Eli's Rehab Report

Reader Question: No Need to Repeat PFSH for Well Patient

Question: What should a physiatrist on his daily rounds document for history when the patient in an inpatient facility is doing well?

South Carolina Subscriber

Answer: The history component of the E/M service is an interval history.

The word "interval" precedes the word "history" in all the subsequent hospital care codes and refers to a period of time since the physician last assessed the patient, according to the "CPT Assistant."

In most situations, the interval history includes documentation of a patient's chief complaint and factors of the history of present illness (HPI).

The HPI includes location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms. Some of these aspects may have changed since the last assessment - potentially, the physiatrist may include even those HPI that remain the same if a conclusive diagnosis was not made since the admission. The physiatrist should also document any new review of systems (ROS) that is pertinent to the patient's condition.

The section of history traditionally not repeated after the initial H&P at admission is past, family, social, history (PFSH) unless changes occur.

So for a patient who is doing well, the physiatrist could document pain status (HPI - location, severity, potentially modifying factors), and bowel, bladder, mobility, and sleep status (ROS - GI, GU, musculoskeletal, constitutional).