Pain Management Coding Alert

E/M Coding: Put Some E/M Coding Questions to Rest with PFSH Knowledge

This history component is often vital to choosing the correct E/M code.

If you occasionally have problems choosing the proper evaluation and management (E/M) service level, you're not alone.

Many coders face this conundrum quite often, and it's no surprise; after all, the 1995 and 1997 E/M Documentation Guidelines recognize seven components to define E/M levels. CPT®, however, recognizes eight components in the HPI, including duration. The history component alone includes the following elements: chief complaint (CC), history of present illness (HPI), review of systems (ROS), and past medical, family, and social history (PFSH).

The guidelines also go into specific detail about each element of the history.

You can get confused quickly with so much history to keep track of. Keep your E//M knowledge base sharp with this quick PFSH refresher course.

Tally All PFSH Factors

The 2017 CPT® manual lists the different elements you should consider when documenting a patient's PFSH. Your options are:

A. Past Medical History

According to CPT® 2017, past medical history includes:

- Previous major illnesses/injuries
- Prior operations
- Previous hospitalization
- Current medications
- Drug and/or food allergies
- Age-appropriate vaccine status
- Age-appropriate food/nutrition status

B. Family History

According to CPT® 2017, family history encompasses an analysis of medical events that occurred in the patient's family. These include:

- The health status or cause of death for parents, siblings, and children;
- Specific diseases linked to problems recognized in the CC or HPI, and/or ROS; and
- Family members' diseases that may be hereditary or put the patient at risk.

"It [family history] really is a list of conditions and diseases that family members have or reasons for death," says **Marcella Bucknam, CPC, CCS-P, COC, CCS, CPC-P, CPC-I, CCC, COBGC**, manager of clinical compliance with PeaceHealth in Vancouver, Wash. "However, it's worth mentioning that it might also be reasonable to document that the patient's family history is unknown if they are adopted or estranged from family."

C. Social History

According to CPT® 2017, social history is an age-appropriate summary of the patient's past and current activities. Examples include:

- Marital status and/or living situation
- Current job
- Occupational history
- Military service
- Drugs, alcohol, and tobacco use
- Education level
- Sexual history
- Other related social circumstances.
- Ill contacts (This could also be listed under family history, sibling at home ill with same or a social history, exposed to strep at daycare, etc.).

"Two of the most commonly documented elements are use of tobacco and use of alcohol," says Bucknam. "These are almost always documented, although providers may not realize that they count as social history." This is especially true if the patient (child) is the one using the tobacco and/or alcohol.

Social history is also the correct place to include work/retirement, hobbies, school, and other factors about the patient's life, according to Bucknam.

Decide PFSH Type Before Coding

There are two kinds of PFSH pertinent and complete.

With a pertinent PFSH, the provider reviews the history areas directly related to the problem identified in the HPI. For pertinent PFSH, the provider must document at least one item from any of the three history areas.

"A pertinent PFSH usually only addresses information specific to the condition being treated during the encounter or that might have changed since the last time care was provided," says Bucknam. "For example, there are rarely changes infamily history and, although for some conditions family history can be very important, it does not usually have an impact on patient care."

On the other hand**,** with a complete PFSH, the provider must review two or three of the history areas, depending upon the category of the E/M service.

"A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services," according to the 1995 and 1997 E/M Documentation Guidelines.

Bucknam went on to illustrate when you would see a complete PFSH.

"You would expect to see a complete PFSH for either a complete PCP [primary care physician] record annually, if the patient has a complex condition or is going to be admitted to the hospital where many different factors could influence care decisions day-to-day over time," says Bucknam.

PFSH Necessary for Most New Patients

There are certain situations that the nature of the care would require a comprehensive PFSH, and a new patient visit would qualify, according to **Chelle Johnson, CPMA, CPC, CPCO, CPPM, CEMC, AAPC Fellow**, staff services coordinator/billing/credentialing/auditing/ coding at County of Stanislaus Health Services Agency in Modesto, Calif.

"A new patient visit requires all facets of the PFSH to be completed to justify a comprehensive history," says Johnson. "This is the first time that the provider is treating the patient."

Johnson went on to explain further.

"Per the Medicare Fee Schedule, the reimbursement for a new office visit [99201-99205] is higher than an established service [99212-99215]," says Johnson. "This is based on the understanding that a provider should be completing a comprehensive PFSH to ensure that they have a full understanding of the patient's history in general, and not just in relationship to that day's visit."

On the other hand, the PFSH for an established patient would differ.

"An established patient visit would not normally require a comprehensive history as generally this was obtained when they were a new patient and the provider can use this documentation to see if there are any contributing factors," says Johnson. "Only an update or confirmation of any changes is needed. An established visit is generally problem focused."