Codify
BY AAPC

# Optometry Coding & Billing Alert

## Documentation: Leave the HPI Details to the Provider

**Identify which portions of the record ancillary staff can capture.**

Your time is valuable and, like most practices, you're likely trying to find ways to have ancillary staff take on duties to free up the physician's time for critical provider-only parts of patient care. But be careful: If you don't follow the E/M guidelines about what portions of an office visit your ancillary staff can actually perform, you are putting your practice at risk of compliance concerns.

Watch the Chief Complaint

All E/M documentation must include a chief complaint (CC), but who in your practice captures the chief complaint may not fit your insurer's requirements.

The chief complaint is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the E/M encounter. It is typically stated in the patient's own words.

**The challenge:** Most payers and auditors want to see that the provider documented the chief complaint, and most experts agree. "The chief complaint should be written by the billing provider," says **Suzan Berman, CPC, CEMC, CEDC,** manager of physician auditing and compliance for West Penn Allegheny Health Systems in Pittsburgh.

**For example:** Palmetto GBA states: "Ancillary staff may only document: Review of systems (ROS), Past, family and social history (PFSH), Vital signs. These three areas must be reviewed by the physician or non-physician practitioner (NPP) who must write a statement that it is reviewed and correct or add to it. Only the physician or NPP that is conducting the E/M service can perform the history of present illness (HPI). This is considered physician work and not relegated to ancillary staff. The exam and medical decision making are also considered physician work and not relegated to ancillary staff. In certain instances, an office or emergency room triage nurse may document pertinent information regarding the chief complaint (CC)/HPI, but this information should be treated as preliminary information." (Source: Frequently asked questions page on www.palmettogba.com/palmetto/providers.nsf)

Other payers may allow ancillary staff such as MAs and nurses to capture the CC details. WPS Medicare, for instance, says ancillary staff can capture CC: "The 1995 and 1997 Documentation Guidelines (DG) do not address who can record the chief complaint. WPS Medicare will allow the CC when recorded by ancillary staff. However, the physician must validate the CC in the documentation." (Source: www.wpsmedicare.com/j5macpartb/resources/provider_types/2009_0526_emqahistory.shtml)

**Don't miss:** If your provider allows ancillary staff to capture the CC, be sure the provider still refers to it in his documentation. "S/he could confirm the chief complaint and add information as long as it is evident this was done (initials, signature, electronic signature, mention by the MD in his/her note, etc.)," Berman says.

To add to the confusion, both the 1995 and 1997 E/M guidelines specifically address which personnel can document review of systems (ROS) and past medical, family, social history (PMFSH) as follows: "The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others." Because the CC, HPI, physical examination, and medical decision making (MDM) are not addressed in this notation, many payers and

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experts by inference state that the provider is the only one who can document these elements.

"The reason there is confusion around this piece is because the guidelines clearly illustrate who can document the review of systems and past, family and social histories to include ancillary staff," Berman agrees. "However, this distinction is not made anywhere else within the guidelines; they do not indicate ancillary personnel being able to document anything else; thus the confusion."

**Bottom line:** Check your payer's rules to ensure you are compliant.

HPI Differs From Other History Components

Any employee who has been adequately trained can help document at least part of a patient's history.

**Support:** E/M service documentation guidelines state that ancillary staff can record the review of systems (ROS) and/or the past, family, and social history (PFSH) portions of the history. Only the physician or other qualified health care professional (such as a nurse practitioner or physician assistant), however, may complete the history of present illness (HPI).

**Tip:** You can check with your payers for specific details on which providers can document which portions of the record. For example, **Meredyth Hurt, CCS-P,** physician coder at Sky Lakes Medical Center in Klamath Falls, Ore., points out that at an August 2012 Noridian Medicare workshop, her MAC gave the following information:

**Question:** "If someone other than a physician collects the history of present illness (HPI), documents it, then the physician reiterates the HPI with the patient, can the physician then refer to the other person's documentation with the notation, 'I re-obtained the HPI, reviewed the documentation and agree?'"

**Answer:** "HPI must be done and individually documented by the physician."

According to Hurt, Medicare B News (Issue 238 July 10 2007) states "The Centers for Medicare and Medicaid Services (CMS) has clarified that only the physician or non-physician practitioner (NPP) who is conducting the evaluation and management (E&M) visit can perform the history of present illness (HPI) and chief complaint (CC). This is physician work and shall not be relegated to ancillary staff."

**Payers agree:** WPS reiterates this guidance on its provider Website: "The billing provider must perform the History of Present Illness (HPI). The ancillary staff cannot collect this information and enter it into the medical record with the provider only signing or acknowledging they read the notation." (Source: www.wpsmedicare.com/part_b/resources/provider_types/em_checklist.shtml).

**Remember:** If another staff member takes part of the history, the provider must sign off on the patient's chart and indicate that he reviewed the history notes. He should include a note supplementing or confirming the information recorded.

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