New Patient **O**
Est. Patient **O**
Consult **O**

E/M Documentation Auditor's Instructions

Name: Date of Service: ID# Doctor:

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 that 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 that classifies the history, circle the type of history within the appropriate grid in section 5.

HPI (History of Present Illness): Characterize HPI by considering **EITHER** the status of 3 chronic or inactive conditions **OR** the number of elements recorded.						**O** Status of 3 Chronic Conditions
O Location **O** Quality	**O** Severity **O** Duration	**O** Timing **O** Context	**O** Associated Signs & Symptoms **O** Modifying Factors		**O** Brief (1-3)		**O** Extended (4 or more)
1995 HPI Guidelines						
O Location **O** Quality	**O** Severity **O** Duration	**O** Timing **O** Context	**O** Associated Signs & Symptoms **O** Modifying Factors		**O** Brief (1-3)		**O** Extended (4 or More)
ROS (Review of Systems):					**O**	**O**	**O**	**O**
O Constitutional **O** Eyes **O** GU	**O** All/Immuno **O** Musculo **O** Resp	**O** Ears, nose, mouth, throat **O** Neuro **O** GI	**O** Hem/lymph **O** Psych	**O** Integumentary **O** Cardiac/ vasc. **O** Endo	N/A	Pertinent to problem (1 system)	Extended (pert & others) (2-9 systems)	Complete (pert & all others) (10 systems)
PFSH (Past, Family, Social History): **O Past history** (the patient's past experiences with illnesses, operations, injuries and treatments) **O Family history** (a review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk) **O Social history** (an age appropriate review of past and current activities)					**O** N/A	**O** N/A	**O** Pertinent 1 history item	**O** *Complete 2-3 history areas
* Complete PFSH **2 history areas:** a) established patients - office (outpatient) care, domiciliary care, home care; b) emergency department; c) subsequent nursing facility care; and d) subsequent hospital care. **3 history areas:** a) new patients - office (outpatient) care, domiciliary care, home care; b) consultations; c) initial hospital care; d) hospital observation; and e) initial nursing facility care.					PROBLEM FOCUSED 99201 99212	EXP. PROBLEM FOCUSED 99202 99213	DETAILED 99203 99214	COMPRE-HENSIVE 99204/99205 99215
					Final History requires all 3 components above are met or exceeded			

Explanation (HPI Elements)

O Location: (Is pain diffuse or localized? Im-lateral or bilateral? Fixed or migratory? Radiating or referred?)	**O** Quality: (Is pain sharp, dull, throbbing, stabbing, constant or intermittent, acute or chronic, stable, improving or worsening?)	**O** Severity: (1-10, with 1 being no pain and 10 being the worst pain experienced)	**O** Duration: (How long have symptoms been present?)	**O** Timing: (Is it nocturnal, diurnal or continuous? Is there a repetitive pattern?)
O Context: (Where is pt and what is pt doing when symptoms or signs begin? What factors were present before and after?)	**O** Modifying Factors: (What does pt do for relief? What makes symptom(s) worse? What meds have been taken? What were results?)	**O** Assoc. Signs & Symptoms: (additional sensations or feelings)	**O** Extended HPI (status of at least 3 chronic or inactive conditions)	

ALL INFO IN THE SHADED AREAS IS FOR THE 1997 GUIDELINES

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.

CPT Type of Exam	95 Guidelines		97 Guidelines	Exam Equals
Problem Focused Exam **(PF)**	One body area or organ system		1-5 bulleted elements	
Expanded Problem Focused Exam **(EPF)**	2-7 Body Systems - No detail of any system required		6-11 bulleted elements	
Detailed Exam **(D)**	2-7 body systems w/affected system in detail		12-17 bulleted elements for 2 or more systems	
Comprehensive Exam **(C)**	8 or more body systems		Not Applicable for 1997 Guidelines	
Comprehensive Exam **(C)**	Not Applicable to 1995 Guidelines		18 or more bulleted elements for 9 or more systems.	
	Not Applicable to 1995 Guidelines		See requirements for individual single system exams	

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 is a maximum number in two categories.) Do not categorize the problem(s) if the encounter is dominated by counseling/coordinating of care, and if duration of time is not specified. In that case, enter 3 in the total box.

Number of Diagnoses or Treatment Options

A	B	x C =	D
Problem(s) Status	**Number**	**Points**	**Result**
Self-limited or minor (stable, improved, or worsening)	Max=2	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no add'l workup planned	Max=1	3	
New problem (to examiner); add'l workup planned		4	
		Total:	

Multiply the number in columns B & C and put the product in column D.
Enter a total for column D.
Bring total to line A in the Final Result for Complexity (table next page).

Amount and/or Complexity of Data Reviewed

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

Amount and/or Complexity of Data Reviewed

Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
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	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
Total:	

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

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).

Risk of Complications and/or Morbidity or Mortality			
Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options
Minimal	O *One self-limited or minor problem*, e.g., cold, insect bite, Tinea Corporis	O Laboratory tests requiring venipuncture O Chest x-rays O EKG / EEG O Urinalysis O Ultrasound, e.g., echo O KOH prep	O Rest O Gargles O Elastic bandages O Superficial dressings
Low	O *Two or more self-limited or minor problems* O *One stable chronic illness*, e.g., well-controlled hypertension or non-insulin dependent diabetes, cataract, BPH O *Acute uncomplicated illness or injury*, e.g., cystitis, allergic rhinitis, simple sprain	O Physiologic tests not under stress, e.g., pulmonary function tests O Non-cardiovascular imaging studies with contrast, e.g., barium enema O Superficial needle biopsies O Clinical laboratory tests requiring arterial puncture O Skin biopsies	O Over-the-counter drugs O Minor surgery with no identified risk factors O Physical therapy O Occupational therapy O IV fluids
Moderate	O *One or more chronic illnesses with mild exacerbation*, progression, or side effects of treatment O *Two or more stable chronic illnesses* O *Undiagnosed new problem with uncertain prognosis*, e.g., lump in breast O *Acute illness with systematic symptoms*, e.g., pyelonephritis, pneumonitis, colitis. O *Acute complicated injury*, e.g., head injury with brief loss of consciousness	O Physiologic tests not under stress, e.g., cardiac stress test, fetal contraction stress test O Diagnostic endoscopies with no identified factors O Deep needle or incisional biopsy O Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram cardiac cath O Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdecentisis	O Minor surgery with identified risk factors O Major surgery (open, percutaneous or endoscopic) with no identified risk factors O Prescription drug management O Therapeutic nuclear medicine O IV fluids with additives O Closed treatment of fracture or dislocation without manipulation
High	O *One or more chronic illnesses with severe exacerbation*, progression, or side effects of treatment O *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 O *An abrupt change in neurologic status*, e.g., seizure, TIA, weakness or sensory loss	O Cardiovascular imaging studies with contrast with identified risk factors O Cardiac electrophysiological tests O Diagnostic endoscopies with identified risk factors O Discography	O Major surgery (open, percutaneous or endoscopic with identified risk factors). O Emergency major surgery (open, percutaneous or endoscopic) O Parenteral controlled substances O Drug therapy requiring intensive monitoring for toxicity O Decision not to resuscitate or de-escalate care because of poor prognosis

Final Result for Complexity

Draw a line down any column with 2 or 3 circles to identity 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.

Final Result for Complexity					
A	Number of diagnosis or treatment options	1 Minimal	2 Limited	3 Multiple	4 Extensive
B	Highest risk options	Minimal	Low	Moderate	High
C	Amount and complexity of data	1 Minimal or low	2 Limited	3 Multiple	4 Extensive
Type of decision making		**Straight Forward**	**Low Complex**	**Moderate Complex**	**High Complex**

4. Time

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.

Does documentation reveal total time?	Time:	Face-to-face in outpatient setting; unit/floor in inpatient setting	__ yes	__ no
Does documentation describe the content of consulting or coordinating care?			__ yes	__ no
Does documentation reveal that more than half of the time was counseling or coordinating care?			__ yes	__ no

* If all answers are "yes," select level based on time.

5. Level of Service

OUTPATIENT, CONSULTS (OUTPATIENT, INPATIENT & CONFIRMATORY), AND ER

	New Office/Consults/ER requires 3 components within shaded area					*Established Office requires 2 components within shaded area			
History	PF	EPF	D ER:EPF	C ER:D	C	PF	EPF	D	C
Examination	PF	EPF	D ER:EPF	C ER:D	C	PF	EPF	D	C
Complexity of Medical Decision	SF	SF ER: L	L ER:M	M	H	SF	L	M	H
Average time (minutes) (Confirmatory consults & ER have no average time)	99201-10 NEW 99241-15 OUTPT CONS 99251-20 IP CONS ER 99281	99202-20 NEW 99242-30 OUTPT CONS 99252-40 IP CONS ER 99282	99203-30 NEW 99243-40 OUTPT CONS 99253-55 IP CONS ER 99283	99204-40 NEW 99244-60 OUTPT CONS 99254-80 IP CONS ER 99284	99205-60 NEW 99245-80 OUTPT CONS 99255-110 IP CONS ER 99285	99212 10 min.	99213 15 min.	99214 25 min.	99215 40 min.
LEVEL	**I**	**II**	**III**	**IV**	**V**	**II**	**III**	**IV**	**V**

* Level I established visit is for when a patient sees the nurse, not the doctor.

INPATIENT

Subsequent Inpatient/Follow-up requires 2 components within shaded area				**Initial Hospital/Observation/Inpatient Consult requires 3 components within shaded area**			
History	PF INTER.	EPF INT.	D interval	History	D & C	C	C
Exam	PF	EPF	D	Exam	D & C	C	C
MDM	SF/L	M	H	MDM	SF/L	M	H
Average Time	15-99231 Subsequent	25-99232 Subsequent	35-99233 Subsequent	Average Time	30-99221 Init. IP 99218 Obs. Care	50-99222 Init. IP 99219 Obs. Care	70-99223 Init. IP 99220 Obs. Care
LEVEL	I	II	III	LEVEL	I	II	III

PF=Problem Focused C=Comprehensive EPF= Expanded Problem Focused D=Detailed L= Low H=High M=Moderate