

## Evaluation & Management Coding – Medical Charge Review

Medical Record Number: \_\_\_\_\_ DOS: \_\_\_\_\_  
Insurance: \_\_\_\_\_ Physician of Record: \_\_\_\_\_

### History

Present

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

**1995 Guidelines (Originated 1/92)** Constitutional, Eyes, ENT, Cardiovas, Resp, Gastro, Urology, Musculoskeletal, Skin, Neuro, Psych, Hem/Lymph/Immuno, Head, Neck, Chest, Abdomen, Genitalia, Back,  
Each Extremity – number of UEs \_\_\_ LEs \_\_\_

**Prob Focused: 1; Exp Prob 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