

COMPLIANCE TIP

TO: Compliance Alert Distribution List

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SUBJECT: Documenting the Patient's Chief Complaint

DATE: March 31, 2016

During routine monitoring reviews, the Office of Compliance has noted that the patient's chief complaint ("CC") is not always documented by the physician or nonphysician practitioner (the "Service Provider"), or if documented, it is a very generic or ambiguous statement.

The Chief Complaint explains the reason for the encounter.

The CC should be a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's own words.

A Chief Complaint is required for all E/M services regardless of location or patient status.

A CC is required for every level of patient history taken for an Evaluation and Management service ("E/M service"). In addition, a CC is required for every type of E/M service, regardless of the location of the patient (inpatient or outpatient) or the status of the patient (new or established, initial or subsequent).

The Chief Complaint must be documented by the Service Provider.

Very few Medicare Part B contractors will allow the CC when recorded by ancillary staff. However, the Medicare contractors for Florida and Georgia are silent on this so we must yield to the federal guidelines. The E/M guidelines indicate that ancillary staff may obtain the Review of Systems (ROS) and Past, Family and Social History (PFSH) but they do not indicate that ancillary staff may obtain the CC or the History of Present Illness (HPI). Certainly ancillary staff may document the CC but this should be considered preliminary information. The Service Provider must confirm and re-document the CC and this is usually done as part of the HPI. By the way, only the HPI documented by the Service Provider may count toward a billable service.

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It would not be appropriate for the Service Provider to document "Chief Complaint as above" when the CC has been documented by ancillary staff. The CC may be listed as a separate element of the patient's history or it may be included in the description of the HPI.

Avoid generic or ambiguous Chief Complaints.

It may sound simple and one may think that a CC is always documented, but many of the records Compliance has reviewed do not reflect a clear chief complaint. At times Compliance has observed the CC documented as "follow up" or "med refill." These are not appropriate chief complaints as they provide no clue as to the presenting problem. A more appropriate CC would include the reason for follow-up or the problem(s) associated with the need for medication refills. For example, "follow-up for diabetes" and "hypertension med refill." "Patient referred by Dr. Smith" is an example of a poorly documented CC for a consult. Actually, there is no CC documented in this example. A more appropriate CC would be documentation of the referral source and the reason for the referral. For example, "Consult requested by Dr. Smith for non-healing wound."

Chief Complaints are required even for subsequent hospital visits and should include why the patient is being managed.

One may think that a CC may be assumed on an inpatient being seen on day 4 of an admission for a particular problem; however, this is not the case. Each subsequent hospital visit requires a chief complaint. Avoid vague statements like "feeling better," "resting quietly," or "no complaints" as the CC. There's a reason the patient is in the hospital and under the care of a particular service. If there are no new problems or changes then document the problem(s) that the service is managing.

Only documenting the Chief Complaint as part of the Assessment is risky business.

Depending on how a Service Provider's documentation templates are set-up, he or she may document the reason for the visit in the assessment section of the note. One could argue that the provider really did record a CC but it is recorded as part of the assessment. This is a risky position to take as the patient's actual CC may be a sign or symptom. The assessment is the conclusion that the Service Provider reaches after evaluating the patient. In addition, what the patient perceives is wrong (expressed as the CC) may not be what is actually wrong (documented under the assessment).

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The Chief Complaint Sets the Tone for the encounter.

The CC is the first thing reviewed in the medical record for each visit and sets the tone for what is needed in the history, exam, and medical decision making. It provides the reader information regarding the nature of the presenting problem and determines how the rest of the visit will progress. Don't forget the importance of documenting a clear and appropriate chief complaint that includes the reason the patient is being seen.

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Please share as appropriate with faculty, residents/fellows, nonphysician practitioners, billing and clinic staff.

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