

Internal Medicine Coding Alert

Reader Question: HPI is Instrumental in E/M Pay

Question: A new patient visited our office for evaluation for an epidermoid (sebaceous) cyst excision. Although the physician documented "sebaceous cyst" in the medical assessment as the chief complaint, he didn't document ROS or a full HPI. The physician completed an expanded, problem-focused exam and medical decision making of low complexity. What should we bill for this encounter?

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Answer: Because the physician doesn't document history of present illness (HPI) for this new-patient encounter, you may not have a billable service.

According to the documentation guidelines for E/M services, the physician must document the HPI portion of the history, and history requires at least one element of the HPI. Further, you need documentation of all three key components (history, exam, and medical decision making) to support a new-patient level E/M code. If you truly have no HPI documentation, you cannot submit a claim for the new patient encounter based on the history, exam, and medical decision making.

Established difference: Things would be different if you were coding this scenario for an established patient, however. In that case 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 ...). Because established patient visits require only two of the three key components and because the physician documented an expanded problem-focused exam and low complexity medical decision making, he has met the requirements for a 99213.

Time may help: If the physician spent more than half of his time with the patient in counseling and/or coordination of care and documents such, then you may be able to code the visit on the basis of time, rather than the key components of history, exam, and medical decision making. If the physician elects to report the encounter based on counseling and/or coordination of care, then he should document the total length of the encounter (i.e. face-to-face time in the office) and describe the counseling and/or activities to coordinate care.

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 nature of the patient's problem and what has happened since its onset or since the patient's last visit (in the case of an established patient with a previously diagnosed problem). If a physician routinely omits the HPI, you'll be hard pressed to establish medical necessity for many patient encounters.