August 19, 2016

Chief Complaint

What do you do when you come across an E&M encounter that has no chief complaint? Do you deem the encounter non-billable?

For years, I have heard it said that EVERY encounter MUST have a chief complaint, bus is that really what documentation guidelines have to say? The only guidance we have on the chief complaint in either 1995 or 1997 Documentation Guidelines is this:

"The Chief Complaint is a Concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.
DG: The medical record should clearly reflect the chief complaint"

In this statement, DG indicates that the medical record SHOULD clearly reflect the chief complaint, but it doesn't say it MUST or that it is REQUIRED. Furthermore, to deem the note non-billable is throwing away the "work" the provider did. We can tell he/she saw the patient, and in *most* cases the chief complaint will be inferred somewhere, but even for those rare charts- remember that it only ***should*** be there.

Now, the chief complaint should be there as it drives the medical necessity of the encounter by defining the patient's presenting problem. Remember that each entry in the medical record must stand independently of the other.

Therefore, if your physician sees the same patient as an

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inpatient for 15 days in a row for the same chief complaint, it ***should*** still be documented on each entry in the medical record to validate the need for each encounter.

The documentation guidelines for the chief complaint do not change based on the E&M service type; for example, new, established, inpatient, etc. Even when documenting preventative encounters, the noted chief complaint should be "annual exam" or "preventive encounter".

The chief complaint is a clear, concise statement that describes the reason for the patient encounter. Guidelines indicate that the chief complaint should be documented using the patient's own words. However, this is also within reason as sometimes the patient may be uncertain as to the need for a follow up.

The point that CMS is making with "in the patient's own words" is to not diagnose in the chief complaint, but keep it specific to the true complaints of the patient. For example, if the patient states he is here for burning and frequency on urination- that would be the chief complaint, not chief complaint: UTI.

We have also hear it said that 'follow up' is not a valid chief complaint, but note in the above referenced guidance on the chief complaint that a physician recommended return is noted as a valid chief complaint option. The point that should be clarified is that while 'follow-up' is a valid chief complaint, it does not identify to the fullest extent the complexity that might be associated with the patient encounter and sets the note up toward an expectation of a less complex encounter. Consider the difference between "patient presents for follow-up" and "patient returns for the follow up of their diabetes".

Chief complaints such as the following should not lead to down-coding of an encounter, but the auditor should use them as training points with the provider of how using such chief complaints may impact the complexity of the encounter:

Poor Chief Complaints:	Revised Chief Complaints:
Patient presents for biopsy results	Chief Complaint: Mass in right breast
Patient presents for lab findings	Chief Complaint: Uncontrolled diabetes
Follow up	Chief Complaint: Follow-up non healing ulcer
Here to establish care	Chief Complaint: Multiple chronic co-morbidities

The true chief complaint in these instances in more clearly as why the MRI or the labs were performed, and to truly

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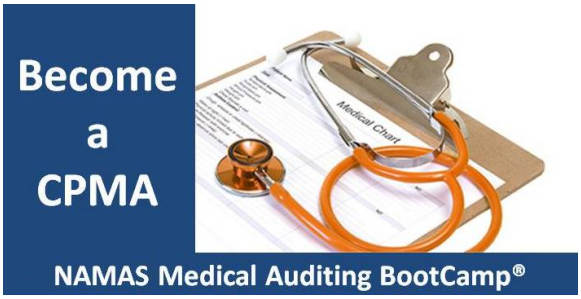

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convey what the real need for the follow up encounter was. The fact that the patient is there for results is secondary to the underlying reason the tests were performed.

Oftentimes we find that physicians include history components in their chief complaint. If the patient is here for a sore throat, then this would be the chief complaint alone. The chief complaint should be kept brief and to the point.

This Week's Audit Tip Provided by:
Shannon DeConda, CPC, CPC-I, CEMC, CMSCS, CPMA

Shannon is a Partner with our parent organization, DoctorsManagement, LLC and the President/Founder of NAMAS

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