Codify
BY AAPC

Internal Medicine Coding Alert

READER QUESTIONS :Achieve Correct HPI Level Every Time

Question: An internal chart audit of our E/M claims shows that our history of present illness (HPI) levels lessened the rightful service level of some claims. How can we get the most accurate HPI level for each E/M?

Montana Subscriber

Answer: Getting a full picture of a patients medical history is a difficult challenge, but its one you can meet.

The following elements go toward determining HPI:

" Location is the place on the patients body where the symptoms exist (for example, the lower right quadrant) or the particular organ from whence the symptoms arise (for example, prostate, bladder, kidney, etc.). For example, if a patient complains of pain, your physician may ask, Is the pain diffuse or localized? Unilateral or bilateral? Fixed or migratory? Does it radiate or is it referred to another location(s)?

" Context is what the patient was doing when the problem occurred (such as patient has pain after urinating).

" Quality represents the characteristics of the chief complaint or signs or symptoms. The physician should encourage the patient to describe the quality of the symptom, since some diseases or conditions produce specific patterns of complaints. For example, pain may be described as sharp, dull, throbbing, stabbing, constant or intermittent, acute or chronic, or stable, improving or worsening.

" Timing is the time of day the patient experienced the signs and symptoms. If your physicians notes say, Pain after waking in the morning, last two weeks, then after waking in the morning is the timing. With renal colic every 20 minutes, every 20 minutes would be the timing. Its important to establish the onset for each symptom or problem, and a rough chronology of the development of the problem. Your physician might want to ask, Is it primarily nocturnal, diurnal, or continuous?

or, Has there been a repetitive pattern for the symptom?

" Severity shows just how bad or serious the patients condition is. Physicians often show severity in their notes with a scale of 1 (least painful) to 10 (most painful). Your physician should get an idea about the severity of the discomfort, sensation, or pain. The patient may describe the severity of the pain by using a self-assessment scale to measure subjective levels (such as 1 to 10, with 1 being no pain and 10 the worst pain experienced). The pain may also be estimated via nonverbal signals, such as the patient lying perfectly still or continuously pacing the floor. Another technique is to ask the patient to compare the pain quantitatively with a previously experienced pain (such as a kidney stone or labor). Can the patient continue to function with the pain or does it result in total immobilization?

" Duration is how long the patients signs and symptoms have been present (for instance, Patient has had severe abdominal pain, last two weeks).

" Modifying factors are things the patient did to try to alleviate the pain, as well as the things the patient did that made the symptoms worse (for example, Patients pain was worsened by exercise or Pain improved/decreased when patient took pain reliever and stayed off her feet). What has the patient attempted to do to obtain relief? What makes the symptom(s) worse? Does the application of heat or cold relieve or worsen a symptom?

Does eating relieve or worsen abdominal discomfort? Does coughing irritate the pain? Have over-the-counter or prescribed medications been attempted?What were the results?

" **Associated signs and symptoms** are any other complaints the patient has in addition to the chief complaint (lower back pain, fever).