIAGNOSES OR TREATMENT OPTIONS

<table>
<thead>
<tr>
<th>Categories for Problems/Major New Symptoms</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self limited or minor stable, improved, or worsening</td>
<td>1</td>
<td>Max - 2</td>
<td></td>
</tr>
<tr>
<td>Established problem stable or improved</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Established problem worsening</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem no additional work-up planned</td>
<td>3</td>
<td>Max - 3</td>
<td></td>
</tr>
<tr>
<td>New problem additional work-up planned</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical Decision Making

• The number of diagnoses and/or management options
  – Self-limited /minor problems (max number of points = 2)
  – New problem w/out workup (max number of points = 3)

• New problem:
  – New to clinician?
  – New to any clinician in your practice?

• Workup:
  – Diagnostic tests done on day of visit?
  – Diagnostic tests planned for future visits
Medical Decision Making

TABLE OF AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

<table>
<thead>
<tr>
<th>Categories of Data to be Reviewed</th>
<th>Number</th>
<th>Points</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT®</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT®</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another healthcare provider</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td></td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

• Amount and/or Complexity of Data
  – Only 1 point should be counted for review or ordering of lab, X-ray, or the other diagnostic tests in the medicine section of the CPT® manual
  – Only 1 point should be counted for lab regardless of the number of lab tests performed (Same rule applies to X-rays and diagnostic tests in the medicine section)
  – Point should not be allowed for obtaining history from someone other than patient for pediatrics
    • Parents or guardians are typically the ones to supply this information to the provider
Medical Decision Making

- Amount and/or Complexity of Data - Points can be counted for:
  - Visualization of X-ray films
    - “Chest X-ray image shows no infiltrates”
    - “X-ray read – normal exam”
  - Review and summarization of other records
    - “Reviewed records from patient’s hospitalization at ….”
  - Discussion of case with another healthcare provider
    - “Discussed the psych testing results with Dr. Welby”

_These are elements often performed, but rarely documented._

### TABLE OF RISK

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problems</th>
<th>Diagnostic Procedures Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>1 self limited or minor problem,</td>
<td>Laboratory requiring venipuncture, Urinalysis, KOH prep, Chest x-ray EKG/EEG, Ultrasound</td>
<td>Rest, gargles, elastic bandage, superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>2 or more self limited or minor problems, 1 or more stable chronic illness, e.g. well controlled hypertension or non insulin dependent diabetes, cataract, BPH</td>
<td>Physiological test not under stress, non cardiovascular imaging studies with contrast, Superficial needle biopsy, Laboratory test requiring an arterial puncture, skin biopsy</td>
<td>OTC drugs, Minor surgery with no risk factors, PT, OT IV fluids without additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>1 or more chronic illnesses with mild exacerbation, progression, or side effects of treatment, Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, Acute illness with systemic symptoms, Acute complicated injury</td>
<td>Physiologic test under stress Diagnostic endoscopies with no identified risk factors, Deep needle or incisional biopsy, Cardiovascular imaging studies with contrast, no risk factors Obtain fluid from body cavity</td>
<td>Minor surgery with risk factors Elective major surgery with no risk factors, Prescription drug mgmt, Therapeutic nuclear medicine, IV fluid with additives</td>
</tr>
<tr>
<td>High</td>
<td>1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment, Acute or chronic illnesses or injuries with that pose a threat to life or bodily function An abrupt change in neurologic status</td>
<td>Cardiovascular imaging studies with contrast with risk factors Cardiac electrophysiologic tests Diagnostic endoscopy with risk factors Discography</td>
<td>Elective major surgery with risk factors, Emergency major surgery, Parenteral controlled substances, Drug therapy with toxicity</td>
</tr>
</tbody>
</table>
E/M Audit Strategies

MDM

• Table of Risk:
  – This table was developed for use for the Medicare population
  – Some problems can be low, moderate or high depending on the severity (example – asthma)
  – Highest in any column determines the risk level
  – Note that prescription drug management is at the moderate risk level

Medical Decision Making

<table>
<thead>
<tr>
<th>MEDICAL DECISION MAKING - Final Result for Complexity: 2 of 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1-Number of Diagnoses or Treatment Options</strong></td>
</tr>
<tr>
<td>2-Amount and/or Complexity of Data</td>
</tr>
<tr>
<td>3-Table of Risk</td>
</tr>
<tr>
<td>Overall Type of Decision Making (2 of 3)</td>
</tr>
</tbody>
</table>
Billing Based on Time

- Level of E/M can be chosen based on the amount of time spent with the patient
  - When more than ½ of the time spent is in counseling and/or coordination of care
    - Level is chosen based on the total time spent w/patient
  - When time is documented
- Only face-to-face time for clinic visits (99201-99215)
- Unit/Floor time can also be used for inpatient visits (99221-99223 and 99231-99233)
- Non-face-to-face time spent before and after the visit cannot be included in the time component

Billing Based on Time

- Documentation must show the following:
  - Total face-to-face or unit/floor time
  - That more than ½ of the visit was spent in counseling or coordination of care
    - Does not have to be exact minutes spent or start/stop times
    - Provider may simply state that more than ½ the visit was spent in counseling
  - A summary of the discussion
  - Any key elements of the visit performed (history, exam, medical decision-making)
Billing Based on Time

• Issues with Billing Based on Time:
  – Underreporting of levels & documentation requirements

• Possible Solutions
  – Educate providers on when to bill based on time
  – Providers should get into the habit of noting the time when they enter an exam room
  – Make it easier for providers to document the time
    • Provide templates for when provider is transcribing
    • If using preprinted encounter forms or an EMR, include a box for providers to check and include the time element
    • Example: “More than half of this _______ minute visit was spent in counseling and/or coordination of care”

E/M Audit Strategies

Think of a compliance plan as “Preventive Medicine for Your Clinic”

• Place to start:
  – OIG’s Compliance Program for Individual and Small Group Physician Practices
  – Published in the Federal Register, Volume 65, No. 194, Thursday, Oct. 5, 2000 Pages 59434 - 59452.
E/M Audit Strategies

• Why audit your E/M services?
  – Reduces your compliance risk
  – Helps to streamline business operations
  – Promotes adherence to statutes, regulations and guidelines

E/M Audit Strategies

• What is E/M Utilization data?
• Why review the utilization of E/M levels reported by the providers in each practice?
**E/M Audit Strategies**

- Most common E/M services under coded: 99213 / 99214
  - Average difference in reimbursement ≈ $34.00

**Example: One Clinic’s Undercoding $ Impact**

- Annualized utilization of 99214 in 2006 = 6,789
- Utilization of 99214 in 2007 = 9,780 (After audit and coding education)
  - Difference = 2,991 X $34.00 = **$101,694.00**
  - Percentage of 99214 increased after auditing and education from around 20% to around 30%
E/M Audit Strategies

Getting Started

• Support and Commitment
• Plan
E/M Audit Strategies

• Start each audit of E/M services with a review of E/M Utilization Data
  – Determine the E/M code distribution for each type of E/M service
  – Compare the utilization of E/M codes for each specialty against the National Summary Data (BESS) found on the CMS website.

Conducting the Audit

• Gather the data/charts
• Gather all documents created during the encounter
• Complete the audit tool
• Report the results
Reporting the Results

• Clear, Concise and Meaningful
• Include pertinent information on the report
  – Patient Identifier (i.e., medical record number)
  – Date of Service
  – Level of Service Coded/Submitted
  – Level of Service Reviewed
  – Reason for Change if applicable

Communication with Providers

• Be prepared – Do your homework
  – Come with actual guidelines (Medicare, Medical Assistance, CPT ®)
  – Create an agenda if having a meeting
• Practice
  – Rehearse or write a draft
• Explain why the issue is important
• Focus on what you are trying to accomplish
• Take notes and Listen
Communication with Providers

Listening Skills

• Listening skills are important
• Don’t spend time preparing your answer while someone is talking
• Maintain eye contact
• If you don’t completely understand a question or need some time to respond:
  – Ask for the question to be repeated
  – Ask clarifying questions – Answer with a question
  – Use a lifeline - Ask the audience
• Listen for the message, not the words

Communication with Providers

When speaking be aware of word choice

• Let’s work together vs You doctors……
• We should …… vs You must…..
• I need your help.. or Help me understand.. vs You don’t understand
• Last, but certainly not least:
  THANK YOU
Communication with Providers

When writing include:

• Date of written communication
• Specific example (pt name, DOS, DOB)
• Copy of note if applicable
• The word(s): Thanks, or Thank you,
• Your name
• Contact information for questions (phone, email, etc)

Resources

• Bess Data

• OIG’s Compliance Program for Individual and Small Group Physician Practices
Resources

- EM Documentation Guidelines

Thank You!
AUDIT SUMMARY FORM

Clinic: ___________________________  Date Review Completed: _______________________
Pro: _______________________________

E/M Components

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Patient Name Last, First</th>
<th>Level Chosen by Provider</th>
<th>Level Documented</th>
<th>HIST</th>
<th>EXAM</th>
<th>MDM</th>
<th>Additional Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Overall Comments:

Level Consistent:  %
Under-Coded:  %
Over-Coded:  %

Level was increased-Provider under-coded
Level was decreased-Provider over-coded

Definitions:
CC Chief Complaint
Comp Comprehensive
Det Detailed
EPF Expanded Problem Focused
HIST History
HPI History of Present Illness
MDM Medical Decision Making
Mod Moderate
PF Problem Focused
PFSH Past, Family and Social History
ROS Review of Systems
SF Straightforward

Reviewer: _________________________
<table>
<thead>
<tr>
<th>Provider Number</th>
<th>Date of Service</th>
<th>Procedure Code Reported</th>
<th>Check one:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Disagree</td>
</tr>
</tbody>
</table>

Documented Procedure Code Level
E/M Documentation Auditor’s Instructions

1. History

Refer to data section (table below) in order to quantify. After referring to data, circle the entry farthest to the RIGHT in the table, which best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the LEFT, identifies the type of history.

After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 5.

<table>
<thead>
<tr>
<th>HPI: Status of chronic conditions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1 condition □ 2 conditions □ 3 conditions</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>□ Past medical history (the patient's past experiences with illnesses, operation, injuries and treatments)</td>
</tr>
<tr>
<td>□ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)</td>
</tr>
<tr>
<td>□ Social history (an age appropriate review of past and current activities)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ROS (review of systems):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Constitutional (e.g., vitals, etc)</td>
</tr>
<tr>
<td>□ Ears, nose, mouth, throat</td>
</tr>
<tr>
<td>□ GI (e.g., abdomen)</td>
</tr>
<tr>
<td>□ Card/vasc</td>
</tr>
<tr>
<td>□ Musculo</td>
</tr>
<tr>
<td>□ Resp</td>
</tr>
<tr>
<td>□ Integumentary (e.g., skin, breast)</td>
</tr>
<tr>
<td>□ GU (e.g., genitourinary system)</td>
</tr>
<tr>
<td>□ Endo (e.g., neuro, immune)</td>
</tr>
<tr>
<td>□ Hem/lymph</td>
</tr>
<tr>
<td>□ All others negative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Location</td>
</tr>
<tr>
<td>□ Severity</td>
</tr>
<tr>
<td>□ Timing</td>
</tr>
<tr>
<td>□ Modifying factors</td>
</tr>
<tr>
<td>□ Quality</td>
</tr>
<tr>
<td>□ Duration</td>
</tr>
<tr>
<td>□ Context</td>
</tr>
<tr>
<td>□ Associated signs and symptoms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PFSH (past medical, family, social history) areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Past medical history (the patient's past experiences with illnesses, operation, injuries and treatments)</td>
</tr>
<tr>
<td>□ Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)</td>
</tr>
<tr>
<td>□ Social history (an age appropriate review of past and current activities)</td>
</tr>
</tbody>
</table>

*Complete PFSH: 2 history areas: a) Established patients - office (outpatient) care; b) Emergency department.

**Complete ROS: 10 or more systems, or some systems with statement "all others negative".

**Complete ROS: 10 or more systems, or some systems with statement "all others negative".

3 history areas: a) New patients - office (outpatient) care, domiciliary care, home care; b) Consultations; c) Initial hospital care; d) Hospital observation; e) Initial Nursing Facility Care.

NOTE: For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Please refer to procedure code descriptions.

2. Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

<table>
<thead>
<tr>
<th>Limited to affected body area or organ system (one body area or system related to problem)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ PROBLEM FOCUSED EXAM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Affected body area or organ system and other symptomatic or related organ system(s) (additional systems up to total of 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ EXPANDED PROBLEM FOCUSED EXAM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 or more depth than above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ DETAILED EXAM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General multi-system exam (8 or more systems) or complete exam of a single organ system (complete single exam not defined in these instructions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ COMPREHENSIVE EXAM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Head, including face</td>
</tr>
<tr>
<td>□ Chest, including breasts and axillae</td>
</tr>
<tr>
<td>□ Abdomen</td>
</tr>
<tr>
<td>□ Neck</td>
</tr>
<tr>
<td>□ Back, including spine</td>
</tr>
<tr>
<td>□ Genitalia, groin, buttocks</td>
</tr>
<tr>
<td>□ Each extremity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organ systems:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Constitutional</td>
</tr>
<tr>
<td>(e.g., vitals, gen app)</td>
</tr>
<tr>
<td>□ Ears, nose, mouth, throat</td>
</tr>
<tr>
<td>□ Resp</td>
</tr>
<tr>
<td>□ Musculo</td>
</tr>
<tr>
<td>□ Psych</td>
</tr>
<tr>
<td>□ Gl</td>
</tr>
<tr>
<td>□ Skin</td>
</tr>
<tr>
<td>□ GU</td>
</tr>
<tr>
<td>□ Neuro</td>
</tr>
<tr>
<td>□ Hem/lymph/imm</td>
</tr>
</tbody>
</table>

*Complete E/M: 10 or more systems, or some systems with statement "all others negative".

NOTE: For certain categories of E/M services that include only an interval history, it is not necessary to record the status of chronic conditions.

<table>
<thead>
<tr>
<th>Status of chronic conditions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Status of 1-2 chronic conditions</td>
</tr>
<tr>
<td>□ Status of 3 chronic conditions</td>
</tr>
</tbody>
</table>

*Complete ROS: 10 or more systems, or some systems with statement "all others negative".

**Complete PFSH: 2 history areas: a) Established patients - office (outpatient) care; b) Emergency department.

3 history areas: a) New patients - office (outpatient) care, domiciliary care, home care; b) Consultations; c) Initial hospital care; d) Hospital observation; e) Initial Nursing Facility Care.

NOTE: For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Please refer to procedure code descriptions.
### 3. Medical Decision Making

**Number of Diagnoses or Treatment Options**

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.) Do not categorize the problem(s) if the encounter is dominated by counseling/coordinating of care, and duration of time is not specified. In that case, enter 3 in the total box.

<table>
<thead>
<tr>
<th>Number of Diagnoses or Treatment Options</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved or worsening)</td>
<td>Max = 2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); stable, improved</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); worsening</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max = 1</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New prob. (to examiner); add. workup planned</td>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Multiply the number in columns B & C and put the product in column D. Enter a total for column D.

**Amount and/or Complexity of Data Reviewed**

For each category of reviewed data identified, circle the number in the points column. Total the points.

### Risk of Complications and/or Morbidity or Mortality

**Level of Risk**

- **Minimal**
  - One self-limited or minor problem, e.g., cold, insect bite, tinea corporis

- **Low**
  - Two or more self-limited or minor problems
  - One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH
  - Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain

- **Moderate**
  - One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment
  - Two or more stable chronic illnesses
  - Undiagnosed new problem with uncertain prognosis, e.g., lump in breast
  - Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis
  - Acute complicated injury, e.g., head injury with brief loss of consciousness

- **High**
  - One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
  - Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure
  - An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss

**Diagnostic Procedure(s) Ordered**

- Laboratory tests requiring venipuncture
- Chest x-rays
- EKG/EEG
- Urinalysis
- Ultrasound, e.g., echo
- KGH prep
- Physiologic tests not under stress, e.g., pulmonary function tests
- Non-cardiovascular imaging studies with contrast, e.g., barium enema
- Superficial needle biopsies
- Clinical laboratory tests requiring arterial puncture
- Skin biopsies
- Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test
- Diagnostic endoscopies with no identified risk factors
- Deep needle or incisional biopsy
- Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac cath
- Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdoscetness
- Cardiovascular imaging studies with contrast with identified risk factors
- Cardiac electrophysiological tests
- Diagnostic endoscopies with identified risk factors
- Discography
- Cardiovascular imaging studies with contrast with identified risk factors
- Cardiac electrophysiological tests
- Diagnostic endoscopies with identified risk factors
- Discography

**Management Options Selected**

- Rest
- Gargles
- Elastic bandages
- Superficial dressings
- Over-the-counter drugs
- Minor surgery with no identified risk factors
- Physical therapy
- Occupational therapy
- IV fluids without additives
- MINOR surgery with identified risk factors
- Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors
- Prescription drug management
- Therapeutic nuclear medicine
- IV fluids with additives
- Closed treatment of fracture or dislocation without manipulation
- Elective major surgery (open, percutaneous or endoscopic with identified risk factors)
- Emergency major surgery (open, percutaneous or endoscopic)
- Parenteral controlled substances
- Drug therapy requiring intensive monitoring for toxicity
- Decision not to resuscitate or to de-escalate care because of poor prognosis

### Final Result for Complexity

**Final Result for Complexity**

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left. After completing this table, which classifies complexity, circle the type of decision making within the appropriate grid in Section 5.

<table>
<thead>
<tr>
<th>A</th>
<th>Number diagnoses or treatment options</th>
<th>B</th>
<th>Highest Risk</th>
<th>C</th>
<th>Amount and complexity of data</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minimal</td>
<td>2</td>
<td>Limited</td>
<td>3</td>
<td>Multiple</td>
<td>≥ 4 Extensive</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td></td>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td></td>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Amount and/or Complexity of Data Reviewed**

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
</tbody>
</table>

**TOTAL**

Bring total to line C in Final Result for Complexity (table below)

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below).

**Final Result for Complexity**

If the physician documents total time and suggests that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

- If all answers are “yes”, select level based on time.
### 5. Level of Service

#### Outpatient, Consultations (Outpatient & Inpatient) and ER

<table>
<thead>
<tr>
<th>Level</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Complexity of medical decision</td>
<td>SF</td>
<td>SF</td>
<td>L</td>
<td>M</td>
<td>H</td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td>10</td>
<td>New (99201)</td>
<td>20</td>
<td>New (99202)</td>
<td>30</td>
</tr>
<tr>
<td>(ER has no average time)</td>
<td>15</td>
<td>Outpt cons (99241)</td>
<td>40</td>
<td>Outpt cons (99242)</td>
<td>60</td>
</tr>
<tr>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Complexity of medical decision</td>
<td>SF</td>
<td>SF</td>
<td>L</td>
<td>M</td>
<td>H</td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td>5</td>
<td>New (99211)</td>
<td>10</td>
<td>New (99212)</td>
<td>15</td>
</tr>
<tr>
<td>(Observation care has no average time)</td>
<td>30</td>
<td>Int hosp (99218)</td>
<td>50</td>
<td>Int hosp (99222)</td>
<td>70</td>
</tr>
</tbody>
</table>

#### Hospital Care

<table>
<thead>
<tr>
<th>Level</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>D/C</td>
<td>C</td>
<td>C</td>
<td>PF interval</td>
</tr>
<tr>
<td>Examination</td>
<td>D/C</td>
<td>C</td>
<td>C</td>
<td>PF</td>
</tr>
<tr>
<td>Complexity of medical decision</td>
<td>SF/L</td>
<td>M</td>
<td>H</td>
<td>SF</td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td>25</td>
<td>99304</td>
<td>35</td>
<td>99305</td>
</tr>
<tr>
<td>(Observation care has no average time)</td>
<td>30</td>
<td>99308</td>
<td>50</td>
<td>99310</td>
</tr>
</tbody>
</table>

#### Nursing Facility Care

<table>
<thead>
<tr>
<th>Level</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>D/C</td>
<td>C</td>
<td>C</td>
<td>PF interval</td>
</tr>
<tr>
<td>Examination</td>
<td>D/C</td>
<td>C</td>
<td>C</td>
<td>PF</td>
</tr>
<tr>
<td>Complexity of medical decision</td>
<td>SF/L</td>
<td>M</td>
<td>H</td>
<td>SF</td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td>25</td>
<td>99304</td>
<td>35</td>
<td>99305</td>
</tr>
<tr>
<td>(Annual Assessment)</td>
<td>30</td>
<td>99318</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services and Home Care

<table>
<thead>
<tr>
<th>Level</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
</tr>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
<td>D</td>
<td>C</td>
</tr>
<tr>
<td>Complexity of medical decision</td>
<td>SF</td>
<td>L</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td>35</td>
<td>Domiciliary (99324)</td>
<td>50</td>
<td>Domiciliary (99325)</td>
</tr>
<tr>
<td>PF = Problem focused</td>
<td>EPF = Expanded problem focused</td>
<td>D = Detailed</td>
<td>C = Comprehensive</td>
<td>SF = Straightforward</td>
</tr>
</tbody>
</table>
### Marshfield Clinic Audit Tool

#### History
- **HPI** (history of present illness) elements:
  - Location
  - Severity
  - Quality
  - Duration
  - Timing
  - Context
  - Modifying factors
  - Associated signs and symptoms

- **ROS** (review of systems):
  - Constitutional
  - Ears, nose, mouth, throat
  - GI
  - Respiratory
  - Cardiovascular
  - Musculoskeletal
  - Neurological

- **PFISH** (past medical, family, social, history) areas:
  - Past history (the patient's past experiences with illnesses, operations, injuries and treatments)
  - Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)
  - Social history (an age appropriate review of past and current activities)

#### Exam
- **Body areas**:
  - Head, including face
  - Chest, including breast and axilla
  - Abdomen
  - Back, including spine

- **Organ systems**:
  - Constitutional
  - Eyes
  - Cardiovascular
  - Respiratory
  - GI
  - Musculoskeletal
  - Neurological

#### Complexity
- **Number of Diagnoses or Treatment Options**
- **Risk of Complications and/or Morbidity or Mortality**

#### Table
<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>X = A</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor problem (stable, improved or worsening)</td>
<td>Max 2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ext. problem (to examiner), stable, improved</td>
<td>Max 2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner), no additional workup planned</td>
<td>Max 2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner), workup planned</td>
<td>Max 2</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
E/M Documentation Auditors' Instructions

1. History

Refer to data section (beneath table) in order to quantify. After referring to data, circle the entry farthest to the right in the table, which best describes the HPI, ROS and PFSH. If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the left identifies the type of history.

After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 5.

<table>
<thead>
<tr>
<th>HPI</th>
<th>Brief (1-3 elements)</th>
<th>Brief (1-3 elements)</th>
<th>Extended (4 or more elements)</th>
<th>Extended (4 or more elements)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROS</td>
<td>None</td>
<td>Pertinent to problem</td>
<td>(1 system)</td>
<td>Complete (10 or more systems, or some systems with statement “all others negative”)</td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>Pertinent (1 history area)</td>
<td>Complete* (2 or 3 history areas)</td>
</tr>
</tbody>
</table>

PFSH (past medical, family, social history) areas:
- Past history (the patient’s past experiences with illnesses, operations, injuries and treatments)
- Family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk)
- Social history (an age appropriate review of past and current activities)

ROS (review of systems):
- Constitutional (weight loss, etc.)
- Cardiovascular
- Musculoskeletal
- Endocrine
- Gastrointestinal
- Integumentary (skin, breast)
- Hematologic/lymphatic
- Genitourinary
- Neurological
- Allergic/immunologic
- Ears, nose, mouth, throat
- Gastrointestinal
- “All others negative”

HPI (history of present illness) elements:
- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

2. Examination

Refer to data section (beneath table) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

Limited to affected body area or organ system (one body area or system related to problem)

Affected body area or organ system and other symptomatic or related organ system(s) (additional systems up to total of 7)

Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 – more depth than above)

General multi-system exam (8 or more systems) or complete exam of a single organ system (complete single system exam not defined in these instructions)

<table>
<thead>
<tr>
<th>Body areas:</th>
<th>Chest, including breasts and axillae</th>
<th>Abdomen</th>
<th>Genitalia, groin, buttocks</th>
<th>Back, including spine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, including face</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Organ systems:     |                                      |         |                           |                      |
|--------------------|                                      |         |                           |                      |
| Constitutional (e.g., vital signs, general appearance) | Ears, nose, mouth, throat | Genitourinary | Psychiatric | Hematologic/lymphatic/immunologic |
| Eyes               |                                      |         |                           |                      |

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Additional copies of E/M Documentation Auditors' Instructions may be ordered from Medical Group Management Association, Order Department, 104 Inverness Terrace East, Englewood, CO 80112-5306.
Revised Audit Tool

New Out Patient/Clinic Visits and Consults (Outpt and Inpt)

Circle level of each component that is documented and draw a line down column with the circle farthest to the left
3 out of 3 Key Components Needed

<table>
<thead>
<tr>
<th>Levels of Service</th>
<th>Date of Service</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Service Chosen by Provider:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Service Documented and Chosen by Reviewer:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**New Out Patient/Clinic Visits and Consults (Outpt and Inpt)**

Circle level of each component that is documented and draw a line down column with the circle farthest to the left
3 out of 3 Key Components Needed

<table>
<thead>
<tr>
<th>Levels of Service</th>
<th>Date of Service</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Prob Foc</td>
<td>Exp Prob Foc</td>
</tr>
<tr>
<td>Exam</td>
<td>Prob Foc</td>
<td>Exp Prob Foc</td>
</tr>
<tr>
<td>MDM</td>
<td>Straight For</td>
<td>Straight For</td>
</tr>
<tr>
<td>New Pt</td>
<td>99201 - 10 min</td>
<td>99202 - 20 min</td>
</tr>
<tr>
<td>OutPt Consult</td>
<td>99241 - 15 min</td>
<td>99242 - 30 min</td>
</tr>
<tr>
<td>In Pt Consult</td>
<td>99251 - 20 min</td>
<td>99252 - 40 min</td>
</tr>
</tbody>
</table>

**Established Outpatient/Clinic Visits**

Circle level of each component that is documented and draw a line down column with 2 or 3 circles OR column with the center circle
2 out of 3 Key Components Needed

<table>
<thead>
<tr>
<th>Levels of Service</th>
<th>Date of Service</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Prob Foc</td>
<td>Exp Prob Foc</td>
</tr>
<tr>
<td>MDM</td>
<td>Straight For</td>
<td>Straight For</td>
</tr>
<tr>
<td>Est Pt</td>
<td>99211 - 5 min</td>
<td>99212 - 10 min</td>
</tr>
</tbody>
</table>

**Emergency Room Visits**

Circle level of each component that is documented and draw a line down column with the circle farthest to the left
3 out of 3 Key Components Needed

<table>
<thead>
<tr>
<th>Levels of Service</th>
<th>Date of Service</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Prob Foc</td>
<td>Exp Prob Foc</td>
</tr>
<tr>
<td>Exam</td>
<td>Prob Foc</td>
<td>Exp Prob Foc</td>
</tr>
<tr>
<td>MDM</td>
<td>Straight For</td>
<td>Straight For</td>
</tr>
<tr>
<td>ER</td>
<td>99281</td>
<td>99282</td>
</tr>
</tbody>
</table>

**Initial Inpatient / Observation**

Circle level of each component that is documented and draw line down the column with the circle farthest to the left
3 out of 3 Key Components Needed

<table>
<thead>
<tr>
<th>Levels of Service</th>
<th>Date of Service</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Prob Foc</td>
<td>Exp PF Interval</td>
</tr>
<tr>
<td>Exam</td>
<td>Prob Foc</td>
<td>Exp PF</td>
</tr>
<tr>
<td>MDM</td>
<td>Straight For/Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Initial H&amp;P</td>
<td>99221 - 30 min</td>
<td>99222 - 50 min</td>
</tr>
<tr>
<td>Initial Observ</td>
<td>99218</td>
<td>99219</td>
</tr>
<tr>
<td>Admit/DC Same Day</td>
<td>99234</td>
<td>99235</td>
</tr>
</tbody>
</table>

**Subsequent Hospital**

Circle level of each component documented
Draw a line down the column with 2 or 3 circles OR column with the center circle
2 out of 3 Key Components Needed

<table>
<thead>
<tr>
<th>Levels of Service</th>
<th>Date of Service</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Prob Foc Interval</td>
<td>Exp PF Interval</td>
</tr>
<tr>
<td>Exam</td>
<td>Prob Foc</td>
<td>Exp PF</td>
</tr>
<tr>
<td>MDM</td>
<td>Straight For/Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Subsequent Hospital</td>
<td>99231 - 15 min</td>
<td>99232 - 25 min</td>
</tr>
</tbody>
</table>

**Discharge Day Management**

For Inpatient discharge day management, if no time is documented or if time documented is 30 minutes or less, then 99238 should be reported

<table>
<thead>
<tr>
<th>Levels of Service</th>
<th>Date of Service</th>
<th>Date of Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient D/C</td>
<td>99238</td>
<td>99239</td>
</tr>
<tr>
<td>Observation D/C</td>
<td>30 min or less</td>
<td>more than 30 min</td>
</tr>
</tbody>
</table>