# Eli's Rehab Report

## Reader Question: Examination Guidelines

**Question:** Once the initial history and review of systems portions of an evaluation and management (E/M) visit have been documented, is it necessary to redocument this inform-ation in detail at each visit, or can the physiatrist simply mention that nothing has changed from the previous visit?

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**Answer:** Clear, concise and comprehensive documentation is very important. To get credit for the history portion of an E/M service, the physiatrist must document that the chart was reviewed for history of present illness (HPI), review of systems (ROS), and family, social and past medical history (FSPH).

The review of systems is a series of questions grouped by organ system, including general/constitutional, skin/ breast, eyes, ears/nose/mouth/throat, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, neurologic, psychiatric, allergic/immunologic, hematologic/ lymphatic and endocrine. A complete review of systems often is not needed or even desirable in a focused evaluation.

HCFAs documentation guidelines for E/M services state that the ROS and the FSPH do not need to be re-recorded if they were obtained during a previous office visit. Any new ROS or FSPH information should be added to the record, but if no new information exists for the current visit, the doctor would write, reviewed information documented on ___ (insert the date the ROS or FSPH was documented). In addition, HCFA allows patient-completed forms (or those forms completed by other staff members) to be used as the ROS or FSPH, but the patients record must include a notation by the doctor indicating that he or she reviewed the information.