Codify
BY AAPC

Internal Medicine Coding Alert

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

Question: A new patient visits the physician 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: According to guidelines, the physician must document the HPI and the exam (with the exception being vitals, which a nurse or PA can document). 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 encounter.

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 nature of the patient's problem and what has happened 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.