Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Exceed Auditors' Expectations With This E/M History Level Guide

Steer clear of the -here for recheck- pitfall

If choosing E/M patient history levels leaves you in a daze, slow down and take a look at this element-by-element breakdown. Then use our handy chart to be sure you-ve met every requirement your payor demands.

Reality: E/Ms are the easiest for regulators to audit, says **Bill Dacey**, in his presentation -E/M Auditing: Regulations vs. Reality- at the 2007 national **American Academy of Professional Coders** conference in Seattle.

One important aspect of selecting the proper E/M code is pinpointing the right history level.

You have four history levels to choose from for your E/M coding:

- problem-focused
- expanded problem-focused
- detailed
- comprehensive.

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

Remember: Carriers believe that even when the provider generates a complete note, you can't choose a code based on information not relevant to the patient's condition, Dacey says.

Always Require a Chief Complaint

Chief complaint (CC): Every E/M history level requires a chief complaint, says Missouri-based coding consultant **Sandra Soerries**. According to the CPT manual, 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.

Example: A patient presents between chemotherapy treatments and complains of nausea.

-Without a chief complaint, you don't have medical necessity,- Soerries says. Look for documentation of specific problems. Even if the patient is returning at your office's request, look for the complaint that prompted the visit, Soerries says.

Bottom line: Look for a complete CC. Payors won't find -Here for recheck- an acceptable chief complaint.

Look for These Factors in Patient Timeline

History of present illness (HPI): HPI should be an actual chronological description of the patient's current illness, Dacey says.

Look for location (example: lung), quality (example: dull pain), severity (example: limited disease process), duration (example: tumor detected last month), timing (example: soon after taking the medication), context (example: while walking quickly), modifying factors (example: better after sleeping), and associated signs and symptoms (example: nausea).

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

Divide ROS Into 3 Categories

Review of systems (ROS): For this requirement, the provider either analyzes a questionnaire filled out by the patient or support staff or directly asks the patient questions (or both). This section does not involve examining or touching the patient.

The CPT manual E/M guidelines list 14 different systems the provider may review:

- constitutional symptoms (example: weight loss)
- eyes (example: blurred vision)
- ears, nose, mouth, throat (example: difficulty swallowing)
- cardiovascular (example: hypertension)
- respiratory (example: shortness of breath)
- gastrointestinal (example: nausea)
- genitourinary (example: urine incontinence)
- musculoskeletal (example: joint pain)
- integumentary (skin and/or breast; example: discolored skin)
- neurological (example: numbness)
- psychiatric (example: depression)
- endocrine (example: taking synthetic hormones)
- hematologic/lymphatic (example: anemia)
- allergic/immunologic (example: immunodeficiency disease).

If documentation covers only the system directly related to the present illness, consider this 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, Soerries says.

A complete ROS requires inquiring into 10 to 14 of the body systems, Soerries says. If the provider asks about all of the systems and only one is showing problems, documenting the problem and -All other systems reviewed and negative- satisfies the complete ROS requirements, unless your payor instructs you otherwise.

Decide PFSH Scope With These Tips

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 you ask only about history related to the main problem, this is a pertinent PFSH. Depending on your payor, a complete PFSH may require review of two or three of the history areas. If you-re reporting for a higher-level E/M, definitely make sure you-ve covered all three history areas, Soerries says.

Beware This Template Trap

Payors and auditors who smell cloned documentation may hit your practice with fines and refund requests. ROS and PFSH templates completed by the patient may be OK, but ask providers to make their documentation for each category specific to each patient.

Tabulate Your History Level

Decide which history level to choose based on how you fulfilled the requirements in the E/M History Level Table.

Example: You have a CC, and medical necessity supports the brief HPI and problem-pertinent ROS the provider documents. Consider this an expanded problem-focused history level.