2023 E&M AUDIT TOOL

For Office, Hospital, Home, Care Plan Oversight or Misc. Services

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Step 1 - Determine the Category/Subcategory (Location/Service Type)				
Office *For Office Visits or Other Outpatient Services (99211, 99202-99215), see E/M Outpatient Office Visit audit tool	Consult	☁ Consult (Dr. Referral, New /Est.)	99242-99245	Time
	Prolonged Services	☁ Direct Patient Contact ☁ W/O Direct Patient Contact	99417 and 99418 99358 and 99359	Time Time
	Preventive	☁ New Patient ☁ Established Patient ☁ Other Preventive Services	99381 - 99387 99391 - 99397 96160 and 96161	Age Age Other
	Counseling	☁ Individual ☁ Group Counseling	99401 - 99409 99411 and 99412	Time Time
Hospital	Regular	☁ Initial Inpatient ☁ Subsequent Hospital Care ☁ Hospital Discharge (Time)	99221 - 99223 99231 - 99233 99234 and 99236	Time Time Time
	Observation	☁ Discharge ☁ Initial Observation Care ☁ Subsequent Observation Care ☁ Obs/Inpt Care w/ same day discharge	99238 and 99239 99221 - 99223 99231 - 99233 99234 - 99236	Time Time Time Time
	Consult	☁ Consult (New or Est. Inpatient)	99242 - 99245	Time
	Emergency	☁ Emergency Department ☁ Critical Care ☁ Other (Directed Emergency Care)	99281 - 99285 99291 and 99292 99288	 Time Other
	Prolonged Services	☁ Direct Patient Contact ☁ W/O Direct Patient Contact	99417 and 99418 99358 and 99359	Time Time
	Newborn/Hospital or Birthing Center Care	☁Newborn Care Services	99460 - 99463	Per Day / Other
	Neonatal / Pediatric	☁Pediatric Critical Care Patient Transport ☁Neonatal and Pediatric Critical Care ☁Initial and Continuing Intensive Care Serv.	99466 -99467, 99485 - 99486 99468 - 99476 99477 - 99480	Time Per Day Per Day
Facility	Nursing Facility	☁ Initial NF Care ☁ Subsequent NF Care ☁ Discharge ☁ Annual Assessment	99304 - 99306 99307 - 99310 99315 and 99316 99307-99310	Time Time Time Time
	Rest Home	☁ New Rest Home Patient ☁ Established Rest Home Patient ☁ Home Care Plan Oversight Services	99341 - 99345 99347 - 99350 99437/99341 0r 99424/99425	Time Time Time
Home		☁ Home Visit for New Patient ☁ Home Visit for Established Patient	99341 - 99345 99347 - 99350	Time Time
Misc.		☁ Physician Standby Services ☁ Case Management	99360 99366 - 99368	Time Time/ Other
		☁ Non-Face-to-Face Services- Telephone ☁ Non-Face-to-Face Services - Online	99441 - 99443 99421- 99423	Time Other
		☁ Special Evaluation and Management ☁Complex Chronic Care ☁Transitional Care Management	99446, 99452 99487-99489 99495 - 99498	Other Time Other
Care Plan Oversight		☁ Home Health Agency ☁ Hospice Patient ☁ Nursing Facility Patient	99374 and 99375 99377 and 99378 99379 and 99380	Time Time Time

Other - E/M code is not dependent on HEM, nor Time, Age or Per Day considerations, but by other criteria stated in the E/M code description.

Step 2 - Determine Level of History

A	**CC** Chief Complaint	The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words.			
B	**HPI** History Of Present Illness	☁ location - e.g. left leg, right eye ☁ quality - e.g. burning, stabbing, dull ☁ severity - e.g. bad, intolerable, slight ☁ duration - e.g. 2 days, 72 hours ☁ timing - e.g. "at night", "after I eat" ☁ context - e.g. "when I walk" ☁ modifying factors - e.g. better after rest ☁ associated signs and symptoms - e.g. redness, swelling, fever			
		☁ **Brief (1-3)**		☁ **Extended (4+)**	
C	**ROS** Review Of Systems (questionnaire and/or questions, <u>not</u> touching or looking - that's the exam)	☁ Constitutional symptoms (e.g., fever, weight loss) ☁ Eyes ☁ Ears, Nose, Mouth, Throat ☁ Cardiovascular ☁ Respiratory ☁ Gastrointestinal ☁ Genitourinary		☁ Musculoskeletal ☁ Integumentary (skin and/or breast) ☁ Neurological ☁ Psychiatric ☁ Endocrine ☁ Hematologic/Lymphatic ☁ Allergic/Immunologic	
		☁ **NA**	☁ **Problem Pertinent** Inquires about the system directly related to the problem(s) identified in the HPI.	☁ **Extended** Inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.	☁ **Complete** Inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.
D	**PFSH** Past Family Social History	☁ <u>past history</u> - the patient's past experiences with illnesses, operations, injuries and treatments ☁ <u>family history</u> - a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk ☁ <u>social history</u> - an age appropriate review of past and current activities			
		☁ **NA**	☁ **Pertinent** (a review of the history area(s) directly related to the problem(s) identified in the HPI)	☁ **Complete** (2 or 3) review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services	
E	**HISTORY LEVEL - 3 of 3 must be met (A chief complaint is indicated at all levels)**				
	HPI Score (line B)	☁ Brief	☁ Brief	☁ Extended	☁ Extended
	ROS Score (line C)	☁ NA	☁ Problem Pertinent	☁ Extended	☁ Complete
	PFSH Score (line D)	☁ NA	☁ NA	☁ Pertinent	☁ Complete
	Final History Score	☁ **Problem Focused**	☁ **Expanded Problem Focused**	☁ **Detailed**	☁ **Comprehensive**

Step 3 - Determine Level of Exam

GENERAL MULTI-SYSTEM EXAM

(For Single System Refer to HCFA "Documentation Guidelines for Evaluation and Management Services)

	System/Body Area	Elements/Bullets
A	☁ Constitutional	☁ Measurement of any 3 of the following 7 vital signs 1) siting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (may be measured and recorded by ancillary staff) ☁ General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming.)
	☁ Eyes	☁ Inspection of conjunctivae and lids ☁ Examination of pupils and irises (e.g., reaction to light and accommodation, size and symmetry) ☁ Ophthalmoscopic examination of optic discs (e.g., size, C?D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
	☁ Ears, Nose, Mouth and Throat (ENMT)	☁ External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses) ☁ Otoscopic examination of external auditory canals and tympanic membranes ☁ Assessment of hearing (e.g., whispered voice, finger rub, tuning fork) ☁ Inspection of nasal mucosa, septum and turbinates ☁ Inspection of lips, teeth and gums ☁ Examination of oropharynx (eg., oral mucosa, hard and soft palates, tongue, tonsils posterior pharynx and salivary glands)
	☁ Neck	☁ Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) ☁ Examination of thyroid (e.g., enlargement, tenderness, mass)
	☁ Respiratory	☁ Assessment or respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) ☁ Percussion of chest (e.g., dullness, flatness, hyperresonance) ☁ Palpation of chest (e.g., tactile fremitus) ☁ Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)
	☁Cardiovascular	☁Palpation of heart (eg, location, size, thrills) ☁ Auscultation of heart with notation of abnormal sounds and murmurs Examination of: ☁ carotid arteries (eg, pulse amplitude, bruits) ☁ abdominal aorta (eg, size, bruits) ☁ femoral arteries (eg, pulse amplitude, bruits) ☁ pedal pulses (eg, pulse amplitude) ☁ extremities for edema and/or varicosities
	☁ Chest (Breasts)	☁ Inspection of breasts (eg, symmetry, nipple discharge) ☁ Palpation of breasts and axillae (eg, masses or lumps, tenderness)
	☁ Gastrointestinal (Abdomen)	☁ Examination of abdomen with notation of presence of masses or tenderness ☁ Examination of liver and spleen ☁ Examination for presence or absence of hernia ☁ Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses ☁ Obtain stool sample for occult blood test when indicated
6	☁ Genitourinary (Male)	☁ Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass) ☁ Examination of the penis ☁ Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness)
	☁ Genitourinary (Female)	Pelvic examination (with or without specimen collection for smears and cultures), including· ☁ Examination of external genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)· ☁ Examination of urethra (eg, masses, tenderness, scarring) ☁ Examination of bladder (eg, fullness, masses, tenderness) ☁ Cervix (eg, general appearance, lesions, discharge) ☁ Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support) ☁ Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)
	☁ Lymphatic	Palpation of lymph nodes in two or more areas:· ☁ Neck ☁ Axillae

		☁ Groin ☁ Other			
	☁ Musculoskeletal	☁ Examination of gait and station ☁ Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes) ☁ 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 extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:· Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions ☁ Assessment of range of motion with notation of any pain, crepitation or contracture ☁ Assessment of stability with notation of any dislocation (luxation), subluxation or laxity ☁ Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements			
	☁ Skin	☁ Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers) ☁ Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)			
	☁ Neurologic	☁ Test cranial nerves with notation of any deficits ☁ Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski) ☁ Examination of sensation (eg, by touch, pin, vibration, proprioception)			
	☁ Psychiatric	☁ Description of patient's judgment and insight Brief assessment of mental status including: ☁ orientation to time, place and person ☁ recent and remote memory ☁ mood and affect (eg, depression, anxiety, agitation)			
B	**EXAM LEVEL**	☁ **Problem Focused** One to five elements identified by a bullet.	☁ **Expanded Problem Focused** At least six elements identified by a bullet.	☁ **Detailed** At least two elements identified by a bullet from each of six areas/systems OR at least twelve elements identified by a bullet in two or more areas/systems.	☁ **Comprehensive** Perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems.

Step 4 - Determine Level of Medical Decision Making

A	Number of Dx/Tx Options	☁ Minimal	☁ Low	☁ Multiple	☁ Extensive

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

B	Amount of Data	☁ Minimal or None	☁ Limited	☁ Moderate	☁ Extensive

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

C	Risk Of Significant Complications, Morbidity, And/Or Mortality (refer to table of risk)	☁ Minimal	☁ Low	☁ Moderate	☁ High

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

The following table ***(see next page)*** may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

Number of diagnoses or management options (see A above)	Amount and/or complexity of data to be reviewed (see B above)	Risk of complications and/or morbidity or mortality (see C above)	Type of decision making
Minimal	Minimal or None	Minimal	**Straightforward**
Limited	Limited	Low	**Low Complexity**
Multiple	Moderate	Moderate	**Moderate Complexity**
Extensive	Extensive	High	**High Complexity**

Step 4-C Table

TABLE OF RISK (1 bullet from any box supports level)			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Options Selected**
Minimal	• One self-limited or minor problem, eg, cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, eg, echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, eg, pulmonary function tests • Non-cardiovascular imaging studies with contrast, eg, 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, eg, lump in breast • Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis • Acute complicated injury, eg, head injury with brief loss of consciousness	• Physiologic tests under stress, eg, 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, eg, arteriogram, cardiac catheterization • Obtain fluid from body cavity, eg 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 pose a threat to life or bodily function, eg, 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, eg, seizure, TIA, weakness, sensory loss	• 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

Step 5 - Determine if Time is Dominant Factor

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

A) Total Time	B) Time spent on Hx, PE, and MDM	C) Time spent on counseling or coordination of care	If C is greater than B then Time is the controlling factor to determining level	
▬	▬	▬	Time Controlling Factor?	Y or N

If YES code using TIME Column in step 6. If NO code using the 3 key areas; History, Exam and Medical Decision Making from steps 2,3 & 4.

Step 6 - Determine Final E&M Level

(tip: "when it's 2 of 3 drop the lowest one when it's 3 of 3 code to the lowest")

		HISTORY				EXAM				MEDICAL DECISION MAKING				TIME
Type of Patient	Codes	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Straightforward	Low Complexity	Moderate Complexity	High Complexity	Approximate Time in Min.
Consult	99241	X				X				X				15
Dr. Referral	99242		X				X			X				30
	99243			X				X			X			40
3 of 3	99244				X				X			X		60
	99245				X				X				X	80
Inpatient Consults	99251	X				X				X				20
	99252		X				X			X	X			40
3 of 3	99253			X				X			X			55
	99254				X				X			X		80
	99255				X				X				X	110
Hosp. Inpt. Initial Care	99221			X				X		X				30
	99222				X				X			X		50
3 of 3	99223				X				X				X	70
Subseq. Hosp. Care	99231	X				X				X	X			15
	99232		X				X					X		25
3 of 3	99233			X				X					X	35

		HISTORY				EXAM				MEDICAL DECISION MAKING				TIME
Type of Patient	Codes	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	Straightforward	Low Complexity	Moderate Complexity	High Complexity	Approximate Time in Min.
Initial Observ. Care	99217	Observation Care Discharge												
	99218			X				X		X	X			30
	99219				X				X			X		50
3 of 3	99220				X				X				X	70
Subseq.Obs. Care	99224	X				X				X	X			15
	99225		X				X					X		25
2of 3	99226			X				X					X	35
Obs/Inpt. Care w Same Day Dischrg.	99234			X	X			X	X	X	X			40
	99235				X				X			X		50
	99236				X				X				X	55
Emerg. Dept.	99281	X				X				X				Time is not a factor.
	99282		X				X				X			
3 of 3	99283		X				X					X		
	99284			X				X				X		
	99285				X				X				X	
Init. Nsg. Facil. Asses. 3 of 3	99304			X	X			X	X	X	X			25
	99305				X				X			X		35
	99306				X				X				X	45
Subs. Nsg. Facil.	99307	X				X				X				10
	99308		X				X				X			15
2 of 3	99309			X				X				X		25
	99310				X				X				X	35
Nsg. Facil. Annual Asses. 3 of 3	99318			X					X		X	X		30
New Rest Home Pt. Visit	99324	X				X				X				20
	99325		X				X				X			30
3 of 3	99326			X				X				X		45
	99327				X				X			X		60
	99328				X				X				X	75

Estab. Rest Home Pt. Visit *2 of 3*	99334	X				X				X				15
	99335		X				X				X			25
	99336			X				X				X		40
	99337				X				X			X	X	60
Home Visit for New Pat. *3 of 3*	99341	X				X				X				20
	99342		X				X				X			30
	99343			X				X				X		45
	99344				X				X			X		60
	99345				X				X				X	75
Home Visit for Estab. Pat. *2 of 3*	99347	X				X				X				15
	99348		X				X				X			25
	99349			X				X				X		40
	99350				X				X			X	X	60