Evaluation and Management (E&M) Audit Form
Colorado Workers' Compensation Exhibit #7

Injured Worker Name:_____ ☐ **New** or ☐ **Established Patient**, **Date of Injury** __/__/__ **E&M**

Provider's Name: _____
Reviewing/Paying Insurer Name: _____

Place of Service: ☐Office, ☐Hospital, ☐Freestanding facility, ☐ ERD, ☐Other_____ **Date of Service**__/__/__

Billed E&M CPT code: _____
Audited E&M Level code: _____

Chief Complaint (required): _____

Medical necessity of the visit must be identifiable somewhere within the written report.

Did the documentation meet the Consultation Criteria Required in Rule 18?

1. Is who requested the consultation in the report? Yes or No
2. Does the report contain one of the following reasons for a consultation:
    a. A specified diagnosis confirmation
    b. Symptom evaluation/diagnosis by a specialist
    c. Evaluation for acceptance of patients ongoing care for a specified condition or problem
3. The consultant's report was submitted to the requesting provider as a:
    a. Carbon Copy (CC); or
    b. Addressed directly to the requesting provider
    c. Not identified at all

Medical Documentation Guidelines Used for this Audit:

☐Exhibit #7 to Rule 18, (effective__/__/____) using either: (circle either a. or b.)
    a. Three Key Components, or
    b. Counseling/Coordination of Care was > 50% of Visit

☐Medicare's 1997 E/M Documentation Guidelines (Requires a different appropriate 1997 Documentation Audit Template)

Exhibit #7 Relevant History Key Component

History of Present Illness (HPI)
- ☐Location: _____
- ☐Quality: _____
- ☐Severity: _____
- ☐Duration: _____
- ☐Timing: _____
- ☐Context: _____
- ☐Modifying factors:_____
- ☐Associated signs: _____

Total # of HPIs___

Review of Systems(ROS)
- ☐Constitutional symptoms
- ☐Eyes
- ☐Ears, Nose, Mouth, Throat
- ☐Cardiovascular
- ☐Respiratory
- ☐Gastrointestinal
- ☐Musculoskeletal
- ☐Integument
- ☐Neurological
- ☐Psychiatric
- ☐Endocrine
- ☐Hematologic/lymphatic
- ☐Allergic/Immunologic
- ☐ Genitourinary

Total # of ROSs:___

Past, Family, Social History (Check Applicable 1-4 types of hxs documented)

☐***Patient current and past medical***
- ☐Current medications
- ☐Prior illnesses
- ☐Operations and hospitalization
- ☐Allergies
- ☐Injuries

☐***Family***
- ☐Parents, siblings, etc.
- ☐Hereditary disease(s)
- ☐Diseases related

☐***Social***
- ☐Living arrangements
- ☐Marital Status – married, single, divorced
- ☐Sexual history
- ☐Use of drugs, alcohol, or tobacco
- ☐Current and/or past physical activities
- ☐Current and/or past hobbies
- ☐Patient's emotional support system
- ☐Identified issues for RTW or Tx Plan

☐***Occupational***
- ☐Currently working or not
- ☐Review of past job history
- ☐Past occupational history
- ☐Education

Total # of Hxs:__

History Elements	***Requirements for a Problem Focused (PF) History Level***	***Requirements for an Expanded Problem Focused (EPF) History Level***	***Requirements for a Detailed (D) History Level***	***Requirements for a Comprehensive (C) History Level***
History of Present Illness/Injury (HPI)	Brief 1-3 elements	Brief 1-3 elements	Extended 4+ elements (Initial visits require(s) an injury causation statement and or an objective functional goal treatment plan. Follow-up visits require objective functional gains/losses, ADLs etc)	Extended 4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which should include objective functional gains/losses, ADLs) (Initial visits require(s) an injury causation statement and or an objective functional goal treatment plan. Follow-up visits require objective functional gains/losses, ADLs or RTW)
Review of Systems (ROS) is not required for established patient visits.	None	Problem pertinent – limited to injured body part	2 to 9 body parts or body systems	Complete 10+
Past Medical, Family and Social and Occupational History (PMFSOH)	None	None	Pertinent 1 of 4 types of histories	2 or more of the 4 types of histories

Was an objective functional goal present in the documentation? Yes__ or No__
Was there an assessment of any functional gains or losses? Yes__ or No__

Exhibit #7 Documented Pertinent and Injury Related Examination Key Component

Constitutional Measurements: any three (3) = 1 bullet

- ☐Sitting or standing B/P
- ☐Supine B/P
- ☐Pulse rate and regularity
- ☐Respirations
- ☐Temperature
- ☐Height
- ☐Weight
- ☐Weight or BMI

Total # of three (3) constitutional measurements:___

Musculoskeletal Separate Body Areas:

- ☐Head and/or neck
- ☐Spine or ribs and pelvis or all three
- ☐Right upper extremity (shoulder, elbow, wrist, entire and)
- ☐Left upper extremity
- ☐Right lower extremity
- ☐Left lower extremity

One Bullet for any three (3) Musculoskeletal Assessments of a given body area includes:

☐ Inspection, percussion, and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions

☐ Assessment of range of motion with notation of any pain (eg straight leg raising) crepitation or contractures

☐ Assessment of stability with notation of any dislocation (luxation), subluxation or laxity

☐ Assessment of muscle strength and tone (eg flaccide, cog wheel, spastic) with notation of any atrophy or abnormal movements (Fasciculation, tardive dyskinesia.

Total # of Separate Body areas with three (3) or more musculoskeletal assessments performed:____

Examination of Gait and Station = ☐ ***One (1) bullet***

☐ ***One bullet for commenting on the general appearance of patient*** if not addressed under neuro or psychiatric (development, nutrition, body habitus, deformities, attention to grooming).

Neck: one bullet for both examinations

- ☐Neck exam (e.g. masses, overall appearance, symmetry, tracheal position, crepitus)
- ☐Thyroid exam (enlargement, tenderness, mass)

Neurological: One bullet for each neurological exam/assessments per extremity ☐***R leg and or*** ☐**L Leg and** ☐**R Arm and** ☐ **L Arm**

- ☐Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities
- ☐UE Unilateral or ☐Bilateral: and or ☐ LE Unilateral or ☐Bilateral -Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)
- ☐ UE Unilateral or ☐Bilateral; and or ☐LE Unilateral or ☐Bilateral Examination of sensation (e.g., by touch, pin, vibration, proprioception)
- ☐One (1) bullet for all of the 12 cranial nerves assessments with notations of any deficits

Cardiovascular

- ☐One (1) bullet per extremity examination/assessment of peripheral vascular system by:
  - Observation (e.g., swelling, varicosities); and
  - Palpation (e.g., pulses, temperature, edema, tenderness)
- ☐One (1) bullet for palpation of heart (e.g., location, size, thrills)
- ☐One (1) bullet for auscultation of heart with notation of abnormal sounds and murmurs
- ☐One (1) bullet for examination of each of the following:
  - carotid arteries (e.g., pulse amplitude, bruits)
  - abdominal aorta (e.g., size, bruits)
  - femoral arteries (e.g., pulse amplitude, bruits)

Skin ☐One (1) bullet for pertinent body part(s) inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, cafeau-lait pots, ulcers)

Respiratory (one (1) bullet for each examination/assessment)

- ☐Assessment of 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)

Gastrointestinal (one (1) bullet for each examination /assessment)

- ☐Examination of abdomen with notation of presence of masses or tenderness and liver and spleen
- ☐Examination of presence or absence of hernia
- ☐Examination (when indicated) of anus, perineum and rectum, including sphincter tone, present of hemorrhoids, rectal masses and/or obtain stool sample of occult blood test when indicated

Psychiatric

- ☐One (1) bullet for assessment of mood and affect (e.g., depression, anxiety, agitation) if not counted under the Neurological system
- ☐One (1) bullet for a mental status examination which includes:
  - Attention span and concentration; and
  - Language (e.g., naming objects, repeating phrases, spontaneous speech) orientation to time, place and person; and
  - Recent and remote memory; and
  - Fund of knowledge (e.g., awareness of current events, past history, vocabulary)

Eyes

- ☐*One (1) bullet for* ***both eyes and all three (3) examinations/assessments***
  - Inspection of conjunctivae and lids; and
  - Examination of pupils and irises (e.g., reaction of light and accommodation, size and symmetry); and
  - Opthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

Ears and Nose, Mouth and Throat

☐One (1) bullet for all of the following examination/assessment:

- External inspection of ears and nose (e.g., overall appearance, scars, lesions, asses)
- Otoscopic examination of external auditory canals and tympanic membranes
- Assessment of hearing with tuning fork and clinical speech reception thresholds (e.g., whispered voice, finger rub, tuning fork)

☐One (1) bullet for all of the following examinations/assessments:

- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces)

Genitourinary

MALE – One (1) bullet for each of the following examination of the male genitalia:

☐The scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)
☐Epididymides (e.g., size, symmetry, masses)
☐Testes (e.g., size symmetry, masses)
☐Urethral meatus (e.g., size location, lesions, discharge)
☐Examination of the penis (e.g., lesions, presence of absence of foreskin, foreskin retract ability, plaque, masses, scarring, deformities)
☐Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)
☐Inspection of anus and perineum

FEMALE –One (1) bullet for each of the following female pelvic examination(s) (with or without specimen collection for smears and cultures):

☐Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele rectocele)
☐Examination of urethra (e.g., masses, tenderness, scarring)
☐Examination of bladder (e.g., fullness, masses, tenderness)
☐Cervix (e.g., general appearance, lesions, discharge)
☐Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
☐Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

Chest ☐One (1) bullet for both examinations/assessments of both breasts)

- Inspection of breasts (e.g., symmetry, nipple discharge); and
- Palpation of breasts and axillae (e.g., masses or lumps, tenderness)

***Lymphatic palpation of lymph nodes* – two (2) or more areas is counted as one (1) bullet:**

☐Neck
☐Axillae
☐Groin and ☐Other_____

Please verify all of the completed examination components listed in the report documents the relevance/relatedness to the injury and or "reasonable and necessity" for that specific patient's condition. Any examination bullet that is not clearly related to the injury or a patient's specific condition will not be counted/considered in the total number of bullets for the level of service.

Level of Examination Performed and Documented	***# of Bullets Required for each Level***
Problem Focused (PF)	1 to 5 elements identified by a bullet as indicated in this guideline
Expanded Problem Focused(EPF)	6 elements identified by a bullet as indicated in this guideline
Detailed(D)	7-12 elements identified by a bullet as indicated in this guideline
Comprehensive(C)	> 13 elements identified by a bullet as indicated in this guideline

Medical Decision Making (MDM) Key Component

1. Number of CONDITIONS & Management Options (list the dx(s) and the worsening if applicable)					
Category of Problem(s)	**Occurrence of Problem(s)**		**Value**		**TOTAL**
Self-limited or minor problem	(max 2)	X	1	=	
Established problem, stable or improved		X	1	=	
Established problem, minor worsening		X	2	=	
Established problem with minor worsening of condition and with improvement within expected time frame		X	2	=	
Established problem without improvement within expected time frame that requires treatment plan changes; with or without additional workup.	(max 1)	X	4	=	
New problem with no additional workup planned; or	(max 1)	X	3	=	
New problem, with additional workup planned		X	4	=	

2. Amount and/or Complexity of Data Reviewed (list the who and/or what testing was ordered or reviewed)	
Date Type:	Points
Lab(s) ordered and/or reports reviewed	1
X-ray(s) ordered and/or reports reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Medicine section (90701-99199) ordered and/or physical therapy reports reviewed and commented on progress (state whether the patient is progressing and how they are functionally progressing or not and document any planned changes to the plan of care)	2
Review and summary of old records and/or discussion with other health provider	2
Independent visualization of images, tracing or specimen	2
TOTAL	

3. Table of Risk (the highest one in any one category determines the overall risk for this portion) (circle what is determining the level)

Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered or Addressed**	**Management Option(s) Selected**
Minimal	One self-limited or minor problem, e.g., cold, insect bite, tinea corpori, minor non-sutured laceration	Lab 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-controlle HTN, NIDDM, cataract, BPH Acute, uncomplicated illness or injury, e.g., allergic rhinitis or simple sprain cyctitis Acute laceration repair	Physiologic tests nor under stress, e.g., PFTs Non-cardiovascular imaging studies w/contrast, e.g., barium enema Superficial needle biopsies Lab tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery w/no identified risk factors PT/OT IV fluids w/o additives Simple or layered closure Vaccine injection
Moderate	One of more chronic illnesses with mild exacerabation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g., new extremity neurologic complaints. Acute illness with systemic symptoms, e.g., pyelonephritis, colitis. Acute complicated injury, e.g., head injury with brie loss of consciousness	Physiologic tests under stress, e.g. cardiac stress test, Discography, stress tests Diagnostic injections Deep needle or incisional biopsies Cardiovascular imaging studies with contrast and no identified risk factors e.g. arteriogram, cardiac catheter. 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 additi Closed Tx of Fx or dislocation w/o manipulation Inability to return the injured worker to work and requires detailed functional improvement plan.
High	One or more chronic illness with severe exacerbation, progression or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multipl trauma, acute MI, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self others; An abrupt change in neurological statu e.g., seizure, TIA, weakness, sensory loss	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors	Elective major surgery with identified risk factors Emergency major surgery Parenteral controlled substances Drug therapy requiring intensive monitoring for Toxicity. Decision not to resuscitate or to De-escalate care because of poor prognosis. Potent for significant permanent work restrictions or tota disability. Management of addiction behavior or other significant psychiatric condition. Treatment plan for patients with symptoms causing severe functional deficits without supporting physiologica \findings or verified related medical diagnosis.

Level of Risk	**1. # of Points for the # of Dxs and Management Option(s)**	**2. # of Points for Amount and Complexity of Data**	**3. Level of Risk**
Straightforward (SF)	**0-1**	**0-1**	**Minimal**
Low (L)	**2**	**2**	**Low**
Moderate (M)	**3**	**3**	**Moderate**
High (H)	**4+**	**4+**	**High**

Overall MDM is determined by 2 of the 3 MDM Tables that are at the same level or higher.

Level of Service Based upon Time

Documentation must be patient specific and pertain directly to the current visit. Information copied directly from prior records without change is not considered current nor counted.

If time is used to establish the level of visit and total amount of time falls in between two (2) levels, then the provider's time shall be more than half way to reaching the higher level.

Timing of Counseling or Coordination of Care-If these activities are done outside of the 24 hours prior to or seven (7) business days after the patient encounter, then 18-5(I)(4) "Treating Physician Telephone or On-line Services" or 18-6(A) "Face-to-Face or Telephonic meeting by a Treating Physician with the Employer … With or Without the Injured Workers" is applicable

a. Did the counseling or coordination or care occur 24 hours prior to the actual patient encounter? Yes ☐ or No ☐
b. Did the counseling or coordination of care occur within seven (7) business days after the actual patient encounter? Yes ☐ or No ☐

Counseling (Yes must be answers to all of these questions before time can be used)

a. Is total time of the visit and total time counseling documented? Yes ☐ or No ☐
b. Was the date of the counseling listed in the documentation? Yes ☐ or No ☐
c. Was > 50% of the time spent with the patient counseling? Yes ☐ or No ☐
d. Did the documentation contain patient responses to show the patient was an active participant in the counseling session? Yes ☐ or No ☐
e. Check one (1) or more of the following face-to-face physician counseling topics done with the patient and/or their family at that visit:
   - ☐ Injury/disease education that includes discussion of diagnostic tests results and a disease specific treatment plan.
   - ☐ Return to work_____
   - ☐ Temporary and/or permanent restrictions_____
   - ☐ Self-management of symptoms while at home and/or work_____
   - ☐ Correct posture/mechanics to perform work functions_____
   - ☐ Job task exercises for muscle strengthening and stretching_____
   - ☐ Appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury/condition_____
   - ☐ Patient/injured worker expectations and specific goals_____
   - ☐ Family and other interpersonal relationships and how they relate to psychological/social issues_____
   - ☐ Discussion of pharmaceutical management (includes drug dosage, specific drug side effects and potential of addiction /problems
   - ☐ Assessment of vocational plans (i.e., restrictions as they relate to current and future employment job requirements)
f. Does the documentation contain specific documentation of the counseling (ie identifies the issues, patients response, decisions made etc): Yes ☐ or No ☐

Additional discussion of any items discussed with patient:

_____
_____
_____
_____
_____
_____
_____
_____

Coordination of Care (Yes must be answered in a.-c. and the person(s) and services/treatments coordinated identified)

a. Is total time of the visit and total time coordination of care documented? Yes ☐ or No ☐
b. Was > 50% of the time spent coordination of care documented? Yes ☐ or No ☐
c. Does the documentation include a date the coordination took place? Yes ☐ or No ☐ occurred: __/__/__
d. Name of person coordination is being made with: _____
   - ❖ Who does this person represent: ☐ employer, ☐ physician, ☐ PT/OT, ☐ Nurse Case Mgr, ☐Insurer, 3rd party, ☐ Other _____
e. Did the physician call/meet a health care provider outside of their own clinic or with the injured workers employer?
   - ❖ Healthcare provider☐ or employer ☐;
f. What services/treatments were coordinated? (check all that apply)
   - ☐RTW_____
   - ☐Treatment _____
   - ☐Diagnostic Testing_____
   - ☐ Other_____

Overall Billable Level of Service

(Circle the E&M Level as determined by the Documentation Guideline Used)

New Patient/Office Consultations - (Requires *all (3) three key components* at the same level or higher)

Level of Service	1. Hx	2. Exam	3. MDM	Avg. time (minutes) as listed for the specific CPT© code
99201/99241	Problem Focused (PF)	PF	Straight Forward (SF)	10
99202/99242	Extended Problem Focused (EPF)	EPF	SF	20
99203/99243	Detailed (D)	D	Low	30
99204/99244	Comprehensive(C)	C	Moderate	45
99205/99245	C	C	High	60

Established Patient Office Visit - (Requires at least *(2) two of the three key component, MDM must be one of the two key components,* at the same level or higher)

Level of Service	1. Hx	2. Exam	3. MDM	Avg. time (minutes) as listed for the specific CPT code
99211	N/A	N/A	N/A	5
99212	PF	PF	SF	10
99213	EPF	EPF	Low	15
99214	D	D	Moderate	25
99215	C	C	High	40