Colorado M.E.S.A. Initiative

Medicare Experts/Senior Access

Innovations in Geriatric Practice and Alzheimer's Care

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

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Documenting Patient History for Evaluation & Management Coding

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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

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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)

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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.

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History Component of E&M

There are 4 levels of history:

1. Problem Focused
2. Expanded Problem Focused
3. Detailed
4. Comprehensive

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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.

Type of History	Chief Complaint	History of Present Illness	Review of Systems	Past Family, and/or Social History
	CC	HPI	ROS	PFSH
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

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Reviewing the History Component

- 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.

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Chief Complaint (CC)

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Chief Complaint (CC)

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.

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History of Present Illness (HPI)

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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

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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)

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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

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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.

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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)

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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.

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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

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Review of Systems (ROS)

There are three types of ROS:

1. Problem pertinent
2. Extended
3. Complete

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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.

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Review of Systems (ROS)

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.

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Review of Systems (ROS)

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.

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Review of Systems (ROS)

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

- CC: Patient complains of "fainting spell."
- ROS:
  1. Constitutional: Weight stable, + fatigue.
  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.
  9. Neurological: + fainting; denies numbness, tingling, and tremors.
  10. Psychiatric: Denies memory loss or depression. Mood pleasant.

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

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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.

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Past, Family, and/or Social History

The two types of PFSH are:

1. Pertinent
2. Complete

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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 <u>one item from any of the three history areas.</u>

   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.

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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.

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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.

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Putting It All Together

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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.

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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.

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Summary of History Elements

HPI: Status of chronic conditions: □ 1 □ 2 □ 3 OR Choose Elements: □ Quality □ Location □ Duration □ Timing □ Context □ Severity □ Modifying Factors □ Associated Signs/Symptoms	□ Status of 1-2 Chronic Conditions OR	□ Status of 1-2 Chronic Conditions OR	□ Status of 3 Chronic Conditions OR	□ Status of 3 Chronic Conditions OR
	□ Brief 1-3 Elements	□ Brief 1-3 Elements	□ Extended ≥ 4 Elements	□ Extended ≥ 4 Elements
ROS: □ Constitutional □ ENT □ Eyes □ MS □ CV □ Skin/Breasts □ Respiratory □ Endocrine □ GI □ GU □ Heme/Lymph □ Neuro □ Psych □ Allergy/Immunology	N/A	□ Pertinent to Problem 1	□ Extended 2-9	□ Complete 10
PFSH: □ Past History (illness, surgeries, injuries) □ Past Family (diseases, hereditary illness) □ Social (review of current, past activities)	N/A	N/A	□ Pertinent 1 Area	□ *Complete 2-3 Areas
*Complete PFSH: • 3 history areas for ALL New Patients • 2 history areas for f-u/Est. Patients	□ **PROBLEM FOCUSED**	□ **EXPANDED PROBLEM FOCUSED**	□ **DETAILED**	□ **COMPREHENSIVE**
	ALL Criteria for selected level MUST be MET or EXCEEDED			

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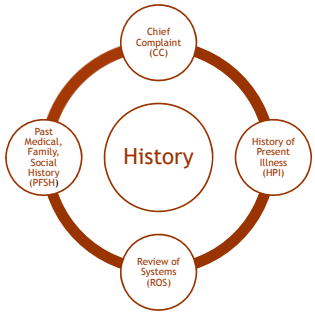
Components Tied Together



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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 more or less prn pain with fair relief.

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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.

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Q&A, Wrap-Up

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Q&A

- If you would like to ask any questions, please type them into the "Questions" box in your Go-to-Webinar control panel now

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MESA Website

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Next Webinar

- Friday, November 2
- 12:15 – 12:45 pm
- Topic TBA
- Check the MESA website or sign up for our eNewsletters to stay informed

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