Codify
BY AAPC

# Internal Medicine Coding Alert

## Reader Question: Coding With No History

**Question:** A 60-year-old man with a history of uncomplicated hypertension develops a scrotal and groin infection. He comes to the hospital with low blood pressure and hypoxemia, goes into shock, respiratory failure, acute renal failure, acidosis and hypocalcemia and requires intubation. The internist was not able to do a review of systems because the patient was on a ventilator. We tend to report this evaluation and management (E/M) service using 99255 (initial inpatient consultation for a new or established patient) except that there is no review of systems. The history of presenting illness was extended, and the medical decision-making was high. How should this be reported?

Rex Mahnensmith
New Haven, Conn.

**Answer:** You probably have enough medical necessity to justify a high-level E/M service, but the actual category of services that you report will depend on the circumstances of the individual case.

If a physician is unable to take a patient history and cannot obtain one from another source (family, old medical records, nurse notes, etc.), Medicares 1997 Evaluation and Management Documentation Guidelines state that the physician should describe the patients condition and the circumstances that preclude obtaining a history. The level of E/M service provided can then be based on the two remaining components: examination and medical decision-making.

To bill this as a consultation, however, there are several criteria that have to be met. Most coding consultants refer to these as the three Rs:

**Request:** The physician handling the patients care must document a request soliciting the opinion on the patients condition. This request should also include the reason or medical necessity behind the consultation. A copy of the request should be kept in the patients medical record.

Review: The physician must review the patients condition. The documentation in the patients medical record should include notes on the patients history and examination as well as any medical decision-making that was done. All three key components of an E/M visit (history, examination and medical decision-making) must be reviewed to determine the level of consultation. (Unless, as mentioned above, the patient is unable to communicate a history).

**Report:** After reviewing the patients condition, a physician must issue a written report back to the requesting physician. A copy of the report should be filed in the patients medical record. In an emergency department or inpatient setting, this report can be a handwritten entry into the medical record, but must contain adequate documentation to support the level of service billed.

Although a physician may initiate treatment of the patient during a consultation, the Medicare Carriers Manual stresses that payment for a consultation should not be made if a transfer of care from the referring physician to the consulting physician takes place at the time of the referral. If the physician becomes the admitting physician, an inpatient admission code (99221-99223) should be used rather than a consultation.

Finally, the services provided might fall under the category of critical care (99291-99292). The CPT states that critical care services include but are not limited to the treatment or prevention or further deterioration of central nervous system failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, postoperative complications, or overwhelming infection. Critical care codes can be used even if these services are provided in a non-ICU setting. But only one physician, the one in control of the case at the time the critical care services are rendered, may bill the critical care code.

The time spent directly with the patient and time spent on the unit engaged in critical care for that patient such as the reviewing of test results or documenting the patients medical record should be included in the calculation of critical care codes, according to the CPT. For any given period of time spent providing critical care services, the physician should devote his or her full attention to the patient.

In the end, the decision of whether to report a consultation, critical care service or other E/M code will depend on the nature of the services provided, whether the physician fulfilled the requirements of a consultation and possibly the length of time spent with the patient.