Make documentation problems history

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AN EASY GUIDE TO DOCUMENTING THE HISTORY OF PRESENT ILLNESS

Unfortunately, few orthopaedic surgeons enjoy learning how to code evaluation and management (E&M) services. A significant portion of practice revenues, however, can be attributed to E&M services. Neglecting the proper documentation and coding of these encounters is a common and costly mistake.

Each patient encounter (e.g. new patient visit, established patient visit, consultation) includes three key components: the history, the physical examination, and the medical decision making. Determining the level of service for a patient encounter requires documentation of either two of these three components, or of all three components, depending on the category of service.

Work that is done must be justified by the patient’s diagnoses. Documentation of this work in the patient’s medical record determines the level of service reported. An article covering the entire scope of E&M coding would be a daunting read and perhaps a bit of a snore. So this article will focus on only one part of E&M documentation: the history of present illness.

Patient history
Because most of the patient history is typically documented by someone other than the physician, this aspect of E&M coding generally gets little attention. In many practices, the patient history is recorded on a form filled out by the patient. The review form, he or she should sign and date it. In the dictation, the physician or NPP should state that the form was reviewed with a brief line, “I reviewed the history form filled out by the patient on Sept. 4, 2007.” This part of the history does not need to be redacted but it must be retained in the patient’s medical record.

The chief complaint (CC) and history of present illness (HPI), however, are different from the rest of the components in the patient history. Reporting and documenting the CC and HPI must be done by the physician or NPP reporting the service.

In 1997, the American Medical Association and the Centers for Medicare and Medicaid Services (CMS) jointly developed E&M documentation guidelines. (The complete guidelines can be found on the CMS Web site, www.cms.gov; type “documentation guidelines” in the search box.) These guidelines clearly state that the physician or NPP must document the CC and HPI. CMS recently restated this decision.

Chief complaint
The CC is a brief statement describing the symptom, problem, condition, physician recommended return, or other reasons for the encounter. The chief complaint is usually stated in the patient’s words.

History of present illness
The history of present illness is the chronological description of the patient’s complaint from the first sign or symptom to the present. It is required for all levels of history and, therefore, for all levels of service.

The four types of history are problem-focused, expanded problem-focused, detailed, and comprehensive. The one that is reported depends on the documentation. The eight elements of the HPI are listed in Table 1.

The problem-focused and expanded problem-focused histories require documentation of at least three elements; detailed and comprehensive histories require documentation of four or more elements.

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>EXPLANATION</th>
<th>EXAMPLE</th>
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<tbody>
<tr>
<td>1. Location</td>
<td>Where is the problem?</td>
<td>Arm, leg, low back</td>
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<tr>
<td>2. Duration</td>
<td>How long have the symptoms been there?</td>
<td>1 day, months, years</td>
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<td>3. Severity</td>
<td>Is the pain minor, moderate, or severe?</td>
<td>Minor pain or 3 of 10</td>
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<td>4. Quality</td>
<td>Describe the quality of the symptom.</td>
<td>Sharp, dull, burning, throbbing, etc.</td>
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<td>5. Context</td>
<td>New patient: How did the symptoms begin?</td>
<td>Gradually over time; suddenly after a fall</td>
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<td>6. Modifying factors</td>
<td>What makes it better?</td>
<td>Heat, ice, rest, elevation, medication</td>
</tr>
<tr>
<td>7. Associated signs and symptoms</td>
<td>Are there other signs or symptoms associated with your primary (main) problem?</td>
<td>Numbers; swelling; limited movement</td>
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<tr>
<td>8. Timing</td>
<td>When do the symptoms occur?</td>
<td>At night, walking stairs, after work, at rest, after exercise</td>
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The project explores both the clinical and business side of medical practice. This will enable the nation’s policymakers to learn what is truly involved in running a practice that can provide patients with expert care and do so in a sustainable way.

A small section in this study pertains to practice expenses and the amounts that are attributable to you. Please encourage your staff to make these numbers available to the Gallup interviewer. This is a vital part of the research, and accurate and complete data are needed. This information remains confidential; Gallup does not identify any individuals or entities participating in this research to any of the participating organizations.

The Physician Practice Information survey is an important and necessary vehicle for positive change. Please watch for it and do your part in completing it in a thorough and accurate manner if yours is among the practices randomly selected to represent orthopaedics.

The AAOS, AMA conducting physician practice information survey

The AAOS, the American Medical Association (AMA), and more than 70 other medical specialty societies are working on a comprehensive multispecialty survey of America’s physician practices. The Gallup Organization will conduct the Physician Practice Information survey among a representative sample of practices in each of the participating specialties.

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