Codify
BY AAPC

Dermatology Coding Alert

Reader Question: No Documented HPI Leads to No Coding for New Patient

Question: A new patient visits the dermatologist with a chief complaint. I don't have a review of system (ROS) or full history because the doctor didn't document a history of present illness (HPI). He did include a brief HPI in the medical assessment that I credited toward the chief complaint. The physician completed an extended, problem-focused exam and medical decision making of low complexity. Can we bill for this encounter?

Minnesota Subscriber

Answer: The AMA/CMS Documentation Guidelines state: "The CC, ROS, and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness." Review the brief HPI information the physician documented to determine if the statement contains both elements of a CC (chief complaint) and HPI. Accordingly, the dermatologist must document the HPI, exam (with the exception being vitals, which an ancillary staff member can document), and the medical decision making (MDM). You need documentation of all three key components (history, exam, and MDM) to support a new patient level E/M code.

If you truly have no HPI documentation, you cannot submit a claim with the new patient E/M codes (99201--99205). However, the unlisted E/M code (99499, Unlisted evaluation and management service) can be billed on a paper claim with attached documentation. An appropriate charge amount should be submitted to approximate the work performed. The claim will need to go through manual review to determine if any payment will be forthcoming from the payer using the unlisted E/M code.

Established difference: If you were coding this scenario for an established patient, you could report 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components ...).

Follow up: Help educate your physicians on the importance of clear E/M documentation. The HPI is a vital part of the patient record that documents the reason why the patient is seeking care and the circumstances surrounding the problem that led up to and includes the present status and any changes since the patient's last visit. If a physician routinely omits the HPI, you'll be hard pressed to establish medical necessity for many patient encounters.