

Documenting a History



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To access the Tulane University Medical Group Health Care Compliance Policy Manual:

<http://www.som.tulane.edu/fpp/pdfdocs/healthcare.pdf>

Source cited: Medicare New Physician and Resident Guide, 7th edition, 2003.

For online copy of documentation guides:

1995 Documentation Guidelines:

<http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf>

1997 Documentation Guidelines:

<http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf>

Documenting an Outpatient Visit

Part 2: Documenting a History

This education is Part 2 of a 9-part series on documenting and selecting the level of service for outpatient visits.

All presentations are available on the Tulane University School of Medicine website:
http://www.som.tulane.edu/fpp/billing_new/

Part 1: Overview of Basic Principles

Part 2: Documenting a History

Part 3: Documenting an Exam

Part 4: Documenting Medical Decision Making

Part 5: Documenting Consults

Part 6: Documenting Pre-Operative and Confirmatory Consults

Part 7: Time-Based Codes

Part 8: Linking to Resident Notes

Part 9: Modifiers -24 and -25

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The HISTORY Component Of An Outpatient Visit Has Four Elements:

- Chief Complaint
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family and Social History (PFSH) The level of history is determined by the amount and type of documentation that is contained in the medical record. There are four levels of history.

Problem-Focused

- Chief Complaint (CC)
- Brief HPI (less than 4 elements documented)
- No Review of Systems required, but some may be documented

Example: CC: Cough

HPI: *Duration:* started 1 week ago,
Severity: Getting worse

Expanded Problem-Focused

- Chief Complaint
- Brief HPI (less than 4 elements documented)
- Problem-pertinent Review of Systems (at least one system documented)

Example: CC: Cough

HPI: *Duration:* started 1 week ago,
Severity: Getting worse
ROS: Positive for pain in chest when coughing (*Respiratory*)

Detailed

- Chief Complaint
- Extended HPI (4+ elements documented)
- Extended Review of Systems (ROS) – problem-pertinent review plus a limited number of additional systems (2-9 systems documented)
- Pertinent Past/Family/Social History is one specific item from any of the three history areas

Example: CC: Cough

HPI: *Duration:* started 1 week ago,
Severity: Getting worse,
Quality: Sharp pain when coughing;
Associated S & S: running 101 degree temp for 3 days
ROS: Pt. states pain in chest when coughing, shortness of breath (*Cardiovascular and Respiratory*), and night sweats (*Constitutional*)
PFSH: Patient has HX of respiratory infections (*Past Medical*); smokes 1 pack per week, trying to quit (*Social*)

Comprehensive

- Chief Complaint
- Extended HPI (4+ elements documented)
- Complete Review of Systems:
Pertinent positive or negatives must be individually documented. For remaining systems, a notation of “All Other Systems Negative” is permissible. In the absence of such a statement, at least 10 systems must be documented.
- Complete Past/Family/Social History: At least one element in EACH of the three areas for new patients. At least one element in TWO of the three areas for established patients.

Example: CC: Cough

HPI: *Duration:* started 1 week ago,
Severity: Getting worse,
Quality: Sharp pain when coughing;
Associated S & S: running 101 degree temp for 3 days
ROS: Pt. states pain in chest when coughing, shortness of breath (*Cardiovascular and Respiratory*), and night sweats (*Constitutional*). All other systems negative.
PFSH: Patient has HX of respiratory infections (*Past Medical*); Patient smokes 1 pack per week, trying to quit (*Social*), *Family History* negative for respiratory or cardiovascular problems.

CHIEF COMPLAINT (CC)

A chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter. A chief complaint is a **REQUIRED ELEMENT** for all levels of outpatient visits.

Examples:

- Left knee swollen and sore
- Cough and fever
- Stomach pain and rectal bleeding

Documentation tip: The Chief Complaint cannot be inferred. The outpatient note must stand alone for billing purposes; reviewers will not refer to prior documentation for a chief complaint. The following are examples of documentation that are not considered Chief Complaints.

- Patient here for follow-up visit (for what?)
- Patient here for second Synvisc injection (what condition is being treated?)

HISTORY OF PRESENT ILLNESS (HPI)

- HPI is a chronological description of the development of the patient’s presenting illness or problem from the first sign and/or symptom, or from the previous encounter to the present.
- Current E/M Guidelines (1995 and 1997) identify eight (8) elements used to provide further elaboration/information about the patient’s condition.
- NOTE: A Nurse or Tech or other non-physician staff CANNOT do the HPI. It must be documented by a physician (attending and/or resident).

Elements of HPI

Dimension	Definition	Examples
Location	Place, site, position of signs & symptoms. Where is the problem located?	Lower back, elbow, stomach
Duration	How long has the patient been experiencing the signs or symptoms?	Been hurting for two weeks, began last month
Timing	When does the patient experience signs or symptoms? What regularity/frequency of occurrences? What time of day?	Stomach pain worse after eating, worse at night; always occurs after exercise
Severity	What is the intensity, degree, or ability to endure signs or symptoms? Scale of 1 to 10?	8 on a scale of 1-10, pain so bad it affects breathing
Quality	What description or characteristics identify the type of signs or symptoms?	Stabbing pain, radiating pain, dull ache, anxiety-producing
Context	Circumstances, cause, precursor, outside factors to describe where patient is or what he is doing when signs or symptoms are experienced.	Shortness of breath when climbing stairs; began after a fall from a ladder
Modifying Factors	What treatment/actions have affected (positive or negative) or altered the signs or symptoms?	Tylenol did not relieve the pain, applying heat seems to help, an antacid provides short term relief, lying down doesn’t help
Associated Signs & Symptom	Are there any other symptoms that appear to accompany the main symptoms? What other factors does patient experience in addition to this discomfort/pain?	Before the headache starts my eyes hurt and I can’t stand light; my heart pounds and I break out in a sweat each time

Example HPI: 45-year old female complains of intermittent sharp pain (timing/quality) in left hip (location) after falling from a ladder yesterday (context). Also states left leg has some numbness (associated signs and symptoms). Pain an 8 on 1-10 scale (severity). Ibuprofen has had no effect on pain (modifying factors).

REVIEW OF SYSTEMS (ROS)

A review of systems (ROS) is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. Information included in the review of systems is used to identify the patient problem, assist in the arrival at a diagnosis, identify differential diagnoses, and determine the testing necessary to attain a definitive diagnosis.

System	Elements of Examination	Examples
Constitutional	Measurement of any 3 of 7 vital signs; General appearance of patient	Chills, fever, weight loss/gain, fatigue, lack of appetite
Eyes	Inspection of conjunctivae and lids; Exam. of pupils and irises; Ophthalmoscopic exam of optic discs and posterior segments	Blurred vision, crossed eyes, eye pain, discharge
Ear, Nose, Mouth, and Throat	External inspection; Otoloscopic exam of external auditory canals/tympanic membranes; Assessment of hearing; Inspection of nasal mucosa, septum and turbinates; Inspection of lips, teeth and gums; Exam of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils, posterior pharynx	Difficulty swallowing, sore throat, earache, post-nasal drip
Cardiovascular	Palpation of heart; Auscultation of heart with notation of abnormal sounds and murmurs; Examination of carotid arteries, abdominal aorta, femoral arteries, pedal pulses, extremities for edema and/or varicosities	Chest pain, palpitations, high/low blood pressure, swelling of ankles/legs, varicose veins, chest pain with exertion
Respiratory	Assessment of respiratory effort; Percussion of chest; Palpation of chest; Auscultation of lungs	Asthma, dry cough, shortness of breath, wheezing
Gastrointestinal	Exam. of abdomen w/notation of presence of masses or tenderness; Exam of liver and spleen; Exam for presence/absence of hernia; Exam (when indicated) of anus, perineum and rectum, including sphincter tone, hemorrhoids, rectal masses; Obtain stool sample for occult blood test when indicated	Bloating, change in bowel habits, constipation, stomach pain, nausea, vomiting
Genitourinary		Hematuria, excessive/reduced urination, kidney/bladder infections
Musculoskeletal	Exam of gait and station; Inspection and/or palpation of digits and nails; Exam of joints, bones and muscles of 1 or more of: head and neck; spine, ribs and pelvis; rt upper extremity; lt upper extremity; rt lower extremity; lt lower extremity (including: inspection and/or palpation with notation of presence of any misalignment; assessment of range of motion w/notation of any pain, crepitation or contracture; assessment of stability with notation of any dislocation, subluxation or laxity; assessment of muscle strength and tone with notation of any atrophy or abnormal movements)	Arthritis, joint pain/ache/stiffness, gout, muscle pain, weakness, "hot" joint
Integumentary (Skin)	Inspection of skin and subcutaneous tissue; Palpation of skin and subcutaneous tissue	Hives, redness, lumps, wounds, rashes, change in nail/hair texture, bruising (<i>could also be hematologic</i>)
Neurological	Test cranial nerves with notation of any deficits; Exam of deep tendon reflexes with notation of pathological reflexes; Exam of sensation	Blackouts, dizziness, fainting, headache, loss of balance, loss of coordination, less of sensation, numbness, seizures
Psychiatric	Description of patient's judgment and insight; Brief assessment of mental status, including: orientation to time, place and person; recent and remote memory; mood and affect	Anxiety, depression, forgetfulness, loss of sleep, nervousness
Endocrine		Diabetes, hot flashes, low sugar, thyroid condition, excessive hunger/thirst
Hematologic/Lymphatic	Palpation of lymph nodes in 2 or more areas: neck, axillae, groin, other	Swollen glands/nodes, nosebleed, bruising
Allergic/Immunologic		Allergies, autoimmune disorder

A ***problem-pertinent*** ROS inquires about the system directly related to the problem(s) identified in the HPI. The patient's positive responses and pertinent negatives for the system (1) related to the problem should be documented.

Example: CC: Left knee pain. **Patient denies numbness, no loss of sensation.**

(Neurology – 1 system)

An ***extended*** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. The patient's positive and pertinent negative responses for two to nine (2-9) systems should be documented.

Example: CC: Persistent nausea. **Patient denies vomiting and change in bowel habits. No loss of appetite or weight loss, no dietary changes. Patient denies any kidney/bladder problems. No difficulty swallowing.**

(GI, Constitutional, GU, ENMT – 4 systems.)

A ***complete*** ROS inquires about the system directly related to the problem(s) identified in the HPI plus all additional body systems. At least ten organ systems (10) must be reviewed. Those systems with positive or pertinent responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.

Example 1: CC: Chest pain. Patient states his heart races on occasion. States he is short of breath after light exertion. States no headache, no fever, no cough. States that he has been anxious since the chest pain occurred. **All other systems negative.**

Example 2: CC: Insomnia. Patient states he wakes from sleep choking and gasping for breath. Denies any depression or anxiety. No chest pain or other cardio complaints. Patient denies allergies. Denies loss of coordination. Denies seizures. Patient states he has post-nasal drip that occasionally causes nausea. Denies any GU complaints. Denies any muscle weakness. Denies any vision disturbances. **(10 ROS documented)**

PAST, FAMILY AND SOCIAL HISTORY (PFSH)

The PFSH consists of a review of three history areas:

- **Past history** includes recording of prior major illnesses and injuries; operations; hospitalizations; current medications; allergies; age-appropriate immunization status; and/or age-appropriate feeding/dietary status.
 - o Appendectomy 2 yrs ago,
 - o Taking HRT since March
 - o Allergic to penicillin and compazine
 - o Diabetes

- **Family history** involves the recording of the health status or cause of death of parents, siblings and children; specific diseases related to problems identified in the chief complaint or history of presenting illness and/or system review; and/or diseases of family members that may be hereditary or place the patient at risk.
 - o Positive for COPD
 - o Family history of migraines
 - o Father died from diabetic complications

- **Social history** contains marital status and/or living arrangements; current employment; occupational history; use of drugs, alcohol and tobacco; level of education; sexual history; or other relevant social factors.
 - o Smokes 1 pack a week
 - o Social drinker 4-5 /week
 - o Construction worker
 - o Married
 - o No current sexual activity

A **pertinent** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI. At least one (1) specific item for **any** of the three history areas must be documented.

A **complete** PFSH for new patients is documentation of at least one (1) element in each of the three (3) areas: Past/Family/Social.

A **complete** PFSH for established patients is documentation of **any** two (2) of the three (3) history areas: Past/Family/Social.

NOTE:

The ROS and/or PFSH 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

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2 pages - Web

DOCUMENTING A HISTORY QUIZ

Name (Print) _____ Date: _____ Score _____

Department: _____ Signature: _____

(Questions 1-7 are worth 10 points each; question 8 is worth 30 points – one for each exercise.)

1. List the four elements of the **History** component of an outpatient visit:

- a. _____
- b. _____
- c. _____
- d. _____

2. A **COMPREHENSIVE** exam consists of:

3. Who can perform an HPI? (Circle all that apply)

- a. Medical Student
- b. Medical Office Assistant
- c. Attending Physician
- d. RN
- e. LPN
- f. Lab Tech
- g. Resident
- h. Nurse Practitioner

4. The HPI is a _____ description of the patient’s present illness or problem.

5. The elements of an HPI are:

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____
- f. _____
- g. _____
- h. _____

6. A **DETAILED** visit documents a/an _____ Review of Systems, with _____ (number) of systems documented.

7. Name **any ten (10)** of the systems referred to in #6, above:

_____, _____, _____,

_____, _____, _____,

_____, _____, _____,

8. Which of the following constitute a complete review of systems: (Circle all that apply)

A

Patient complains of muscle aches, fever, cough, chills, nausea. Occasionally vomits after eating a big meal. Denies urinary/kidney symptoms. All other systems negative.

B

Patient notices blurred vision, occasional diarrhea, nausea and vomiting, sonophobia, feels weak, photophobia, headache, reports no bladder/kidney problems. Denies any swollen glands.

C

Patient denies serious headaches or seizures. State she feels depressed due to current situation. Vision impaired. She states she has cataracts. No ear or throat complaints. No cardiac complaints. Denies any endocrine problems; not diabetic. Denies any GI problems. Occasional stress incontinence. All other systems non-contributory

Signature: _____

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