

Review of Systems for Optometry

Medical recordkeeping has historically included specific history-taking for the patient's medical and family history. In eye care, specific questioning related to the patient and family ocular history is put on the same or higher level than the medical history. But the patient's medical history has a significant role in the optometric management of patients. The medical history was always important, but it became increasingly valuable in the era therapeutic eye care.

Traditional case history taking two or three decades ago was pretty straightforward. The record would document if the patient had high blood pressure or diabetes (pertinent negative history wasn't common) and the patient's medications were listed. A history of allergies was also noted, and then the eye examination went forward. Today, optometrists manage the primary eye care of their patients and often are in direct communication with the primary care physician and specialized providers which necessitates better documentation of the patient's overall health characteristics.

With the 1997 Documentation Guidelines for Evaluation and Management Coding, optometrists as single-organ providers were able to document care that might be as detailed as 99215. The guidelines spoke to the various parts of documentation and reinforced the need for health care providers to take a thorough general medical history no matter what specialty they might practice. The term "Review of Systems" (ROS) was introduced and immediately became a standard for recordkeeping no matter what kind of patient evaluation or coding was accomplished. Doctors and staff began to review the ROS at every patient visit to ensure a detailed understanding of the patient's medical status.

ROS is generally well understood by optometrists. Many paper and electronic record systems have created their own version of ROS. There is no standard ROS for eye care providers. However, the goal of good ROS would be to inquire within each of the 14 medical areas of concern as to positive or negative findings that might relate to the eye as well as to the overall care of the eye care patient.

Most doctors that use an ROS document in their practice have compiled a list of conditions for each of the 14 areas. To share any one list might not establish a standard, but it could create a dialogue amongst optometrists as to an ideal ROS list. The following list is an example of a current ROS form being used by a number of optometrists (topic area is highlighted and conditions of concern follow):

Constitutional
Developmental Disability
Cancer
Fatigue Syndrome

Cardiovascular

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Hypertension
Stroke
Heart Disease
Vascular Disease

Endocrine
Non-insulin dependent diabetes
Insulin dependent diabetes
Thyroid dysfunction
Hormonal dysfunction

Neurological
Multiple Sclerosis
Epilepsy
Cerebral Palsy
Tumor

Psychiatric
Depression

Ears/Nose/Mouth/Throat
Hearing Loss
Sinusitis
Dry Mouth
Laryngitis

Allergic/Immunologic
Drug Allergies
Environmental Allergies
Rheumatoid Arthritis
Lupus

Respiratory
Cigarette Smoker
Asthma
Bronchitis
Emphysema
Chronic Obstructive Pulmonary Disease

Musculoskeletal
Osteoarthritis
Fibromyalgia
Muscular Dystrophy
Ankylosing Spondylitis

Gastrointestinal
Chron's
Colitis
Ulcer

Genitourinary
Kidney disease
Prostate disease/cancer
STD – herpetic/chlamydia

Hematologic/Lymphatic
Hypercholesteremia
Anemia
Large-volume blood loss
Leukemia

Integumentary
Eczema
Rosacea
Psoriasis

Eyes
Glaucoma
Cataract
Age-related Macular Degeneration
Surgery
Patching
Inflammatory Disorders

The subject of how to handle the Eye History in ROS has been debated for some time. As an auditor might “grade” a chart for accuracy in coding, any past ocular history for the patient can satisfy the requirement of the Eyes topic within ROS. For the purposes of this discussion, a general history of the patient’s eye history at the first encounter and any subsequent encounters is at the discretion of the doctor and would count as one system reviewed in the ROS.

In order to increase the value of the ROS to the optometrist, it has been advocated to track the patient’s medication history along with the ROS. That is, if a patient is on Zocor for hypercholesteremia, the recording of it within the Hematologic makes the ROS an effective, easy-to-manage master problem list. Another example of the wonderful traits of the ROS is the tracking of allergies. While most health professionals take an allergy history as a stand-alone component of the medical history, it can truly be taken as a component of the ROS.

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Grading the ROS is simple. It is "Problem Pertinent" if one system is reviewed, "Extended" if two to nine systems are reviewed, and "Complete" if ten to all fourteen systems are reviewed. In order to document the ROS process, the doctor or staff should comment "negative" to any questions asked within each topic area. If a list of conditions is checked as negative, the patient must have been presented with the list of conditions and reported verbally or within a history intake form that the conditions do not exist. When the patient returns for other visits, the ROS should be taken to the degree necessary by the patient presentation, and the doctor or staff must report how the ROS was reviewed. An initialed and dated note in the medical record to ensure that the master problem list was evaluated is a must if the ROS is being used to select a coding level. The ROS is one of three components of the Patient Case History section, the others being History of Present Illness, and Past/Family/Social History. Coding of the level of patient care can be directly connected to the ROS performed.

The Review of Systems component of patient history-taking can provide an optometrist with a robust profile of the patient's physical well-being. Special attention to the Review of Systems can allow an optometrist to predict drug interactions, or to associate ocular findings with systemic conditions or treatments. Optometrists who have not focused on the ROS will be compelled to do so as electronic health records become more important, since portable patient history data is a focus issue of the national discussion of widespread electronic records implementation in the next five years.