

Key Components

- The 3 Key components of E/M are:
 - history;
 - examination;
 - medical decision making;
- The other contributing components are:
 - counseling;
 - coordination of care;
 - nature of presenting problem; and
 - time.

History Components

- Each type of history includes some or all of the following elements:
 - Chief complaint (CC);
 - History of present illness (HPI);
 - Review of systems (ROS); and
 - Past, family and/or social history (PFSH).

Patient History

- History can be obtained via a form completed by the patient.
- The patient indicates if they have/had any of the symptoms or conditions on the form.
- If provider has a need to review patient history at a follow up visit document in the record for that day indicating date of the original history form.
- Note: If there is no date then History review is not counted toward the E/M level.
- Recommend signing the patient history form on the first visit when you have reviewed

Patient History

- The 1995 E/M Documentation Guidelines state that:
"The review of system and/or past, family, social history may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others."
- When a patient form is utilized the guideline requires that the provider review and confirm the information.
- All positive responses on the history form by the patient should have an explanation.

Chief Complaint (CC)

- CC - a concise statement describing: the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.
- 1995 E/M Guidelines state documentation should clearly reflect the chief complaint
- If your MA has not documented a CC, or has documented N/A or zero, you must document a CC.
- Do not use “follow up” or location i.e. “knee” without identifying the problem being followed

History of Present Illness (HPI)

- HPI is a “chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present”.
- It includes the following elements:
 - location,
 - quality,
 - severity,
 - duration,
 - timing,
 - context,
 - modifying factors, and
 - associated signs and symptoms.



Types of HPI

- E/M recognizes two types of HPI
- **Brief** - 1-3 elements of the HPI.
 - Example – patient complains of pain in left elbow (*location*) for 2 days (*duration*) = 2 HPI elements
- **Extended** – 4 or more elements of HPI.
 - Example – patient complains of sharp (*quality*) pain in left elbow (*location*) for 2 days (*duration*). Pain is helped with Aleve (*modifying factor*). = 4 HPI elements
- Tip: Recommend using a sheet to document the mechanism of injury and HPI information to be used when dictating.

Review of Systems (ROS)

- A ROS is a Q & A to identify signs/symptoms which the patient may be experiencing or has experienced.
- The following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

Past Medical, Family and Social History (PFSH)

- This information can be obtained by the provider or documented by the patient on the patient history form
- The PFSH consists of a review of the following:
 - Past history that discusses past experiences with illnesses, operations, injuries and treatments.
 - Family history of medical events in patient's family, including diseases that may be hereditary or place a patient at risk.
 - Social history that includes age-appropriate review of past and current activities.

Examination

- 1995 E/M Documentation Guidelines recognize 4 levels of examination:
 - Problem Focused (1+ Body area/organ system)
 - Expanded Problem Focused (2-7 body area/organ systems)
 - Detailed (2-7 body area/organ system - requires detailed exam of affected area)
 - Comprehensive (multi system 8 or more body areas or organ systems)
 - Note: for a comprehensive exam it requires 8 or more body areas *or* organ systems, cannot be a combination.

Exam – Body Areas

- For purposes of exam, the following **body areas** are recognized:
 - Head, including the face,
 - Neck,
 - Chest, including breasts and axillae,
 - Abdomen,
 - Genitalia, groin, buttocks,
 - Back, including spine,
 - Each extremity.

Exam – Organ systems

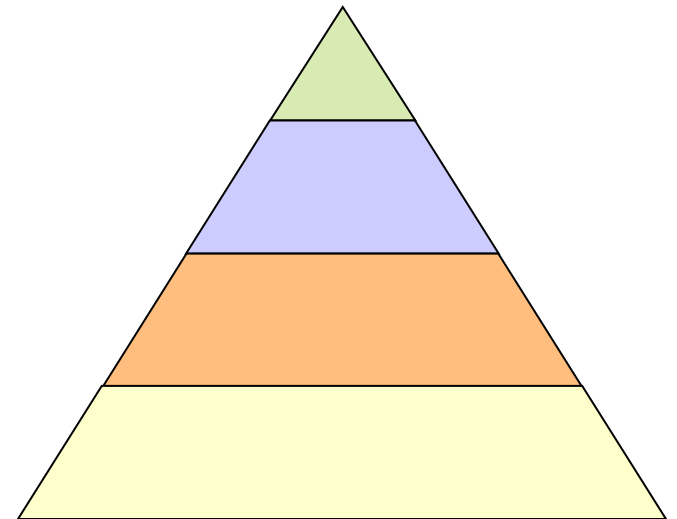
- For purposes of exam, the following **organ systems** are recognized:
 - Constitutional (e.g., vital signs, general appearance),
 - Eyes,
 - Ears, nose, mouth and throat,
 - Cardiovascular,
 - Respiratory,
 - Gastrointestinal,
 - Genitourinary,
 - Musculoskeletal,
 - Skin,
 - Neurologic,
 - Psychiatric,
 - Hematologic/lymphatic/immunologic.

Examination

- For new patients a level 4 or 5 visit requires documentation of a comprehensive examination
- This would require documentation of exam for 8 or more body areas or organ systems, or multiple trauma
- All *positive* responses on the objective (exam) portion require a detailed narrative explaining the finding
- Abnormal or unexpected findings an unaffected or asymptomatic body area(s) or organ system(s) should also be described

Medical Decision Making (MDM)

- The levels of E/M services recognize four types of medical decision making
 - straightforward
 - low complexity
 - moderate complexity
 - high complexity



Medical Decision Making

- Medical Decision Making (MDM) is the complexity of establishing a diagnosis and/or selecting a management option as measured by:
 - number of possible diagnoses and/or number of management options that must be considered;
 - amount and/or complexity of medical records, diagnostic tests, and/or other information obtained, reviewed, and analyzed; and
 - risk of significant complications, morbidity, and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Number of Diagnosis or Management Options

- Generally, decision making for a diagnosed problem is easier than that for an undiagnosed one.
- The number and type of diagnostic tests may be an indicator of the number of possible diagnoses.
- Problems which are improving/resolving are less complex than those which are worsening or failing to change as expected.
- The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

Number of Diagnosis or Management Options

- For each encounter, an assessment, clinical impression, or diagnosis should be documented.
- Management plans and/or further evaluation or workup should be documented.
- For a presenting problem with an established diagnosis the record should reflect whether the problem is:
 - a) improved, well controlled, resolving, or resolved; or,
 - b) inadequately controlled, worsening, or failing to change as expected.

Number of Diagnosis or Management Options

- If no definitive diagnosis clinical impression may be stated in the form of a differential diagnoses or as "possible," "probable," or "rule out" (R/O).
- Return to work restrictions, are essential in the management of injured workers and are valued as a part of the management option.
- Under the USHW coding policy determining work restrictions and physical capacity estimates will increase the complexity of management options.

Number of Diagnosis or Management Options

- The initiation of, or changes in, treatment should be documented.
- Treatment includes patient instructions, nursing instructions, therapies, and medications.
- If referrals are made, consultations requested, or advice sought, record should indicate to whom or where the referral or consultation is made and why.
- Any co-morbidities or other medical conditions that the patient may have should also be documented in regard to decision making

General MDM Rules

- You should always document :
 - stability of patient illness or injury
 - any complications or underlying conditions that could complicate patient's condition
 - decision to keep patient on same medication even if no changes were made
 - your decision to obtain old/other records or films
 - any discussion of testing with the performing provider, i.e. stress echo results with Cardiologist
 - any discussion of the case with another physician
 - any additional workup you are planning i.e. MRI, CT, biopsy.

Diagnostic Testing

- All diagnostic testing performed in the center must have the results documented by the provider on the forms
 - X-rays and EKG's should have the reading documented as the test is billed for both the technical and professional components.
 - All labs performed in the clinic i.e. rapid strep, hemocult, UA, etc, must have the results recorded by the provider in the documentation.
 - The documentation must also include the medical necessity or rationale for performing the tests

Drugs and Supplies

- All dispensed and utilized supplies must be documented in the medical record.
- Unit amount of supplies or medications must be documented
- All dispensed medications must be indicated with number and dosage
- Clearly indicate which medications or supplies were dispensed vs. prescribed.

Diagnosis

- Be as specific as possible when documenting diagnosis of patient condition
 - Example: Closed Carpal Fracture
 - 10 ICD-9 codes – 1 for each bone.
 - Be specific, avoid use of “unspecified” code
- Document all changes in patient condition
- Document any new diagnosis added for the patient
- Indicate the primary diagnosis for the encounter
- Document rule out or suspected conditions – although they cannot be coded they can add weight to your medical decision making
- List any underlying conditions that may impact the patients complaint

Points to remember

- Ensure patient history is complete, make any pertinent comments on the encounter form.
- Document a thorough HPI on all new patient encounters
- Elaborate on any objective abnormal findings
- Document all planned workup and/or discussion of case with other providers
- If using history form sign form on first visit.
- Document any medical conditions, even those not being treated, that could complicate the patients condition.