Internal Medicine Coding Alert

Use These HPI Tips to Clean Up Your Physician Documentation

With others involved, you can deliver the best possible claim

Helping your internist become a detail-savvy documenter can lead to higher dividends -- especially when you are confronted with the history of present illness (HPI) element.

And if you consider these five ways to beef up your HPI documentation, you can watch your coding become more accurate and your claims more compliant.

1. Get Information Up Front

Your appointment scheduler can get some details from patients when they call for appointments. This can include things as simple as verifying the patient's address, phone number, insurance plan and plan contact number.

How this helps: Any information you can obtain beforehand and have in the computer system will streamline the process once the patient comes for her visit. That means less aggravation for her and for other patients who don't have to wait as long for your attention.

2. Let Your Hired Staff Pitch In

Enlist help from your nurses or nurse assistants to get more thorough documentation. Some groups have their nurses obtain the patient's vitals and chief complaint when they take the patient to a room.

How this helps: Your nurse is communicating with the patient, which helps her feel more comfortable and gives her the opportunity to voice concerns immediately. When your internist comes in to see the patient, he can summarize the information but spend his time with examination and treatment rather than obtaining general information.

3. Rely on Templates and Forms

One of the easiest ways to ensure providers don't miss documenting any of the E/M visit components is to create templates they can follow.

"I often see the review of systems (ROS) lacking," says **Julee Shiley, CPC, CCS-P, CMC,** a coding consultant at Critical Health Systems in Raleigh, N.C. "This should be included in the dictation template, or this information is sometimes included on an 'intake' form." Have your provider reference the ROS in his hand written note, dictation or electronic medical record (EMR). The provider should initial and date the form so the details can be included in the HPI.

"The history is a three-of-three area," Shiley says. "Therefore, if you have an excellent HPI and problem-pertinent PFS (past, family and social history) but no ROS, the history component drops to the lowest E/M level."

How this helps: Using templates customized to your specialty can help physicians assign the correct level for visits, remind them to verify information they might have forgotten, and more. "Since we've gone to templates, it's gotten easier because they just have to make a check mark," says **Kathy Campbell, CPC,** a coder in Bloomington, Ind.

Caution: Some experts warn against relying too much on templates, saying your physician could get in trouble with payers. If your practice uses templates, be sure the documentation is patient-specific and specific to that date of service. There should be documentation that the physician reviewed this information with the patient.

4. Resurrect Past Information

When compiling HPI, experts stress that you must remember the past, as it informs your coding future.

"We have to remind our providers that they may use previous dates of service, history form, reason for visit forms and other documentation as part of the HPI," Shiley says. "They sometimes forget that this can be counted and may lower the appropriate E/M level if the reference is made but not documented properly."

Example: An established patient with a chronic condition, such as diabetes, visits your practice. If the examination shows that her condition is unchanged, deferred or minimal, your code selection falls to the history and decision-making criteria. "For medication refill visits, we often see circumstances where the history is essential to correct code selection because of the nature of the visit and lack of necessity for extensive examination," Shiley says.

5. Watch for Medical Necessity

Be sure your provider's documentation meets the medical necessity test.

"In other words, even though the documentation may be substantial, ask, 'What is really necessary for the stated condition?' " Shiley says. Match the two sides of the necessity/documentation equation and rest assured you're filing the most accurate claims.

Consider this passage from the Medicare Claims Processing Manual: "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.

"The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during [the encounter], or as soon as practicable after it is provided in order to maintain an accurate medical record."