Part B Insider (Multispecialty) Coding Alert

Physician Notes: Unable to Get Patient History? Follow These Tips

Plus: CMS set to deny 'related' claims.

Nearly every physician has been there you're trying to get a patient's history so you can complete your E/M documentation, but you simply can't collect the details, either due to memory issues or medical problems that preclude the patient from sharing his history with you. Fortunately, Medicare has rules for how to handle this situation.

If you're unable to obtain the history, the documentation must reflect which components you couldn't collect (history of present illness [HPI], review of systems [ROS] or past, family and social history [PFSH]), said Part B payer Palmetto in its weekly E/M pointer last week.

In addition, you must outline the circumstances that made it impossible to get the history (for instance, the patient had dementia or Alzheimer's). If you use the term "poor historian," you must elaborate and share why (for instance, the patient had a traumatic brain injury last year and has trouble remembering information prior to the injury).

You must also document your attempts to obtain the history from family members, nurses, the medical record, and other sources. "If patient or family can provide information at a later time, the provider may add an addendum containing this information," Palmetto says in its tip.

In other news...

Financial implications for your denials may get much steeper, thanks to a new CMS directive on related claims.

Medicare contractors that have denied a claim under medical review "have the discretion to deny other related claims submitted before or after the claim in question," CMS instructs in CR 8425, issued Feb. 5. "If documentation associated with one claim can be used to validate another claim, those claims may be considered 'related,'" CMS says.

"The MAC, Recovery Auditor, and ZPIC are not required to request additional documentation for the related claims before issuing a denial for the related claims," CMS adds.

CMS offers the following example of what could constitute a "related" claim, according to the transmittal: "A diagnostic test claim and associated documentation is reviewed and determined to be not reasonable and necessary and therefore the professional component can be determined to be not reasonable and necessary."

Translation: If a separate physician orders an x-ray and your radiologist performs an interpretation, but the claim is later found to be not reasonable and necessary, you could be forced to return the reimbursement your radiologist collected for his modifier 26 (Professional component) services.

To read the complete change request, visit www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R505PI.pdf.