February 9, 2018

Weekly **Auditing and Compliance** Tip

National Alliance of Medical Auditing Specialists | 877-418-5564 | namas.co | namas@namas.co

Ins and Outs of HPI

A recent study showed that between certified coders, there is a 43% disagreement rate between coders when it comes to the level of service on an Evaluation & Management (E&M) encounter. This level of disagreement can lead to some interesting conversations. Is it any wonder that I often compare the science of coding and auditing to feeding time in the hyena cage?

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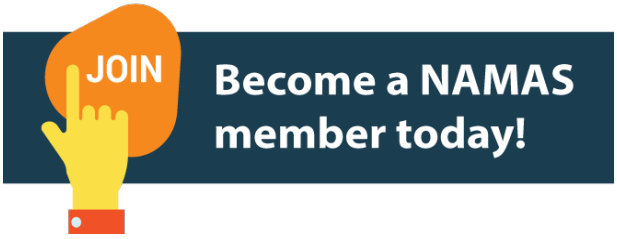
I'd like to focus this article on one particular element of the E&M service that can be particularly contentious between auditors, that being History of Present Illness, or HPI.

Auditors are at a natural disadvantage, in that we are not providers of medical services. When reviewing documentation from different providers, we come across multiple ways of stating similar information. This becomes a challenge when we attempt to assign one of the eight categories of HPI. Let's take a look at some of the categories that lead to disagreement.

We begin with Location. On the surface, this should be an easy one, as location refers to a specific location or region of radiation of the symptoms. The biggest hurdle we encounter with location is whether or not location can be implied given the presenting symptoms. It is actually a myth that location can be implied. As an example, even if a patient presents to the physician



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with a complaint of a cough, we cannot as auditors make the leap that the location is the respiratory system. Any documentation must have location specifically called out in order for it to be credited under the HPI.

In the age of ICD-10, laterality is a concern when it comes to location, but it is important to know that there is no language specific to either the 1995 or 1997 documentation guidelines that would disqualify the use of location as an HPI bullet based on laterality being missing (example: "Patient complains of pain in elbow").

The next questionable area is Context. Context is the story behind the chief complaint. It can be in the form of background, as in what was present before and/or after the beginning of the problem. Crediting a note for context cannot be a matter of course when it comes to template design. As an example, a patient presenting for management of chronic conditions such as diabetes or hypertension with a notation of "no known injury" isn't of particular importance. However, when it comes to a patient presenting with right knee pain, a notation of "no known injury" is of assistance to the provider to treating and properly diagnosing the problem.

As an experienced auditor, it becomes almost a matter of course that when a medication is mentioned within the bounds of the HPI section that it automatically falls under modifying factors. If the medication is mentioned as being attempted or having been successful at alleviating symptoms, it would indeed fall under modifying factors. However, if a medication reaction is indicated as a root cause of the chief complaint, the medication would fall under the context bullet.

As with any HPI, having a clear description of the chief complaint will be the driver of HPI bullets. Auditing provider documentation doesn't have to be fodder for the hyena cage. It just needs to be audited in a way that credits the provider for a clear assessment of the symptoms and conditions for which the patient presents.

This Week's Audit Tip Written By:

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Consultant for our parent organization, DoctorsManagement

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Pre-Conference: Sunday, November 11
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Venue: Wyndham Grand Clearwater Beach, Clearwater Beach, FL

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(What You Need to Know Webinar Series)
Speaker: Michelle West
February 13, 2018
2pm EST

Creating a Culture of Compliance in 2018
(Compliance Webinar Series)
Speaker: Sean Weiss, CHC, CMCO, CEMA, CPMA, CMPE, CPC-P, CPC
February 20, 2018
2pm EST

Exam of the E&M Encounter
(Hands-on Webinar Series)
Speaker: Pam Vanderbilt, CPC, CPMA, CPPM, CPC-I, CEMC, CEMA
February 27, 2018

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