Evaluation and Management (E/M) Training

Module 2

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Module 2

Determining the Level of an Evaluation and Management (E/M) Code

Introduction

E/M codes (99201–99499) describe a provider's service to a patient including evaluating the patient's condition(s) and determining the management of care required to treat the patient.

There are seven components making up an E/M service: History, Exam, Medical Decision Making (MDM), Counseling, Coordination of Care, Nature of Presenting Problem, and Time. Three of these components—History, Exam, and MDM—are considered key components to determining the overall level of an E/M Service.

Using his or her best clinical judgment, experience, and training, the provider determines the extent of the history, exam, and medical decision making required, based on Medical Necessity (or, what is necessary to treat the patient for a given condition/complaint). The medically necessary components are "added together" to determine an overall level of service.

Returning to the instructions in the Evaluation and Management Services Guidelines in your CPT® code book, the six steps to determining the level of an evaluation and management service include:

1. Select the category or subcategory of service and review the guidelines;
2. Review the level of E/M service descriptors and examples;
3. Determine the level of history;
4. Determine the level of exam;
5. Determine the level of medical decision making; and
6. Select the appropriate level of E/M service.

We discussed selecting the category or subcategory of service and reviewed the guidelines in Module 1. Our next step is to review the level of E/M service descriptors and examples.

CPT® code descriptors will indicate the key component requirements for reporting a specific code. In some cases, to report a given level of service, you must meet all three key components. In other cases, the code descriptor may allow you to report a given level of service by meeting two of the three key components at the specified level.

In the description of the majority of evaluation and management codes, the number of key components is specified. For example:

> 99201—Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:
>
> 99213—Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

You may want to take some time to highlight or underline the components required for each code.

Code descriptors also define the specific details of the service, which include: place and or type of service; content of the service provided; nature of the presenting problem; and the time generally required to provide the service. In addition, there are examples of varying levels of service described in Appendix C of your CPT® codebook.

Determine the Level of Services

Once the category and subcategory of services have been chosen, the guidelines reviewed, and the code descriptors and examples reviewed, the components are added together to find the level of the EM service.

Levels of E/M codes in each category are often referred to as level 1, level 2, level 3, etc., depending on the last number of the code referred to in the category. The higher the level, the more components required to meet that level of service.

Example

New Patient Office or Other Outpatient Visits:

99201 Office visit, new patient: level 1

99202 Office visit, new patient: level 2

99203 Office visit, new patient: level 3

99204 Office visit, new patient: level 4

99205 Office visit, new patient: level 5

Each level of service has a unique description and requirements for its category or subcategory.

Example

Codes 99203 (Office or other outpatient visit, level 3, new patient) and 99213 (Office or other outpatient visit, level 3, established patient) have different requirements for the level of history, exam and medical decision making:

E/M Code	99203	99213
Key Components Required	3 of 3	2 of 3
Level of History	Detailed	Expanded Problem Focused
Level of Exam	Detailed	Expanded Problem Focused
Level of Medical Decision Making	Low Complexity	Low Complexity

The levels of history, exam, and medical decision making are defined in your Evaluation and Management Guidelines of your CPT® coding manual. They are further defined, with specific detail, in the 1995 and 1997 Evaluation and Management Guidelines by CMS.

1995 and 1997 E/M Documentation Guidelines

The 1995 Documentation Guidelines for Evaluation and Management Services and the 1997 Documentation Guidelines for Evaluation and Management Services were developed to assist providers in determining the level of service provided to a patient. Both sets of guidelines can be found on the CMS Web site (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html).

Either the 1995 or the 1997 set of guidelines can be used for any particular E/M service. The main difference between the 1995 and 1997 Documentation Guidelines for Evaluation and Management services is the leveling of the exam component. The set of guidelines most beneficial to the provider (eg, results in a higher level of code) should be used. There are instances when the insurance carrier or company policy will dictate which guideline is used or if either set of guidelines can be used. When determining a level of visit, it is important to know company policy, as well as payer policy to determine the correct level of codes.

History

The history is used for the provider to troubleshoot the chief complaint based on an interview with the patient. History is divided into the following components:

Chief Complaint (CC)

History of Present Illness (HPI)

Review of Systems (ROS)

Past, Family, and Social History (PFSH)

Some categories of service only require an interval history, such as subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care. An interval history is the history during the time period since the physician last performed an assessment of the patient. As such, a PFSH is not required for an interval history.

Chief Complaint (CC)

Both the 1995 and 1997 Documentation Guidelines require a chief complaint. A chief complaint is a medically necessary reason for the patient to meet with the physician. The chief complaint is part of the history component. If there is no chief complaint, the service is preventive and would need to be reported using a code from the Preventive Services Category.

The chief complaint is often stated in the patient's words, for example, "My knee hurts," or "Patient complains of an ear ache." Occasionally, documentation states the reason for a visit is "follow up." A simple statement of "follow up" is not sufficient for a chief complaint. It is necessary for a provider to document the condition being followed up on. A more concise statement would be, "follow up of broken ankle," or "follow up of hypertension."

Example

CHIEF COMPLAINT: Left elbow injury.

History of Present Illness (HPI)

Based on the chief complaint, a provider will ask questions to get a complete description and chronologic account of the problem to be treated. According to CMS, the HPI must be documented by the physician; it cannot be documented by ancillary staff.

The description of HPI is listed in the Evaluation and Management Guidelines of the CPT® coding manual. The 1995 and 1997 Documentation Guidelines for Evaluation and Management Services recognizes eight HPI components:

1. Location: The anatomical place, position, or site of the chief complaint (eg, back pain, sore elbow, cut on leg, etc.)
2. Quality: A problem's characteristics, such as how it looks or feels (eg, yellow discharge, radiating pain, burning urination, etc.)
3. Severity: A degree or measurement of how bad it is (eg, improved, unbearable pain, 8 on a scale of 1 to 10, etc.)
4. Duration: How long the complaint has been occurring, or when it first occurred (eg, since childhood, first noticed a month ago, etc.)
5. Timing: A measurement of when, or at what frequency, he or she notices a problem (eg, intermittent, constant, only in the evening, etc.)
6. Context: What the patient was doing, environmental factors, and/or circumstances surrounding the complaint (eg, while standing, during exercise, after a fall, etc.)
7. Modifying factors: Anything that makes the problem better or worse (eg, improves with aspirin, worse when sitting, better when lying down, etc.). If medication is documented as a modifying factor, it should also be noted the result of using the medication (eg, Tylenol reduces the pain).
8. Associated signs and symptoms: Additional complaints that may be related to the chief complaint.

The number of components documented for the history of present illness will determine the HPI level. The history of present illness can be considered brief or extended.

HPI Level	Elements Required	Example
Brief	1 to 3 HPI	Patient is here for knee (location) pain lasting 2 weeks (duration).
Extended	4 or more HPI	Patient is here for intermittent (timing) knee (location) pain lasting 2 weeks (duration). She states it is a dull (quality) pain that increases when she runs (modifying factor).

The 1997 E/M Documentation Guidelines also allow credit in the HPI for patients who are seen for chronic conditions. The status of at least three chronic conditions must be documented. A statement such as, "Patient is here for follow-up on diabetes, hypertension, and hypercholesterolemia" is not sufficient documentation to count three chronic conditions as an extended HPI. The documentation should state the status of the condition.

Example

Diabetes: He is a Type II diabetic under good control and is very diligent with managing his sugars. Compared to last visit the diabetes remains controlled by improved diet and increased exercise.

Hypertension: Compared to last visit the hypertension is improved and remains controlled by the patient increasing daily activity and taking ACE inhibitors.

Hypercholesterolemia: Compared to last visit the cholesterol is stable. The patient is maintaining goals of total cholesterol < 200, LDL <100, HDL >4O.

Statements for three chronic or inactive conditions are not credited specifically under the 1995 E/M Documentation Guidelines, but may be given credit by the 1997 E/M Documentation Guidelines as chronic conditions when the status of those conditions is the reason for the visit.

For most payers, you should not "mix and match" 1995 and 1997 Documentation Guidelines. If you select 1997 E/M Documentation Guidelines for the history component, you should use the same guidelines to determine the exam level and MDM.

Example

History of Present Illness (HPI)—Extended

HISTORY OF PRESENT ILLNESS: This is a 19-year-old female who presents with pain in her left elbow. 1 She states that this morning, around 8 o'clock in the morning, 2 she tripped over a vacuum, fell, landing on an outstretched arm. 3 It felt like her left arm was stuck in place straightened, so she bent it and now it feels worse than before like she cannot bend or straighten her elbow. 4 Went to an urgent care around 5 o'clock. X-rays were done which were normal. She was told that she might need an MRI to look for a ligamentous injury. She was referred to the ED. She presents at midnight tonight complaining of elbow pain 5 and is requesting an MRI of her elbow. No numbness or tingling in the fingers. No pain into the wrist or into the shoulder joint. Never injured this elbow before. She is wearing a sling upon presentation. She took ibuprofen earlier in the day. 6 & 7

REVIEW OF SYSTEMS: All systems reviewed and negative except for those stated in HPI. 7

1 Location.

2 Duration.

3 Context.

4 Severity.

5 Location again.

6 For these statements to be used in the HPI as modifying factors, there would need to be a statement indicating the result of the sling and the ibuprofen...did it make it better, worse?

7 Used in Review of Systems: See below.

Review of Systems (ROS)

The Review of Systems (ROS) consists of questions to inventory the body systems to assist in identifying signs or symptoms the patient has experienced or is currently experiencing. The questioning of multiple body systems assists the

provider in finding subtle changes in the patient and further focus on problems.

Both 1995 and 1997 E/M Documentation Guidelines define the ROS as an account of body systems obtained through questioning to identify patient signs and/or symptoms. The ROS might include verbal questioning by the provider or by a separate patient intake or questionnaire form. According to CMS' documentation guidelines, the ROS can be obtained by ancillary staff (eg, nurse) on a form completed by the patient. When a separate form is used, the provider must document that he/she reviewed the information along with notations supplementing or confirming the information.

In the event a physician is unable to obtain a history from a patient (eg, the patient is nonresponsive), the physician should document he or she is unable to obtain a history and the reason.

Example

REVIEW OF SYSTEMS: No review of systems is available due to patient unresponsive.

Example

Patient History Form

Patient Name:				DOB:		
Review of Systems						
Yes	**No**	**General**		**Yes**	**No**	**Hematology/Lymphatic**
		Chills				Easy bleeding
		Fatigue				Easy bruising
		Fever				Anemia
		Night Sweats				Blood clotting disorder
		Unexplained weight loss/gain				Swollen glands
Allergy/Immunology						Enlarged lymph nodes
		Hives		**Genitourinary**		
		Itchy eyes				Blood in urine
		Sneezing				Burning on urination
Ophthalmologic						Dysuria
		Blurring of vision				Urinary frequency
		Double vision		**Musculoskeletal**		
		Eye pain				Shoulder pain
		Vision loss				Wrist pain
		Watery eyes				Foot pain
HENT						Back pain
		Ear pain				Bone pain
		Loss of Hearing				Hip pain
		Loss of smell				Neck pain
		Sinus pain		**Skin**		
		Change in voice				Skin changes
		Difficulty swallowing				Rash
		Dry mouth				Change in moles
		Sore throat				Change in nails
Respiratory				**Neurologic**		
		Cough				Balance difficulty
		Dyspnea on exertion				Headache
		Hemoptysis				Memory loss
		Orthopnea				Migraines
		Wheezing				Paresthesias
Cardiovascular						Tingling/numbness
		Syncope				Vertigo
		Chest pain				Weakness
		Fatigue		**Psychiatric:**		
		Orthopnea				Anxiety
		Palpitations				Confusion
Gastrointestinal						Depression
		Abdominal pain				Hallucinations
		Black stools				Irritability
		Blood in stool				Mood swings
		Change in stool				Paranoia
		Constipation				Suicidal ideation
		Dysphagia		**Other:**		
		Nausea/Vomiting				
		Hemorrhoids				

There are three types of review of systems.

ROS Level	Elements Required	Example
Problem pertinent	1 (addresses only the body system directly related to the problem)	Patient denies itching or blisters with the hives.
Extended	2-9 (The system directly affected and related systems are reviewed)	She denies any N/V, diarrhea, or changes in her bowel or bladder function. She denies any SOB or palpitations. She denies headache or visual disturbance.
Complete	10+	General/Constitutional: Appetite normal, denies chills, fatigue, fever, night sweats, weight changes. Allergy/Immunology: Denies angioedema, hives, itchy eyes, sneezing. Ophthalmology: Denies blurring of vision, double vision, eye pain, vision loss, watery eyes. HEENT/Neck: Denies ear pain, loss of hearing, epistaxis, loss of smell, sinus pain, change in voice, difficulty swallowing, dry mouth, sore throat. Respiratory: Denies cough, dyspnea on exertion, hemoptysis, orthopnea, wheezing. Cardiovascular: Denies, syncope, chest pain, fatigue, orthopnea, palpitations. Gastrointestinal: Denies abdominal pain, black stools, blood in stool, change in stool, constipation, diarrhea, dysphagia, being gassy, heartburn, hemorrhoids, nausea, vomiting. Hematology: Denies easy bleeding, easy bruising, enlarged lymph nodes, swollen glands. Genitourinary: Denies blood in urine, burning on urination, dysuria, nocturia, urinary frequency. Musculoskeletal: Denies shoulder pain, wrist pain, foot pain, arthritis, back pain, bone pain, hip pain, knee pain, neck pain, tingling/numbness. Skin: Denies skin changes, rash, change in moles, change in nails. Neurologic: Denies balance difficulty, confusion, headache, memory loss, migraines, paresthesias, tingling/numbness, vertigo, weakness. Psychiatric: Denies anxiety, confusion, depression, hallucinations, irritability, mood swings, paranoia, suicidal ideation.

A complete review of systems can be documented by either individually documenting 10 or more systems, or by documenting the positive or pertinent negatives responses individually and adding a notation that all other systems were reviewed and are negative. Some carriers may allow the use of "noncontributory" in the documentation of a complete review of systems. Other carriers may consider "noncontributory" to mean it does not impact the treatment of the patient and therefore was not obtained. The payer guidelines should be verified when using "noncontributory."

Medical necessity determines the extent of the ROS. For instance, it might be considered necessary to obtain a complete ROS when a new patient presents for an office visit, but medically unnecessary to repeat that complete review on every follow-up.

Example

Review of Systems—complete

HISTORY OF PRESENT ILLNESS: This is a 19-year-old female who presents with pain in her left elbow. She states that this morning, around 8 o'clock in the morning, she tripped over a vacuum, fell, landing on an outstretched arm. It felt like her left arm was stuck in place straightened, so she bent it and now it feels worse than before like she cannot bend or straighten her elbow. Went to an urgent care around 5 o'clock. X-rays were done which were normal. She was told that she might need an MRI to look for a ligamentous injury. She was referred to the ED. She presents at midnight tonight complaining of elbow pain and is requesting an MRI of her elbow. 1 No numbness or tingling in the fingers. 2 No pain into the wrist or into the shoulder joint. Never injured this elbow before. She is wearing a sling upon presentation. She took ibuprofen earlier in the day. 3

REVIEW OF SYSTEMS: All systems reviewed and negative except for those stated in HPI. 4

1 Used in History of Present Illness. See above.

2 Neurologic.

3 Musculoskeletal.

4 Complete ROS.

Past, Family, and Social History (PFSH)

The Past, Family, and Social history describe occurrences with illness, surgeries, and treatments the patient and the patient's family have incurred, as well as social factors influencing the patient's health.

The past history focuses on the patient's prior medical treatments and can include:

- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies
- Age appropriate immunization status
- Age appropriate feeding/dietary status

Family History describes occurrences in the patient's family and typically includes a list of diseases or hereditary conditions that may place the patient at risk (for example, a family history of hypertension, diabetes, or cancer). This section also may include the age of death or living status of immediate family.

Social History identifies current and past patient activities, such as:

- Social status or living arrangements (if child, social status of parents)
- Employment status
- Occupational history
- Drug, tobacco, alcohol use (if child, exposure to second-hand smoke)
- Education level
- Sexual history
- Any social event/occurrence impacting patient's condition

There are two types of PFSH: Pertinent and complete.

PFSH Level	Elements Required	Example
Pertinent	1	**PMH:** Prozac for depression x 3 years; 3 pregnancies, 1 spontaneous Ab, 2 SVDs, 1 at term, 1 at 35 weeks, living male age 8 years, female age 5 years. Postpartum BTL for contraception 5 years ago. No chronic illnesses.
Complete	2 of 3 For the following categories, a complete PFSH only requires two of the three history areas to be documented (Past, Family, or Social): Office or other outpatient services, established patient Emergency Department Domiciliary care, established patient Home care, established patient 3 of 3 For other categories, at least one item from each history area (Past, Family, and Social) must be documented. These categories include: Office or other outpatient services, new patient Hospital observation services Hospital inpatient services, initial care Consultations Annual nursing facility assessments Domiciliary care, new patient Home care, new patient	PAST MEDICAL HISTORY: 1. Atrial flutter, diagnosed 1/2011 - -EKG appears consistent with right atrial flutter, negative in inferior leads and slightly positive in VI; perhaps clockwise atrial flutter 2. Hypertension 3. Hyperlipidemia 4. Minimal CAD-1/2011 left heart catheterization only demonstrating luminal irregularities PAST SURGICAL HISTORY: 1. Tonsillectomy 2. Right inguinal hernia repair 3. Left knee arthroscopic surgery PREVIOUS CARDIAC EVALUATION: 1/2011 LHC: Minimal CAD, normal LV systolic function 1/2011 TTE: EF greater than 55%, moderate LVH, left atrium mildly dilated, mild TR ALLERGIES: No history of contrast or iodine allergy CURRENT ALLERGY LIST: NKDA CURRENT MEDICATION LIST: DAILY VITAMIN FORMULA ORAL TABLET, daily ASPIRIN BUFFERED ORAL TABLET 325 MG, daily SIMVASTATIN ORAL TABLET 40 MG, daily LISINOPRIL ORAL TABLET 10 MG, 1/2 daily MULTAQ ORAL TABLET 400 MG, 1 Every Day MEDICATION INFORMATION SOURCE: Medication information source comes from the patient's memory. SOCIAL HISTORY: The patient is married. He works as a principal at a local school. No tobacco use ever, he drinks 8-10 alcoholic beverages per week, no history of illicit drug use. FAMILY HISTORY: The patient has no family history of sudden death or significant arrhythmias. No family history of premature coronary artery disease.

Totaling the Level of History

According to the documentation guidelines, the Chief Complaint, Review of Systems, and Past, Family, and Social History may be listed as separate elements of history, or they may be included in the description of the history of present illness. It is pertinent for a coder to be able to determine the levels of history regardless of how they are documented.

When the level of each element of history has been determined, the levels are combined to determine the overall level of history. There are four levels of history defined in your Evaluation and Management Guidelines:

Problem Focused

Expanded Problem Focused

Detailed

Comprehensive

To determine the level accurately, it is best to use a grid method:

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, Social History (PFSH)	Level of History
Brief	N/A	N/A	Problem Focused
Brief	Problem Pertinent	N/A	Expanded Problem Focused
Extended	Extended	Pertinent	Detailed
Extended	Complete	Complete	Comprehensive

The level of history required for each level of service is stated in the description of the CPT® code.

Example

99281 Emergency department visit for the evaluation and management of a patient, which requires these 3 components:

- A problem focused history
- A problem focused examination
- Straightforward medical decision making

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor.

Documentation Dissection: Hospital Admit History

Admission diagnosis: Pelvic pain, probable pelvic inflammatory disease; rule out ectopic; rule out appendicitis.

History: This established patient is a 37 y.o. G3 P1012 [1] white female seen in the office this afternoon for recent onset [2] of a foul discharge and pelvic pain. [3] LMP was 5 weeks ago, she is often irregular. [4] She reports 7 days ago having relations with her former partner on consecutive days. [5] 3 to 4 days following the weekend, she noted the gradual onset [6] of a foul smelling yellow-green discharge [7] and cramping. [8] Over the subsequent 3 days this discharge has increased requiring a Peri-Pad. She has had to change the pad q hour. [9] She has also noted the increase in pelvic and lower abdominal pain and cramping. The pain is worse than her normal menstrual cramps, [10] not helped with the application of heat. There was initially a small improvement with oral Ibuprofen; it has not helped today. [11] Upon questioning her partner, he reports some mild burning with urination for 5 days, otherwise no symptoms. She does not have a thermometer, has not taken her temperature. She has felt uncomfortably warm the last 2 days and today has had occasional chills. [12]

ROS: She denies any N/V, diarrhea, or changes in her bowels [13] or bladder function. [14] She denies any SOB [15] or palpitations. [16] She denies headache [17] or visual disturbance. [18]

PMH: Prozac for depression x 3 years; 3 pregnancies, 1 spontaneous Ab, 2 SVDs, 1 at term, 1 at 35 weeks, living male age 8 years, female age 5 years. Postpartum BTL for contraception 5 years ago. No chronic illnesses. [19]

SH & FH: Single parent, lives with children age 5 and 8 years. Currently works as a medical record auditor. [20] Parents are living and healthy. Mother has type II diabetes. Is the oldest with 3 living siblings in good health. [21]

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1. PFSH: Past Medical History.
2. HPI: Duration.
3. HPI: Location.
4. ROS: Genitourinary.
5. PFSH: Social History.
6. HPI: Timing.
7. HPI: Quality.
8. HPI: Associated Signs & Symptoms.
9. HPI: Severity.
10. HPI: Severity.
11. HPI: Modifying factors.
12. ROS: Constitutional.
13. ROS: Gastrointestinal.
14. ROS: Genitourinary.
15. ROS: Respiratory.
16. ROS: Cardiovascular.
17. ROS: Neurologic.
18. ROS: Eyes.
19. PFSH: Past Medical History.
20. PFSH: Social History.
21. PFSH: Family History.

Table A: History—Hospital Admit

History				
HPI Duration, Quality, Location, Genitourinary, Timing, Associated Signs & Symptoms, Severity	Brief (1–3)	Brief (1–3)	Extended (4 or more)	Extended (4 or more)
ROS Constitutional, Gastrointestinal, Genitourinary, Respiratory, Cardiovascular, Neurologic, Eyes	None	Pertinent to problem (1 system)	Extended (2–9 systems)	Complete
PFSH Past history (past illnesses, operations, injuries, treatments, current medications, allergies) Family history (health of parents and siblings) Social history (living arrangements, children)	None	None	Pertinent (1 history area)	Complete (2 (est) or 3 (new) history areas)
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

Looking at the grid, you must meet or exceed all levels of history. Because the ROS is extended, the highest level of history obtained is detailed.

Documentation Dissection: Consultation History

REASON FOR CONSULT: Atrial flutter

HISTORY OF PRESENT ILLNESS: The patient is a 60-year-old male who comes today at the request of Dr. Y for a consultation of his atrial flutter. [1] He was originally diagnosed with this in January of 2011. [2] At that time he developed extensive palpitations [3] as well as chest tightness. [4] He was subsequently found to be in atrial flutter and was admitted to St. Francis Hospital. He spontaneously converted to sinus rhythm. He underwent echo showing normal LV function and left heart catheterization showing no significant CAD. Since that time the patient has been taking aspirin and Multaq. His Multaq was stopped December 2011 secondary to patient preference. He subsequently had an episode when he was working out [5] in which he had a fast irregular heartbeat. [6] He also felt short of breath, fatigue, and dizzy during this episode. [7] He restarted his Multaq and the symptoms improved. [8] Since that time he does not feel that he has had further episodes of palpitations.

[1] Documentation of the request for consult.

[2] HPI: Duration.

[3] HPI: Severity.

[4] HPI: Associated Signs & Symptoms.

[5] HPI: Context.

[6] HPI: Quality.

[7] HPI: Associated Signs & Symptoms.

[8] HPI: Modifying Factor.

The patient reports that he is quite active. He exercises 4 days a week and is able to perform cardio workout up to 30 minutes. [9] He denies chest pain, chest tightness, or syncope. [10]

PAST MEDICAL HISTORY:

1. Atrial flutter, diagnosed 1/2011 - -EKG appears consistent with right atrial flutter, negative in inferior leads and slightly positive in VI; perhaps clockwise atrial flutter
2. Hypertension
3. Hyperlipidemia
4. Minimal CAD-1/2011 left heart catheterization only demonstrating luminal irregularities

PAST SURGICAL HISTORY:

1. Tonsillectomy
2. Right inguinal hernia repair
3. Left knee arthroscopic surgery

PREVIOUS CARDIAC EVALUATION:

1/2011 LHC: Minimal CAD, normal LV systolic function

1/2011 TTE: EF greater than 55%, moderate LVH, left atrium mildly dilated, mild TR

ALLERGIES: No history of contrast or iodine allergy

CURRENT ALLERGY LIST: NKDA

CURRENT MEDICATION LIST:

DAILY VITAMIN FORMULA ORAL TABLET, daily

ASPIRIN BUFFERED ORAL TABLET 325 MG, daily

SIMVASTATIN ORAL TABLET 40 MG, daily

LISINOPRIL ORAL TABLET 10 MG, 1/2 daily

MULTAQ ORAL TABLET 400 MG, 1 Every Day

MEDICATION INFORMATION SOURCE: Medication information source comes from the patient's memory.

Nurse's initials://sp [11]

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[9] PFSH: Social History.

[10] ROS: Cardiovascular.

[11] PFSH: Past Medical History.

SOCIAL HISTORY:

The patient is married. He works as a principal at a local school. No tobacco use ever, he drinks 8-10 alcoholic beverages per week, no history of illicit drug use. 12

FAMILY HISTORY: The patient has no family history of sudden death or significant arrhythmias. No family history of premature coronary artery disease. 13

REVIEW OF SYSTEMS: Please see HPI above for relevant cardiac ROS. Otherwise, a full review of systems including constitutional, neurologic, ENT, pulmonary, gastrointestinal, genitourinary, musculoskeletal, endocrine, and psychiatric systems was reviewed. These were all negative except as noted in the HPI above and urinary frequency at night. 14

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12 PFSH: Social History.

13 PFSH: Family History.

14 ROS: Complete ROS.

Table A: History—Consultation

History				
HPI Duration, severity, associated signs & symptoms, modifying factors, context, quality	Brief (1–3)	Brief (1–3)	Extended (4 or more)	Extended (4 or more)
ROS Complete (full ROS negative…)	None	Pertinent to problem (1 system)	Extended (2–9 systems)	Complete
PFSH Past history (past illnesses, operations, injuries, treatments, current medications, allergies) Social history (married, exercise, tobacco, alcohol, drug use) Family (no family history noted for cardiac)	None	None	Pertinent (1 history area)	Complete (2 (est) or 3 (new) history areas)
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

Looking at the grid, you must meet or exceed all levels of history. This documentation meets a comprehensive level of history.

Documentation Dissection: Emergency Department History

Example: Emergency Department

CHIEF COMPLAINT: Left elbow injury.

HISTORY OF PRESENT ILLNESS: This is a 19-year-old female who presents with pain in her left elbow. 1 She states that this morning, around 8 o'clock in the morning, 2 she tripped over a vacuum, fell, landing on an outstretched arm. 3 It felt like her left arm was stuck in place straightened, so she bent it and now it feels worse than before like she cannot bend or straighten her elbow. 4 Went to an urgent care around 5 o'clock. X-rays were done which were normal. She was told that she might need an MRI to look for a ligamentous injury. She was referred to the ED. She presents at midnight tonight complaining of elbow pain and is requesting an MRI of her elbow. No numbness or tingling in the fingers. 5 No pain into the wrist or into the shoulder joint. Never injured this elbow before. She is wearing a sling upon presentation. She took ibuprofen earlier in the day. 6

REVIEW OF SYSTEMS: All systems reviewed and negative except for those stated in HPI. 7

PAST MEDICAL HISTORY: She denies. 8

PAST SURGICAL HISTORY: She denies. 8

SOCIAL HISTORY: She is a smoker. 9

ALLERGIES: Allergic to erythromycin. 10

MEDICATIONS: She is on Zyrtec. 10

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1 HPI: Location.

2 HPI: Duration.

3 HPI: Context.

4 HPI: Severity.

5 ROS: Neurologic.

6 ROS: Musculoskeletal.

7 ROS: Complete.

8 PFSH: Past Medical History.

9 PFSH: Social History.

10 PFSH: Past Medical History.

Table A: History—Emergency Department

History				
HPI Location, duration, context, severity	Brief (1–3)	Brief (1–3)	Extended (4 or more)	Extended (4 or more)
ROS Neuro, Musculo, all other negative	None	Pertinent to problem (1 system)	Extended (2–9 systems)	Complete
PFSH Past history (past illnesses, operations, injuries, treatments, current medications, allergies) Social history (smoker)	None	None	Pertinent (1 history area)	Complete (2 (est) or 3 (new) history areas)
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

Looking at the grid, you must meet or exceed all levels of history. This documentation meets a comprehensive level of history.

Key Points to Consider

When Selecting a History Level:

1. If documentation establishes the provider cannot obtain a history from the patient or other source (for example, if the patient is unconscious), the provider is not penalized, nor are the overall medical necessity level and provider work discounted automatically.

2. Additional history supplied by a family member or a caregiver and documented by the provider can be credited toward the overall E/M service's MDM component.

3. An ROS and/or PFSH taken from a previous encounter may be updated without complete re-documentation for most payers. The provider should indicate the new history status and indicate where the original documentation is stored.

4. There is a fine line between the signs and symptoms the patient shares in the HPI, and those obtained via the ROS. Individual payers have the power to interpret the documentation guidelines in their own way, and many prohibit using one documented statement to count for two separate history elements. For example, if the documentation reads, "The patient states that her hip has been painful," credit would not be given to both the HPI location and to the musculoskeletal ROS (this is "double-dipping"). If, on the other hand, the documentation reads, "The patient states that her hip has been painful. She denies any other musculoskeletal complaint," there is a distinct component of both the HPI (painful hip) and a separate musculoskeletal ROS (no other musculoskeletal complaint). There are times when two separate audits of the same service may produce different results, and neither party can be proven technically or medically wrong. A reviewer may argue an HPI element

is a "quality" versus an "associated sign and symptom or other element," or that "no known drug allergies" documentation constitutes an ROS element rather than a past history element.

Correct interpretation requires consistency, verifiable references, a logical argument, and—ultimately—medical necessity.