Part B Insider (Multispecialty) Coding Alert

E/M Coding: Make Your Documentation Problems Ancient History

3 payers share tips on what you should do if you can't obtain a history from a patient.

Examining a patient is typically straightforward for most practitioners—but getting the history can be a little trickier, particularly if the patient can't speak and no family is present to fill in the blanks. But failure to obtain a history doesn't mean your claims are doomed. In fact, most payers have specific rules on how to react in this situation.

The Insider recently scanned hundreds of pages of payer policies, with the following being most applicable to this issue and can help you collect when your patients can't share their histories.

Remember to Show the Reason

If you can't get a history from a patient, you should always document the reason it was unobtainable. According to Part B MAC Palmetto GBA's Oct. 9 "Weekly Tip," if you are unable to obtain a history, your documentation has to show the following:

- The components that were unobtainable (HPI, ROS and/or PFSH)
- Circumstances that preclude obtaining the HPI, ROS, and PFSH (dementia, sedated on a vent, etc.). When using 'poor' historian the documentation must support why (e.g. dementia).

Attempt to obtain from other resources:

- A family member, spouse, nurse etc. was not present or was unable to provide additional information
- The medical record (chart, ambulance run sheet, etc.) did not contain the information needed

If you are able to get the information later, you can write an addendum to the documentation that includes it, Palmetto adds.

Don't Always Default to Comprehensive History

A theory has floated around the provider community for decades indicating that if you can't obtain a patient history, you can default to a comprehensive history. But this theory is just that—and is in no way rooted in truth unless you have direction in writing from your payer indicating that you can choose your level this way.

Part B MAC WPS Medicare recently addressed this in its "History Element of Evaluation and Management Q&As" document, noting, "There is nothing notated in the 1995 or 1997 Documentation Guidelines to indicate any level of history is automatic."

Instead, WPS says, the provider should document why the patient can't offer any help with his history and also record any work that he did to try and obtain history from other sources. "This could include family members, other medical personnel, obtaining old medical records (if available) and using information contained therein to document the history (if any) that is available," WPS says.

Base E/M Level on Other Elements

When you're treating an established patient in the office and can't get any history from him, you can select a level of service using the examination and medical decision-making elements, since established patient E/M office visits only require two of the three elements.

If you're treating a new patient or using any E/M code that requires that you base your level on all three key elements, you have a few options, according to the Wisconsin Medical Society's presentation, "The Top 10 Documentation Error Pitfalls," which is on Anthem Blue Cross Blue Shield's website.

If you're treating a Medicare patient, you can report the unlisted E/M code 99499, but for a commercial insurer you may be able to default to the lowest level within the code category, the document indicates.

Other MACs may have different rules on how to choose your level of service in this situation, and most have not published any guidelines on this topic other than to say you must document the reasons you couldn't obtain the history. Part B practices are advised to contact their MACs directly for their preferred reporting guidelines for new patients when the history is unobtainable.