Dermatology Coding Alert

E/M: How Much ROS Documentation Is Enough?

Keep sufficient paperwork on hand to back up EHR.

Transitioning to the world of electronic health records (EHRs) can make your coding easier on many levels, but don't take it for granted. Physicians often fall short in their review of systems (ROS) documentation whether you use paper charts or rely on EHRs, but you can help correct the deficiency.

Consider this situation and decide how you would handle it before reading on for our experts' advice.

Scenario: The dermatology practice uses EHRs, and one dermatologist has a sheet listing any concerns or problems that the patient fills out prior to her visit. The dermatologist uses the sheet as his review of systems (ROS) for chart note documentation. He lists anything the patient marks as positive and then states "all others negative." He discards the original form the patient completes.

Concern: What happens if the chart is audited -- would the practice be required to produce the original patient form as proof of the dermatologist's statement "all others negative"? Or would including a blank form showing what each patient is given to fill out be adequate when paired with the dermatologist's notes?

Keep the Paper Trail

The main problem with the scenario above is the lack of paperwork from the patient -- notes based on the information without the patient's original responses aren't enough to cover your bases.

"A blank sheet or having nothing to support the review of systems is considered 'not documented,'" says **Deborah Grider, CPC, CPC-I, CPC-H, CPC-P, CEMC, COBGC, CDERC, CCS-P,** vice president of strategic development for the American Academy of Professional Coders. "The CMS guidelines are clear that there must be evidence that the information was reviewed and updated." Evidence such as the patient form in our scenario should be kept because it's part of the medical record. "It should be scanned into their system," Grider says. "The CMS E/M guidelines for both 1995 and 1997 are very clear on this."

Know the Current Guidelines

CMS establishes guidelines with Medicare patients in mind, but they can still apply to your dermatology practice. Most private payers follow CMS's lead on coding guidelines, including documentation for ROS.

According to the CMS 1995 and 1997 E/M Documentation Guidelines, "the ROS and/or PFSH (personal family and social history) 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."

On paper: "This guideline fits quite well in a paper chart, where the provider would review the form, sign off on it, and place it in the patient's medical record," says **Colleen Wade, CPC, CPC-H, CPC-I, CEMC, PCS, FCS,** a billing and coding auditor with the University of Medicine and Dentistry of New Jersey in Stratford. "The provider would then reference this form in his own note, listing any additional personally obtained findings and verification of its review."

Adapt for EHRs: You can follow the same tactics when using an EHR, Wade says. First, confirm that the form includes elements from all ROS systems as identified in the E/M guidelines. "If this is the case, I would then advise the provider to only use the statement 'all others negative' when all systems have, in fact, been responded to by the patient with either a positive or a negative," Wade advises. Also have the physician review and sign off on the form the patient completed, just as he would with paper records. He should then comment on the form in his electronic note and include notations of

additional personally obtained information and verification of his review.

Pointer: Scan the form into the EHR. "I would not recommend destroying any form filled out by the patient without first making an electronic copy, even if the provider transcribes all the information contained on it to the EHR," Wade says.

Double Check Documentation

Wade also recommends reviewing your practice's questionnaire to ensure it lists all systems.

"Remember, if the provider says 'all others were reviewed,'CMS is going to take the provider at his word and assume there was a review of 14 systems," she explains. "If the questionnaire only lists 10 systems, the provider should amend his statement to reflect the number of systems actually reviewed."

For example, the provider's documentation might state, "A total of 10 systems were reviewed, and with the above exceptions [indicating the pertinent positives], all others reviewed were negative." "This allows the provider an opportunity to take advantage of the CMS caveat and to accurately reflect the services performed," Wade says.

Note: The "CMS caveat" is considering an ROS of 10 of the 14 systems as supporting a comprehensive history level. See "Brush Up on What Constitutes ROS" (inset box) for the definition.

Why the steps: If going through this process seems like overkill,just remember how useful it could be down the road. "This process is beneficial when dealing with chart reviews and/or audits, and would also be valuable in case of any medical-legal issues or questions of clinical accuracy," Wade says.

To read the complete E/M guidelines, visit www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf.