SLUCare E/M AUDIT WORKSHEET WITH TP INFORMATION

Invoice Number # _____Patient Name: _____DOS:_____ Reviewer_____

Teaching Phys: _____ Specialty: _____ Audit Date: _____

_____

CPT Code(s) Billed: **Modifier:**	**CPT Code(s) Audited**
ICD-10 Billed	**ICD-10 Codes Documented**
SLU CAPS:	**Billed code supported by medical necessity? Y □ N □**
Linked to resident note? Y □ N □ TP Guides Met? Y □ N □ NA □	**TP Revision Statement: Y □ N □**
Requested Report: Date _____ Received Report: _____	

Comments:

History: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 3 circles, the column containing a circle farthest the **left**, identifies the type of history.

History

CHIEF COMPLAINT:

HPI (history of present illness) elements: ('97:extended also includes status of 3 or > chronic conditions) ❑ Location ❑ Severity ❑ Timing ❑ Modifying Factors ❑ Quality ❑ Duration ❑ Context ❑ Associated signs and symptoms		❑ Brief (1-3)		❑ Extended 4 or more Or '97 chronic 3 or >
ROS (Review of systems): ❑ Constitutional (wt loss, etc) ❑ Ears, nose, mouth, throat ❑ GI ❑ Integumentary (skin, breast) ❑ Endo ❑ Eyes ❑ Card/vasc ❑ GU ❑ Neuro ❑ Hem/Lymph ❑ Resp ❑ Musculoskelet ❑ Psych ❑ All/immuno ❑ All others negative	❑ 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 illness, 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		❑ None	❑ Pertinent (1 history area)	❑ * Complete (2 or 3 history areas)
* Complete PFSH: **10 or more systems, or some systems with statement all others negative **2 hx areas:** a)Estab pts. Office (outpt) care; domicilary care; home care b) Emergency dept c) Subsequent nursing facility **3 hx areas:** a)New pts. Office (outpt) care; domicilary care; home care b) Consultations c)Initial hospital care d)Hospital observation e)Comprehensive nursing facility assessments	**PROBLEM FOCUSED**	**EXP. PROB. FOCUSED**	**DETAILED**	**COMPRE-HENSIVE**

Examination

Body Areas:							
❑ Head, Including face	❑ Chest, including breasts and axillae	❑ Abdomen	❑ Back, including spine	□ 1 body area or system **'95**:Limited to affected body area or organ system (one body area or system related to problem) **'97**=Specialty and GMS: 1-5 elements identified by bullet	□ 2 to 7 systems **'95**:Affected body area or organ system and other symptomatic or related organ system(s) **'97**=Specialty and GMS: At least 6 elements identified by bullet	□ 2 to 7 system **'95**:Extended exam of affected area(s) and other symptomatic or related organ system(s) with 2 systems with extended detail. **'97**=Specialty: At least 12 elements identified by bullet (9 for eye and psyc) GMS= At least 2 bullets from each of 6 areas or at least 12 in 2 or areas	□ 8 or >systems **'95**: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) **'97**=Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area. GMS: At least 2 elements with bullet from each of 9 areas/systems
❑ Neck		❑ Genitalia, groin, buttocks	❑ Each extremity				
Organ Systems:							
❑ Constitutional (wt loss, etc)	❑ Cardio/vasc	❑ GU	❑ Neuro				
❑ Eyes	❑ Resp	❑ Musculo - skeletal	❑ Psych				
❑ Ears, nose, mouth, throat	❑ GI	❑ Skin	❑ Hematologic/ Lymph/Immu				
				PROBLEM FOCUSED	**EXP. PROB. FOCUSED**	**DETAILED**	**COMPREHENSIVE**

Medical Decision Making

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 additional workup planned		*Max=1*	3	
New prob. (to examiner); add. workup planned			4	
			Total	

Multiply the # 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 next page)

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

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 pt	**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:

Risk of Complications and/or Morbidity or Mortality
Risk related to the *Presenting Problem* is based on the **risk anticipated between the current and next encounter.**
Risk related to *Diagnostic Procedures* or *Management Options* is based on the **risk anticipated during and immediately after procedure or txt.**

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)

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	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound • 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 • 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 not under stress, e.g., cardiac stress test, fetal contraction 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 or 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 with identified risk factors) • 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.

Final Result for Complexity

A	Number diagnoses or treatment options	**≤ 1** Minimal	**2** Limited	**3** Multiple	**≥ 4** Extensive
B	Amount and complexity of data	**≤ 1** Minimal	**2** Limited	**3** Multiple	**≥ 4** Extensive
C	Highest Risk	Minimal	Low	Moderate	High
Type of decision making		**STRAIGHT-FORWARD**	**LOW COMPLEX.**	**MODERATE COMPLEX.**	**HIGH COMPLEX.**

Time

If the physician documents total time and suggests that counseling or coordination of 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 with patient/family in outpatient setting. Unit /floor in inpatient setting)	❑ **Yes**	❑ **NO**
Does documentation describe the content of counseling or coordinating care?	❑ **Yes**	❑ **No**
Does documentation reveal that more than half of the time was counseling or coordinating care?	❑ **Yes**	❑ **No**

Level of Service

Outpatient, Consults (OUTPATIENT & INPATIENT) and ER

	New Office/Consults/ER (Requires 3 key components)					Established Office (Requires 2 key components)				
History	**PF**	**EPF**	**D** ***ER:EPF***	**C** ***ER:D***	**C**	***Minimal problem that may***	**PF**	**EPF**	**D**	**C**
Examination	**PF**	**EPF**	**D** ***ER:EPF***	**C** ***ER:D***	**C**	***Not require the***	**PF**	**EPF**	**D**	**C**
Complexity of MDM	**SF**	**SF** ***ER:L***	**L** ***ER:M***	**M**	**H**	***Presence of a physician***	**SF**	**L**	**M**	**H**
Average time (minutes)	10 New (99201) 15 Outpt cons (99241) 20 Inpt cons (99251) ER (99281)	20 New (99202) 30 Outpt cons (99242) 40 Inpt cons (99252) ER (99282)	30 New (99203) 40 Outpt cons (99243) 55 Inpt cons (99253) ER (99283)	45 New (99204) 60 Outpt cons (99244) 80 Inpt cons (99254) ER (99284)	60 New (99205) 80 Outpt cons (99245) 110 Inpt cons (99255) ER (99285)	5 (99211)	10 (99212)	15 (99213)	25 (99214)	40 (99215)
Level	**I**	**II**	**III**	**IV**	**V**	**I**	**II**	**III**	**IV**	**V**

	Initial Hospital/Observation (Requires 3 key components)			Subsequent Inpatient (Requires 2 key components)		
History	**D**	**C**	**C**	**PF Interval**	**EPF Interval**	**D Interval**
Examination	**D**	**C**	**C**	**PF**	**EPF**	**D**
Complexity of MDM	**SF/L**	**M**	**H**	**SF/L**	**M**	**H**
Average time (minutes)	30 Init hosp (99221) Observ care (99218)	50 Init hosp (99222) Observ care (99219)	70 Init hosp (99223) Observ care (99220)	15 Subsequent (99231)	25 Subsequent (99232)	35 Sub. (99233)
Level	**I**	**II**	**III**	**I**	**II**	**III**