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Psychiatry Coding & Reimbursement Alert

E/M Key Elements: Cash in on Higher Level E/M Opportunities With Thorough ROS Documentation

Hint: Enlighten your clinician about the importance of documenting negative responses.

You'll need to crosscheck if your psychiatrist is completing documentation when conducting a review of systems (ROS). Doing so can reduce your chances of losing out on deserved reimbursement if the doctor's capturing all the ROS elements appropriately.

Refresher: The third element of the history component, after the chief complaint (CC) and the history of the present illness (HPI), is the ROS. This portion of the history trips up many coders; often, they must select a lower code simply because the provider inadvertently under documented the system review.

Differentiate ROS Levels

"The review of systems is a subjective account of a patient's perception of their status obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced affecting any of the 14 applicable organ systems," explains **Nicole Orofino, CPC,** owner of Innovative Coding Analysis in Allentown, Penn..

You'll need to know the differences between the three ROS levels to determine the proper level of history and therefore, E/M code level:

Problem-pertinent: A problem-pertinent ROS occurs when the provider reviews a single system during the encounter, presumably the system directly related to the problem(s) identified in the patient's history of present illness (HPI). For a psychiatry practice, for example, "problem-pertinent" typically refers to the psychiatric system, which means your psychiatrist asks questions and documents the patient's positive responses and pertinent negatives related to that system.

In addition to a brief HPI, a problem-pertinent ROS supports an expanded problem-focused history, which is an element of a level two, new patient, office/outpatient E/M service (99202) or a level three, established patient E/M service (99213) in the same setting.

Extended: When your psychiatrist conducts an extended ROS, he reviews the system directly related to the problem(s) identified in the HPI and a "limited" number of additional systems. According to Medicare (and most other payers), "extended" should cover a total of two to nine systems, one of which will typically be the psychiatric system for psychiatry patients.

Along with an extended HPI and a pertinent past, family or social history, an extended ROS can support a detailed level of history, which is part of a level three, new patient office/outpatient visit (99203) or a level four established patient service (99214).

Complete: When your provider inquires about the system(s) directly related to the problem(s) identified in the HPI, plus all additional body systems, he has done a "complete" ROS. Per the documentation guidelines for E/M services, at least 10 organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented.

For the remaining systems, a notation indicating all other systems are negative is permissible. However, in the absence of such a notation, at least ten systems must be individually documented. Along with an extended HPI and a complete past, family and social history, a complete ROS can support a comprehensive level of history, which is an element of

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level four or five, new patient, E/M services in the office/outpatient setting (99204-99205) or a level five, established patient visit (99215) in the same setting.

Learn the Systems You Will Be Counting

There are 14 systems your provider may review: constitutional symptoms (e.g., fever, weight loss); eyes; ear, nose, mouth, and throat (ENT); cardiovascular; respiratory; gastrointestinal; genitourinary, musculoskeletal; integumentary; neurological; psychiatric; endocrine; hematologic/lymphatic; and allergic/immunologic, Orofino explains.

Example: Your psychiatrist reviews a new patient for eating disorders. As part of the patient's history, your psychiatrist only inquires and documents responses to questions about the psychiatric system. If so, then this represents a problem-pertinent ROS, since only one system (the psychiatric) was addressed.

In the same example, if your psychiatrist also inquires about the patient's skin (integumentary), pharynx (ENT), breathing (respiratory), and abdominal tenderness (gastrointestinal) and documents the patient's responses, that results in an extended ROS.

How it works for a complete ROS: Your psychiatrist must individually document the systems with positive or pertinent negative responses. For any remaining systems up to the required 10, he can make a notation that "all other systems are negative" or "remainder negative." In the past, however, some payers have disallowed this inclusive statement, and required an individual listing of systems only.

Tip: Remind your provider to document every system he reviews, so you can count it in your coding. Your psychiatrist might have the habit of only documenting positive findings, but you should make it clear that documenting pertinent negative findings is just as important for supporting the ROS and thus the History component of the billable E/M level. If your provider doesn't document the work, he won't get credit for it. You'll have no choice but to code a lower level visit if you can't justify the ROS portion, because the level of history depends on all elements (HPI, ROS, and PFSH).

Determine Who Can Record the ROS

Your psychiatrist does not necessarily need to record the ROS himself. "The ROS may be documented by the patient or auxiliary staff as long as your clinician initials and dates the pre-populated forms and states they reviewed and/or agree with this documentation," Orofino says.

Example: ROS can be done by a physician assistant (PA), nurse practitioner (NP), or a medical assistant (MA). You may even have the patient fill out an ROS questionnaire, which the doctor reviews and signs. Your providers can use a form like the one on page 20 to personally capture the ROS, or the patient may complete the form himself. Either way, have your provider reference the ROS in the dictation, and initial and date the form.

"I don't feel that the doctor has to re-document the ROS, but do feel that he needs to review it with the patient," says **Becky Boone, CPC, CUC,** certified reimbursement assistant for the University of Missouri Department of Surgery in Columbia. "It helps our doctors and nurse practitioners to have the patient fill out a questionnaire when they come to an appointment to make sure that all problems are addressed during their encounter. I encourage this as a good way to make sure that ROS is addressed and documented appropriately."

Important: Patient-completed ROS templates may be OK, but ask your physician to make his documentation specific to each patient. Also, be sure your provider documents that the ROS was reviewed with the patient by noting any additional pertinent information. Forms completed by the patient at the initial visit can be used again during subsequent established patient visits provided that the physician reviews the initial form, updates the form with any changes, and then initials and dates the form indicating his review.

Pointer: "When a practice is under audit by an insurance company and documentation for E/M codes is requested, the forms the patient filled out, including the ROS, should be included to gain credit for the ROS, unless the physician takes the visit and dictates a comprehensive overview of what is contained in the chart," Orofino explains.

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