Internal Medicine Coding Alert

Avoid Auditor's Crosshairs With These E/M Truths

Securing the correct history level is easy with this element-by-element study

You don't have to be overwhelmed by E/M history levels' laundry list of requirements. Take each one step at a time, and then use our handy history chart to choose the right level for your patient.

You have four levels to choose from:

• problem-focused

• expanded problem-focused

• detailed or

• comprehensive.

When determining the appropriate history level for your E/M codes, consider the following elements.

CC: E/M Always Demands Medical Necessity

Every E/M history level requires a chief complaint (CC). According to CPT, this is a concise statement, usually in the patient's words, explaining the main reason for the appointment. Look for a symptom, problem, condition or diagnosis.

Documentation should note specific problems to support medical necessity for the visit. Even if your office asked the patient to return, look for the complaint that prompted the visit.

Example: A patient presents for abdominal pain, and the provider documents abdominal pain as her CC.

Bottom line: Look for a complete CC. Payers require documentation of medical necessity for each encounter.

HPI: Look for These Factors in Patient Timeline

The second E/M history element, history of present illness (HPI), should be an actual chronological description of the patient's current illness, says **Bill Dacey, MHA, MBA, CPC,** in his presentation "E/M Auditing: Regulations vs. Reality" at the 2007 national American Academy of Professional Coders conference in Seattle. The internist usually performs the HPI element. Check your documentation for location (example: uterus), quality (such as dull pain), severity (e.g., going through four pads in an hour), duration (started last month), timing (soon after taking the medication), context (while walking quickly), modifying factors (better after sleeping), and associated signs and symptoms (develops shortness of breadth and diaphoresis with onset of chest pain).

If you have documentation of one to three of these categories, consider this a brief HPI. Four or more equals an extended HPI.

ROS: Count Systems to Determine Proper Level

For the third E/M history element, review of systems (ROS), the provider either analyzes a questionnaire filled out by the patient or support staff or directly asks the patient questions (or both). Keep in mind, however, that this section does not involve the internist examining or touching the patient.

Red flag: Payers and auditors who smell cloned documentation may hit your practice with fines and refund requests. Patient-completed ROS templates may be OK, but ask providers to make their documentation specific to each patient. Also, be sure that the internist documents that the ROS was reviewed with the patient by noting any pertinent information. A statement of "ROS unchanged" or "same as last visit" is not acceptable. The main purpose of the ROS is to be sure no important symptoms have been missed, especially in areas not already covered in the HPI, says **Rebecca Parker, MD, FACEP,** president of Team Parker LLC, a coding, billing and compliance consulting firm in Lakewood, Ill.

What to do: If documentation covers only the system directly related to the present illness, this is a problem-pertinent ROS.

Inquiring about the most directly related system as well as a limited number of others (for a total of two to nine) is an extended ROS.

A complete ROS requires inquiring into 10 to 14 of the body systems. If the provider asks about all the systems and only one is showing problems, documenting the problem and stating in the medical record, "All other systems reviewed and negative" satisfies the complete ROS requirements, unless your payer instructs otherwise.

PFSH: Decide Scope With These Tips

The final element for you to consider is past, family and social history (PFSH).

Past history refers to the patient's own medical history, such as previous surgeries. Family history includes medical events in the patient's family line, such as hereditary diseases that put the patient at risk. Social history reviews the individual's past and current activities (for example, occupational history or tobacco use).

If the provider asks only about history related to the main problem, this is a pertinent PFSH.

Depending on the type of E/M service you're billing, a complete PFSH may require your physician to document reviewing two or three of the history areas. In particular, new patient office visits and consultations require all three areas (past, family and social) for a complete PFSH. If you're reporting for a higher-level E/M, definitely make sure you've covered all three history areas.

Tabulate Your History Level

Decide which history level to choose based on how you fulfilled the requirements in the chart on page 5. For example, you have a CC, and documentation supports the brief HPI and problem pertinent ROS and no PFSH, consider this an expanded problem-focused history.