

**TITLE: Crediting Unobtainable History**

**POLICY/PURPOSE:**

The 1995 and 1997 versions of the *Documentation Guidelines for Evaluation and Management Services* represent the official standard for auditing and coding physician Evaluation and Management services (E/M). However, these guidelines do not provide instruction on how unobtainable history is to be credited, only what is to be documented. As such, this policy sets forth this organization's interpretation to ensure consistency in application and to prevent inadvertent E/M upcoding as a result of routinely crediting unobtainable history at the comprehensive level.

**DEFINITIONS:**

1. **Crediting** – counting pieces of medical record documentation toward the level of service billed.
2. **Unobtainable History** – patient history which cannot be obtained, or can only be obtained to a severely limited extent, due to the patient's inability to communicate or convey history and where there is no other source from which to obtain the level of history necessitated by the patient's presenting problem(s). The patient's inability to communicate could be caused by acute or chronic circumstances (e.g., severe mental retardation, unconsciousness).

**PROCEDURE:**

1. **Crediting Unobtainable History in E/M Code Selection**
  - A. In those situations when the history is unobtainable due to the patient's condition and/or circumstance, and the normal level of history which would be obtained given the patient's presenting problem(s) cannot be obtained from the patient or another source, document the reason why the history was unobtainable, any part(s) of the history that was obtained, and the source(s).  
The level of (E/M) visit billed will be based on the lower of the remaining key components, i.e., the physical exam and the medical decision making. The only exception to this would be certain Emergency Department (ED) visits elaborated upon in Section II (B).
  - B. A caveat may apply for ED visits where: 1) the medical decision making is of high complexity; 2) the presenting problem(s) are of high severity and pose an immediate, significant threat to life or physiologic function; and 3) the provider has documented specific constraints imposed by the urgency of the patient's condition which prevented him/her from

obtaining or performing a comprehensive history and/or exam. In this case neither a comprehensive history nor a comprehensive examination need be performed in order to support billing a level 5 ED visit (procedure code 99285).

Because the American Medical Association's CPT® manual does not extend this caveat to any other visit types or levels, this exception may only be applied to ED visits in the limited circumstances elaborated upon above.

## **2. Documentation**

The medical record must reflect why the history is unobtainable and the sources other than the patient from which the provider attempted to obtain patient history. For example, information about the patient could be obtained from the patient's caregiver, a family member, emergency medical technicians, an ambulance run sheet, a nursing home administrator, etc. An exception to this would be when billing for level 5 ED visits as stipulated under section II (B). However, in the case of the ED caveat, the provider must still document the specific constraints imposed by the urgency of the patient's condition which prevented him/her from obtaining or performing a comprehensive history and/or exam.

### **REFERENCES:** AMA. 2011 CPT.

CMS. 1995 Documentation Guidelines for Evaluation and Management Services.

CMS. 1997 Documentation Guidelines for Evaluation and Management Services.

### **APPROVED BY:** Maryann C. Palmeter

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