AdvancedHEALTH

Best Practice for E&M History Documentation

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Background

CMS paid out $36.3 billion in improper payments in 2017

64.1% is attributed to insufficient documentation

CMS will heighten claims scrutiny at the direction of the OIG

Insufficient Documentation

This presentation will focus on:

- History component of level 3 and above
- E&M codes that are most prone to errors
- Documentation deficiencies that can reduce reimbursement and invite payer audits

History Component

The levels of E/M services are based on four types of history:

- Problem Focused (99201-99212-99231)
- Expanded Problem Focused (99202-99213-99232)
- Detailed (99203-99214-99221-99233)
- Comprehensive (99204-99205-99222-99223-99215)

Each type of history includes some or all of the following elements:

- Chief complaint **(CC)**
- History of present illness **(HPI)**
- Review of systems **(ROS)**
- Past, family and/or social history **(PFSH)**

Chief Complaint (CC)

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return or other factor that is the reason for the encounter, usually stated in the patient's words.

Examples:

- Chief Complaint: Osteoarthritis
- CC: Sore throat
- CC: Dizziness

CC – Follow Up

- The medical record must clearly reflect the chief complaint
- Do not use the term “Follow-up or F/U” without expanding upon the reason for the follow-up

Chief Complaint Reminder

- 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 present illness

History of Present Illness – (HPI)

The history of present illness (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. It includes the following 8 elements:

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

- **Higher level E&M codes require 4 or more of these elements****

HPI

- An extended HPI includes documentation for at least four HPI elements or the status of at least three chronic or inactive conditions (for both 1995 and 1997 guidelines)
- The status of at least three chronic or inactive conditions should be documented in the History component
- It is typically in a sentence format; however, the provider may list the chronic/inactive conditions along with the status

HPI

Example based on four or more elements:

Patient complains of chest pain, which began two hours ago. Occurs with minimal exertion. Rates pain a '9' on a scale of 1-10. The patient has never experienced anything like this previously.

Location: Chest

Duration: Two hours ago

Context: Occurs with minimal exertion

Severity: Rates pain a '9' on a scale of 1-10

Example based on the status of at least three chronic or inactive conditions:

Type II Diabetes, uncontrolled, BS 170

Hypertension, well controlled

Hyperlipidemia, stable on Lipitor

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:

- **Problem pertinent** - inquires about the system directly related to the problem identified in the HPI
- **Extended** (2-9 elements) - inquires about the system directly related to the problem identified in the HPI and a limited number (two to nine) of additional systems
- **Complete** – (10 elements minimum) - inquires about the systems directly related to the problems identified in the HPI plus all additional organ systems

ROS Troublespots

- A complete ROS inquires about the systems directly related to the problems 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
- Avoid using the following statements, “10 systems negative, 12 systems negative, etc.” since this does not tell us which of the 14 systems were negative

Past, Family And/Or Social History (PFSH)

- The **PFSH** consists of a review of three areas:
- **Past history -** the patient's past experiences with illnesses, operations, injuries and treatments
- **Family history -** a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk
- **Social history -** an age appropriate review of past and current activities

Past, Family And/Or Social History (PFSH)

- The two types of PFSH are: pertinent and complete.
- 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
- 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

Reminders

- Only the physician or NPP that is conducting the E/M service can perform the history of present illness (HPI). This is considered physician work and not relegated to ancillary staff. The exam and medical decision making are also considered physician work and not relegated to ancillary staff
- **Ancillary staff may perform/document the:**

1) Review of systems (ROS)
2) Past, family and social history (PFSH)
3) Vital signs

Reminders

If the physician is unable to obtain a history from the patient or other source, the documentation must clearly reflect:

- The components that were unobtainable (HPI, ROS and/or PFSH)
- Circumstances that preclude obtaining the HPI, ROS, and PFSH (dementia, sedated on a vent, etc.). **When using "poor" historian the documentation must support why (e.g. dementia)**
- Avoid using "non-contributory, unremarkable or negative", because it does not indicate what was addressed. If you cannot obtain the family history you must support the reason why (e.g. the patient was adopted)
- **Attempt to obtain from other resources:**
- A family member, spouse, nurse etc. was not present or was unable to provide additional information
- The medical record (chart, ambulance run sheet, etc.) did not contain the information needed

In Conclusion

- Ensure your records capture what you perform during each encounter.
- Connect the documentation dots to revenue outcomes.
- Remember the payer documentation standard is “if it wasn’t documented, it wasn’t done”.

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