

**Clarification of Evaluation and Management Services:**  
**History of Present Illness**

by  
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Recently in a bulletin published by Noridian Administrative Services, the carrier for CMS which processes physician claims for thirteen states in the western portion of the country, clarified the documentation requirements for history of present illness. The history of present illness component is the most important component of the history element for rendering care for the patient according to CMS. While the 1995 and 1997 written guidelines indicate that the review of systems and past family and social history may be documented by the patient or staff, the guidelines have never defined if the staff was allowed to document the history of present illness.

The bulletin indicates the RVU value for the physician's or non physician's reimbursements include the physician or NPP being involved in obtaining the history of present illness from the patient. Payment is made based on the fact that all "physician or NPP" criteria has been met and can be supported with the appropriate documentation.

The article gives an example of what is NOT appropriate documentation from the physician to support reimbursement for the service:

"Reviewing information obtained by ancillary staff and writing a declarative sentence does not suffice for the history of present illness. An example of unacceptable HPI documentation would be 'I have reviewed the HPI and agree with above.'"

The articles goes on to indicate that the physician may use ancillary staff (Register Nurse, Licensed Practical Nurse, Medical Assistant) to scribe the information and it is appropriate to use the staff to question the patient to obtain the preliminary information. It needs to be confirmed by the physician.. It is most important that the physician be a part of obtaining the information and not just review the information.

If your group is using paper charts for documentation of services, this could be support by difference in writing as well as notes from the physician expanding on the information obtained from the patient. If you are using paper templates which contain boxes for checking off information; it is imperative that the physician be the one responsible for obtaining the information from the patient which is indicated by checking a box.

If your group is using electronic medical records, the verification of who obtained the information is much more difficult since the information is in a typed format and ancillary staff may have access to the computer as well as the physician. It would be recommend that the physician indicate in the note that they participated in obtaining the information and that possibly a clinic protocol is established that indicated that the physician is the one responsible for obtaining the history of present illness information and ancillary staff may or may not document the information obtained depending upon the physician.

The documentation of history of present illness seems to be a small issue. However, when it comes to supporting the physician's services on post payment review, there are a couple of key items to remember:

1. Patients are frequently asked to verify if the service was performed as documented.
2. The staff may be queried regarding their involvement in documentation for the patient's encounter.

Make sure your documentation is appropriate for your services. There should never be a doubt as to the physician's involvement in obtaining the history of present illness. This work is physician's responsibility in treating the patient for their chief complaint.