E/M Audit Checklist

A focused review tool for medical decision-making, time, risk, data, documentation, and level-of-service validation.

Audit purpose: Verify that the reported E/M category and level are supported by the medical record, current coding guidance, medical necessity, and applicable payer requirements.

Encounter & Code Family Verification

- ■ Correct patient, date of service, provider, and place of service are identified.
- ■ The selected E/M code family matches the documented setting and encounter type.
- ■ New versus established patient status is verified when applicable.
- ■ Initial, subsequent, discharge, consultation, emergency, nursing facility, home, or other category requirements are reviewed as applicable.
- ■ The reported service is eligible for selection by medical decision-making, total time, or another category-specific method.

Medical Decision-Making Overview

- ■ The record clearly identifies the problems evaluated or managed during the encounter.
- ■ The amount and complexity of data reviewed and analyzed are supported.
- ■ The risk of patient management is documented and clinically relevant.
- ■ The reported MDM level is based on the required number of MDM elements.
- ■ No element is credited solely because information appears elsewhere in the record without evidence that it affected the encounter.

Problems Addressed

- ■ Each condition credited toward MDM was evaluated or treated during the encounter.
- ■ The documented status of each problem supports its assigned complexity.
- ■ Stable, worsening, uncontrolled, acute, chronic, and threat-related descriptions are clinically supported.
- ■ Conditions merely listed in the history or problem list are not counted unless addressed.
- ■ The assessment and plan show how each credited problem affected management.

Data Reviewed & Analyzed

- ■ Tests, documents, records, and historian information credited toward data are identified.
- ■ Orders and reviews are not counted twice when the applicable rules treat them as a single data element.
- ■ Independent interpretation is separately documented and is not already included in another reported service.
- ■ Discussion with an external physician or qualified health care professional is documented when credited.
- ■ The data level is calculated using current category-specific E/M requirements.

Risk of Patient Management

- ■ Management decisions are clearly documented.
- ■ Prescription drug management, procedures, hospitalization decisions, or other risk factors are supported by the record.
- ■ Risk is based on the management of the patient, not solely on the seriousness of a diagnosis.
- ■ Social factors affecting management are documented when relevant.
- ■ The documented risk supports the level selected under current E/M guidance.

Time-Based Code Selection

- ■ The selected E/M category permits code selection by time.
- ■ Total qualifying time is documented for the correct date or service period.
- ■ The documented time meets the current threshold for the reported code.
- ■ Only qualifying physician or other qualified health care professional activities are included.
- ■ Separately reported procedures and nonqualifying activities are excluded.
- ■ Shared or split service time is evaluated under current payer and organizational requirements when applicable.

Level-of-Service Validation

- ■ The reported level is supported by MDM, time, or the applicable category-specific requirements.
- ■ History and examination are medically appropriate and support the clinical record, even when they do not determine the level.
- ■ The service is not upcoded based on volume of documentation, template length, or copied text.
- ■ The final code selection is consistent with the documented work and medical necessity.
- ■ Applicable payer, facility, and organizational policies have been considered.

Modifiers & Separately Reported Services

- ■ Modifier 25 is supported by a significant, separately identifiable E/M service when reported with a procedure.
- ■ Modifier 24 is supported by an unrelated E/M service during a postoperative period when applicable.
- ■ Modifier 57 is supported by the decision for major surgery when applicable.
- ■ A separate E/M service is not reported for work integral to another procedure or service.
- ■ Documentation supports all other modifiers and distinct-service reporting.

Documentation Integrity

- ■ The note is authenticated by the responsible professional.
- ■ The assessment and plan are clear, complete, and internally consistent.
- ■ Copied or carried-forward information is clinically relevant and does not inflate the level.
- ■ Contradictory documentation is resolved before final audit determination.
- ■ Amendments, addenda, and late entries comply with organizational policy.

Final Audit Determination

- ■ The audited E/M code is supported as reported.
- ■ A lower or higher level is supported by the documentation.
- ■ A different E/M category or code family is appropriate.
- ■ A modifier correction is required.
- ■ Additional documentation clarification or provider education is recommended.
- ■ The finding, rationale, guideline source, and corrective action are documented.

Audit Finding Classification

■ Supported as reported	■ Level correction required	■ Code family correction required
■ Modifier correction required	■ Documentation deficiency	■ Education opportunity

Auditor reminder: Credit only the work that is documented, applicable to the encounter, and permitted under the current E/M category rules.

Educational Disclaimer