

A Guide to the Review of Systems

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The most common reason for physician's owing money after a third-party review of Evaluation and Management (E/M) services is either a missing or inadequate documentation of the review of systems (ROS) component of the history. This applies to both plenary and podiatric physicians alike. While a ROS is not required for the most basic level of history (problem-focused), it is required for all three upper levels of history. The review of systems is defined in the 1997 HCFA/AMA E/M Guidelines as 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." The ROS may also be an inquiry related to body systems that may be affected by management options. For the purposes of the ROS, the following systems are recognized:

- * Constitutional symptoms (fever, weight loss)**
- * Eyes**
- * Ears, Nose, Mouth, and Throat**
- * Cardiovascular**
- * Respiratory**
- * Gastrointestinal**
- * Genitourinary**
- * Musculoskeletal**
- * Integumentary (skin or breast)**
- * Neurological**
- * Psychiatric**
- * Endocrine**
- * Hematologic/Lymphatic**
- * Allergic/Immunologic**

The Relationship of the ROS to the Level of E/M Code Chosen

The 1995 and 1997 AMA HCFA E/M Guidelines

(<http://www.cms.hhs.gov/medlearn/emdoc.asp>) describe three levels of ROS: A problem-pertinent ROS inquires about the system directly related to the problem (s) identified in the history of present illness (HPI). The documentation guideline (DG) states that the patient's positive responses and pertinent negatives for the system related to the problem should be recorded.

An extended ROS inquires about the system directly related to the problem (s) identified in the history of present illness (HPI) and a limited number of additional systems. The documentation guideline (DG) states that the patient’s positive responses and pertinent negatives for two to nine systems should be recorded.

A complete ROS inquires about the system (s) directly related to the problem (s) identified in the history of present illness (HPI) plus all additional systems. The documentation guideline (DG) states that at least ten systems must be reviewed. Those systems with positive responses and pertinent negatives must be individually documented. For the remaining organ systems, a notation indicating that all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.

One key point is the requirement for the documentation of all positives and pertinent negatives for all the questions that were posed.

Which Levels of E/M Codes Require the ROS?

The intensity of an E/M service is usually determined by the three key components: history, exam, and decision making. New patient office encounters require that all three key components meet or exceed the level of CPT chosen. Review of the coding matrix in the chart on page xx reveals that a properly documented CPT 99203 requires at least a detailed history, at least a detailed exam, and at least low decision making. In contrast, established patient office visits require that only two of the three key components meet or exceed the level of code chosen. Therefore, the lowest component may be removed from consideration when calculating the level of established patient office visit. For example, review of the matrix in the chart shows that a properly documented CPT 99213 could be achieved without any documentation of a physical exam - provided the history was at least expanded problem-focused and the decision-making was at least low level.

The chart is from Malkin’s Mediforms E/M Coding Manual. I left out the time usually associated with each level of CPT code as it is not pertinent to this discussion.

| | | | | | |
|-----------------------------------|--------------|--------------|--------------|--------------|--------------|
| Require 3/3 Key Components | 99201 | 99202 | 99203 | 99204 | 99205 |
| History | PF | EPF | DET | COMP | COMP |
| Exam | PF | EPF | DET | COMP | COMP |
| Decision Making | SF | SF | LOW | MOD | HIGH |
| History | PF | EPF | DET | COMP | |
| Exam | PF | EPF | DET | COMP | |
| Decision Making | SF | LOW | MOD | HIGH | |
| Require 2/3 Key Components | 99212 | 99213 | 99214 | 99215 | |

Key: PF = problem focused, EPF = expanded problem focused, DET = detailed, comp = comprehensive, SF = straightforward ,MOD = moderate

The 1995 and 1997 E/M Guidelines state that a problem-focused history requires a chief complaint and 1-3 items from the history of present illness. No ROS is required. All higher levels of history require a ROS. An expanded problem focused history is defined as documentation of the chief complaint, 1-3 elements of the history of present illness, and the review of at least one system. A detailed history requires a chief complaint, four or more elements of the HPI, at least two systems be reviewed, and one item from either the past medical, family or social history.

All three key components are required to establish the level of the following CPT codes, and all of the CPT codes below require at least one system to be reviewed:

**CPT 99202 (office visit, new patient)
CPT 99252 (inpatient consult, new or established patient)
CPT 99242 (office consult, new patient)
CPT 99342 (home visit, new patient)
CPT 99282 (ER visit new or established patient)
CPT 99322 (Domiciliary, rest home, boarding home, assisted living new patient)**

The following CPT codes require at least two systems be reviewed:

**CPT 99203 (office visit, new patient)
CPT 99253 (inpatient consult, new or established patient)
CPT 99243 (office consult, new patient)
CPT 99343 (home visit, new patient)
CPT 99283 (ER visit, new or established patient)
CPT 99323 (Domiciliary, rest home, boarding home, assisted living new patient)**

The following series of CPT codes require that only two of three key components meet or exceed the level of CPT code chosen, and require the review of at least one system PROVIDED the history is considered a key component in establishing the level of CPT code:

**CPT 99213 (office visit, established patient)
CPT 99312 (nursing home visit, new or established patient)
CPT 99232 (inpatient hospital, established patient)
CPT 99348 (home visit, established patient)**

The following series of CPT codes require that only two of three key components meet or exceed the level of CPT code chosen, and require the review of at least two systems PROVIDED the history is considered a key component in establishing the level of CPT code:

CPT 99214 (office visit, established patient)
CPT 99313 nursing home visit, new or established patient)
CPT 99233 (inpatient hospital, established patient)
CPT 99348 (home visit, established patient)

How Is The Review Of Systems Used To Help Diagnosis Or Manage Common Podiatric Medical Complaints?

First, let's examine a few definitions from Stedman's Medical Dictionary (27th edition). A sign is defined as "any abnormality indicative of disease, discoverable on examination of the patient; an objective indication of disease, in contrast to a symptom, which is a subjective indication of disease. "In contrast, a symptom is defined as "any morbid phenomenon or departure from the normal in structure, function, or sensation, experienced by the patient and indicative of disease."

The questions posed by the examiner for the ROS will often vary depending on whether a problem being managed is new to the examiner, or is one that is established to the examiner. In encounters centered around new complaints, the ROS is the portion of the historical information a physician obtains in an effort to either narrow down the differential diagnosis of a patient's chief complaint (such as establishing if plantar heel pain is biomechanical or is a symptom of systemic disease) or to establish if a particular management option being considered for a problem is safe and appropriate for the patient (the patient has no current signs or symptoms of an undiagnosed disease which would contraindicate an NSAID). Essentially, in obtaining a ROS, a physician is attempting to explore signs or symptoms of an undiagnosed disease state rather than establish the presence of already diagnosed disease which is properly documented in the past medical history portion of the medical record.

In management of established complaints, the ROS is most commonly used to establish the presence or absence of untoward effects potentially created by management options (GI symptoms from an NSAID or an antibiotic prescribed at a previous visit).

Cases Studies

From a podiatric perspective, the musculoskeletal, integumentary, cardiovascular, neurological, GI, and GU systems are the most commonly reviewed systems. Let's look at a few classic examples:

Case One: A patient presents with a chief complaint of heel pain and the following history is documented:

CC: Pt is a 57 y.o. white male seen in the office c/o pain in the heel

HPI: Plantar right heel x 3 weeks and getting worse. Post-static dyskinesia in am lasts 10 min. No previous professional or self-treatment. No similar past problem. No history acute trauma.

ROS:

Musculoskeletal: denies any other joint aches or pains, denies low back problems.

Neurological: denies shooting or burning pains, numbness or tingling.

Gastrointestinal: denies dyspepsia or other active GI symptoms.

PMH: HTN, CHF

Meds: Altace, Lanoxin, HCTZ

No known drug allergies

Why is musculoskeletal system important to ask? First, the chief complaint is in the musculoskeletal system. Secondly, how does one determine if heel pain has a systemic etiology or is strictly biomechanical? Establishing that the patient is experiencing no other aches or pains is a good start because it shows that the condition may not be a manifestation of a systemic arthritis.

Why ask questions about the neurological system? How does one know that heel pain is not caused by a radiculopathy emanating from the lumbar spine? If one cannot elicit a history of low back pain, burning pain, nor radiating pains, the chances are fairly good that the pain is not of neurological origin. If the patient was experiencing numbness, burning, or tingling the possibility of a tarsal tunnel syndrome or other neurological etiology must be considered.

Why ask about GI? If an NSAID is planned to manage the heel pain, being certain the patient does not have any active GI problems is always good medicine! A remote possibility is that the heel pain is related to a gastrointestinal disorder.

Case Two: A patient presents with a chief complaint of thick nails:

CC: Pt. is a 64 y.o. black male new patient seen in office c/o painful thick great toenails

HPI: He started with the great toes, getting worse, causes pain in shoes, and no past professional treatment is noted.

ROS:

Integument: denies rashes, scaling, pruritus, fingernails problems or history of other skin conditions.

GI: Pt. denies light stools.

GU: Pt. denies dark urine.

Constitutional: Pt. denies fatigue, loss of appetite.

PMH: Denies HTN, cardiac disease, and DM.

Meds: none

No known drug allergies

Why ask about the integument? Lichen planus and psoriasis are the two most common dermatological diseases to be considered in the differential diagnosis of onychomycosis. The history of scaling and itching could be significant in that tinea pedis often precedes onychomycosis. Why ask about GI? Light stools are a clinical sign of pre-existing liver disease. Why ask about GU? Dark urine is a sign of pre-existing liver disease. Why constitutional? Fatigue may be a sign of pre-existing liver disease as well. Obviously the last three systems have special relevance when one is considering active treatment of onychomycosis with an oral anti-fungal medication.

Case Three: A newly diagnosed diabetic is referred to the office on consultation:

CC: Pt. is a 65 y.o. white female seen as a new patient in consultation from Dr. Jones for a baseline diabetic evaluation.

HPI: Patient reports has been diagnosed a diabetic for one month and has never seen a podiatrist previously. Reports last FBS was 220.

ROS:

Integument: denies rashes, scaling, pruritus, or history of other skin conditions.

Neurological: reports occasional numbness and tingling plantar feet B/L but no burning.

Cardiovascular: denies cold feet, night cramps, and intermittent claudication

PMH: DM2 x 1 month. On initial diagnosis glucose was 325.

Meds: Actos and Glucophage.

No known drug allergies.

In patients with diabetes, a history of signs or symptoms of skin disease, documentation of the symptoms of peripheral neuropathy or vascular disease are clinically relevant, even in the absence of complaints from the patient .

Case Four: A new patient is seen in consultation at a nursing facility

CC: Pt. is a 77 y.o. white male seen at the request of Dr. XYZ for evaluation of a heel ulcer.

HPI: Patient is confused and is unable to answer basic questions such as the current time or his location. He is unaware he has a medical problem. His history and physical and medication were reviewed in the medical record.

ROS: unable to review due to mental status.

PMH: Senile dementia, Alzheimer's type.

Meds: Aricept.

No known drug allergies.

Most reviewers would allow for the highest level of ROS provided it was documented that one could not obtain a review of systems and the reasons why. The ROS is by its nature a contemporaneous activity and therefore could not be obtained from a chart review.

What About the ROS in Encounters For Established Problems?

If a patient is improving as expected with the treatment plan, the ROS is usually related to establishing the presence or absence of common complications of the treatment plan, i.e., management options. For example, a patient with heel pain who was prescribed an NSAID one week prior presents for a follow-up E/M. In the history of present illness portion of the medical record, the physician documents that the patient is taking the NSAID as directed (BID after meals for example). An inquiry is made as to whether the patient is experiencing any side effects such as dyspepsia, nausea, diarrhea (all GI system), peripheral edema (cardiovascular system), or skin rash (integumentary system) which are the most common adverse effects of an NSAID and this would be recorded in the ROS.

A second example is a patient with onychomycosis who has been prescribed the topical antifungal medication Penlac eight weeks prior and then presents for follow-up evaluation. At that visit the patient is asked if s/he are experiencing any redness or burning around the nails.

Documentation of these pertinent negatives, which are the most common side-effects of Penlac, will serve as the ROS.

Lastly, a patient managed with an oral anti-fungal presents for a follow-up seven weeks after initiation of the medication and is questioned about the presence or absence of light stools, dark urine, skin rash, or fatigue. Documentation of these pertinent negatives serves as the ROS since these are the clinical symptoms of liver inflammation.

What Is Properly Considered A Review Of Systems and What Is Not?

I once gave a talk in which the question of how to consider the phrase, “Last fasting blood sugar was 125” in a chart audit. Some in the audience felt this was a ROS item. In my opinion, this item is more properly “counted” as part of the HPI since it is actually the status of a chronic condition (diabetes). On the other hand, if questions were asked of the patient to establish the symptoms associated with poor glycemic control, such as polyuria, polydipsia , polyphagia, fatigue, vision disturbance, or weight loss, these items certainly would qualify as a review of systems..

Other Helpful Documentation Tips

There are a few important statements made in the 1997 AMA/HCFA E/M Guidelines to aid the physician:

*** “The ROS does not need to be listed as a separate element of the history, but may be included in the description of the HPI” (Of course, one element cannot count as both an item of the HPI and also be part of the review of systems; it must be counted in just one or the other).**

*** “A ROS that was recorded at a previous encounter does not need to be re-recorded if there is evidence the physician reviewed and updated the previous information. This may occur when a physician updates his own record or in an institutional setting or group practice where many physicians use a common medical record. The review and update may be made by describing any new ROS information or noting there has been no change in this information; and noting the date and location of the earlier ROS.”**

*** “The ROS may be recorded by the 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.”**

*** “If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance which precludes obtaining a history.”**

The last statement is especially relevant in dealing with confused patients due to Alzheimer’s disease or other types of dementia. Through my conversations with Empire Medicare, when these instances occur, the history would be essentially not considered in a positive or negative way when determining the level of E/M code. Obviously, certain information should be obtained from other medical records when possible but a contemporaneous questioning of the patient necessary for a ROS may be impossible.

For additional information on E/M coding, including reproducible ROS forms for use by the doctor in medical terminology or laymen's terms for completion by the patient, see Malkin's Mediforms available by calling my office and requesting further information, 973-226-2263.

Disclaimer:

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Coding and documentation rules are not simply black and white, and are subject to many interpretations. The various Medicare carriers differ in their medical policies for coding and documentation of the identical patient encounter. Unfortunately, there are many private insurers that maintain unique coding and documentation requirements that are in conflict with the AMA CPT Manual.

The reader is urged to contact his or her local insurance carrier to discuss any statements made in this article considered controversial. In cases where variability exists, the physician must conform to the rules promulgated by the local carrier.