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Internal Medicine Coding Alert

Use Knowledge of HPI to Curtail Underpaid E/M Claims

Many office visits that should score a level-four or -five E/M code are reported as level three or four, a problem that can often be traced back to coders' misinterpretations of the history documentation.

To move efficiently through the HPI documentation of your E/M claims, you should know what elements you're looking for and the myriad of ways physicians can document them. The faster and more accurately you can find these elements, the more money you save, because insufficient history of present illness (HPI) can be a "very expensive problem," says **Todd Thomas, CPC, CCS-P,** president of Thomas & Associates in Oklahoma City.

HPI: Know What You're Looking For

Here's a short review of the HPI elements, and tips on how to detect them and when to count them toward the history level:

1. Location is the place on the patient's body where the patient is experiencing signs and symptoms. Remember, location doesn't mean the place where the patient was when the injury occurred, but an anatomic geographic description, Thomas says. For example, "left ankle pain" in the chart indicates location, but "while at work" doesn't.

2. Context means what the patient was doing when he or she experienced signs and symptoms. If a patient cuts her hand while sharpening a knife, then sharpening the knife is the context, Thomas says. Another example of context from a chart might be "occurred at work" or "while sitting down," he adds.

3. Quality describes the chief complaint or sign or symptoms. "We're looking for an adjective," Thomas says. So if the patient has a throbbing headache, "throbbing" indicates the quality. Other quality adjectives for this problem could include "pounding," "shooting," "crushing" and "stabbing," he adds.

4. Timing is when the patient experiences the signs and symptoms. If the chart reads "nausea/vomiting in the morning," "in the morning" is your timing, Thomas says. Don't confuse timing and duration, he warns. Timing locates the time of day the problem occurred, and duration describes how long the patient has felt symptoms. If a patient comes into the office and says, "I've been short of breath since the morning," that statement actually describes duration because the statement reports a time period that hasn't ended. "In the morning" designates an exact time period that is over.

5. Severity describes how bad the patient's problem is. In the physician's history documentation, you will commonly see the severity reported on a scale of 1 to 10 that rates pain, Thomas says. On a handwritten chart, you might see a fraction like "7/10," he explains.

6. Duration is the time duration of the patient's signs and symptoms (explained above under "Timing"). An example of duration is when a patient reports, "I've been vomiting for the last two hours." "The last two hours" is the duration, Thomas says.

7. Modifying factors are the things the patient has done to alleviate the pain from signs or symptoms or the things that make the symptoms worse. For example, urinary incontinence gets worse with caffeine. The physician's notes "relieved by" or "exacerbated by" will help you locate these factors, he says. The charts may also explain treatment prior to arrival; for example, "Patient has taken Tylenol for fever."

8. Signs and symptoms are any problem(s) in addition to the chief complaint that the patient complains of or denies. The chart might read, "Patient complains of urinary frequency, also some burning." Chest pain would be the chief complaint,

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and shortness of breath would be an associated sign or symptom, Thomas says. Remember to include documentation that discloses when a sign or symptom is not present. "We are not looking at the chart from a clinical mind-set," Thomas says. "We're trying to assign a value to the physician's effort," so the physician should get credit for determining the presence and absence of signs and symptoms.

Your HPI elements must come from physician documentation. Under Medicare's requirements, the physician, not a nonphysician practitioner or any other source, must document the chief complaint and HPI, says **Sandra Soerries, CPC, CPC-H,** director of healthcare compliance services for Tait Advisory Services in Kansas City, Mo.

Also, remind your physicians to specifically designate the chief complaint. "Without the chief complaint in the medical record there's no medical necessity," Soerries warns.

In whatever way seems appropriate for your practice, let your internists know: Insufficient documentation means a brief instead of an extended HPI, Thomas says, and that, again, is an "expensive problem."

Don't Believe the Myth of Double-Dipping

Double-dipping is not just a social faux pas; it can get your practice into compliance trouble. But don't be duped by your own fear. In certain circumstances, you can use the same E/M documentation statement twice.

Double-dipping for E/M claims, counting the same documentation statement as two different elements, is a no-no when the two elements are within one E/M component, Thomas says. The history components are the history of present illness (HPI), review of systems (ROS), and the past, family and social history (PFSH).

So, if you have the patient saying, "My problem started yesterday," you can't consider that single statement as the timing element and the duration element in the HPI. Or if the documentation states, "Patient has no chest pains," you cannot count it for the cardiovascular and musculoskeletal elements in the ROS, Thomas says.

You can count the same statement, however, for two different elements in different components, say, the HPI and ROS, Thomas states. And this is what coders may not know or are afraid to follow. You can use the statement "Patient has no chest pains" for the cardiovascular element in the ROS and an associated sign and symptom in the HPI.

"I have reviewed many charts over the years that could have been and should have been coded at a higher [E/M] level," Thomas says. And he credits the down-coding to the coder who works "under the myth of a double-dipping issue."

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