1. Can you please send me a copy of the auditing form you use when you review physician documentation?
2. Can I use three chronic problems to complete an extended HPI (as allowed under the 1997 guidelines) and still use the 1995 physical exam?
3. What exactly is required for an expanded problem focused exam using the 1995 E/M guidelines? Can I use body areas and/or organ systems? How many are needed?
4. What exactly is required in terms of the number of body areas and/or organ systems to qualify for a detailed exam using the 1995 E/M guidelines?
5. Do you use the numeric conversion for the 1995 E/M guidelines (i.e. problem focused exam: one system and/or body area, EPF exam: 2 – 4 organ systems and/or body areas, Detailed exam: 5 – 7 body areas and/or organ systems, Comprehensive: 8 organ systems)?
6. Can I use chronic problems to complete a brief HPI using both the 1995 and 1997 E/M guidelines? If so, how many are needed and what documentation is required?
7. What is meant by “chronic or inactive problems” when completing the HPI? Is there a time threshold that must be crossed for a problem to qualify as “chronic”? Does this mean I would not get credit for describing the status of a problem if it is a new or active problem?
8. Instead of “chronic problems” can I use “current” problems being addressed to qualify for a brief or extended HPI? For example, when documenting a hospital progress note, can I comment on current, active problems in the HPI or must we use chronic problems all the time?
9. Can I use the HPI elements to describe acute or chronic diseases. For example, if I say, “The patient is here to be evaluated for severe HTN discovered two weeks ago.” Would I get credit for two HPI elements (severity, duration)?
10. Can I document the most clinically relevant systems and then say, “all other systems reviewed and are negative” in order to qualify for a complete (10 system) ROS?
11. If my office uses a questionnaire for the PFSH and ROS, is it mandatory that the physician sign and date the form?
12. If I use a questionnaire for the ROS and PFSH, what documentation is required in my note to get full credit?
13. When referring to my own previously dictated notes for the ROS and PFSH, what documentation is required in the current note to get full credit? Do I really have to note the date AND location of the previous note, i.e., “Previous PFSH and complete ROS was reviewed with the patient and is unchanged. For details, please refer to my dictated note IN THIS CHART dated 5/6/09.”
14. Can I refer to someone else’s dictated note and get credit for those parts of the history I reviewed?
15. Can I say “normal” for physical exam elements when using the 1995 and 1997 guidelines and if so how much documentation is required?
16. How do you quantify the key component of medical decision-making when you audit physician documentation? Do you use a point system?
17. If I review my own previous notes and summarize my findings, would I get credit for “review and summation of old records”?
18. Do I get credit for negative HPI elements, e.g. if I ask the patient about modifying factors and say “no modifying factors are present” would I get credit for this HPI element?
19. Can I use elements of HPI as elements of ROS and have them both count, or is it one or the other? For example if the patient has chest pain which is “associated with shortness of breath” in the HPI, does this also count as an element of respiratory ROS?
20. If I document allergies, do I get credit for an element of past medical history or is this counted as part of the review of systems (Allergic/Immunologic) or both?
21. Can I get credit for multiple answers for a single HPI element: i.e., “chest pain associated with nausea and shortness of breath” (Do I get one HPI element or two because I named TWO associated signs and/or symptoms?)
22. Can I describe four “associated comorbidities” to qualify for an extended HPI using the 1995 E/M guidelines and if so, what is meant by “associated comorbidities” and what documentation is required?
23. What is required to get credit for prescription drug management? Do I have to stop, start or change a medication dosage, or can I get credit for making the decision to continue a specific medication?
24. If I personally review more than one image, tracing or specimen, do I get two points for EACH image, tracing or specimen reviewed as long as I record my findings in the note?
25. What does a “self-limited or minor problem” mean? Can you please give some examples?
26. What if the patient is unable to give a history because they are sedated or unconscious? Can I still get credit for a comprehensive history as long as I document the reason I could not obtain the information from the patient?
27. What if I am unable to perform a complete exam because patient is unable or unwilling to cooperate? (e.g., intubated and sedated, combative or comatose)? Can I still get credit for a high level exam using the “history caveat”? Or do I not get credit for the exam for these patients.
28. When calculating the medical decision-making, are problems defined as “old” or “new” relative to the patient or to the physician?
29. Can you “extrapolate” the HPI from the assessment and plan if the current problems are described as stable or worsening, etc? Or do I have to document the information in the actual HPI?
30. What drugs are designated as “requiring intensive monitoring” for toxicity?