

Provider Name \_\_\_\_\_ Location: \_\_\_\_\_ Date of Visit \_\_\_\_\_ MRN \_\_\_\_\_

Auditor Name: \_\_\_\_\_ E&M code(s): \_\_\_\_\_ ICD9/CPT \_\_\_\_\_

**HISTORY Additional ICD9/CPT codes:**

<b>Chief Complaint (CC):</b> <input type="checkbox"/>				
History of Present Illness (HPI): <input type="checkbox"/> Brief (1-3 elements) <input type="checkbox"/> Extended (4+ elements OR status of 3+ chronic illnesses)				
<input type="checkbox"/> Location	<input type="checkbox"/> Severity	<input type="checkbox"/> Timing	<input type="checkbox"/> Modifying Factors	<input type="checkbox"/> 3+ Chronic Illnesses
<input type="checkbox"/> Quality	<input type="checkbox"/> Duration	<input type="checkbox"/> Context	<input type="checkbox"/> Associated Signs & Symptoms	
Past, Family, and Social History (PFSH): <input type="checkbox"/> None <input type="checkbox"/> Pertinent (1 of any) <input type="checkbox"/> Complete (2 or 3 of 3)				
<input type="checkbox"/> Past: Allergies; Current Medications; Immunizations; Previous Trauma; Surgeries; Previous Illnesses/Hospitalizations				
<input type="checkbox"/> Family: Health of Parents, Siblings, Children; Family Members w/ diseases related to the Chief Complaint				
<input type="checkbox"/> Social: Drug, Alcohol, Tobacco Use; Employment; Sexual History; Marital Status; Education; Occupational History				
Review of Systems: <input type="checkbox"/> None <input type="checkbox"/> Problem Pertinent (1 system) <input type="checkbox"/> Extended (2-9 systems) <input type="checkbox"/> Complete (10+ systems)				
<input type="checkbox"/> Constitutional	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Integumentary	<input type="checkbox"/> Endocrine
<input type="checkbox"/> Eyes	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Neurological	<input type="checkbox"/> Hematologic/Lymphatic
<input type="checkbox"/> Ears, Nose, Mouth/Throat	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Allergic/Immunologic	

**SCORE: HISTORY COMPONENT**

<input type="checkbox"/> Problem Focused	<input type="checkbox"/> Expanded Problem Focused	<input type="checkbox"/> Detailed	<input type="checkbox"/> Comprehensive
CC; Brief HPI	CC; Brief HPI; Problem Pertinent ROS	CC; Extended HPI; Pertinent PFSH; Extended ROS	CC; Extended HPI, Complete PFSH; Complete ROS

**PHYSICAL EXAM**

Body Area/Organ System (BA/OS)	Elements of Examination
<input type="checkbox"/> Constitutional:	<input type="checkbox"/> Measurement of any three vital signs <input type="checkbox"/> General appearance of patient
<input type="checkbox"/> Eyes:	<input type="checkbox"/> Inspection of conjunctivae and lids <input type="checkbox"/> Examination of pupils and irises <input type="checkbox"/> Ophthalmoscopic exam of optic discs
<input type="checkbox"/> Ears, Nose, Mouth/Throat:	<input type="checkbox"/> External inspection of ears and nose <input type="checkbox"/> Assessment of hearing <input type="checkbox"/> Inspection of lips, teeth and gums <input type="checkbox"/> Otoscopic exam of external auditory canals and tympanic membranes <input type="checkbox"/> Examination of oropharynx <input type="checkbox"/> Inspection of nasal mucosa, septum and turbinates
<input type="checkbox"/> Neck:	<input type="checkbox"/> Examination of neck <input type="checkbox"/> Examination of thyroid
<input type="checkbox"/> Respiratory:	<input type="checkbox"/> Assessment of respiratory effort <input type="checkbox"/> Percussion of chest <input type="checkbox"/> Palpation of chest <input type="checkbox"/> Auscultation of lungs
<input type="checkbox"/> Cardiovascular:	<input type="checkbox"/> Palpation of heart <input type="checkbox"/> Auscultation of heart Examination of: <input type="checkbox"/> carotid arteries <input type="checkbox"/> abdominal aorta <input type="checkbox"/> femoral arteries <input type="checkbox"/> pedal pulses <input type="checkbox"/> Extremities for edema/varicosities
<input type="checkbox"/> Chest (Breasts):	<input type="checkbox"/> Inspection of breasts <input type="checkbox"/> Palpation of breasts and axillae
<input type="checkbox"/> Gastrointestinal:	Examination of: <input type="checkbox"/> abdomen, note masses or tenderness <input type="checkbox"/> liver and spleen <input type="checkbox"/> presence or absence of hernia <input type="checkbox"/> Examination of anus, perineum and rectum when indicated <input type="checkbox"/> Stool sample for occult blood when indicated
<input type="checkbox"/> Genitourinary:	Male: exam of scrotal contents <input type="checkbox"/> penis <input type="checkbox"/> prostate Female: exam of ext. genitalia <input type="checkbox"/> exam of urethra <input type="checkbox"/> exam of bladder <input type="checkbox"/> cervix <input type="checkbox"/> uterus <input type="checkbox"/> adnexa
<input type="checkbox"/> Lymphatic:	Palpation of lymph nodes in (two or more): <input type="checkbox"/> Neck <input type="checkbox"/> Axillae <input type="checkbox"/> Groin <input type="checkbox"/> Other
<input type="checkbox"/> Musculoskeletal:	<input type="checkbox"/> Examination of gait and station <input type="checkbox"/> Inspection and/or palpation of digits and nails Examination of joints, bones and muscles of one or more of the following six areas: 1) Head and neck; 2) Spine, ribs and pelvis; 3) Right upper ext; 4) Left upper ext; 5) Right lower ext; 6) Left lower ext. Examination to include: <input type="checkbox"/> Inspection and/or palpation <input type="checkbox"/> Assessment of range of motion <input type="checkbox"/> Assessment of stability <input type="checkbox"/> Assessment of muscle strength and tone
<input type="checkbox"/> Skin:	<input type="checkbox"/> Inspection of skin and subcutaneous tissue <input type="checkbox"/> Palpation of skin and subcutaneous tissue
<input type="checkbox"/> Neurologic:	<input type="checkbox"/> Test cranial nerves, note any deficits <input type="checkbox"/> Examination of deep tendon reflexes <input type="checkbox"/> Examination of sensation
<input type="checkbox"/> Psychiatric:	<input type="checkbox"/> Judgment and insight <input type="checkbox"/> Orientation to person, place and time <input type="checkbox"/> Recent and remote memory <input type="checkbox"/> Mood and affect

**SCORE: PHYSICAL EXAMINATION COMPONENT (1997 Guidelines)**

<input type="checkbox"/> Problem Focused	<input type="checkbox"/> Expanded Problem Focused	<input type="checkbox"/> Detailed	<input type="checkbox"/> Comprehensive
1+ BA/OS (1-5 bulleted elements)	1+ BA/OS (6-11 bulleted elements)	6 BA/OS (2 bullets each) OR (12-17 bulleted elements)	At least 9 BA/OS (2 bullets each = 18 bullets minimum)

**MEDICAL DECISION MAKING**

Number of Diagnoses or Management Options:

Problems to Examining Physician	Number X	Points =	Result
Self limited or minor		1 point	(max = 2)
Established problem; stable or improving		1 point	
Established problem; worsening		2 points	
New Problem; no additional work-up planned		3 points	(max = 3)
New Problem; additional work-up planned		4 points	
		Total	

Amount and/or Complexity of Data to be Reviewed:

Review and/or order of clinical lab tests	<input type="checkbox"/> 1 point
Review and/or order of tests in the radiology section of CPT	<input type="checkbox"/> 1 point
Review and/or order of tests in the medicine section of CPT	<input type="checkbox"/> 1 point
Discussion of tests with the performing physician	<input type="checkbox"/> 1 point
Decision to obtain old records and/or obtain history from someone other than the patient	<input type="checkbox"/> 1 point
Review and summarization of old records; additional history from others; discussion of case with another physician	<input type="checkbox"/> 2 points
Independent visualization of image, tracing or specimen itself (not a review of prepared report)	<input type="checkbox"/> 2 points
<b>Total</b>	

Risk of Significant Complications, Morbidity, and/or Mortality: Highest Level Determines Overall Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s)	Management Options Selected
<input type="checkbox"/> Minimal	One self-limited or minor problem.	Lab tests via venipuncture; X-rays; EKGs ultrasounds; Urinalysis; KOH prep.	Rest, gargles; bandages; Dressings; Elastic bandages
<input type="checkbox"/> Low	Two or more self-limited or minor problems; One stable chronic illness; Acute uncomplicated illness or injury.	Physiologic tests w/o stress; Lab tests via arterial puncture; Superficial biopsies; Non-cardiovascular imaging w/ contrast.	Minor surgery w/o risk factors; OTC drugs; PT or OT; IV therapy w/o additives.
<input type="checkbox"/> Moderate	Chronic illness w/ exacerbation; 2+ stable chronic illnesses; Acute illness w/ systemic symptoms; Complicated acute injury; Undiagnosed new prob. w/ uncertain prognosis.	Physiologic tests w/ stress; endoscopies; Deep biopsies; Fluid from body cavity; Cardiovascular imaging w/o risk factors.	Minor surgery w/ risk factors; Rx drug management; Closed treatment fracture or dislocation; IV therapy w/ additives; Ther nuclear medicine; elective major surgery.
<input type="checkbox"/> High	Chronic illness w/ exacerbation; Life threatening illness/injury; Change in neurologic status.	Cardiovascular imaging w/ contrast, risk; Abrupt endoscopies w/ risk factors; Discography; Cardiac electrophysiological tests.	Elective major surgery/ risk; emergency surgery; Drug therapy w/ monitoring; Do not resuscitate; Parenteral controlled substances.

SCORE: MEDICAL DECISION MAKING COMPONENT Must meet or exceed 2 out of 3

	<input type="checkbox"/> Straightforward	<input type="checkbox"/> Low Complexity	<input type="checkbox"/> Moderate Complexity	<input type="checkbox"/> High Complexity
Number of Diagnoses and/or Treatment Options (total points)	1 = Minimal	2 = Limited	3 = Multiple	4+ = Extensive
Amount and/or Complexity of Data to be Reviewed (total points)	1 = Minimal	2 = Limited	3 = Multiple	4+ = Extensive
Level of Risk	Minimal	Low	Moderate	High

VISIT CODE:  NEW PATIENT (Must meet 3 out of 3)  ESTABLISHED PATIENT (Must meet 2 out of 3)

E&M Code	History	Examination	Medical Decision Making
New: <input type="checkbox"/> Level 1 - 99201	<input type="checkbox"/> Problem Focused	<input type="checkbox"/> Problem Focused	<input type="checkbox"/> Straightforward
<input type="checkbox"/> Level 2 - 99202	<input type="checkbox"/> Expanded Problem Focused	<input type="checkbox"/> Expanded Problem Focused	<input type="checkbox"/> Straightforward
<input type="checkbox"/> Level 3 - 99203	<input type="checkbox"/> Detailed	<input type="checkbox"/> Detailed	<input type="checkbox"/> Low Complexity
<input type="checkbox"/> Level 4 - 99204	<input type="checkbox"/> Comprehensive	<input type="checkbox"/> Comprehensive	<input type="checkbox"/> Moderate Complexity
<input type="checkbox"/> Level 5 - 99205	<input type="checkbox"/> Comprehensive	<input type="checkbox"/> Comprehensive	<input type="checkbox"/> High Complexity
Est: <input type="checkbox"/> Level 1 - 99211	<input type="checkbox"/> Minimal	<input type="checkbox"/> Minimal	<input type="checkbox"/> Straightforward
<input type="checkbox"/> Level 2 - 99212	<input type="checkbox"/> Problem Focused	<input type="checkbox"/> Problem Focused	<input type="checkbox"/> Straightforward
<input type="checkbox"/> Level 3 - 99213	<input type="checkbox"/> Expanded Problem Focused	<input type="checkbox"/> Expanded Problem Focused	<input type="checkbox"/> Low Complexity
<input type="checkbox"/> Level 4 - 99214	<input type="checkbox"/> Detailed	<input type="checkbox"/> Detailed	<input type="checkbox"/> Moderate Complexity
<input type="checkbox"/> Level 5 - 99215	<input type="checkbox"/> Comprehensive	<input type="checkbox"/> Comprehensive	<input type="checkbox"/> High Complexity