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Review of Systems (ROS)

Every once in a while we all need refresher on things we have been doing forever. A lot of time we go along thinking 'I got this down; I don't need to check myself all the time.'

Well sometimes we do.

So I thought I would take this opportunity to review what goes into a Review of Systems (ROS).

REVIEW OF SYSTEMS (ROS)

A ROS is 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.

For purposes of ROS, the following systems are recognized and some examples are given:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory – cough or breathing problems
- Gastrointestinal – stomach upset or diarrhea
- Genitourinary
- Musculoskeletal – joint issues
- Integumentary (skin and/or breast) – rashes or itching
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

A ***problem pertinent*** ROS inquires about the system directly related to the problem(s) identified in the HPI.
Documentation guidelines: The patient's positive responses and pertinent negatives for the system related to the problem should be documented.

An ***extended*** ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.
Documentation guidelines: The patient's positive responses and pertinent negatives for two to nine systems should be documented.

A ***complete*** ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.
Documentation guidelines: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, **a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.**[1]

Please note that CMS requires an "all other systems were reviewed and found to be negative" statement if indeed all other systems were reviewed and found to be negative and all the pertinent positives and negatives are listed.

The following is a list of unacceptable ROS statements:
- "Otherwise negative" if there is no statement about all systems reviewed
- "Negative"
- "Negative per Green Sheet"

It may seem easier to use the caveat and state that the patient is unable to cooperate in a ROS. But if it is clear from the documentation that there is a caregiver or family member present this is not appropriate. In these cases you should make your best effort to obtain a ROS from the family or caregiver. If you are still unable to obtain an ROS you just state why the ROS was unobtainable.

Please remember if you referred to the HPI when you intend to have a full ROS to make sure it is actually there. If it is not present the chart will be downcoded.

This is an important part of documentation and if it is not done correctly it could mean the difference between a level 5 and a level 3 in some instances.

Coming next month we will review the HPI and History.

– Wendy J Alley, *CPC*

[1] Excerpt from CMS 1995 DOCUMENTATION GUIDELINES FOR EVALUATION & MANAGEMENT SERVICES pg. 7

For information about us
and our services contact:

Ginger A Ryder, CMPE, CHBME, CPC
429 SW 41st St, Renton, WA 98057
(425) 656-7377
ginger@e-medex.com
www.e-medex.com

Deep sedation in the Emergency Department

On December 11, 2009 CMS released updated Interpretive Guidelines for anesthesia services. The guidelines and the FAQs note that "The ED is a unique environment where patients present on an unscheduled basis with often very complex problems… In addition, emergency medicine-trained physicians have very specific skill sets to manage airways and ventilation that is necessary to provide patient rescue. Therefore, these practitioners are uniquely qualified to provide all levels of analgesia/sedation and anesthesia (moderate to deep to general)."

The American Society of Anesthesiologists (ASA) has also recently issued their "Statement on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners." Also noted in their letter was the fact that sedation can be performed initially by an emergency physician, and once stable sedation and adequate monitoring are established, the emergency nurse can monitor the patient while the physician performs the procedure.

Hospitals will be responsible for establishing policies and procedures based on nationally recognized guidelines. In the FAQ portion of the revised guidelines, ACEP has been listed by CMS as an organization that has appropriate expertise and which has used consensus-setting process of professionals with appropriate expertise in developing its guidelines.

The following is the most recent policy statement for sedation in the ED from ACEP:

SEDATION IN THE EMERGENCY DEPARTMENT
APPROVED BY THE ACEP BOARD JANUARY 13, 2011

Procedural sedation involves the use of sedative and analgesic agents to reduce the anxiety and pain suffered by patients during procedures. Procedural sedation decreases the length of time necessary to perform a procedure, increases the likelihood of success, and reduces the potential risk of injury to the patient or healthcare worker due to uncontrolled movements.

Procedural sedation encompasses a continuum of altered levels of consciousness including minimal, moderate, deep, and dissociative sedation levels.

Procedural sedation is a critically important component of comprehensive emergency care and a required core competency of emergency medicine residency training. This training includes rescue airway interventions for support of patient ventilation and oxygenation, as well as support and monitoring of patient cardiovascular status.

Evidence in the medical literature has established that procedural sedation, including light, moderate, and deep levels of sedation, can be safely and effectively performed in the emergency department by emergency physicians, both in the care of adult and pediatric emergency populations.

There is no single agent, or combination of agents that can be recommended for every patient or sedation procedure. Clinicians must weigh the relative needs for pain control (analgesia), sedation, and the potential risks, benefits, and alternatives when individualizing their plan for patient sedation.

Agents commonly used for sedation of patients in the emergency department include but are not limited to opioids, benzodiazepines, and barbiturates as well as other specific agents such as ketamine, propofol, remifentanil, dexmedetomidine, etomidate, and nitrous oxide.

Adjunctive techniques, such as distraction and visual imagery, should be used as needed to reduce patients' fear, discomfort, and anxiety. Although physical restraints may be needed to prevent inadvertent movements, pharmacologic and nonpharmacologic techniques should be used to reduce pain- and fear-related movements whenever possible.

The American College of Emergency Physicians (ACEP) is the authoritative body for the establishment of guidelines for sedation of patients in the emergency setting. To promote the safe and effective use of sedation in emergency department patients, ACEP recommends the following:

> Emergency physicians who have received the appropriate training and skills necessary to safely provide procedural sedation should be eligible for credentialing in all levels of procedural sedation.
> The decision to provide sedation and the selection of the specific pharmacologic agents should be individualized for each patient by the emergency physician and should not be otherwise restricted.
> Emergency physicians and staff are expected to be familiar with the pharmaceutical agents they use and be prepared to manage their potential complications.
> To minimize complications, the appropriate drugs and dosages must be chosen and administered in an appropriately monitored setting, and a patient evaluation should be performed before, during, and after their use.
> Institutional and departmental guidelines related to the sedation of patients should include credentialing and verification of competency of providers, selection and preparation of patients, informed consent, equipment and monitoring requirements, staff training and competency verification, criteria for discharge, and continuous quality improvement.

As is true with all procedures, it is important to remember to document these services well. For anesthesia services, this will include the target level of sedation, medications administered to achieve anesthesia/analgesia, monitoring of vital signs and level of consciousness throughout the procedure as well as the start and stop time as these codes are time-based.

– ***Debora Butcher,*** *CPC*

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and our services contact:

Ginger A Ryder, CMPE, CHBME, CPC
429 SW 41st St, Renton, WA 98057
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www.e-medex.com