

An Independent Licensee of the Blue Cross and Blue Shield Association

E/M DOCUMENTATION AUDITORS' WORKSHEET 1995 Guidelines

Member	Last Name or Identifying Number
	Provider Name
	Date of Service
P	rocedure Code(s) Reported
	□Auditor Agrees □Auditor Disagrees
	Code Assigned by Auditor

Record Audited by Date

E/M Documentation Auditors' Instructions

1. History

Chie	f Complaint:		History Record	led by:			
After		lassifies the history, circle the ty		appropriat	e grid in Sect	ion 5	
	Status of 3 Chronic Conditio	ns is <u>not available</u> within the contex	at of 1995 Guidelines ——				→
	HPI (history of present illness □Location □ Severity □ Quality □ Duration	elements: ☐ Timing ☐ Modifying facto ☐ Context ☐ Associated sign		Brief	Brief	Extended (4 or more)	Extended (4 or more)
ISTORY	ROS (review of systems): ☐ Eyes ☐ Ears, nose, mouth, th ☐ Cardiovascular ☐ Gastrointestinal ☐ Integumentary	☐ Constitutional (wt loss, etc roat ☐ Endocrine ☐ Genitourinary ☐ Hematological/Lymph ☐ Respiratory	c) All others negative Musculoskeletal Neurological Psychological Allergy/Immuno	None	Pertinent to Problem (1 system)	Extended (2-9 Systems)	**Complete
PFSH (past medical, family, social history) areas: ☐ Past history (the patient's past experiences with illnesses, operation, 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)					□ None	Pertinent (1or 2 history areas)	Complete* (2 or 3 history areas)
	HISTORY SCORE			PROBLEM FOCUSED	EXP.PROB. FOCUSED	Detailed	COMPREHENSIVE
*Com	3 history areas: a)	a) Established patients – office (outp. b) Subsequent nursing facility care; d New patients – office (outpatient) ca Initial hospital care; d) Hospital obse) Subsequent hospital ca are, domiciliary care, hon	are ne care; b) In	itial consultatio	ns;	nt;
	or more systems, or some system Examination	ns with statement "all others negative	e"				
		in order to quantify. After referring the appropriate grid in Section		e type of ex	amination.		
Lim	ited to affected body area or o	organ system (one body area or	system related to prob	olem)	PROBLEM	FOCUSE	DEXAM
		em and other symptomatic or rel		EXPAND			

Limited to affected body area or organ system (one body area or system related to problem)	PROBLEM FOCUSED EXAM
Affected body area or organ system and other symptomatic or related organ system(s) (additional systems)	EXPANDED PROBLEM FOCUSED EXAM
Extended exam of affected area(s) and other symptomatic or related organ system(s) (additional systems up to total of 7 (more depth and elaboration than above)	DETAILED EXAM
General multi-system exam (8 or more systems) or complete exam of a single organ system (Body areas do not count)	COMPREHENSIVE EXAM

	Body area:										
	□Head, including face □ Chest, including breasts and axillae □ Abdomen □Neck							1 body area	2 – 4	5-7	8 or
4	□ Back, including spi	ne□ Genitalia, groir	n, buttocks		□Ead	ch extremity	/	-	body	body	more
1			OR					or	areas	areas or	organ
1	Organ systems:								or	organ	systems
П	□Constitutional		Respiratory				□Psych	organ	organ	: systems :	or
	(e.g., vitals, gen app)	mouth, throat \Box	Gastrointestinal	_		□Hem/lym	ph/imm	system	systems	<u>WITH</u>	comprehens.
	□Eyes	□Cardiovascular		□ G	U	□ Neuro				MORE	single organ system exam
										DEPTH	oyotom oxam
Γ	г с	/	`					PROBLEM	EXP.PROB	DETAILED	COMPRE
1	Exam Score –)					FOCUSED	FOCUSED	DETAILED	HENSIVE
- 1											

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. (Maximum number = 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.

Number of Diagnoses or Treatment Options							
Α	В	хс	= 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 additional workup planned	Max=1	3					
New prob (to examiner); add 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 Final Result for Complexity (table below)

Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the point's 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 of 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 form 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 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	v. The overall measure of risk is the highest				
Risk of Con	nplications and/or Morbidity or Mortality	level circled. Enter the level of risk identified in Final Result for Complexity (table below)					
Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected				
Minimal	One self-limited or minor problem e.g. cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, e.g., echo KOH prep	Rest Gargles Elastic bandages Superficial dressings				
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	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	Over the counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives				
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	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, culdocentesis	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				
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	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography	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

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.

Fin	Final Result for Complexity											
A	Number diagnoses or treatment options	≤ 1 Minimal 2 Limited		3 Multiple	≥ 4 Extensive							
В	Highest Risk	st Risk Minimal		Moderate	High							
C.	Amount and complexity of data < 1 Minimor Low		2 Limited	3 Multiple	≥ 4 Extensive							
Тур	e of decision making	STRAIGHT- FORWARD	LOW COMPLEX.	MODERATE COMPLEX.	HIGH COMPLEX.							

1	П	n

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 coordinating care?		Yes		No				
Does documentation reveal to		Yes		No				

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

Outpatient, Consults (OUTPATIENT & INPATIENT) and ER

		New Of		Estab	olished (Office				
		Requires 3 o	omponents within		Re	quires 2 com	ponents with	nin shaded a	rea	
History	PF	EPF	D	С	С	Minimal problem	PF	EPF	D	С
,	ER:PF	ER :EPF	ER :EPF	ER: D	ER: C	that may				
Examination	PF	EPF	D	С	С	not require presence	PF	EPF	D	С
	ER:PF	ER:EPF	ER:EPF	ER: D	ER: C	of				
Complexity of medical	SF	SF	L	M	Н	physician	SF		М	н
decision	ER:SF	ER:L	ER:M	ER: M	ER: H	Y	0.	_		
Average Time (minutes) (ER has no average time)			30 New (99203) 40 Outpt cons (99243) 55 Inpat cons (99253) ER (99283)	45 New (99204) 60 Outpt cons (99244) 80 Inpat cons (99254) ER (99285)	60 New (99205) 80 Outpt cons (99245) 110 Inpat cons (99255) ER (99285)		10 (99212)	15 (99213)	25 (99214)	40 (99215)
Level	I	II	III	IV	V	- 1	II	III	IV	٧

INPATIENT	Initial Hospital/Observation			Subsequent Inpatient/Follow-up				
	Requires	3 components within sh	aded area	Requires 2 components within shaded area				
History	D or C	С	С	PF interval	EPF interval	D interval		
Examination	D or C	С	С	PF	EPF	D		
Complexity of medical decision	SF/L	М	Н	SF/L	М	Н		
Average time (minutes) (Observation care has no average time)	30 Init hosp (99221) Obs care (99218)	50 init hosp (99222) Obs care (99219)	70 Init hosp (99223) Obs care (99220)	15 Subsequent (99231)	25 Subsequent (99232)	35 Subsequent (99233)		
Level	1	II	III	1	II	III		

NURSING FACILITY	Annual Assessment/Admission Old Plan Review New Plan Admission Requires 3 components within shaded area			Subsequent Nursing Facility			
				Requires 2 components within shaded area			
History	D or C	С	С	PF interval	EPF interval	D interval	Comp
Examination	D or C	С	С	PF	EPF	D	Comp
Complexity of medical decision	SF/L	M	Н	SF	L	М	High
Average time (minutes) (Observation care has no average time)	25 Initial (99304) Observ care (99218)	35 Initial (99305) Observ care (99219)	45 Initial (99306) Observ care (99220)	10 Subsequent (99307)	15 Subsequent (99308)	25 Subsequent (99309) 35 Subsequent (99310)	
Level	I	II	III	I	II	Ш	IV