HCFA clarifications on E&M guidelines:

Templates for ROS ok, but computer forms may cause audit trouble

You can you use a template for review of systems (ROS), provided you explain all significant normal and abnormal findings in a comments section of your form. This is just one of the many tricky questions answered at the recent AMA/HCFA workshop on E&M documentation (PPC 10/97). Here is an excerpt of minutes from the meeting, courtesy of attendee Deb Troklus, Compliance Officer at the University of Louisville:

From Aaron Primack, MD Medical Officer HCFA Administration Program Integrity

1. APPROACHES TO DOCUMENTATION

- Forms for ROS and PFSH are acceptable as long as all significant normal and abnormal findings are "explained briefly in a comments section. Computer forms are also acceptable, including macros, although this approach may raise questions during an audit, particularly if all notes look alike." Pre-printed prompts such as headings that identify major parts of the exam and ROS, that can then be filled-in by individualized text are acceptable and are a useful tool to help organize the resident and physician's note to assure all required elements are addressed in the documentation.
- The chief complaint may be simply expressed as "follow up visit." For example, when the teaching physician (TP) instructs the patient to schedule a return, follow-up visit, the TP does not necessarily need to explain the problem again in the chief complaint as it will become apparent in the note.
- Dictation. HCFA is not in a position to insist for payment purposes that all dictation or computer generated reports (that are not electronically signed) be personally initialed or signed by the physician. However, HCFA strongly recommends that the physician initial or sign all reports that appear on the medical record. The only thing HCFA can insist on is a date and a legible name of the provider. Electronic signatures, which are different from the above are acceptable. Electronic signatures are different in that they are typically generated "on-line" by the physician and are password protected.
- Signature stamps are acceptable as long as the physician performing the service is the only person using the stamp, and no one else has access to it. Support staff are not permitted to use the stamp on behalf of the performing physician. The AAMC (Assn. of American Medical Colleges) discourages members from using signature stamps. "We believe that on audit, signature stamps could be problematic."

Medical necessity of testing must be easily inferable, if not then must spell it out in the note. Can't just say, "Feels lousy get liver function tests."

From PRESENTER. Bart McCann, MD, Executive Medical Director HCFA

2. HISTORY

- Extended HPI can be achieved by describing the status of 3 chronic or inactive conditions. Simply listing them in a problem list without making a statement about their status would not do. "Hodgkin's disease" alone is not acceptable. However, "Hodgkin's disease, 10 years ago, no current symptoms" is. "Diabetes well controlled" would be acceptable whereas simply stating "diabetes" would not. The condition does not have to be a disease entity per se, describing the status of the three following chronic problems would do -- headache, low back pain GI distress.
- The ROS does not have to be listed separately; it can be part of the HPI. When this occurs, people may have difficulty distinguishing between the HPI elements and the ROS elements. As long as any single phrase is not counted twice the ROS can be picked out from the combined narrative. A statement like "ROS- resp as noted above (in HPI) remainder negative" would work as you would pick out the systems from the HPI. A standard form for ROS is acceptable as long as there is room for comments on abnormal findings.
- History unobtainable. Look for as much history as you can and they will be generous, as long as it is clear in the note you attempted to get as much info as possible. In other words, it is acceptable to bill comprehensive level history in these cases.
- Allergies can be counted as ROS or past history.
- The physician must write an HPI statement. It is understood that residents and other ancillary staff may collect some of this information as well but this does not absolve the physician, of the duty to verify the information and summarize the HPI statement his/herself.
- The ROS, past, family and social history may be obtained and documented by someone other than the physician. However, the physician must review and comment on the information, whereas in the HPI the entire thing must be done by the physician.

(over)

3. EXAM

- When you see "e.g." in the documentation requirements, the words that follow serve as a guide as to what to look for, and are not meant to require documentation on any patient. For example, "e.g. development, nutrition, body habitus, deformities, attention to grooming." It is acceptable to document any kind of statement about the general appearance.
- When it says "and" in a bullet, comment on one of the items, but perform both items. When it says "and/or," you do not need to perform both.
- In general, there are more performance requirements than documentation requirements.

4. MEDICAL DECISION MAKING

- HCFA and the AMA are reluctant to create numerical requirements for this area.
- The grid that was used as an educational tool is just that and there is a reluctance to complicate this any further by incorporating that scoring sheet into the official requirements.

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