Baptist Health Medical Group
BAPTIST HEALTH SOUTH FLORIDA

The Physician Edition

BHMG Quality and Performance Improvement Department
January, 2017

6th Edition Coding Education Provider Newsletter

E&M Coding Education Questions?
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A New Year, but History does not Change!

Documentation of the history element of an E/M service tells a story about an illness, and how it has affected a patient. The story must have a beginning, some development, and an ending to adequately describe the E/M of the patient's presenting problem(s).

To help you meet documentation requirements, specifically relating to the history component, let's take a closer look at the requirements, as laid out by the Centers for Medicare & Medicaid Services (CMS):

- Every encounter must have a chief complaint.
- The chief complaint is the patient's presenting problem. "Follow-up" is not a chief complaint.
- 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.
- 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.)
- 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.
- 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.

Documenting Your Key Element- History of Present Illness (HPI)

The maximum HPI elements you need for your History documentation is four (4), so make them count. The key to quality HPI documentation is to utilze key or descriptive words, when addressing any of the eight (8) reconigized HPI. Familarize yourself with the 8 elements and the documented supported by each.

HPI Element	Definition	Example
Duration	How long has the patient been experiencing the signs or symptoms?	Been hurting for two weeks, began last month
Timing	When does the patient experience signs or symptoms? What regularity/frequency of occurrences? What time of day?	Stomach pain worse after eating, worse at night; always occurs after exercise
Location	Place, site, position of signs & symptoms. Where is the problem located?	Lower back, elbow, stomach
Severity	What is the intensity, degree, or ability to endure signs or symptoms? Scale of 1 to 10?	8 on a scale of 1-10, pain so bad it affects breathing

Documenting Your HISTORY- Tell the Story

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Quality	What description or characteristics identify the type of signs or symptoms?	Stabbing pain, radiating pain, dull ache, anxiety- producing
Context	Circumstances, cause, outside factors to describe where patient is or what he is doing when signs or symptoms occur.	Shortness of breath when climbing stairs; began after a fall from a ladder
Modifying Factors	What treatment/actions have affected (positive or negative) or altered the signs or symptoms?	Tylenol did not relieve the pain, applying heat seems to help, an antacid provides short term relief, lying down doesn't help
Associated Signs & Symptom	Are there any other symptoms that appear to accompany the main symptoms? What other factors does patient experience in addition to this discomfort/pain?	Before the headache starts my eyes hurt and I can't stand light; my heart pounds and I break out in a sweat each time

Example HPI: 45-year old female complains of ***intermittent sharp pain*** (*timing/quality)* in ***left hip*** (*location*) ***after falling from a ladder yesterday*** (*context*). Also states ***left leg has some numbness*** (*associated signs and symptoms*). ***Pain an 8 on 1-10 scale*** (*severity*). ***Ibuprofen has had no effect on pain*** (*modifying factors*).

Review of Systems

A review of systems (ROS) is an inventory of body systems obtained through a series of questions to identify signs and/or symptoms which the patient may be experiencing or has experienced.

Information included in the review of systems is used to identify:

- The patient problem,
- Assist in the arrival at a diagnosis,
- Identify differential diagnoses, and
- Determine the testing necessary to attain a definitive diagnosis.

REMEMBER: The ROS should be pertaining to the Chief Compliant/ Nature of the Presenting Problem.

Past Family, Social and Medical History

The PFSH consists of a review of three history areas. **Only one of each category is needed**:

- **MEDICAL HISTORY**
  - Prior major illnesses/injuries; operations; hospitalizations; current medications; allergies; age-appropriate immunization status
- **FAMILY HISTORY**
  - Health status or cause of death of parents, siblings and children; specific diseases related to problems identified in the chief complaint; and/or hereditary diseases.
- **SOCIAL HISTORY**
  - Marital status, living arrangements; current employment; occupational history; use of drugs, alcohol and tobacco; level of education; sexual history; or relevant social factors.

KEY POINT TO REMEMBER with HISTORY DOCUMENTATION: Medical Necessity plays a major role in your documentation! Over-documenting does not support a higher code.