Office of Compliance
Complete & Accurate Documentation
Core Curriculum for GWU Residents
The medical record tells the story of the patient from start to finish. If the story is told accurately it will include documentation that can be used as:
• Every evaluation and management visit should start with a chief complaint - in other words the reason why the patient needs to be seen today.

• Documentation of the chief complaint is required in order to establish medical necessity.
Key Components of E/M Services

In general, the selection of E/M Service codes is based on a combination of the levels for 3 key components*:

1) History
2) Physical Exam
3) Medical Decision-Making
HPI (history of present illness) elements:

- Location
- Severity
- Timing
- Modifying factors
- Quality
- Duration
- Context
- Associated signs and symptoms

Brief = 1-3
Extended = 4-8
HPI Examples

HPI: 67 y/o F, fell from standing with head trauma. Patient has ALS, communicates by phone text. States that she tripped on her walker and fell, hitting her head. Denies LOC.

HPI: 67 y/o F, fell **this morning** from standing with head trauma. Patient has ALS, communicates by phone text. States that she tripped on her walker and fell, hitting her head. Denies LOC.

<table>
<thead>
<tr>
<th>Location</th>
<th>Context</th>
<th>Assoc. Signs &amp; Symptoms</th>
<th>Duration</th>
</tr>
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<tbody>
<tr>
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</table>
3 types of Review of Systems include:

- **Problem Pertinent (1)**
  Limited to the system related to HPI.

- **Extended Review of Systems (2-9)**
  Includes system related to HPI and extends to additional relevant systems.

- **Complete Review of Systems (10)**
  Inventory includes a minimum of 10 systems.
  Pertinent positives and negatives must be individually documented.

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**Review of Systems**

GENERAL: DENIES: Fevers; REPORTS: Sweats; Weight loss
RESPIRATORY: DENIES: Cough; Dyspnea
CARDIOVASCULAR: DENIES: Chest pain
GASTROINTESTINAL: DENIES: Abdominal pain; Nausea; Vomiting; REPORTS: Diarrhea; Rectal bleeding
MUSCULOSKELETAL: COMMENTS: Pain in left foot

“All other systems reviewed and are negative except as noted in the HPI.”
A “complete” history requires documentation of all 3 PSFH components for new visits and 2 components for established visit.

**PMH** – major illnesses, operations, current medications, and allergies.

**Social history** - marital status, current employment, occupational history, alcohol use, smoking status, use of illicit drugs, etc.

**Family history** - health status of 1st degree relatives, hereditary diseases, or specific diseases that relate to the problem(s) identified in the CC or HPI.

- “family history: noncontributory”
- “family history: denies”
# Organ Systems vs. Body Areas

<table>
<thead>
<tr>
<th>Body areas:</th>
<th>Organ systems:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, including face</td>
<td>Constitutional (e.g., vitals, gen app)</td>
</tr>
<tr>
<td>Chest, including breasts and axillae</td>
<td>Ears, nose, mouth, throat</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Resp</td>
</tr>
<tr>
<td>Neck</td>
<td>GI</td>
</tr>
<tr>
<td>Back, including spine</td>
<td>Musculo</td>
</tr>
<tr>
<td>Genitalia, groin, buttocks</td>
<td>Skin</td>
</tr>
<tr>
<td>Each extremity</td>
<td>Psych</td>
</tr>
<tr>
<td></td>
<td>Hem/lymph/imm</td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
</tr>
<tr>
<td></td>
<td>GU</td>
</tr>
<tr>
<td></td>
<td>GU</td>
</tr>
<tr>
<td></td>
<td>Neuro</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1 body area or system</th>
<th>Up to 7 systems</th>
<th>Up to 7 systems</th>
<th>8 or more systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAM</td>
<td>PROBLEM FOCUSED</td>
<td>EXP.PROB. FOCUSED</td>
<td>DETAILED</td>
<td>COMPREHENSIVE</td>
</tr>
</tbody>
</table>

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- **Head, including face**
- **Chest, including breasts and axillae**
- **Abdomen**
- **Back, including spine**
- **Genitalia, groin, buttocks**
- **Each extremity**
- **Constitutional (e.g., vitals, gen app)**
- **Ears, nose, mouth, throat**
- **Resp**
- **Musculo**
- **Psych**
- **Hem/lymph/imm**
- **Cardiovascular**
- **GU**
- **GU**
- **Neuro**
Detailed Physical Exams
Novitas developed a 4x4 rule as the criteria for a detailed physical exam. This requires 4 elements examined in 4 body areas or 4 organ systems.

Example:
“CV – Heart regular rate and rhythm. No rub, murmur or gallop”
“Chest – Lungs clear to auscultation. Respiratory effort easy on room air.”
Symmetrical lung expansion. No adventitious sounds.”
“Ears, Nose, Mouth, Throat – mucous moist membrane, oropharynx clear, hearing normal to finger rub, external ears normal.”
“Skin – Warm and dry, no rash or lesions”

*in some cases, a detailed exam can also be determined based on clinical inference
Physical Exam

Res-Int-PA-NP / Attending Exam:
OTHER: NAD, slightly uncomfortable
RRR
CTAB
Abd: Soft, mildly distended, non tender, no peritoneal signs

CONSTITUTIONAL: Frail
LUNGS: Crackles
CARDIO: Irregular heart rate
ABDOMEN: Hyperactive bowel sounds
PSYCH: Confusion, memory loss
SKIN: Decubitus ulcer

Expanded Problem Focused Exam
Physical Exam

GENERAL APPEARANCE: NAD, alert and oriented, on aspen collar
HEENT: Pupils equal, round, reactive to light and accommodation
LUNGS: Clear to auscultation bilaterally
CARDIO: Regular rate and rhythm, no murmurs, rubs, gallops
ABDOMEN: Normoactive bowel sounds, non-tender, not distended, no rebound, no guarding
EXTREMITIES: No edema
NEURO: Alert and oriented 4/4
SKIN: Intact to inspection

1 element from 8 systems = comprehensive
Putting It All Together

So what documentation is required to support your patient service?

<table>
<thead>
<tr>
<th>CC</th>
<th>1. <strong>Chief Complaint</strong></th>
<th><strong>Always</strong> required for every patient service; establishes medical necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. <strong>HISTORY</strong></td>
<td><strong>HPI</strong></td>
<td>1-3 Brief</td>
</tr>
<tr>
<td></td>
<td><strong>ROS</strong></td>
<td>1 Pertinent</td>
</tr>
<tr>
<td></td>
<td><strong>PFS History</strong></td>
<td><strong>3 History Areas:</strong> New Patients, Consults, Initial Inpatient</td>
</tr>
<tr>
<td>3. <strong>EXAM</strong></td>
<td><strong>Physical Exam</strong></td>
<td>1 Organ System or Body Area Problem Focused</td>
</tr>
<tr>
<td>4. <strong>MDM</strong></td>
<td><strong>Medical Decision Making</strong></td>
<td>An assessment of the number of diagnoses considered, the review and ordering of data and the risk to the patient.</td>
</tr>
</tbody>
</table>

**Remember:**

- New Patients require all 3 elements: History, Exam and Medical Decision Making. If one element is lacking documentation it will affect the final code level.

- “Non-Contributory” can be used for Family History if not pertinent to the patient’s presenting problem.

- “All other systems reviewed and are negative” can be used on negative ROS if pertinent systems are reviewed & documented.
Day 1:
**A/P - Bacteremia**
- discussed with Dr. Alpha and Dr. Beta – if this is prostate infection, may need longer treatment; he has had 11 days of Meropenem thus far
  - Meropenem stopped earlier but will continue while in house (discussed with Dr. Zeta in ID)
  - probiotics for c diff prophylaxis
  - transaminitis due to sepsis and shock liver now resolved

Day 2:
**A/P - Bacteremia**
- discussed with Dr. Alpha and Dr. Beta – if this is prostate infection, may need longer treatment; he has had 11 days of Meropenem thus far
  - Meropenem stopped earlier but will continue while in house (discussed with Dr. Zeta in ID)
  - probiotics for c diff prophylaxis
  - transaminitis due to sepsis and shock liver now resolved.

If you do copy and paste make sure you:

- Only copy from that patient’s record
- Only your own entry (or another provider in your dept)
- **MAKE IT ACCURATE AND PERTINENT FOR THAT ENCOUNTER**
Specialty Exams

Recognized Specialties

- Cardiovascular
- Dermatology
- Ears, Nose & Throat
- Eyes
- General Multi-System
- Genitourinary (Female)
- Genitourinary (Male)
- Hematologic/Lymphatic/Immunologic
- Musculoskeletal
- Neurology
- Psychiatry
- Respiratory
Resources

- E/M University
- MFA Physicians’ Guide to Coding and Documentation
- Novitas Website (webinars, FAQ, Learning Mgt System)
- Your specialty professional association
- Your departmental coder
- Compliance