Codify by AAPC

Pain Management Coding Alert

E/M Coding: Stay Sharp on PFSH to Master E/M History

PFSH rules dictate what constitutes each history element.

Correctly documenting a patient's past medical, family, and social history (PFSH) is a key component in determining E/M levels, but coders often have trouble grasping the meaning of this key piece of evaluation and management (E/M) service documentation.

And without a tight grip on the intricacies of PFSH, you risk miscoding your provider's E/M services.

Help's here: Follow these four tips and make PSFH decisions with confidence and clarity.

Tip 1: Know What Information is Needed

First, here's a quick PFSH refresher. When we talk about history in a coding sense, we're actually talking about three distinct and different aspects of a patient's life prior to encountering your provider.

Family history: According to CPT® guidelines, a family history is "a review of medical events in the patient's family that includes significant information about:

- "The health status or cause of death of parents, siblings, and children;
- "Specific diseases related to problems recognized in the Chief Complaint [CC] or History of the Present Illness [HPI], and/or System Review [ROS]
- "Diseases of family members that may be hereditary or put the patient at risk."

Past medical history: This is "a review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

- "Prior major illnesses and injuries
- "Prior operations
- "Prior hospitalizations
- "Current medications
- "Allergies [eg, drug, food]
- "Age-appropriate immunization status
- Age-appropriate feeding/dietary status."

Social history: This history is "an age appropriate review of past and current activities that includes significant information about:

- "Marital status and/or living arrangements
- "Current employment
- "Occupational history
- "Military history
- "Use of drugs, alcohol, and tobacco
- "Level of education
- "Sexual history
- "Other relevant social factors."

Tip 2: Know the Difference Between Pertinent and Complete

CPT® 2023 American Medical Association. All rights reserved.

Codify by AAPC

CPT® uses these two terms to distinguish between types of PFSH, but you have to turn to Centers for Medicare and Medicaid Services (CMS) guidelines to find the definitions you need to apply to both.

"A pertinent PFSH is a review of at least one of the history areas directly related to the problem identified in the HPI, whereas a complete PFSH is of a review of two or all three of the PFSH history areas," explains **Chelle Johnson, CPMA, CPC, CPCO, CPPM, CEMC, AAPC Fellow**, billing/credentialing/auditing/coding coordinator at County of Stanislaus Health Services Agency in Modesto, California.

Coding caution: You'll need all three PFSH elements when the E/M service requires a "comprehensive assessment or reassessment of the patient," according to CMS. For all other E/M service levels that require a comprehensive history, you only need to document two areas (Source: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf). The E/M documentation guidelines specify which categories of E/M services require two versus three elements of PFSH to be complete.

Tip 3: Know Why This Is Important

"The distinction between pertinent and compete PFSH is important because it relates to the level of history that is supported by the documentation, which, in turn, may impact the level of E/M code supported by the documentation," according to **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. For example, to support a level of 99203 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity ...) for a new patient, or 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity ...) for an established patient (if history is one of the three components on which you're basing your code selection), "you will need a pertinent PFSH, which is a required element for a detailed history," Moore reminds coders.

In order to code the highest E/M levels for new patients (99204 and 99205) and the highest level for an established patient (99215), however, you will need to document a comprehensive history. For that, you will need a complete PFSH.

CPT® 2023 American Medical Association. All rights reserved.