Psychiatry Coding & Reimbursement Alert

Key Elements: Sift Through PFSH Details or Lose More Than $70 Per Encounter

Hint: Don't forget including history captured in previous visits.

If your psychiatrist is overlooking the necessity of thoroughly documenting all aspects of past, family and social history (PFSH), you might be downcoding the E/M service performed, thus losing out on higher reimbursement for the encounter.

Determine the Level of PFSH

For coding purposes, the history portion of an E/M service requires all three elements history of present illness (HPI), review of systems (ROS), and past, family and social history (PFSH)to be met (if applicable) for a given level of history.

Therefore, the presence or absence of PFSH and the extent of PFSH, if present, helps determine patient history level, which has a great effect on the E/M level you can report. If you do not know the PFSH level, you will either be unable to decide which level of E/M code you should use on the claim or have to use a level of E/M service that does not require PFSH for the corresponding level of history, which may be a lower level of E/M service than would otherwise be reportable.

There are three levels of PFSH: none, pertinent, and complete, says **Leah Gross, CPC,** coding lead at Metro Urology in St. Paul, Minn.

Pertinent: To reach a detailed level of history for the encounter, you need a pertinent PFSH. According to Medicare's Documentation Guidelines for E/M Services, you need at least one specific item from any of the three PFSH areas to achieve the pertinent level. When the provider asks only about one of these three history areas related to the main problem, this is a pertinent PFSH.

Complete: A complete PFSH includes, per Medicare's Documentation Guidelines, at least one specific item from two of the three areas for the following categories of E/M services:

- Established patient office/outpatient services
- Emergency department services
- Established patient domiciliary care
- Established patient home care.

For all other E/M services, a complete PFSH includes at least one specific item from each of the three areas.

Pointer: You need only one element of PFSH to receive some credit for the PFSH history component of the encounter. Best bet: "Document it all. You never know what may be pertinent to the patient's current situation!" Gross advises.

Choose a Code Based on PFSH Element Requirement

Once you determine the level of PFSH your provider's documentation contains, you can see which codes that history element supports.

Beware: If your provider does not document any PFSH elements, you can only reach an expanded problem-focused level of history, warns **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPCH, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. In the office or other outpatient setting, that means the highest codes you'll be able to report are a level-two new patient code (99202) or a level-three established patient code (99213). Reporting 99202 pays $74.51 (the national unadjusted rate based on the Medicare Physician Fee Schedule

assignment of 2.19 RVUs times the 2013 conversion factor of 34.023) in the non-facility setting, and 99213 pays $72.81 (2.14 RVUs) in the same setting.

Pertinent PFSH supports a detailed history level. With detailed history, you can potentially report a level-three new patient code (99203) and a level-four established patient code (99214). You'll earn $108.19 for 99203 (3.18 RVUs) and $106.83 (3.14 RVUs) for 99214 in the non-facility setting.

To get to level-four and five new patient visits and level-five established patient visits, you need to have a comprehensive level of history, Cobuzzi says. To do that, you must find complete PFSH in your provider's documentation. If you can achieve 99204 or 99205, you'll earn $164.67 (4.84 RVUs) and $203.80 (5.99 RVUs), respectively. You can expect $142.90 (4.20 RVUs) for 99215 □ just over $70 more than if you're forced to report 99213 because you didn't have enough PFSH.

Imagine this scenario: Your provider sees a new patient suffering from depression for the past six months. He captures an extended history of present illness, complete review of systems, one point of past history, and one point of family history; performs a comprehensive exam; and reaches moderate complexity medical decision making, including initiation of a new prescription medication. But the doctor neglects to review social history with the patient, because the paper template he still uses doesn't have a place for social history notes.

Money matters: Because the physician only documented two aspects of PFSH and the patient is new, the documented PFSH is only considered pertinent, rather than complete. Consequently, you only have a detailed history and can only report 99203 versus 99204 if the doctor had captured a complete PFSH and, thus, a comprehensive history □ a loss of $56.48.

Note: Since established patient office visits require two of three key components, a higher level service is still possible based on the service's examination and medical decision making (MDM) types. "For an established patient, you may decide to leave history off and count only the exam and MDM and then just have the low history," Cobuzzi says. "So, if you have a weak history, you might still reach the higher level E/M."

Count Unchanged PFSH in Current Encounter

Based on E/M guidelines, if a patient's PFSH has not changed since a prior visit, your provider doesn't have to document the information again. He does, however, need to document that he reviewed the previous information to be sure it's up to date and also note in the present encounter's documentation the date and location of the earlier PFSH. Some payers will give no PFSH credit if you overlook one of these criterions.

In writing: Both the 1995 and 1997 E/M documentation guidelines include the following: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:

- describing any new ROS and/or PFSH information or noting there has been no change in the information; and
- noting the date and location of the earlier ROS and/or PFSH.

For example: Your provider may note, "PFSH: Same as documented in my note of January 7, 2013." If there's been a change, he should record it, such as: "PFSH: Same as documented in my note of January 7, 2013, except the patient is now taking a statin prescribed by his primary care physician."

Good news: As with the review of systems (ROS), Medicare states that either the patient or ancillary staff can fill out a history form for PFSH. "The patient usually will get a questionnaire to fill out with these questions, and often the nurse or medical assistant will expand on the answers." Gross says. "However, the physician must document that he or she reviewed these answers to receive credit." As long as the physician signs the form or ancillary staff's notes and documents that he reviewed them, you can meet the requirements for PFSH with that information.