Webinar Presentation

Documenting Patient History for Evaluation & Management (E&M) Coding

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Intro to The Colorado M.E.S.A Initiative

- The Colorado M.E.S.A. Initiative
  - Medicare Experts / Senior Access
  - Be adept at Medicare coding & documentation so you are paid fairly for work
  - Be comfortable serving patients with dementia & other geriatric syndromes
- A collaboration:
  - Alzheimer’s Association, Colorado Chapter
  - Senior Care of Colorado/IPC
  - Funded by The Colorado Health Foundation, The Kaiser Permanente Foundation, and Caring for Colorado

Documenting Patient History for Evaluation & Management Coding

History Component of E&M

There are three key components when selecting the appropriate level of E&M service provided:

1. History (focus of this webinar)
2. Examination
3. Medical decision making
History Component of E&M

The history is further categorized into four subcomponents:
1. Chief Complaint (CC)
2. History of Present Illness (HPI)
3. Review of Systems (ROS)
4. Past, Family, and/or Social History (PFSH)

History Component of E&M

- Insufficient documentation of any subcomponent can, and often does, result in incorrect coding of the entire service.
- Information contained in the history is absolutely necessary to substantiate medical decision-making and medical necessity.

History Component of E&M

There are 4 levels of history:
1. Problem Focused
2. Expanded Problem Focused
3. Detailed
4. Comprehensive
Reviewing the History Component

- To qualify for a given level of history, all 4 elements indicated in the row of the table below must be met.
- Qualifying elements must be supported by documentation in the medical record.

<table>
<thead>
<tr>
<th>Type of History</th>
<th>Chief Complaint</th>
<th>History of Present Illness</th>
<th>Review of Systems</th>
<th>Past Family, and/or Social History</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC</td>
<td>Required</td>
<td>Detailed</td>
<td>Complete</td>
<td>Complete</td>
</tr>
<tr>
<td>Problem Focused</td>
<td>Required</td>
<td>Detailed</td>
<td>Complete</td>
<td>Complete</td>
</tr>
<tr>
<td>Examined Problem Focused</td>
<td>Required</td>
<td>Detailed</td>
<td>Complete</td>
<td>Complete</td>
</tr>
<tr>
<td>Detailed</td>
<td>Required</td>
<td>Detailed</td>
<td>Complete</td>
<td>Complete</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Required</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
</tr>
</tbody>
</table>

While documentation of the Chief Complaint (CC) is required for all levels, the extent of information gathered for the remaining elements related to a patient’s history is dependent upon clinical judgment and the nature of the presenting problem.
Chief Complaint (CC)

- A concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter.
- Usually stated in the patient’s own words.
  - Example: Patient complains of upset stomach, aching joints, and fatigue.
- The medical record should clearly reflect the CC.

History of Present Illness (HPI)

- HPI is a chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present.
- HPI is characterized by considering either
  - the status of chronic conditions or
  - the number of elements recorded.
History of Present Illness (HPI)

HPI elements are:
- Location (example: left leg)
- Quality (example: aching, burning, radiating pain)
- Severity (example: 10 on a scale of 1 to 10)
- Duration (example: started three days ago)
- Timing (example: constant or comes and goes)
- Context (example: lifted large object at work)
- Modifying factors (example: better when heat is applied)
- Associated signs and symptoms (example: numbness in toes)

History of Present Illness (HPI)

When documenting the status of chronic problems in lieu of the HPI elements:
- The visit must necessitate evaluation of the chronic conditions.
- Provide the status (controlled, uncontrolled, etc) along with the medication(s) and any information deemed applicable for the encounter.
- The documentation in the medical record must state the status of the chronic condition in order to meet the requirement.
  - Example: Hypertension - stable on Atenolol.

History of Present Illness (HPI)

There are two types of HPIs: brief and extended.

1. A brief HPI includes documentation of one to three (1-3) HPI elements or the status of one to two (1-2) chronic conditions.

   In the following example, three HPI elements are documented: location, quality, and duration.
   - CC: Patient complains of earache.
   - Brief HPI: Dull ache in left ear over the past 24 hours.
**History of Present Illness (HPI)**

2. **An extended HPI:**
   - **1995 documentation guidelines**
     - Should describe four or more elements of the present HPI or associated comorbidities.
   - **1997 documentation guidelines**
     - Should describe at least four elements of the present HPI or the status of at least three chronic or inactive conditions.

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**History of Present Illness (HPI)**

In the following extended HPI example, five HPI elements are documented: location, quality, duration, context, and modifying factors.

- **CC:** Patient complains of earache.
- **Extended HPI:**
  - Patient complains of dull ache in left ear over the past 24 hours.
  - Patient states he went swimming two days ago.
  - Symptoms somewhat relieved by warm compress and ibuprofen.

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**Review of Systems (ROS)**
Review of Systems (ROS)

- ROS is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced.

Review of Systems (ROS)

- Constitutional Symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Review of Systems (ROS)

There are three types of ROS:
1. Problem pertinent
2. Extended
3. Complete
Review of Systems (ROS)

1. A problem pertinent ROS inquires about the system directly related to the problem identified in the HPI.
   In the following example one system, the ear, is reviewed:
   • CC: Earache
   • ROS: Positive for left ear pain. Denies dizziness, tinnitus, fullness, or headache.

2. An extended ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number (two to nine) of additional systems.
   In the following example two systems, cardiovascular and respiratory, are reviewed:
   • CC: Follow up visit in office after cardiac catheterization. Patient states "I feel great."
   • ROS: Patient states he feels great and denies chest pain, syncope, palpitations, and shortness of breath. Relates occasional unilateral, asymptomatic edema of left leg.

3. A complete ROS
   • Inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional (minimum of ten) organ systems.
   • Those systems with positive or pertinent negative responses must be individually documented.
   • For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.
Review of Systems (ROS)

In the following example, ten signs and symptoms are reviewed:

- CC: Patient complains of “fainting spell.”
- ROS:
  2. Eyes: - loss of peripheral vision.
  3. Ear, Nose, Mouth, Throat: No complaints.
  4. Cardiovascular: + palpitations; denies chest pain; denies calf pain, pressure, or edema.
  5. Respiratory: + shortness of breath on exertion.
  6. Gastrointestinal: Appetite good; denies heartburn and indigestion; + episodes of nausea. Bowel movement daily; denies constipation or loose stools.
  7. Urinary: Denies incontinence, frequency, urgency, nocturia, pain, or discomfort.
  8. Skin: + clammy, moist skin.

Past, Family, and/or Social History (PFSH)

Past, Family, and/or Social History (PFSH) consists of a review of three areas:

1. Past history including experiences with illnesses, operations, injuries, and treatments.
2. Family history including a review of medical events, diseases, and hereditary conditions that may place the patient at risk.
3. Social history including an age appropriate review of past and current activities.
Past, Family, and/or Social History

The two types of PFSH are:
1. Pertinent
2. Complete

Past, Family, and/or Social History

1. A pertinent PFSH is a review of the history areas directly related to the problem(s) identified in the HPI. The pertinent PFSH must document at least one item from any of the three history areas.
   • In the following example, the patient’s past surgical history is reviewed as it relates to the identified HPI:
     • HPI: Coronary artery disease.
     • PFSH: Patient returns to office for follow up of coronary artery bypass graft in 1992. Recent cardiac catheterization demonstrates 50 percent occlusion of vein graft to obtuse marginal artery.

Past, Family, and/or Social History

2. A complete PFSH is:
   • A review of two or all three of the areas, depending on the category of E&M service.
   • A complete PFSH requires a review of all three history areas for services that, by their nature, include a comprehensive assessment or reassessment of the patient.
   • A review of two history areas is sufficient for other services.
History as it Relates to Current HPI

In the following example, the patient’s genetic history is reviewed as it relates to the current HPI:

- **HPI:** Coronary artery disease.
- **PFSH:** Family history reveals the following:
  - Maternal grandparents - Both + for coronary artery disease; grandfather: deceased at age 69; grandmother: still living.
  - Paternal grandparents - Grandmother: + diabetes, hypertension; grandfather: + heart attack at age 55.
  - Parents - Mother: + obesity, diabetes; father: + heart attack at age 51, deceased at age 57 of heart attack.
  - Siblings - Sister: + diabetes, obesity, hypertension, age 39; brother: + heart attack at age 45, living.

Putting It All Together

Notes on the Documentation of History

- The CC, ROS, and PFSH may be listed as separate elements of history or they may be included in the description of the history of the present illness.
- A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information.
  - This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:
    - Describing any new ROS and/or PFSH information or noting there has been no change in the information; and
    - Noting the date and location of the earlier ROS and/or PFSH.
Notes on the Documentation of History

- The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient.
- To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
- If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance which precludes obtaining a history.

Summary of History Elements

<table>
<thead>
<tr>
<th>HPI</th>
<th>Status of 1-2 Chronic Conditions</th>
<th>Status of 3 Chronic Conditions</th>
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</table>

- ROS
  - Constitutional
  - ENT
  - Eyes
  - MS
  - CV
  - Skin/Breasts
  - Respiratory
  - Endocrine
  - GI
  - GU
  - Heme/Lymph
  - Neuro
  - Psych
  - Allergy/Immunology

- PFSH
  - Past History (illness, surgeries, injuries)
  - Past Family (diseases, hereditary illness)
  - Social (review of current, past activities)

Components Tied Together

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Family, Social, Personal History (PFSH)
- Review of Systems (ROS)
Sample Documentation

Patient Name: John Doe  Date of Service: 05/05/2010
Date of Birth: 01/01/1935

Chief Complaint: Bilateral knee pain

History of Present Illness (HPI):
Mr. Doe is a 75-year-old male with bilateral knee osteoarthritis, last seen six months ago. Complains of increased pain in both knees over the past month. Rates pain three out of 10 on a 10-point visual analog pain scale. States the pain increased with movement. Relieved with ibuprofen.

Review of Systems (ROS):
No falls. Denies GI distress, dyspepsia, nausea, blood in stool. No edema.

Past, Family, Social History (PFSH):
Medications:
Ibuprofen 400 mg daily or less pm pain with fair relief.

Key Points

- Insufficient documentation of any subcomponent can and often does result in incorrect coding of the entire service.
- In addition, information contained in the history is absolutely necessary to substantiate medical decision-making and medical necessity, not just of the E&M service but of any and all resulting diagnostic and/or therapeutic services reported.

Q&A, Wrap-Up
Q&A

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Next Webinar

• Friday, November 2
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• Topic TBA
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