Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: Get in the Habit of Taking A History That Won't Repeat Itself

These 5 tips will lead the way to taking the perfect history in your documentation.

The task seems simple: The practitioner has to obtain all of the details of where the patient's illness came from and what the patient is experiencing. This may be simple from a coding standpoint, but if your physician doesn't document the necessary elements for you to compile a useful history, your claim could be downcoded, or even uncodeable.

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.

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, they may ask the patient, "On a scale of one to ten, how much does your hip hurt when you first get out of bed in the morning?" 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. (For more on PMFSH, see our sidebar, "Use These Tips to Determine PMFSH" on page 3.)

4. Give the patients a form. Your patients can fill out their history as long as the doctor writes down that he reviewed it and is aware of it. 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. The doctor might want to either write the exam results on the back and fill in medical decision-making to create a complete report, or can 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' coding down to lower new patient codes because the physician can't obtain an accurate history, often due to conditions such as a concussion, heavy bleeding, 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.