Internal Medicine Coding Alert

Document Full Patient History To Avoid Medicare Scrutiny

Internists who take shortcuts when documenting a patients history during an evaluation and management (E/M) service may find themselves without the backup materials needed to withstand the scrutiny of a Medicare audit. Although many coding experts feel that most internists are getting a medically appropriate history from their patients, they also believe that physicians need to work on writing down everything that occurs during the visit.

The need for proper documentation of E/M services was recently underscored in a memo from **Nancy-Ann Min DeParle**, the administrator of the Health Care Financing Administration (HCFA). The memo, dated June 1, states that Medicare audits for this year will focus on CPT codes 99214 (established patient office or other outpatient visit) and 99233 (subsequent hospital care).

These codes accounted for a significant portion of the coding errors in the last two audits, DeParle announced. In fact, documentation for many of these services was only found to be sufficient to support services more appropriately described by 99212 and 99231.

The memo should be taken seriously, but internists should not respond to it by systematically downcoding their E/M visits by one or two levels, according to **Susan Calloway-Stradley, CPC, CCS-P**, a coding and reimbursement consultant and educator in North Augusta, S.C. This memo is not saying that the wrong codes are being used, but rather that the documentation is not there to support the level of service reported, she explains. Medicare wants you to prove that you did the work.

Internists need to write down everything that happened during the E/M encounter, she continues. They need to take down detailed histories if they want to bill for a higher level of E/M service, especially with new patients, because all three components history, examination and medical decision-making must be considered.

Four Levels of History

Both Medicare and CPT agree that there are four levels of history for an E/M service.

1. A problem-focused history contains:
Chief complaint;
Brief history of present illness (one to three elements); and
No review of systems or past, family, social history is required.

It is a component of the following E/M codes frequently used by internists: 99201 (new patient office visit), 99212 (established patient office visit), 99231 (subsequent hospital care), 99241 (office consultation), 99251 (initial inpatient consultation), 99261 (follow-up inpatient consultation, established patient), 99271 (confirmatory consultation) and 99281 (emergency department visit). It also can be a component in nursing facility and home visit E/M codes.

2. An expanded problem-focused history contains:
Chief complaint;
Brief history of present illness (one to three elements);
Problem-pertinent review of systems (one system); and
No past, family, social history is required.

It is a component of the following E/M codes frequently used by internists: 99202 (new patient office visit), 99213 (established patient office visit), 99232 (subsequent hospital care), 99242 (office consultation, new or established

patient), 99252 (initial inpatient consultation), 99262 (follow-up inpatient consultation, established patient), 99272 (confirmatory consultation) and 99282/99283 (emergency department visit). It also can be a component in nursing facility and home visit E/M codes.

3. A detailed history contains:
Chief complaint;
Extended history of present illness (four or more elements, or three or more chronic or inactive conditions if 1997 Medicare E/M guidelines are being followed);
Problem-pertinent system review extended to include a review of a limited number of additional systems (two to nine systems); and
Pertinent past, family, and/or social history directly related to the patients problems (one or two areas of history).

It is a component of the following E/M codes frequently used by internists: 99203 (new patient office visit), 99214 (established patient office visit), 99218 (initial observation care), 99221 (initial hospital care), 99233 (subsequent hospital care), 99234 (observation or inpatient hospital care), 99243 (office consultation), 99253 (initial inpatient consultation), 99263 (follow-up inpatient consultation, established patient), 99273 (confirmatory consultation) and 99284 (emergency room visit). It also can be a component in nursing facility and home visit E/M codes.

4. A comprehensive history contains:
Chief complaint;
Extended history of present illness (four or more elements, or three or more chronic or inactive conditions if 1997 Medicare E/M guidelines are being followed);
Review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems (more than 10 systems); and
Complete past, family and social history (two or three history areas).

It is a component of the following E/M codes frequently used by internists: 99204/99205 (new patient office visit), 99215 (established patient office visit), 99219/99220 (initial observation care), 99222/99223 (initial hospital care), 99235/99236 (observation or inpatient hospital care), 99244/99245 (office consultation), 99254/99255 (initial inpatient consultation), 99274/99275 (confirmatory consultation) and 99285 (emergency department visit). It also can be a component in nursing facility and home visit E/M codes.

Extended HPI Can Be Brief

The chief complaint and related history of present illness (HPI) tend to be areas where internists have to do the most documentation because the review of systems (ROS) and past, family and social history (PFSH) are usually covered by the patient intake form (also referred to as the patient history or patient information form) that is filled out by the patient, often with the help of a nurse. The chief complaint is a concise statement explaining why the patient is here, according to **Stephanie Jones, CPC**, a multispecialty coding consultant in Boca Raton, Fla. All E/M services need a reason for the visit, which will be found in the chief complaint.

The HPI is a more thorough description of the development of the patients chief complaint, says Jones. It includes the following eight elements: location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms.

A very brief sentence can convey several of these elements at once. A patient who fell off a step stool (context) two days ago (duration) and now has a sharp (quality) pain in his or her knee (location) that feels better after taking two aspirin (modifying factors) has just given an extended history of presenting illness because five elements are included, Jones says.

Three Chronic Conditions Can Be Extended HPI

Although Jones believes that internists should be taking an HPI every time a patient walks in the door because there always has to be a reason for a visit, she notes that the 1997 Medicare E/M guidelines allow an exception to the HPI

requirements. If an internist goes by these more detailed guidelines instead of the ones from 1995, an extended HPI also can consist of three or more chronic or inactive conditions instead of four or more of the HPI elements. So under the 1997 guidelines, a patient who has diabetes, hypertension and high cholesterol would automatically have an extended HPI.

If the patient cant give an HPI for reasons such as he or she doesnt speak English, is suffering from dementia, or is unconscious, then history ceases to be a component in the E/M service, Jones adds. In that situation, the internist needs to note the inability to communicate with the patient. Examination and medical decision-making then become the only two components for E/M code selection.

Asymptomatic Patients Have Brief HPIs

Internists will have difficulty doing an extended HPI when patients are asymptomatic. Frequently, we get new patients who are coming in because they did a cholesterol screening at a shopping mall and found out they have a cholesterol level of 300, explains **Michael Haynes, MD, FACP**, an internist and pulmonologist, who also is the compliance director at University Medical Associates, a multispecialty, multiphysician medical practice in Augusta, Ga. We may order more tests or even put the patient immediately on medication, but we cant do much of an HPI because the patient is asymptomatic.

In these cases, it is likely that a lower level of E/M service should be reported even if the internist is doing a moderately high level of medical decision-making, Jones says. If the chief complaint and HPI consist only of the results of the patients cholesterol screening, then there will be only one to three elements in the HPI, not the four or more necessary for an extended history. It still boils down to the number of elements that can be documented, she concludes.

ROS and PFSH Carry Forward From Initial Visit

The ROS consists of the positive and negative responses the patient gives to series of questions designed to inventory the systems of the body. Frequently, it is part of the patient intake form, Jones says.

The review of systems is designed to provide more information on the presenting complaint, says **Susan L. Turney, MD, MS, FACP**, medical director of reimbursement at the Marshfield Clinic in Marshfield, Wis., and a member of the AMA CPT advisory committee. It also helps the internist determine if something other than the presenting complaint is going on with the patient.

The elements of a system review have been identified by Medicare and CPT to be the following: constitutional (general appearance, weight loss, etc.); eyes; ears, nose, mouth and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary (skin and/or breast); neurological; psychiatric; endocrine; hematologic/lymphatic; allergic/immunologic.

Because the patient intake form is an effective method for discussing the ROS with a patient, an internist often can quickly review the 10 or more systems needed for a comprehensive level of review. To indicate the internist did an ROS, however, it is critical that the internist note the review of the form in the patients medical record, and initial and date the patient information form. In a subsequent visit, if the patient has no significant changes, Medicare will allow the ROS to carry forward from the initial visit. The internist should write no change on the patient information form, sign and date it, and make a similar notation in the patients medical record, says Jones.

The final aspect of the history is the PFSH, which is a review of the patients experience with illnesses, injuries and treatments as well as age-appropriate questions about past and current activities (marital status, occupation, sexual history, and use of drugs, alcohol and tobacco). Many of these questions also will be on the patient information form, Jones explains. Again, the internist needs to document the review of the PFSH by indicating in both the patients record and the patient intake form that this area was discussed during the visit.

In subsequent visits, the PFSH from the initial visit can be carried forward if there are no significant changes. The phrase no change should be written on the patient information and signed and dated by the internist, who also should make a

similar note in the patients medical record.

Signing and Dating Patient Info Form Is Critical

Although reviewing the patient intake form, signing it and dating it may seem to be trivial technicalities, Jones stresses that these are crucial to justifying a higher level of E/M code.

I have yet to met an internist that didnt do a review of systems or ask about the patients past history, she states. But they often fail to document that they went over the patient intake form. All they have to do is initial and date the form and make a note of the review in the patients medical record.

Internists often fail to write down all the questions they ask of a patient. Its those no-brainer questions everyone asks about drug allergies, previous surgeries, use of tobacco, drugs and alcohol that need to be written down, even when the answer is no, cautions Jones.

History Should Reflect Complexity of Problem

Because all of these elements can be confusing, internists might want to start by using the overall severity of the problem to determine the level of history that needs to be documented. Internists should not solely focus on the number of elements needed to met a particular level of E/M coding, Turney suggests. Instead, they should complete a history that is reflective of the patients problem. The history obtained from the patient should be documented. The documentation should then be used to determine the type of history that was provided.

Turney says that the internist can determine the history level by first asking himself or herself whether the patients problem is simple or complex. If the problem is a simple one, the internist should determine whether the history was a problem-focused or expanded problem-focused history. If the problem is more complex, the internist must determine whether it is a detailed or comprehensive history.

For example, the internist spends 80 minutes with the patient and documents the history, exam and medical decision-making. This service seems like it should be a level-five consult, Turney continues. If that internist happens to leave out one element in the ROS, I hope that an auditor would be reasonable and wouldnt downcode the visit based solely on lack of one element, when the note would otherwise substantiate the high level of service provided. The original intent of the documentation guidelines was that they were to be used as guidelines and not as documentation standards.

On the other hand, just because you have an extended HPI and a complete ROS and PFSH doesnt mean you have a comprehensive history. There has to be medical necessity for taking a comprehensive history, Turney explains. You shouldnt bill for updating a patients record.

Hanley agrees and cites the example of a patient who comes into the office with a sore throat. You can do a comprehensive history and exam on that patient, but it probably isnt a level-four E/M service unless you suspect the sore throat is a sign of leukemia.

Checklists and Cheat Sheets Help

Checklists, forms and cheat sheets also can be extremely helpful when trying to determine the level of E/M code to report. In addition to the patient intake forms that are standard in most internal medicine practices, Hanley also keeps two small cards in his pocket to help him with his coding. The first card contains the elements and bullet points of the history and exam components of the E/M service. The second card contains information on the elements of medical decision-making.

A full-text version of the HCFA memo about
99214 and 99233 is available on the Internet at www.hcfa.gov/medicare/mip/cfolettr.htm.