Pain Management Coding Alert

Mythbusters: Dodge HPI Pitfalls with this List of Truths

HPI's philosophy counts on SOCRATES.

PM coders that get confused when coming up with a patient's history of present illness (HPI) level, don't fret.

The skinny: HPI calculation is one of the more challenging parts of coding your provider's evaluation and management (E/M) service. That's because the guidelines are both lengthy and complicated. And, to add to the confusion, there are two sets of them.

Get your facts straight, and cast the mistruths aside, with this HPI mythbusters.

Know HPI Locations

HPI is an element within the history component - one of the three key factors used in selecting the correct level of E/M service. The CPT® manual defines HPI as "a chronological description of the development of the patient's present illness from the first sign and/or symptom to the present" and goes on to identify eight individual HPI elements.

Fun fact: You can remember those elements using the mnemonic SOCRATES.

- **Site (Location):** The anatomical place or site of the chief complaint.
- **Onset (Duration):** Length of time of the complaint.
- **Context:** The circumstances/environment in which the symptoms occur.
- **Radiation (Quality):** How the complaint feels (stabbing, achy, itchy, better, worse, etc.).
- **Associated signs and symptoms:** Other related factors or symptoms, positive or negative.
- **Timing:** How often the symptoms occur (frequently, occasionally, etc.).
- **Exacerbating/Alleviating (Modifying factors):** Anything that relieves or aggravates the problem.
- **Severity:** The degree of intensity of the signs or symptoms (1-10 pain scale, wincing, doubled over in pain, etc.).

There are two levels of HPI - brief and extended. Per both the 1995 and 1997 guidelines, you tally HPI by reviewing the notes and deciding how many of the above eight elements the provider reviewed relative to the patient's chief complaint (CC).

For a brief, problem-focused, or expanded problem-focused HPI the documentation needs to include one to three of the above elements.

For an extended, detailed, or comprehensive HPI the documentation needs to include four or more of the above elements.

Myth 1: Listing HPI Conditions Is Sufficient Documentation

Not so, says **Mary I. Falbo, MBA, CPC**, CEO of Millennium Healthcare Consulting Inc. in Lansdale, Pennsylvania. "Just listing is not enough. Your provider needs to document the status of each condition for the condition to count."

Myth 2: HPI Doesn't Consider Duration an Element

Technically, this is true. The CPT® guidelines state that HPI should include "a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms." The list contains no mention of onset or duration.

However, as **Donelle Holle, RN**, President of Peds Coding Inc., and a healthcare, coding, and reimbursement consultant in Fort Wayne, Indiana points out, the confusion over this issue arises because "the Centers for Medicare and Medicaid Services (CMS) does recognize duration as an element of HPI. Most auditors," Holle goes on to say, "go by CMS in regard to HPI because they are the highest guideline out there, and most carriers follow the guidelines put out by CMS."

Remember: If you are unsure of a payer's HPI element list, call your representative to check and then document the response.

Myth 3: Non-HPI Elements Can Never Count in HPI

Actually, this is permissible, providing it is done in the right way. Falbo offers the following example: "If, during the review of systems [ROS] portion of the exam, the provider documents 'shortness of breath with chest pain,'" Falbo explains, "it would be appropriate to credit 'shortness of breath' in the ROS documentation and as a sign and symptom for the HPI."

Holle agrees, adding that this can be a source of great coding confusion. "Stating a cough is in the lungs is not specifying location," Holle says, "but stating having chest pain under the ribs when coughing would be location."

Once again, however, Falbo cautions that individual payers' guidelines may differ, so it would be a good idea to seek clarification from them first about their ruling.

Myth 4: You Can Sub Chronic Conditions for HPI

This is where the 1995 and 1997 guidelines get muddied. If you are using the 1995 guidelines, documenting chronic conditions is not acceptable. Under 1997 guidelines, however, you can use one or two chronic medical problems instead of one to three HPI elements for a brief problem-focused or expanded problem-focused HPI, and three chronic medical problems instead of four HPI elements for an extended, detailed, comprehensive HPI. But whichever set of guidelines you use, make sure you use one or the other, not both.

The golden rule: Holle offers this important piece of advice for coders: "your provider has to obtain this portion of the history. In many offices," Holle continues, "the clinical staff will list the chief complaint and maybe even a couple statements. However, the provider will need to perform and document the HPI portion of the service for it to count in an audit."