

E/M Auditing: History is the Key

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SUMMARY

Review the history component in your E/M documentation to make sure it tells the patient's presenting story.

E/M Auditing: History is the Key

Evaluation and management (E/M) documentation requirements are complex, but it's imperative for documentation to meet or exceed the criteria with every encounter. This ensures high quality patient care and proper reimbursement, and protects against malpractice allegations. Good documentation is also your provider's best defense in a payer or governmental audit.

One area that typically needs work when it comes to better E/M documentation is the history component. Let's review some tips to help strengthen documentation of your patients' history.

MEDICAL NECESSITY TRUMPS ALL

The No. 1 requirement driving any medical service is always medical necessity. According to the Medicare Claims Processing Manual, section 30.6.1.A:

"Medical necessity of a service is the overarching criterion for payment in addition to the

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individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."

How is medical necessity determined? It's based on the information captured in the history of present illness (HPI), which is also typically deficient in provider documentation.

ANATOMY OF THE HISTORY COMPONENT

To understand what's expected in E/M documentation, it's helpful to know the purpose each requirement fulfills. At its most rudimentary, an E/M service for a problem-focused encounter consists of the following:

1. The patient arrives with a problem and tells the provider about it. The provider asks questions about symptoms to help determine the cause and/or status of the problem (history component).
2. Next, the physician examines the body area(s) and organ system(s) from where the problem originates to verify the patient's complaint. The provider also looks for other indications, causes, and problems (exam component).
3. The provider considers all of the information gathered and decides on a plan to address the problem. The plan may include further testing, a referral to another doctor, or a treatment plan (medical decision making [MDM] component).

Our focus is history, so let's take a closer look at the requirements for that particular component, as laid out by the Centers for Medicare & Medicaid Services (CMS).

1. Every encounter must have a chief complaint. It can be separate from the HPI and review of systems (ROS), or it can be part of the HPI or ROS; however, it must make the reason for the visit obvious.
2. The chief complaint is the patient's presenting problem. "Follow up" is not a chief complaint.
3. If the patient doesn't have a problem (for instance, she just needs an annual exam), there is no chief complaint. You must bill a preventive E/M service.
4. Every encounter must have a minimum of one HPI or the status of at least one chronic illness. The provider must describe the problem (how bad it is, how long it has been going on, etc.).
5. Visits that will be billed at a high level E/M (level IV or V, for most categories) must have at least four HPI documented, or the status of three or more chronic illnesses. The problem has to be serious enough to justify a higher level of service, and the medical record must reflect this.
6. HPI may be documented by the performing provider ONLY. Copying the nurse's notes does not count.
7. ROS is the patient's positive and negative responses about his or her experiences with symptoms. ROS is the patient's observations, not those of the provider.
8. ROS and past, family, social history (PFSH) may be recorded by someone other than the provider (e.g., ancillary staff, the patient), as long as the provider references the information in his or her own notes.

HPI BY ELEMENTS

HPI is easier to understand using examples

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because there are a lot of nuances in the different elements. Some, such as location and severity, are fairly straightforward. Others, such as timing and context, can be more difficult to spot. See if you can correctly identify the HPI in these examples:

Example A: Patient presents with nausea, vomiting, and fatigue x3 weeks. She complains of feeling extremely nauseous in the mornings and after eating.

- CC: Nausea
- Associated signs symptoms: Vomiting and fatigue
- Duration: 3 weeks
- Severity: Extremely nauseous
- Timing: In the mornings
- Context: After eating

Example B: Patient complains of productive cough, nasal congestion, and fever x1 week. Not improving with OTC meds.

- CC: Cough
- Quality: Productive
- Location: Nasal congestion
- Associated signs and symptoms:

Nasal congestion and/or fever

- Duration: 1 week
- Modifying factors: Not improving with OTC meds.

As illustrated in examples A and B, great documentation doesn't need to be lengthy, even to satisfy the requirements for higher level E/M services. Quality matters more than quantity. The information should be relevant to the presenting problem(s), and it should answer the questions each HPI element asks:

Location: Where is the problem? This element is important when a symptom could occur in multiple parts of the body (pain, lesions, swelling, etc.). Examples are "back pain," "nasal congestion," and "swelling of the right ankle."

Quality: How would you characterize the problem? This is a description of the problem that gives a better idea of its nature or characteristics (e.g., sharp or shooting pain, dry cough, or sore throat).

Severity: How bad is the problem? Examples include "extremely nauseated," "moderate

pain," or "level 5 pain," "mild irritation," and "minimal bruising."

Duration: How long has the problem bothered you? This is the total time the patient has experienced the problem since the onset. The provider may specifically state "onset two weeks ago," or the duration may be listed as simply "x2 days."

Timing: How often does the problem bother you? This element describes the frequency of the problem(s): whether it occurs constantly, off and on, or consistently at a particular time of day. Ideally, providers should be mindful of how others may interpret time and avoid ambiguous statements such as "symptom occurs intermittently" without supplying more information (e.g., the relevant definition of "intermittent"). Examples include: "worse in the mornings," "occurs constantly," and "patient experiences two migraines per week."

Context: Is the problem associated with any particular event or action? Don't confuse this with timing. Context describes some action or event that may be linked directly to the problem. Context refers to circumstances; whereas, timing refers to frequency. Exam-

ples of context include, "dizzy upon standing," "wheezing is worse after running," "patient was exposed to the flu four days before onset of fever."

Associated signs/symptoms: Have you noticed any other symptoms since the problem started to bother you? This element doesn't describe separate problems per se. Associated signs/symptoms are "tag-along" problems that likely stem from the same issue as the chief complaint. For example, a chief complaint of nausea may be accompanied by associated symptoms of vomiting and diarrhea. Pain is frequently associated with swelling or redness, and headaches may include sensitivity to light or sound.

Modifying Factors: Have you done anything to make the problem better or worse? This is any action of the patient in an attempt to relieve the problem, or something he or she has done to make it worse. The action and result should both be indicated. For example, "no relief from OTC meds" or "patient reports less pain after using a heating pad."

HPI BY CHRONIC ILLNESSES

When a patient receives ongoing care for a chronic illness, the HPI elements become

relatively worthless and redundant. For that reason, CMS also allows providing the status of chronic illnesses an alternative method to describe the history of the presenting problem. To count as HPI, the name of the illness must be stated, along with the status of the illness and a description of the treatment plan. For example, "Follow up for HTN. Patient tolerating BP medication well.* No chest pain, SOB, or palpitations."

If the documentation is abundant with information, stop looking for HPI after you've reached four (which is enough to qualify as an "extended" HPI).

*Note: To make this statement eligible for credit, the type of medication should be mentioned somewhere in the documentation, such as in the treatment plan.

ROS SHOULD MATCH HPI

When an ROS has been documented in a template (particularly in an electronic health record note), watch out for statements conflicting with the HPI, and only count statements reflecting the patient's observations. For example, "AO x3" is sometimes included in the ROS section, but it represents the provider's observation that the patient is alert and oriented to time, place, and person. This should be credited under the psychiatric portion of the exam.

The system(s) directly pertaining to the chief complaint should be indicated as "positive" for symptoms, with elaboration. All systems that are "positive" for symptoms, and those with "pertinent negatives," should include at least a brief explanation of present or absent symptoms. Pertinent negatives are "negative" responses where you would expect to see a "positive" response for symptoms.

If you must determine which statements are HPI and which are ROS, balance the amount of HPI and ROS to maximize your history level. If there's not enough information to give you at least four HPI and two ROS, assign one HPI and leave the rest to ROS. If the

documentation is abundant with information, stop looking for HPI after you've reached four (which is enough to qualify as an "extended" HPI).

DECONSTRUCTING PFSH

Past, family and social history is required only for detailed and comprehensive history levels. PFSH may be recorded by ancillary staff or by the patient (on the same day or during a previous encounter)—as long as the provider specifically acknowledges the information in their own documentation.

- Past history includes the patient's history with previous illnesses, surgeries, and treatments. Past medications and allergies could be counted in this area.
- Family history includes any family history of diseases or illnesses.
- Social history might include things such as whether the patient smokes, drinks, uses drugs, is married/divorced, where he or she works, or the activities that he or she participates in, if the information has the potential to influence the patient's health status.

MAKE IT A HISTORICAL DOCUMENT

The history element of an E/M service should tell the story about an illness and how it affects the patient. Like all good stories, the documentation must have a beginning, some development, and an ending to adequately describe the E/M of the patient's presenting problem(s). The note doesn't need to be long or complicated to get the point across, but it should have all of the necessary details to ensure a happy ending.

Three Key Takeaways

1. It's imperative for E/M documentation to meet or exceed the criteria with every encounter.
2. Medical necessity is the key requirement and outcome of E/M coding.
3. Know what each requirement fulfills to better prove medical necessity.



AUTHOR BIO

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