CODING Q&A

Medical Necessity in E/M Coding, Part 2: ROS and PFSH

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Last month, we presented definitions for medical necessity offered by the AMA and the Centers for Medicare & Medicaid Services (CMS). We looked at the elements appropriate to perform and document in the History of Present Illness (HPI). And we briefly discussed Recovery Audit Contractors (RAC) audits. (If you missed it, the column is archived on the *JUCM* website [*http://jucm.com*] in the May 2011 issue.)

This month, our focus is on Review of Systems (ROS) and Past History, Family History, and Social History (PFSH). What makes this discussion particularly important to have at this time is that some coding auditors with little understanding of urgent care medicine have been inappropriately downcoding E/M levels. Coding for ROS and PFSH are cases in point.

To the board-certified primary care or emergency physician, the issues we are about to explore may seem elementary. But due to the aggressive nature of some coding audits, the rationale for performing ROS and PFSH in the urgent care setting is necessary to clarify.

This series of columns is not meant to offer encyclopedic coverage of medical necessity in E/M coding. Instead, it seeks to focus on some occasionally challenging coding issues faced by urgent care clinicians, with examples to illustrate when and why a given code is appropriate.

With that preamble, let's look why ROS and PFSH are clinically relevant, legitimately code-worthy components in the evaluation and management of the urgent care patient.

Q. Which elements are appropriate to perform and document in the ROS for a typical urgent care visit?

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A. Nowhere is there a greater misunderstanding of the typical urgent care encounter than in the area of ROS. Many auditors see no need for a significant ROS for patients with minor medical problems. Some physicians argue that the ROS has little usefulness in the urgent care setting. Nothing could be further from the truth.

If you are among the doubters, take this challenge: Perform a full ROS on patients for one week and see if you still feel the same way. But be prepared to be surprised. For it is precisely in the urgent care setting, where a patient who rarely seeks medical care is often seen and little is known of his or her baseline health status, that the ROS can make a dramatic improvement in the quality of care.

For example, on the second day after I implemented a policy of performing a full ROS for all my patient encounters, I saw a patient in his mid-40s for a refill of his antidepressant. He was otherwise healthy, but on the full ROS he had noted a complaint of chest pressure. He said that it was "almost not worth mentioning," since it was quite minor and he only felt pressure when he pushed a heavily loaded wheelbarrow uphill. Two days later, he underwent cardiac bypass surgery for critical three-vessel disease. If I had not performed a full ROS, he would likely be dead today.

Another example involved an undocumented immigrant who had cut his fingertip at work three days earlier and now presented with secondary cellulitis. He denied any medical history, but on ROS mentioned that he woke up at night an average of three times to urinate. I asked if he had diabetes. He said he had a history of diabetes but had stopped taking insulin and has not had any problems since. A radiograph of his finger, however, revealed diffuse osteopenia of the distil phalanx. He was immediately admitted to the hospital for intravenous antibiotic treatment for his osteomyelitis. Without the full ROS, a radiograph might not have been performed, and the patient might have lost his finger.

Much as in emergency medicine, a full ROS in urgent care medicine can make a critical contribution to patient care.

With an established patient, some physicians fear that performing a complete ROS would be seen as an attempt to "upcode" a visit. However, in both the 1995 and 1997 CMS guidelines for the established E/M code, documentation on ROS of only two systems is needed for coding a Level 4 Office Visit (99214). In the urgent care setting, even with an established patient, it is almost always appropriate to document the system related to the complaint and the constitutional system (fever, chills, weight loss, weight gain, etc).

Even with an established patient presenting with a seemingly simple sore throat, inquiring about the following systems would meet the level of medical necessity:

- Fever, chills, sweats, malaise (constitutional)—to assess for the likelihood of streptococcal infection or infectious mononucleosis
- Ear pain, drooling (ENT)—to assess for the likelihood of a secondary infection, tonsilar abscess, or epiglottitis
- Focal or diffuse "gland" swelling (hematologic/lymphatic)—to assess for the likelihood of infectious mononucleosis
- Confusion, depression, or racing ideas (psychiatric)—to assess for severity of infection and/or the ability of the patient to follow a multi-day prescribed regimen
- Cough, shortness of breath (respiratory)—to assess respiratory involvement of an infectious entity
- Headache, dizziness, light-headedness (neurological)—to assess for dehydration or even meningitis
- Seasonal allergic symptoms (allergic/immunologic)—to assess allergic causation
- Rashes (integumentary)—as in strep throat with scarlet fever
- Nausea, vomiting (gastrointestinal)—to assess for risk of dehydration
- Absence of urination or dark urine (genitourinary)—to assess for dehydration or early evidence of hepatitis due to infectious mononucleosis

With an established patient, unless you are coding a Level 5 Established Patient Visit (99215), you need not fear that a complete ROS will be viewed as an attempt to upcode the visit, as only two systems in the ROS are required for a Level 4 E/M code (99214). Thus, in the urgent care setting, documenting two systems is almost always appropriate. In addition, short of a 99215 code in an established patient, whether the physician documents two systems or 12 on the ROS, the E/M code will not be affected. ■

Q. Which elements are appropriate to perform and document in the PFSH for a typical urgent care visit?

A. When teaching the importance of taking a history to medical students or young physicians, it is important

"A complete PFSH is appropriate for most patient encounters in the urgent care setting."

to emphasize, "If you don't ask, the patient will not tell you." Patients (much like chart auditors) often do not realize the importance of a medical history. Consider once again the patient with a seemingly simple sore throat:

Past History

It is appropriate to review every patient's history of:

- Medical conditions. For example, it is relevant to know whether a patient with a upper respiratory infection has been diagnosed with an immune deficiency, frequent ear infections, or a strep throat infection that resulted in rheumatic fever.
- Allergies. The physician must avoid prescribing medications to which the patient is allergic.
- Medications. It is critical to know what medications the patient is taking (or has recently taken) to avoid drug-drug interactions. Patients on simvastatin (Zocor) for hypercholesterolemia, for example, should avoid such macrolide antibiotics as erythromycin to avoid severe consequences. Patients on MAO inhibitors should be warned of the severe (often lethal) consequences of taking simple over-the-counter cold remedies even a few days after discontinuing the MAOI.
- Surgeries. Whenever a patient is seen for a condition that might involve a bacterial pathogen, it is relevant to know whether the patient has any implants (for example, cardiac valves, artificial joints, or ventriculoperitoneal shunts), as these may be seeded by a bacterial infection.

Family History

For the initial encounter, it is appropriate to find out if the patient has a family history of any inherited medical problems. For children, it is especially important to be aware of congenital conditions that other siblings have to avoid misdiagnosing a rare presentation of a common problem that is really a common presentation of a rare genetic condition. A family history of hemophilia, cystic fibrosis, or sickle cell anemia, for example, will significantly affect the differential diagnosis and prognosis for many conditions.

You might ask what relevance this could have for a patient. But if a physician considers prescribing a sulfa drug or even aspirin, this would be relatively contraindicated in a patient with a close relative with a history of G6PD deficiency.

I once saw a patient for what at first appeared to be a simple herniated lumbar disc. Within two weeks, the patient had

an extremely rapid and severe atrophy of the affected calf muscle. What no physician picked up—because no one asked—was that the patient had a strong family history for amyotrophic lateral sclerosis, which very rarely can have a familial form. He underwent surgery and his pain was relieved. A month later, he rapidly deteriorated with amyotrophic lateral sclerosis. Thus, at least on the initial encounter, excellent urgent care requires obtaining and documenting a family history.

Social History

An auditor might state that an urgent care physician should have no interest in taking a social history. Smoking and secondhand smoke, however, can effect the patient's susceptibility to upper respiratory infections and many other conditions commonly seen in the urgent care setting. In addition, the most impactful time to reinforce the harmful effects of smoking is when the patient is suffering from the actual condition.

For children, stability of the home environment can significantly affect the patient's ability to take a full course of antibiotic or other medications. In a chaotic home environment, the physician may determine that it is unlikely that the child will receive a full course of treatment. The physician may opt for a single dose of an injectable antibiotic over a multi-day regimen of an oral antibiotic.

Adult patients who use alcohol to excess may have significant compliance issues, so medication regimens that are shorter, or that involve injectable drugs, may be indicated.

As such, all three elements of PFSH are appropriate for a typical initial encounter with a patient in the urgent care setting. Both the 1995 and 1997 CMS guidelines for E/M documentation state that a physician seeing a new patient must document all three components of PFSH to obtain credit for a complete PFSH.

For an established patient, one might argue that it is not always necessary to update the family history. From a coding perspective, however, this makes no difference; for an established patient, the physician must document only two areas of the PFSH to obtain credit for a complete PFSH. Thus, a complete PFSH is appropriate for most patient encounters in the urgent care setting. ■

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