Understanding Your Risk
"What happens when you don't play by the rules"

The History of Present Illness (HPI), is by in large one of the most critical aspects of any progress note. Yes, we all know it is made up of either elements (location, duration, context, timing, severity, modifying factors, and associated signs and symptoms) or for complete HPIs, the status of chronic (three) conditions. However, the most important part of the HPI is not in what you document but who actually documents it! I spend approximately 48 weeks per year on the road working in practices from one physician up to integrated health systems with more than 2000 providers and I always find someone who is derelict in their duties as a provider (Physician or NPP). It is the physician and or other qualified health care provider's responsibility to perform and document the HPI. That means ancillary (MA, RN, LPN, etc.) staff **cannot** perform this function and document it.

In 1997 The Health Care Financing Administration (HCFA) put forth guidelines, which clearly stated the physician must perform the HPI. This has held true throughout the years and is still true today. CMS through Wisconsin Physician Services (WPS) on July 15, 2014 updated their Q&A to show the following:

Q 18. Who can perform the History of Present Illness (HPI) portion of the patient's history?

A 18. The history portion refers to the subjective information obtained by the physician or ancillary staff. Although ancillary staff can perform the other parts of the history, *that staff cannot perform the HPI. Only the physician can perform the HPI.*

Q 19. If the nurse takes the HPI, can the physician then state, "HPI as above by the nurse" or just "HPI as above in the documentation"?

A. 19. No. *The physician billing the service must document the HPI.*

Where this becomes a big risk to an organization is for those who are on an EMR. It is very easy for ancillary staff to perform the Chief Complain (CC) and then move right into the HPI, pointing and clicking buttons to capture the elements needed. However, if you are using your EMR as they were designed to be used, the person making the entry into that section would have to electronically sign the note, attesting to the validity of the information. If your ancillary staff are electronically signing that section, during an audit an auditor could and would refuse that section; all but eliminating one of the "Key" Components of an EM Services. For new patients or consults this would drop the service to a level one or convert it to an established patient. In a worst case scenario they would consider the service non-billable and deem it an overpayment/error and demand a refund.
So what portion of the History can your ancillary staff perform? Based on Documentation Guidelines from The CMS they can perform the Review of Systems (ROS) and the Past, Family or Social History (PFSH). That's it!
How do you avoid making this costly error? Simple, make sure your ancillary staff when triaging a patient know the rules:

1. Document the Chief Complaint (A clear, concise statement for the reason of the encounter. It can be a symptom, sign a condition, or physician recommended return);
2. Document the Review of Systems (if applicable), and;
3. Document the PFSH (if applicable)

This will force the physician or NPP to perform the HPI capturing relevant elements or documenting the status of chronic conditions. Follow these simple guidelines and you will mitigate your risk in a risky area.

This Week's Tip Provided by:

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