Part B Insider (Multispecialty) Coding Alert

Reader Question: You Don't Get A Pass on History Portion of E/M

Question: I need help with the E/M for a patient with dementia. The patient took a fall and has a contusion to an elbow and to the temple area; she was unconscious when my doctor saw her in the hospital. She was unable to communicate, but there is no mention of why in the physical examination. Dementia is mentioned in the assessment. Would this be considered a comprehensive examination?

Answer: There is no Medicare guideline that states that if your physician is unable to communicate with the patient, you can assume a comprehensive examination. Regardless of whether the patient is conscious or not, your physician should still be able to conduct an exam.

However, there is a documentation exception when it comes to the history portion of the encounter. The 1997 Documentation Guidelines state: "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." When this happens, many payers allow you to assign a comprehensive level of history.

Potentially there would be issues obtaining a review of systems and/or the past medical, family, and social history elements of the history key components.

Smart idea: You should ask your Medicare contractor or private payer what level of history you can count if your physician is not able to communicate with the patient. Your payer may have a policy like the ones below that outline what documentation requirements you need to meet to assign a history level with no patient input.

Example: In the Frequently Asked Questions area of its Website, Palmetto Jurisdiction 11, which covers your state of Virginia, states that: "The documentation must clearly reflect:

- Why the HPI, ROS, and PFSH was unobtainable (severely demented, sedated on a vent, etc.). If they use 'poor' historian the documentation must support why (severely demented)
- No family members were present to provide information
- Unable to obtain information from medical record (chart, ambulance run sheet, etc.)

If patient or family can provide information at a later time, the provider may add an addendum containing information. If the above guidelines are met, the provider will receive a comprehensive history (must be medically necessary)."

Example 2: In the E/M Q&A section of its Web site, Wisconsin Physicians Service Insurance Corporation (WPS), Jurisdiction 5, covering Iowa, Nebraska, Kansas, and Missouri "There is nothing notated in the 1995 or 1997 DG to indicate any level of history is automatic. The physician should document the reason the patient is unable to provide history and document his/her efforts to 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 some of the history components (past medical, family, social)."