Evaluation & Management Coding – Medical Charge Review

Medical Record Number: ___________________  DOS: ___________________
Insurance: _______________________________  Physician of Record: ________________

History
1. Chief Complaint
2. H.P.I (Location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms)
   Brief = 1 to 3; Extended = 4 or more
3. ROS (constitutional, eyes, mouth, ENT, CV, Resp, GI, GU, Neuro, Musculoskeletal, Integumentary, Endo, Psych, Hem / Lymph, Allergy, Immuno)
   Extended = more than 2; Complete = 10 or more or statement “all other systems neg”
4. Past, Family, Social History (PFSH) Includes medication review and occupational health
   Past Hx_____________________
   Social Hx____________________
   Family Hx____________________

PFSH not necessary for codes with only an interval history

Hx Level: Prob Focused:_________ Exp Prob Focused:_________ Detailed:_________ Comprehensive:_________

Examination
Prob Focused: 1; Exp Problem Focused: 2 or more; Detailed: 7; Comprehensive: 8 or more

1997 Guidelines/Exams: General Multi System and Single Organ System exams (see reference cards for Eye, ENT, Cardiovascular, Genitourinary, General Multi System, Hem/Lymph/Immuno, Musculoskeletal, Neurological, Psychiatric, Respiratory, Skin)
Prob Focused (Level 1 & 2 exam) = 1 to 5 elements
Exp Problem Focused (Level 3 exam) = 6 or more elements
Detailed (Level 4 exam) = 2 elements in 6 systems or 12 elements in 2 systems for Gen Multi System exam
OR
   = 12 or more elements for Single Organ System exam
Comprehensive (Level 5 exam) = 2 elements in 9 systems / areas for Gen Multi System exam
OR
   = All elements identified by a bullet in each major system, and one element in each minor System

Exam Level: Prob focused: _____ Exp Prob Focused: ______ Detailed: ______ Comprehensive:________

Medical Decision Making (Two of the Three areas must be met or exceeded)
1. Number of Diagnoses and or management options (Clinical Assessment, Impressions, Referrals, and Changes in Rx)
   • Self Limited / minor problem, stable, improved, worsening = 1 point (Max = 2 pts)
   • Established problem stable = 1 point
   • Established problem worsening = 2 points
   • New problem no additional work up = 3 points (Max = 3 pts)
   • New problem with additional work up = 4 points
Min = 1; Limited = 2; Multi = 3; Extensive = 4  Total Dx = ____________

2. Amount and / or complexity of the data to be reviewed
   • Ordered / reviewed labs / x-rays = 1 point for each (Blood work, U/A, chest x-ray)
   • Independent review of tracings, specimens = 2 points
   • Review / summarization of old records from someone other than patient = 2 points
   • Decision to obtain old records from someone other than the patient = 1 point
   • Discussion of tests with performing physician = 1 point
Min = 1; limited = 2; Multi = 3; Extensive = 4  Total Data = ____________

3. Level of Risk  Refer to Risk Table  The highest level of risk in any one category establishes over all risk
Min = 1;  Low = 2;  Mod = 3;  High = 4  Total Risk = ____________

Total Dx:_________  Total Data:_________  Total Risk:_________ = Medical Decision:_________
Level of History: _______ Level of Exam: _______ Level of Med Dec: _______ = CPT Code_________

MRN # ____________________________
Physician __________________________

Critical Care Services

Time Recorded: Yes___ No ___ (do not code critical care if time not documented)

Circle all services included in critical care that are documented:
- Interpretation of cardiac output (93561-62)
- Blood gases & other info, stored in computers (90990)
- Temp transcut pacing (92953)
- Vascular access procedure (36000, 36410, 36415, 36540, 36600)
- Chest x-rays (71010, 71020, 71015)
- Pulse Oximetry (94760, 94761, and 97462)
- Gastric intubation (91105, 43752)
- Vent management (94002 – 94004, 94660, 94662)

Documentation of an E&M service dominated by Counseling or Coordination of Care

If Counseling or coordination of care is greater than 50% of the encounter, time becomes the key element for code selection. The documentation should include the total time spent with the patient, and must include a brief summary of the discussion.

Time reported: Yes_________ No______________ N/A_______________
_____________________________________________________________________

Documentation By:
Teaching Physician (Attending)_______________________________________
Attending note follows and verifies findings in the resident’s note______________
Attending’s presence noted by other source_______________________________
Countersignature_____________________________________________________
No Documentation for DOS____________________________________________
Code selection based on combination of attending and resident notes_________
Outpatient Primary Care Exception services: Attending confirms / revises and notes the finding of the resident____________

Documentation is: signed, stamped, electronic, dictated, legible (circle all that are found)

Code selection

Initial Visits and Consults – All three key elements must be met. If not, select the lowest level met.
Subsequent visits – Two of three key elements must be met. If several different levels are documented, select the middle level element that was documented.

CPT Code Charged: ______________ CPT Code Documented: ______________
Modifier Charged: ______________ Modifier Documented: ______________
ICD Code Charged: ______________ ICD Code Documented: ______________
Date of Review: _______________ Reviewer: ___________________________

NOTES:

Columbia University Medical Center
Office for Billing Compliance
Initiated 1/97
Rev 3/99
Rev 3/01
Rev 2/02
Rev 3/02
Rev 1/07