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EVALUATION & MANAGEMENT: Learn The Exceptions To History Documentation Requirements

Master the 'ED caveat' to save your physician's reimbursement

Those who can't obtain a history aren't necessarily doomed to repeat it.

Example: Your physician sees a patient who's in a coma, demented or otherwise unable to dictate a full history. There are no family members or caregivers able to fill in the gaps. Without a full history, is your physician stuck with the lowest-level evaluation and management code? Not if you can master the ins and outs of E/M coding.

There are a couple of circumstances under which the E/M documentation rules will let your doctor off the hook without a full history:

The 'History caveat.' In the Medicare documentation guidelines, one of the bullets states that if the physician is unable to obtain a history from the patient or any other source, the record should state the patient's condition or other circumstance that precludes taking a reading, says **Joan Gilhooly** with **Medical Business Resources** in Evanston, IL.

"They need to indicate what they were able to obtain and why they couldn't get more in order to get credit for what the history would have been if the patient had been able to respond to their questions," explains Gilhooly.

The 'ED caveat.' Because of the life-threatening nature of the patient's condition, you don't have the time or wherewithal to take a full history. Instead, the doctor just does whatever she can to save the patient. This applies only to top-level emergency department (ED) code 99285, and only in life-threatening situations, cautions Gilhooly.

This caveat appears in a Q&A in the February 1996 CPT Assistant, says Gilhooly. The **American Medical Association** states that 99285 is unique in that it requires only the three key elements of an E/M as far as the patient's condition allows.

The descriptor for 99285 also includes the phrase "within the constraints imposed by the urgency of the patient's condition and/or mental status," notes **Dianne Wilkinson**, compliance officer and quality manager with **MedSouth Healthcare** in Dyersburg, TN.
For example: A patient comes in with crushing chest pain and numbness in her left arm. The physician stars the chest-pain protocol, assuming this is a heart attack and it's not appropriate to check all of the patient's other vital symptoms or obtain a full history. This is still a top-level ED visit, but it doesn't include a comprehensive history, says Gilhooly.

"I have no problem auditing at a 99285 level when the doc says 'unable to obtain ROS, patient unresponsive,'" says Wilkinson. Some auditors won't give credit for a 99285 unless the doctor actually documents where he or she tried to obtain history elsewhere, she adds, "But I don't go that far."

Look for other sources: Just because the patient can't talk does not mean your physician is off the hook for obtaining a history. Your physician should look to all the other possibilities, including family members, caregivers, old patient records, nursing home staff or the paramedics who brought the patient in, Gilhooly cautions.

If a patient comes into the ED without a life-threatening illness but is still unable to answer questions, the ED physician has the same requirement as other doctors to obtain a history from other sources, says Gilhooly.

Admit defeat: If you can't obtain at least a detailed history from a patient, you can't bill any of the hospital admission codes. A level-one admission requires a detailed or comprehensive history, and higher levels require a comprehensive history. This requirement helps hospital coding comply with hospital Conditions of Participation and **Joint Commission on Accreditation of Healthcare Organizations** rules.

So if you don't obtain a full history, you have to bill unlisted E/M code 99499 instead, says Gilhooly.