

PREPAYMENT AUDIT FORM

Patient Name: _____ Auditor: _____

Med. Rec. No: _____ Audit Date: _____

Date of Service: _____ Physician/No: _____

Charge Ticket Review:

E/M Level Circled: _____ Procedure(s): _____

Diagnosis on ticket: (1) _____ (2) _____
 (3) _____ (4) _____

Lab/Xray on ticket: _____

Progress Note Review:

Diagnoses: (1) _____ (2) _____ Auditor's E/M _____
 (3) _____ (4) _____

Procedure(s): _____

Lab/X-ray: _____

Does the progress note diagnoses match the charge ticket? Yes No

Comments: _____

Chart Review

Patient Status: New Established

EM Category: Office Consultation

Chief Complaint: _____

For re-evaluation use 1997 guidelines
 Chronic disease _____
 Chronic disease _____
 Chronic disease _____

HISTORY	HPI (History of Present Illness) <input type="checkbox"/> Location <input type="checkbox"/> Severity <input type="checkbox"/> Timing <input type="checkbox"/> Modifying factors <input type="checkbox"/> Quality <input type="checkbox"/> Duration <input type="checkbox"/> Context <input type="checkbox"/> Associated signs & symptoms		1-3 elements		>4 elements >3 Status of chronics	
	ROS (Review of Systems) <input type="checkbox"/> Constitutional (wt loss, etc) <input type="checkbox"/> Ears,nose mouth,thrt <input type="checkbox"/> Eyes <input type="checkbox"/> GI <input type="checkbox"/> Integument (skin,breast) <input type="checkbox"/> Neuro <input type="checkbox"/> Endo <input type="checkbox"/> Hem/lymph <input type="checkbox"/> Env. All/Imm <input type="checkbox"/> Musculo <input type="checkbox"/> Psych <input type="checkbox"/> "All others negative"	None	Pert to Problem 1 system	Extended 2-9 systems	Complete >10 systems or "All neg"	
	PFSH (Past family and social history) <input type="checkbox"/> Past medical history/NKDA <input type="checkbox"/> Family history <input type="checkbox"/> Social history	Established	None	None	1	2 or 3
		New/Consults	None	None	1 or 2	3
History Level Selected Must have 3 for 3		Problem Focus	Extend Problem Focus	Detailed	Comprehensive	

EXAM	Examination/Organ Systems: <input type="checkbox"/> Constitutional (eg.vitals,gen app) <input type="checkbox"/> Ears,nose, mouth,thrt <input type="checkbox"/> Eyes <input type="checkbox"/> Affected body area: _____ <input type="checkbox"/> Resp <input type="checkbox"/> Musclo <input type="checkbox"/> Psych <input type="checkbox"/> GI <input type="checkbox"/> Skin <input type="checkbox"/> Neuro <input type="checkbox"/> Hem/lymph/Imp	Body area or system related problem	2 – 4 sys or 6 bullets	5 – 7 sys or 12 bullets from 2 sys	8 or more systems or 18 bullets from 9 systems
	Exam Level Selected	Problem Focus	Extend Problem Focus	Detailed	Comprehensive

Time: If the physician documents total time and suggests that counseling or coordinating care dominates the encounter (more than 50%), time may determine level of service. **If all answers are "yes", may select level based on time.**

- Does documentation reveal total time? (Time is face-to-face in OP or IP setting) Yes No
- Does documentation describe the content of counseling or coordinating care? Yes No
- Does documentation reveal that more than half of time was counseling or coordinating care? Yes No