Internal Medicine Coding Alert

E/M: History: Accurate History Documentation Holds Key In Perfect E/M Billing

Beware of counting elements in more than one place.

When your internist is recording a patient's history as part of the evaluation and management, you might lose out on deserved money if your physician in not documenting all details recorded, thus downcoding your claim.

Although the task seems simple wherein your physician has to obtain all of the details of where the patient's illness came from and what the patient is experiencing, your clinician might not be documenting in the patient's note all the details captured.

Luckily, you can show your physicians how to obtain the perfect history, with the following five tips.

1. **Remember the difference between the history and the exam.** Especially when it comes to the review of systems (ROS) portion of the history, doctors may try to write down things that should actually be counted toward the exam and not the history. Teach your physicians that ROS typically comes from discussing the issue with the patient, whereas the physical exam comes from the doctor's firsthand observations. For example, noting the patient's answer to questions about fever or chills is part of the ROS; noting the patient's temperature as recorded in the exam room is part of the examination.

2. **Make sure the physician gets the information down on paper.** Often, physicians will ask all the right questions, but they won't write down the answers. For instance, your physician might ask the patient, "On a scale of one to ten, how do you rate the throat pain that you are experiencing?" but then they might forget to write down the pain index number, which can be counted toward "severity" in the history of present illness (HPI).

3. **Avoid double-dipping**. You shouldn't list the same items under more than one area of the history. For example, allergies can fall under either ROS, or past, medical, family and social history (PMFSH). You can count it once in either place, but you can't double-dip.

4. **Give the patients a form**. Your patients can fill out part of their history as long as the doctor writes down that he reviewed it and is aware of it. Specifically, the Medicare "Documentation Guidelines for Evaluation and Management Services" states, "The ROS and/or PFSH may be recorded by 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."Create your own tailored form, and then ask the doctor to go through the form with the patient and ask the patient to elaborate on her answers, as needed. The form might include space for the doctor to note the HPI, and the doctor might want to either write the exam results on the back while filling in medical decision-making to create a complete report or check off items in the electronic health record while going over the patient's history to ensure everyone knows he reviewed it.

5. **Know the loophole for patients unable to give history.** Many coders have dropped their physicians' new patient coding down one or more levels, because the physician can't obtain an accurate history, often due to patient conditions such as a dementia, concussion, stroke, or a coma. However, CMS does have an exception to the rule that a new patient code requires you to take a history.

"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," CMS says in its "Evaluation and Management Services Guide," available at

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf.