Exam Documentation Just Got Harder

The countdown to January implementation is under way. Here’s how the revised guidelines will affect you.

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Who cares, you ask? Well, HCFA does, so you should, too, especially if you treat Medicare patients and would like to avoid an audit and the penalties that can come with it. Your chances of being audited are perhaps higher now than ever before, for several reasons. For one, a government audit of fee-for-service payments made under Medicare in 1996 found an estimated $2.8 billion in improper payments attributed either to insufficient documentation or complete lack of documentation for physician services. As part of a “corrective action plan,” HCFA will conduct prepayment medical reviews of E/M codes using the documentation guidelines. Claims will be chosen for review using an as-yet-

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undetermined, random method. As many as 3 percent of claims will be subject to review, according to HCFA.

Moreover, the very existence of the more explicit exam guidelines makes audits more likely. Now that Medicare can audit E/M services, do you have any doubt that it will? And many managed care organizations and insurers tend to follow the Medicare example, so you may reasonably expect them to adopt the revised documentation guidelines, too.

We will do our best to help orient you to the guidelines so that you can satisfy the requirements of all your payers. In this article, we’ll briefly review the guidelines for history and medical decision making (which are pretty much as they were two years ago), and we’ll explain the newly revised exam guidelines as they apply to the exams family physicians typically perform. A second article planned for our November/December issue will cover single-system exam documentation and other changes and provide more tips for making documentation easier.

As many as 3 percent of claims will be subject to review.

The definition of an extended HPI has been expanded to include the status of chronic or inactive conditions.

The basic definitions for the levels of exam did not change.

The new guidelines define clinical content for each level of exam and establish specific documentation requirements.

First, the good news

Not all the changes have to do with exam documentation, and not all of them mean more work for family physicians. One change in particular makes life easier. The publication of the revised guidelines makes official a change we first told you about last year (see “Important Changes in the Documentation Guidelines,” FPM, February 1996): HCFA and the AMA have revised the definition of an extended history of the present illness (HPI) to address the patient who presents with chronic, rather than acute, problems. The revised documentation guidelines state, “An extended HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions” (emphasis added).

The addition of “or the status of at least three chronic or inactive conditions” fixes a problem with the original guidelines, which forced physicians to struggle to identify conventional elements of the HPI (location, quality, duration, etc.) in essentially asymptomatic patients in order to document an HPI appropriate to fairly involved visits, such as a visit for monitoring well-controlled diabetes, hypertension and chronic obstructive pulmonary disease. With the revised guideline, you simply have to note the status of the multiple chronic conditions.

The revised guidelines do not redefine the brief HPI.

A quick review

Other than that modification in the HPI, the guidelines for history remain unchanged. The levels of E/M services are based, in part, on four types of history: problem focused, expanded problem focused, detailed and comprehensive.

We’ll not attempt to review all the guidelines in their entirety, but judging from the confusion at a recent AMA-sponsored meeting for specialty societies charged with disseminating information about the new guidelines to their members, a few of the guidelines related to history bear repeating:

• The chief complaint (CC), ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the HPI.
• 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, the physician must add a notation supplementing or confirming the information recorded by others. (The omission of HPI here is not an oversight. The physician should take the HPI or significantly expand on an HPI taken by ancillary staff.)
• For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care.

None of the guidelines related to medical decision making have changed. The levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity), and the complexity of decision making is still measured by the following elements:

• The number of possible diagnoses and/or the number of management options that must be considered;

• The amount and/or complexity of medical records, diagnostic tests and/or other information that must be obtained, reviewed and analyzed;

• The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

A different set of rules still applies for cases dominated by counseling or coordination of care. Time becomes the key factor in determining the level of E/M service provided in such cases where more than 50 percent of the encounter (i.e., face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility) is spent in counseling or coordination of care. Here is the related documentation guideline: “If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.”

Exams: what hasn’t changed
As we’ve said, the new guidelines add considerable complexities to exam documentation, so it won’t take long to describe what hasn’t changed. Here’s what remains intact.

The levels of E/M service are based, in part, on four levels of examination. The definitions remain unchanged:

• Problem focused — a limited exam of the affected body area or organ system.

• Expanded problem focused — a limited exam of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).

• Detailed — an extended exam of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).

• Comprehensive — a general multisystem exam, or a complete exam of a single organ system and other symptomatic or related body area(s) or organ system(s).

Also, three basic documentation guidelines remain applicable, regardless of the level of exam:

• Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.

• Abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s) should be described.

• A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

That’s it. Now for the fun part.

What has changed
Previously, the level of exam generally depended on the number of organ systems you examined and documented in the medical record. The documentation guidelines did not specify what constituted an exam of any organ system and, thus, they did not indicate how much documentation was necessary to substantiate that you did examine the system in question.

No more. HCFA and the AMA have developed a detailed chart that is very specific about the exam elements that must be performed and documented. A copy is reproduced on pages 78-79. In the chart, the shaded headings list the organ systems and body areas as CPT categorizes them. The elements of the exam related to each body area or organ system are identified by bullets (•). Parenthetical examples provide clarification and guidance within the chart. Any numeric
### General multisystem examination

#### Constitutional
- Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (may be measured and recorded by ancillary staff)
- General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

#### Respiratory
- Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Percussion of chest (e.g., dullness, flatness, hyperresonance)
- Palpation of chest (e.g., tactile fremitus)
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

#### Cardiovascular
- Palpation of heart (e.g., location, size, thrills)
- Auscultation of heart with notation of abnormal sounds and murmurs

#### Eyes
- Inspection of conjunctivae and lids
- Examination of pupils and irises (e.g., reaction to light and accommodation, size and symmetry)
- Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

#### Ears, Nose, Mouth and Throat
- External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses)
- Otoscopic examination of external auditory canals and tympanic membranes
- Assessment of hearing (e.g., whispered voice, finger rub, tuning fork)
- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx

#### Neck
- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of thyroid (e.g., enlargement, tenderness, mass)

#### Chest (Breasts)
- Inspection of breasts (e.g., symmetry, nipple discharge)
- Palpation of breasts and axillae (e.g., masses or lumps, tenderness)

#### Gastrointestinal (Abdomen)
- Examination of abdomen with notation of presence of masses or tenderness
- Examination of liver and spleen
- Examination for presence or absence of hernia
- Examination of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses
- Obtain stool sample for occult blood test when indicated

### Genitourinary
Male:
• Examination of the scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)
• Examination of the penis
• Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)

Female:
Pelvic examination (with or without specimen collection for smears and cultures), including:
• Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
• Examination of urethra (e.g., masses, tenderness, scarring)
• Examination of bladder (e.g., fullness, masses, tenderness)
• Cervix (e.g., general appearance, lesions, discharge)
• Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
• Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

Lymphatic
Palpation of lymph nodes in two or more areas:
• Neck
• Axillae
• Groin
• Other

Musculoskeletal
• Examination of gait and station
• Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)

Examination of joint(s), bone(s) and muscle(s) of one or more of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:
• Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions
• Assessment of range of motion with notation of any pain, crepitation or contracture
• Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
• Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

Skin
• Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
• Palpation of skin and subcutaneous tissue (e.g., induration, subcutaneous nodules, tightening)

Neurologic
• Test cranial nerves with notation of any deficits
• Examination of deep tendon reflexes with notation of pathological reflexes (e.g., Babinski)
• Examination of sensation (e.g., by touch, pin, vibration, proprioception)

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 (e.g., depression, anxiety, agitation)
A problem focused exam requires that one to five bulleted elements in the HCFA table be performed and documented.

An expanded problem focused exam requires that six to 11 elements be performed and documented.

A detailed exam requires that 12 elements from two or more systems or areas be performed and documented.

All elements must be performed, and two in each of at least nine systems or areas must be documented for a comprehensive exam.

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Exam content and documentation requirements

<table>
<thead>
<tr>
<th>Exam type</th>
<th>Requirements</th>
<th>Systems/ Areas</th>
<th>Bulleted elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem focused</td>
<td>Perform and document one to five elements identified by a bullet.</td>
<td>1+</td>
<td>1-5</td>
</tr>
<tr>
<td>Expanded problem focused</td>
<td>Perform and document at least six elements identified by a bullet.</td>
<td>1+</td>
<td>6-11</td>
</tr>
<tr>
<td>Detailed</td>
<td>Perform and document at least 12 elements identified by a bullet.</td>
<td>2+</td>
<td>12+</td>
</tr>
<tr>
<td>Comprehensive (General multisystem)</td>
<td>Perform all elements identified by a bullet and document at least two elements identified by a bullet from each of at least nine systems/areas.</td>
<td>9+</td>
<td>18+</td>
</tr>
</tbody>
</table>

*While the guidelines say explicitly that you must perform all the elements of the exam identified by bullets in the nine or more systems or body areas you examine, they require that you document only two per system or area.
that this is only one possibility.

Note the peculiar wording of the requirement for the comprehensive multisystem exam: While the guidelines say explicitly that you must perform all the elements of the exam identified by bullets in the nine or more systems or body areas you examine, they require that you document only two per system or area. This is evidently deliberate on the part of HCFA and the AMA. The rationale, as best we can understand, is that requiring all bulleted items to be covered in the exam ensures that the physician work going into the exam is adequate to justify the level of reimbursement, while requiring documentation of only two elements somewhat relieves the physician’s documentation task. That said, the best rule of thumb is still to document everything you do. Your liability exposure will be lessened, and a more complete medical record also may result in better patient care.

What does it all mean?
Well, for one thing, it means that the requirements for the problem focused exam are minimal; if you or your ancillary staff measure and document even three of the seven vital signs listed in the chart, you have documented a problem focused exam. For instance, a notation of “BP 126/86, P 82, WT 190” means you’ve met the requirements of the first bullet under the Constitutional system, and since you performed and documented “one to five elements identified by a bullet in one or more organ system(s) or body area(s),” you’ve met the requirements for documenting a problem focused exam.

For an expanded problem focused exam, the threshold is six elements identified by a bullet in one or more organ system(s) or body area(s). Imagine that you see a 55-year-old man who has returned for follow-up of his hypertension. His only complaint is a scratchy throat that he’s had for the past several days. Your observations are noted as follows:

BP 126/86, P 82, WT 190. HEENT: PERRLA, EOMs intact, TMs nl, oropharynx benign. NECK: Supple w/o JVD, bruits or thyromegaly. CHEST: BS clr to percussion and auscultation. HEART: WNL w/o gallop, murmur, rub, click or irregularity. EXT: W/O edema, pulses intact.

The following elements identified by bullets in the HCFA table are documented in the note:

- Constitutional: Measurement of any three of the following seven vital signs ... (“BP 126/86, P 82, WT 190”);
- Ears, Nose, Mouth and Throat: Examination of oropharynx (“oropharynx benign”);
- Ears, Nose, Mouth and Throat: Otoscopic examination of external auditory canals and tympanic membranes (“TMs nl”);
- Eye: Examination of pupils and irises (“HEENT: PERRLA”);
- Neck: Examination of neck (“NECK: Supple w/o JVD, bruits or thyromegaly”);
- Neck: Examination of thyroid (“NECK: Supple w/o JVD, bruits or thyromegaly”);
- Respiratory: Percussion of chest (“CHEST: BS clr to percussion and auscultation”);
- Respiratory: Auscultation of lungs (“CHEST: BS clr to percussion and auscultation”);
- Cardiovascular: Examination of extremities for edema and/or varicosities (“EXT: W/O edema, pulses intact”);
- Cardiovascular: Auscultation of heart with notation of abnormal sounds and murmurs (“HEART: WNL w/o gallop, murmur, rub, click or irregularity”).

To be precise, you have documented that you examined at least 10 elements identified by a bullet. That’s more than enough to substantiate that you did an expanded problem focused exam and almost enough for a detailed exam. In fact, if you had happened to add a comment about the patient’s general
appearance (a bulleted item under the Constitutional system) and, say, if you had found and noted swollen lymph nodes in the neck (palpation of the lymph nodes in the neck is a bulleted item under Lymphatic system), you’d have documented 12 items in two or more systems, which is the minimum required for a detailed exam.

Finally, there is the comprehensive multisystem exam. Previously, the guidelines required that such an exam include findings from eight or more of the 12 organ systems. The new guidelines require documentation of at least two elements from each of nine body areas or systems out of the 14 body areas or systems recognized. This is more stringent in that it raises the bar from eight to nine and requires documenting two exam elements for each system or area examined, but it is less stringent at least in that you can now count organ systems and body areas.

In the example discussed above, the physician performed and documented at least two elements from each of the following six body areas or organ systems: Constitutional (assuming the addition of a note about general appearance); Ears, Nose, Mouth and Throat; Neck; Respiratory; Cardiovascular; and Lymphatic (assuming the addition of a note about palpating lymph nodes in the neck and another area of the body). A comprehensive multisystem exam would pretty clearly be inappropriate given the clinical situation and chief complaint, but just by way of illustration, it would also require the physician to document at least two elements from three of the following additional body areas or organ systems to bring the total number of body areas or organ systems to nine: Eyes; Chest (Breasts); Gastrointestinal (Abdomen); Genitourinary; Musculoskeletal; Skin; Neurologic; and Psychiatric.

As noted above, the guidelines require that all the elements listed be performed for each body area or organ system examined, even if only two are documented.

If you can feel your own head and heart starting to pound, it may help to remind yourself that you perform far more problem focused, expanded problem focused and detailed exams than you do comprehensive multisystem exams. Documenting each of these exams won’t be as difficult. Chances are the new guidelines won’t affect the way you choose CPT codes for the E/M services you provide. The main lesson to take away from the new guidelines is that it’s more important than ever to document everything you do.

Help or hindrance?
Whether the revised guidelines really do clarify and standardize the expectations related to levels of exam is likely to be debated by family physicians. Whatever the answer, the revised documentation guidelines are a fact of life with which you will have to cope. Douglas E. Henley, MD, past president of the AAFP and a member of the AMA CPT Editorial Panel, acknowledges that reactions to the guidelines will be mixed. “When people first look at these guidelines, they may regard them as cookbook medicine or just another hassle factor. But I think once they really study the guidelines, they will realize that they’re already doing these things. They’re probably doing more. They just have to document it.”

That documenting in accordance with the guidelines will take extra effort is clearly understood, Henley says, but the effort will be rewarded because family physicians will be paid better. “The guidelines, particularly for the established patient at the 99213 and 99214 levels, will enable us to code with assurance at a higher level,” he says.

Editor’s note: In the November/December issue of FPM, we’ll offer some tips for making exam documentation easier.

1. In the process of developing these articles, the FPM staff will be working on a new edition of Mastering Medicare’s New Documentation Guidelines, the collection of FPM articles...