Internal Medicine Coding Alert

Reader Question: History Requirements

Question: Our physician was recently called to the hospital to consult on a patient who was obtunded and, therefore, unable to give a history. Because a consultation requires all three key components, how should we bill for this service? I have heard that if a patient is unable to give a history, the history element can be counted at the highest level.

Minnesota Subscriber

Answer: Although there is an exception to the history requirement for urgent/emergent circumstances, it is not clear that your scenario meets that requirement. First, to qualify for this exception, the physician must be unable to obtain a history not only from the patient but from any other source. In addition, the medical record must document that the patient is at a high risk and immediate attention is critical. When the physician documents the patients urgent medical condition, the risk of delaying immediate treatment, the patients inability to communicate, and the lack of other source for history, the level of history can be counted as comprehensive. These circumstances normally present in emergency departments in patients with life-threatening conditions such as cardiac or respiratory arrest.

Your scenario, on the other hand, appears to be analogous to that of pediatricians. Pediatricians are unable to obtain a history directly from their patients who are infants or young children. For instance, a pediatrician called to a neonatal intensive care unit (NICU) to consult on an infant must obtain the patients history from the caregivers in the NICU as well as the patients medical record. It is likely that your physician was able to obtain a history from nursing staff, the requesting physician, the written consult request and/or the patients record. The documentation guidelines state:

Relevant findings from the review of old records, and/or receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of old records reviewed or additional history obtained from family without elaboration is insufficient.

If the history obtained from hospital staff is insufficient to diagnose or treat the patient, and your physician needs to review old medical records for additional relevant information, this action should be documented and the level of medical decision-making may increase.