CMS and TJC History and Physical Requirements for Hospitals (Including CAHs)

Tuesday, November 18th, 2014
Speaker

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- Board Member of the Emergency Medicine Patient Safety Foundation
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Learning Objectives

1. Recall CMS H&P requirements.

2. Discuss TJC standards on H&P.

3. Review medical staff by-laws requirements for H&Ps.

4. Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.

5. Evaluate compliance requirements and penalties.
You Don’t Want One of These
The Conditions of Participation (CoPs)

- Regulations first published in 1986
  - Many revisions since
  - Manual updated June 6, 2014
  - Tag 001 to 1164 and 471 pages now
  - Also remember any state specific law on H&Ps

- First regulations are published in the Federal Register then CMS publishes the Interpretive Guidelines and some have survey procedures
  - Hospitals should check this website once a month for changes

1. www.gpoaccess.gov/fr/index.html  
Location of CMS Hospital CoP Manuals

CMS Hospital CoP Manuals new address
State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 116, 06-06-14)

Transmittals for Appendix A

Survey Protocol

Introduction

Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 – Post-Survey Activities

CMS Survey and Certification Website

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
## Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

<table>
<thead>
<tr>
<th>Title</th>
<th>Memo #</th>
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<tr>
<td>Approval of The Compliance Team’s (TCT’s) Rural Health Clinic (RHC) Accreditation Program</td>
<td>14-39-AO/RHCs</td>
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<td>Advance Guidance - Revisions to State Operations Manual (SOM), Appendix PP- Guidance to Surveyors for Long-Term Care (LTC) Facilities and Chapter 4</td>
<td>14-37-NH</td>
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<td>Infection Control Breaches Which Warrant Referral to Public Health Authorities</td>
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<td>Final Rule - Promoting Program Efficiency, Transparency, and Burden Reduction; Part II - Informational Only</td>
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<td>Advance Copy of Revised F371; Interpretive guidance and Procedures for Sanitary Conditions, Preparation of Eggs in Nursing Homes</td>
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<td>Update of State Operations Manual (SOM) Chapter 5. Triaging Complaints</td>
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Number of Deficiencies

- CMS issued its first deficiency report in March 22, 2013
- CMS updating quarterly
- Hospitals can read why hospitals got cited for being out of compliance
- Does list hospital’s name and address
- Helps hospitals to determine top problematic standards by CMS
- H&P in tag numbers 358, 359, 461, 463 and 952
Access to Hospital Complaint Data

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1899

Center for Clinical Standards and Quality/Survey & Certification Group

DATE: March 22, 2013
TO: State Survey Agency Directors
FROM: Director Survey and Certification Group

Ref: S&C: 13-21-ALL

Memorandum Summary

- Survey Findings Posted on https://www.cms.gov: In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on Nursing Home Compare. In March 2013, CMS began posting CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memorandum describes the contents and location of these files.
- Other Web-based Tools Based on These Data: At least two additional websites, provided by private parties (ProPublica and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.
- Plans of Correction (POC): The posted CMS data do not contain any POC information. State Survey Agencies (SAs) and CMS Regional Offices (ROs) may use an increase in requests for both the CMS-2567 and any associated POCs.
- Question & Answers: We plan to issue an update to this memorandum that will include an attachment of frequently asked questions in order to provide answers to other queries that may arise.

Background – Nursing Home Survey Findings

In July 2012, CMS began posting nursing home statements of deficiencies; derived from the Form
Updated Deficiency Data Reports

Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for one hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital’s compliance:

- Components appropriately certified as other kinds of providers or suppliers, i.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice. Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act, and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments.

Accredited Hospitals - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital's compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital's provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct
## Data Report H&P Deficiencies July 24, 2014

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<tr>
<th>Tag Number</th>
<th>Number of Deficiencies</th>
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<td>952</td>
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H&P A-358

- H&P requirements also in tag number 461 and 463
  - CMS changes standard to be consistent with TJC standard
- Standard: The MS must adopt bylaws to carry out their responsibilities on H&Ps
- The bylaws must include a requirement that a H&P be completed no more than 30 days before surgery
  - So upon arrival need to look at date on H&P to make sure it is no older than 30 days
(Rev. 95, Issued: 12-12-13, Effective: 06-07-13, Implementation: 06-07-13)

[The bylaws must:]

482.22(c)(5) Include a requirement that --

(i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

Interpretive Guidelines §482.22(c)(5)(i)

The purpose of a medical history and physical examination (H&P) is to determine whether there is anything in the patient's overall condition that would affect the planned
History and Physicals

- If the H&P has been done more than 30 days ago then it must be redone

- Say for example the family physician did the H&P 3 weeks ago and so within the time frame but something may have changed since then

- CMS requires that the H&P be updated prior to surgery or a procedure requiring anesthesia
  - Remember anesthesia included deep sedation beside general, regional, and monitored anesthesia care (MAC)

- Must be on chart before surgery or a procedure requiring anesthesia services
History and Physicals

- The H&P must be done by a physician, oromaxillofacial surgeon or other qualified LIP
  - Must be in accordance with state law and hospital P&P
  - Most states include PA and NP
- The H&P must be done within 24 hours after admission on each patient
  - So patient is admitted for pneumonia the H&P must be done and on the chart within 24 hours time period
  - Does not say it has to be signed off just on the chart
  - It can be handwritten, transcribed, or dictated
H&P 358 Interpretive Guidelines

- Purpose of medical history and physical (H&P) is to determine if there is anything in the patient’s overall condition that would affect the planned course
  - Such as a medication allergy
  - A new or existing co-morbid condition that requires intervention to reduce risk to the patient
- The Medical Staff by-laws need to include these requirements
- Same requirements for inpatient or outpatients
H&P Admission 358

- There needs to be an updated entry in the medical record to reflect any changes

- Person who does the H&P must be licensed and qualified
  - For example, state scope of practice must allow and hospital policy for AHP like PA or NP

- Example, family physician does H&P 2 weeks ago for patient having CABG today

- Surgeon would review, update, and determine if any changes since it was done and authenticate document
H&P Done by a Physician or LIP

- CMS says H&P must be completed and documented by a physician or oromaxillofacial surgeon
  - Physician is defined to include a MD or DO, podiatrist, optometrist, dentist or chiropractor
  - But physician must be legally authorized to do this by the state law
  - Must be within the physician’s scope of practice so in many states a podiatrist can do a H&P
  - As discussed many states allow a PA or NP
More than one qualified practitioner can participate in performing, documenting, and updating the H&P.

If this is done, the practitioner who is authenticating the H&P is responsible for its contents.

If H&P is conducted within 30 days before admission or registration,

Then update must be completed and documented by one who is C&P by the medical staff to perform an H&P.
History and Physicals

- Can include in progress notes or use a stamp, sticker, check box, or entry on H&P form
- Should say that H&P was reviewed, the patient examined, and that “no change” has occurred in the patient’s condition since the H&P was completed
- There needs to be a complete H&P in the chart for every patient except in emergencies and can make entry in progress notes
History and Physicals

- Regulation expanded the number of categories of people who can do a H&P
  - Most state law and the hospitals allows a PA or NP to perform a H&P now
- Remember, the Physician is still responsible for the contents and must sign off the H&P when done by one of these allied health professionals
- Need to do PI to make sure all H&P are on the chart especially when the patient goes to surgery
H&P 358 Survey Procedure

- This section has a survey procedure
- These are like questions and things the surveyor is suppose to look at
- The surveyor is to review the MS bylaws to make sure that a H&P is no older than 30 days and 24 after admission
- Will verify that the H&P is done by a qualified person as allowed by state law and hospital P&P
- Will verify that H&P is done for all surgeries and procedures requiring anesthesia services
Survey Procedures §482.22(c)(5)(i)

- Review the medical staff bylaws to determine whether they require that a physical examination and medical history be done for each patient no more than 30 days before or 24 hours after admission or registration by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy. Verify whether the bylaws require the H&P be completed prior to surgery or a procedure requiring anesthesia services.

- Review the hospital’s policy, if any, to determine whether other qualified licensed individuals are permitted to conduct H&Ps to ensure that it is consistent with the State’s scope of practice law or regulations.

- Verify that non-physicians who perform H&Ps within the hospital are qualified and have been credentialed and privileged in accordance with the hospital’s policy.

- Review a sample of inpatient and outpatient medical records that include a variety of patient populations undergoing both surgical and non-surgical procedures to verify that:
  
  o There is an H&P that was completed no more than 30 days before or 24 hours after admission or registration, but, in all cases, prior to surgery or a procedure requiring anesthesia services; and

  o The H&P was performed by a physician, an oromaxillofacial surgeon, or other qualified licensed individual authorized in accordance with State law and hospital policy.
H&P 358 Survey Procedure

- Surveyor is to verify that if a non-physician does the H&P that they are **C&P** with the hospital policy.

- Surveyor is told to review a number of both inpatient and outpatient medical records to make sure it was done within 30 days before or 24 hours after admission.

- Will make sure consistent with state law and hospital policy.

- Surveyor instructed to look for the MS by-law on H&Ps.
So What’s in Your H&P?

Chief Complaint:
"swelling of tongue and difficulty breathing and swallowing"

History of Present Illness:
77 y o woman in NAD with a h/o CAD, DM2, asthma and HTN on altace for 8 years awoke from sleep around 2:30 am this morning of a sore throat and swelling of tongue. She came immediately to the ED b/c she was having difficulty swallowing and some trouble breathing due to obstruction caused by the swelling. She has never had a similar reaction ever before and she did not have any associated SOB, chest pain, itching, or nausea. She has not noticed any rashes, and has been afebrile. She says that she feels like it is swollen down in her esophagus as well. In the ED she was given 25mg benadryl IV, 125 mg solumedrol IV and pepcid 20 mg IV. This has helped the swelling some but her throat still hurts and it hurts to swallow. Nothing else was able to relieve the pain and nothing make it worse though she has not tried to drink any fluids because of trouble swallowing. She denies any recent travel, recent exposure to unusual plants or animals or other allergens. She has not started any new medications, has not used any new lotions or perfumes and has not eaten any unusual foods. Patient has not taken any of her oral medications today.

Surgical History:
s/p vaginal wall operation for prolapse 2006
s/p Cardiac stent in 1999
s/p hysterecmy in 1970s
s/p kidney stone retrieval 1960s

Medical History:
+CAD w/ Left heart cath in 2005 showing 40% LAD, 50% small D2, 40% RCA and 30% large OM; 2006 TTE showing LVEF 60-65% with diastolic dysfunction, LVH, mild LA dilation
+Hyperlipidemia
+HTN
+DM 2, last A1c 6.7 in 9/2005
+Asthma/COPD
+GERD
+h/o iron deficiency anemia
So What’s in Your H&P?

CC: “chest pain”

HPI: is a 76 yo man with h/o HTN, DM, and sleep apnea who presented to the ED complaining of chest pain. He states that the pain began the day before and consisted of a sharp pain that lasted around 30 seconds, followed by a dull pain that would last around 2 minutes. The pain was located over his left chest area somewhat near his shoulder. The onset of pain came while the patient was walking in his home. He did not sit and rest during the pain, but continued to do household chores. Later on in the afternoon he went to the gym where he walked 1 mile on the treadmill, rode the bike for 5 minutes, and swam in the pool. After returning from the gym he did some work out in the yard, cutting back some vines. He did not have any recurrences of chest pain while at the gym or later in the evening. The following morning (of his presentation to the ED) he noticed the pain as he was getting out of bed. Once again it was a dull pain, preceded by a short interval of a sharp pain. The patient did experience some tingling in his right arm after the pain ceased. He continued to have several episodes of the pain throughout the morning, so his daughter-in-law decided to take him to the ED around 12:30 pm. The painful episodes did not increase in intensity or severity during this time. At the ED the patient was given nitroglycerin, which he claims helped alleviate the pain somewhat. has not experienced any shortness of breath, nausea, or diaphoresis during these episodes of pain. He has never had chest pain in the past. He has been told “years ago” that he has a right bundle branch block and premature heart beats.

PMH
Active medical problems:
- HTN
- Diabetes
- Sleep apnca
Past surgeries
- cervical fusion of C3-C7 with laminectomy
- bilateral knee replacement
Medications – obtained from Med list that patient brought in
- Hyzaar 100/25MG QD
- Furosemide 20MG QD
- Tramadol HCL 50MG QD
- Exotrin 81mg QD
- Calcium 333MG, Magnesium 133MG, Zinc 5MG QD
- Vitamin C 500MG 3 tablets daily
- Vitamin E 400 IU QD
- Beta Carotene 25,000 IU QD
Allergies
- Penicillin: anaphylaxis/swelling of face
- Scallops: anaphylaxis/swelling of face

Family History
- Mom: died due to complications of childbirth when pt was 6; health problems unknown by patient
- Dad: died in 70's due to heart disease; other health problems unknown by patient
- Brother: healthy
- 4 children: 1 son has h/o non-hodgkin's lymphoma

Social History
Pt is a retired [redacted] who lives in Chapel Hill with his wife. He denies smoking and illicit drugs. He drinks 3-4 alcoholic drinks each week.

ROS
General: no fever, no chills, no sweat. 15 pound weight loss recently. No fatigue.
Eyes/Ears/Nose/Mouth/Throat: no vertigo, no vision changes, no eye pain. No neck stiffness. Pt denies sour taste in back of throat/regurgitation. He denies reflux/heart burn.
Cardiovascular: recent chest pain-not substernal. No shortness of breath, no palpitations, no edema. No syncope.
Respiratory: occasional nonproductive cough. No hemoptysis. No wheeze.
GI: no N/V, diarrhea, blood per rectum. No abdominal pain. No change in bowel habits
Genitourinary: occasionally has incomplete voiding. Some difficulty initiating urination.
MSK: rotator cuff injury to right shoulder. No pain or swelling of joints. No cramps.
Neuro: no headaches. no confusion or slurred speech. No tremor. Some tingling in right arm after episode of chest pain.
Psychiatric: no depression or change in mood.

Physical Exam
Vitals: BP 108/58 (was 147/62 at presentation to ED); HR 72; RR 12; O2 sat 97% on 2L
General: well appearing elderly man. NAD
HEENT: PERRL. Clear sclera. No rhinitis. Moist mucous membranes of oral cavity
Lymph nodes: no lymphadenopathy
Cardio: RRR. S1, S2 normal without murmur/gallop/rub. No S3, S4. chest pain elicited with palpation of left chest
Labs
Na 135
K 4.1
Cl 98
Bicarb 26
BUN 21
Cr 1.2
Glucose 280
CK 143
CK-MB 5.4
Troponin <0.029
PT 10.3
INR 0.9
PTT 27.5
D-Dimer 311
WBC 4.6
Hgb 13.4
HCT 37.8
PLT 205
EKG: premature atrial complexes, otherwise normal

Problem List
1. chest pain
2. HTN
3. Diabetes
4. sleep apnea

Assessment
This is a 76 yo gentleman with PMH significant for HTN, DM, and sleep apnea who presented to the ED with 1 day history of intermittent chest pain.

Differential Diagnosis of chest pain
1. MI
Myocardial infarction occurs when blood supply to the myocardium via coronary arteries is interrupted resulting in ischemia. Risk factors for a MI are atherosclerosis, angina, previous MI or stroke, older age, smoking, hyperlipidemia, diabetes, HTN, obesity, etc. A patient that is having an acute myocardial infarction will typically present with substernal chest pain that may radiate to the shoulder, jaw, or arm as well as SOB, N/V, palpitations, and diaphoresis. On EKG there will be evidence of ST elevation or
So What’s in Your H&P?

Patient: [Redacted]
Date of Admission: 11/28/06

CC: Increased weakness and slurred speech

HPI:
The patient is a 61 yo gentleman with h/o CVA in September 2005, hypertension, hyperlipidemia, type 2 diabetes, seizure d/o, and cocaine abuse who presents with increased global weakness, slurred speech, and altered mental status. At approximately 4:00 AM, the patient was found by wife sitting on the couch, unable to stand up, respond appropriately to questioning, or speak clearly. The room was in disarray, possibly indicating a fall of some kind, and there was also evidence of urinary incontinence with a wet area on the couch. On presentation to the ED, the patient was found to have right upper and lower extremity weakness, slurred speech, and disorientation. The patient was unable to explain most of the night’s events but did state that he fell on his buttocks. He also thought he was speaking funny despite knowing what he wanted to say. Although patient did have some residual right sided weakness from the previous stroke that requires the use of a cane, wife noted that this episode was markedly worse in terms of lower extremity strength and ambulation. Patient endorses significant cocaine use and noncompliance with medications since May 2006. When seen in ED at 11:30 AM, patient at baseline per wife. Patient denies head trauma, headache, change in vision, nausea, and vomiting. No dizziness, SOB, chest pain, or palpitations. Patient denied urinary incontinence despite evidence described above.

PMHx:
* CVA: September 2005
  * MRI w/o contrast: acute lacunar strokes in anterior basal ganglia and internal capsule on left and in the left central pons; nonspecific small area of enhancement in right basal ganglia possibly from subacute strokes; old encephalomalacic changes in both frontal lobes
  * Bilateral carotid u/s: negative study – no atherosclerotic plaque seen in either bifurcation region
  * On d/c, started on baby aspirin x 2 per day; discontinued by patient
* HTN: Long standing h/o uncontrolled hypertension, currently untreated
* Hyperlipidemia: last fasting lipid panel in 1/06; total cholesterol at 178, triglycerides at 127, HDL at 42, LDL at 111; now untreated due to medication noncompliance. Current guidelines of ATP III place goal LDL at ~100 with DM as CHD equivalent risk factor and optimally less than 70.
* DM type 2: diet controlled. Last HbA1c in 1/06 at 5.6. No known neuropathy/retinopathy/nephropathy. No previous labs seen for urinary microalbumin, last ophthalmology appt “a while ago”.
History and Physicals Tag A-359

- Standard: The bylaws must include an updated exam of the patient within 24 hours after admission and within 30 days before admission or registration
  - Exam must also include it is reviewed before surgery
- Must make sure that the H&P is documented in the medical record
- Repeats many of the same provisions listed in tag 358 including must be done by one C&P by MS to perform
- Reiterates must be on chart prior to surgery or a procedure requiring anesthesia
A-0359

(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

[The bylaws must:]

482.22(c)(5) - [Include a requirement that --]

(ii) An updated examination of the patient, including any changes in the patient’s condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

Interpretive Guidelines 482.22(c)(5)(ii)

The Medical Staff bylaws must include a requirement that when a medical history and physical examination has been completed within 30 days before admission or registration, an updated medical record entry must be completed and documented in the patient’s medical record within 24 hours after admission or registration. The examination must be conducted by a licensed practitioner who is credentialed and privileged by the hospital’s medical staff to perform an H&P. In all cases, the update must take place prior to surgery or a procedure requiring anesthesia services. The update note must document an
The physicians or LIPs use their clinical judgment,

Based upon his/her assessment of the patient’s condition and co-morbidities, if any,

In relation to the patient’s planned course of treatment to decide the extent of the update assessment needed

As well as the information to be included in the update note in the patient’s medical record.
Again if physician or practitioner finds no change then he or she may chart

- H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed (71 FR 68676)

if the practitioner finds that the H&P done before admission is incomplete, inaccurate, or otherwise unacceptable,

- The practitioner reviewing the H&P, examining the patient, and completing the update may disregard the existing H&P, and conduct and document in the medical record a new H&P
Any changes would need to be documented in the update note and placed in the medical record.

If patient going to surgery the updated note must be in the chart before the surgery or a procedure requiring anesthesia.

If patient admitted updated note must appear in the chart and within the 24 hours of registration or admission.

This one also has a survey procedure which instructs the surveyor to observe the following 3 things.
Survey Procedures §482.22(c)(5)(ii)

- Review the medical staff bylaws to determine whether they include provisions requiring that, when the medical history and physical examination was completed within 30 days before admission or registration, an updated medical record entry documenting an examination for changes in the patient's condition was completed and documented in the patient's medical record within 24 hours after admission or registration.

- Determine whether the bylaws require that, in all cases involving surgery or a procedure requiring anesthesia services, the update to the H&P must be completed and documented prior to the surgery or procedure.

- In the sample of medical records selected for review, look for cases where the medical history and physical examination was completed within 30 days before admission or registration. Verify that an updated medical record entry documenting an examination for any changes in the patient's condition was completed and documented in the patient’s medical record within 24 hours after admission or registration. Verify that in all cases involving surgery or a procedure requiring anesthesia services, the update was completed and documented prior to the surgery or procedure.
Tag numbers 358 and 359 are in the Medical Staff chapter

CMS also has tag numbers 458 and 461 on H&P that appears in the Medical Records section

Tag 952 in surgery services

Tag 458 and 461 both updated June 7, 2013

Contains many of the same sections as discussed previously

Standard: All medical records must document evidence of the history and physical
482.24(c)(4) - All records must document the following, as appropriate:
   (i) Evidence of--

   (A) A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient’s medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

Interpretive Guidelines §482.24(c)(4)(i)(A)

The medical record must include documentation that a medical history and physical examination (H&P) was completed and documented for each patient no more than 30 days prior to hospital admission or registration, or 24 hours after hospital admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services.
History and Physicals Tag 458

- Same requirements
  - Completed within 24 hours of admission
  - No older than 30 days
  - Updated prior to surgery or a procedure requiring anesthesia
  - Same survey procedures where surveyor is instructed to check to make the above is complied with
History and Physicals Tag 461

- Standard: All medical records must document evidence that the updated examination of the patient is done
  - If H&P is completed within 30 days
  - If admitted then H&P documented within 24 hours
  - Updates documented prior to surgery or procedure requiring anesthesia
  - If patient readmitted within 30 days can use the H&P document and show update
  - Reiterated how to document no change
Tag 461 in Medical Records on H&P

A-0461
(Rev. 95, Issued: 12-12-13, Effective: 06-07-13, Implementation: 06-07-13)

482.24(c)(4) - [All records must document the following, as appropriate:

(i) Evidence of --]

(B) An updated examination of the patient, including any changes in the patient’s condition, when the medical history and physical examination are completed within 30 days before admission or registration. Documentation of the updated examination must be placed in the patient’s medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

Interpretive Guidelines §482.24(c)(4)(i)(B)

When an H&P is completed within the 30 days before admission or registration, the hospital must ensure that an updated medical record entry documenting an examination for any changes in the patient’s condition is placed in the patient’s medical record within
Surgery Section Tag 952

- CMS has a 5\textsuperscript{th} tag number with H&P requirements at Tag 952

- Standard: Prior to surgery, or a procedure requiring anesthesia a H&P
  - Must be completed within 24 hours after admission or registration
  - If done within 30 days before
  - Just provide an update prior to surgery
  - Surveyor to assess if done timely
  - So repeats same sections as discussed
§482.51(b) (1) - Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies:

(i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration.

(ii) An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration.

Interpretive Guidelines §482.51(b)(1)
CMS Clarified H&P in a Memo

- CMS publishes 75 pages of proposed changes to the hospital CoPs in 2012
  - 18 pages if you use the three column PDF version
- Contained in the Federal Register on October 24, 2011
  - Vol. 76, No. 205, Starts at page 65891
- This resulted in more than 2 dozen important changes which were effective June 7, 2013
- Clarified H&P in the memo
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482 and 485
[CMS-3244-P]
RIN 0938-AQ89

Medicare and Medicaid Programs:
Reform of Hospital and Critical Access Hospital Conditions of Participation

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services.

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the requirements that hospitals and critical access hospitals (CAHs) must meet to participate in the Medicare and Medicaid programs. These proposed changes are an integral part of our efforts to reduce procedural burdens on providers. This proposed rule reflects the Centers for Medicare and Medicaid Services’ (CMS’) commitment to the general principles of the President’s Executive Order 13563, released January 18, 2011, entitled “Improving Regulation and Regulatory Review.”

DATES: To be assured consideration, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:


b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-9944 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed site as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

Acronyms

AHA American Hospital Association
AOA American Osteopathic Association
APRN Advanced Practice Registered Nurse
BBA Balanced Budget Act
CAH Critical Access Hospital
CGN CMS Certification Number
CDC Centers for Disease Control and Prevention
C/C Condition for Coverage
CoP Condition of Participation
CMS Centers for Medicare & Medicaid Services
DNV Det Norske Veritas
EACH Essential Access Community Hospital
H&P History and Physical Examination
HAI Healthcare-Associated Infection
HFAP Healthcare Facilities Accreditation Program

CMS Clarified H&P

stakeholders. We are specifically seeking comment on this issue.

Medical Record Services (§ 482.24)

We considered modifying the regulatory requirement at current § 482.24(c)(2) to clarify the intent of the rule in situations where a patient has received a medical history and physical examination (H&P) by either a non-hospital practitioner or a practitioner with hospital privileges prior to the patient’s hospital visit. When an H&P has been completed for a patient within the most recent 30-day period prior to the patient’s admission or registration, the current regulation requires a hospital to ensure documentation of, “[a]n updated examination of the patient, including any changes in the patient’s condition. ** **”

We believe that some stakeholders may be interpreting our current requirements in a way that would require a hospital to conduct a full update to an H&P that was conducted within 30 days prior to the patient’s admission or registration. As put forth in our November 27, 2006 final rule related to this issue (“Medicare and Medicaid Programs: Hospital Conditions the planned course of treatment. If, upon examination, the licensed practitioner finds no change in the patient’s condition since the H&P was completed, he/she may indicate in the patient’s medical record that the H&P was reviewed, the patient was examined, and that “no change” has occurred in the patient’s condition since the H&P was completed. We note that we do not specify the extent of the examination that must be conducted; rather, we defer to the clinical judgment of hospital staff to determine the extent of the necessary H&P update. We believe that our interpretation of the H&P update requirement assures that all patients undergoing surgery or anesthesia are properly evaluated for all contraindications in accordance with the clinical judgment of hospital staff without an undue duplication of services and documentation. Therefore, we do not believe that the regulation should be amended. We are specifically seeking comment on this issue.

Physical Environment (§ 482.41)

Currently, hospitals are required to meet the standards of the 2000 edition of the Life Safety Code (LSC), which is
Clarifying Changes  H&P

- History and Physicals is a hot spot with CMS
- CMS wants to clarify the intent of the rule where a H&P is done by a non-hospital practitioner or a practitioner with hospital privileges prior to the patient’s hospital visit
- The H&P must be no older than 30 days
- The H&P must be updated the day of surgery
- CMS thinks that some may think a full H&P is required when only an updated H&P for changes is required
CMS says a hospital may adopt a P&P allowing a H&P to be used by a practitioner who may not be a member of the hospital's MS or who does not have admitting privileges by that hospital, or by a QLP who does not practice at that hospital but is acting within his/her scope of practice under State law or regulation.

- The H&P can be updated for any changes.
- The exam must be conducted by a practitioner who is C&P to perform the H&P by the hospital MS.
Clarifying Changes H&P

- The update note to the H&P must document the examine for any changes since the H&P was initially done.

- If the practitioner finds no change then the following can be documented:
  - The patient was examined, the H&P was reviewed and that no change has occurred in the patient's condition since the H&P was completed.

- The extent of the exam is not specified and CMS leaves it to the clinical judgment of the hospital staff.
  - Includes patients undergoing surgery or anesthesia.
Critical Access Hospital CoP Sections on H&P
State Operations Manual
Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 110, 04-11-14)

Transmittals for Appendix W

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Survey Protocol

Regulations and Interpretive Guidelines for CAHs

§ 485.608 Condition of Participation: Compliance With Federal, State, and Local Laws and Regulations
§ 485.608(a) Standard: Compliance With Federal Laws and Regulations
§ 485.608(b) Standard: Compliance With State and Local Laws and Regulations
§ 485.608(c) Standard: Licensure of CAH
CAH Tag 305 and 320

- Critical Access Hospitals have a separate hospitals CoP manual
- Always make sure the hospital has the correct manual
- Sections on H&P in tag 305 and 320
- Section much shorter than regular hospitals under Appendix A
- If 10 bed rehab unit or behavioral unit must follow Appendix A for larger hospitals and not CAH manual under Appendix W
History and Physicals  CAH Only  C-305

- All or part of H&P must be delegated to other practitioners if allowed by state law and CAH
  - Such as NP or PA
- However MD/DO assume full responsibility
- MD/DO must also sign
- Surveyor will look at bylaws to determine when H&P must be done
- Make sure H&P on chart before patient goes to surgery unless an emergency
- Important issue with CMS and TJC
Tag 305 In CAH Manual

C-0305

§485.638(a)(4)(ii) Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;

Interpretive Guidelines §485.638(a)(4)(ii)

All or part of the history and physical exam (H & P) may be delegated to other practitioners in accordance with State law and CAH policy, but the MD/DO must sign the H & P and assume full responsibility for the H & P. This means that a nurse practitioner or a physician assistant meeting these criteria may perform the H & P.

Survey Procedures §485.638(a)(4)(ii)

- Determine that the bylaws require a physical examination and medical history be done for each patient.

- For sampled records, does the appropriate practitioner sign reports of physical examinations, diagnostic and laboratory test results, and consultative findings?
H&P CAH Only C-320

- Complete H&P must be done in accordance with acceptable standards of practice
- H&P must be documented in medical record
- Must be in the chart prior to surgery unless it is an emergency
  - If emergency need VS, critical information about patient’s condition, must include cardiovascular status and pulmonary status
- All or part may be delegated to other practitioners if allowed by your state law and CAH
  - Like PA or NP
- Surgeon must sign and assumes full responsibility
Tag 320 in CAH Manual

Pre-Operative History and Physical (H & P)

A complete history and physical must be conducted in accordance with acceptable standards of practice, and the written document placed on the medical record, prior to surgery. All or part of the H & P may be delegated to other practitioners in accordance with State law and CAH policy, but the surgeon must sign the H & P and assume full responsibility for the H & P. This means that a nurse practitioner or a physician assistant, meeting these criteria, may perform the H & P.

In all circumstances, when an H & P has been conducted, but is not present on the chart prior to surgery, or in emergency situations where a complete H & P cannot be conducted prior to surgery, a brief admission note on the chart is necessary. The note should include at a minimum critical information about the patient’s condition including pulmonary status, cardiovascular status, BP, vital signs, etc.
The Joint Commission H&P Standards

The Medical Staff, Record of Care, and Provision of Care Standards
Standard states that hospital must assess and reassess the patients and their conditions according to defined time frames.

EP4 Requires that the H&P be no more than 30 days old and done within 24 hours after registration or inpatient admission.

But prior to surgery or a procedure requiring anesthesia.

EP5 Must be done within 24 hours after registration or admission.

H&P must be updated prior to surgery.
RC.02.01.03 Document H&P

- RC.02.01.03 States the patient’s medical record documents operative or other high risk procedures and the use of moderate and deep sedation and anesthesia.

- EP3 Must document the H&P in medical record before an operative or high risk procedure is performed.
MS.01.01.01  H&Ps

- MS.01.01.01 States that MS bylaws address self governance and accountability to the board
- EP16 Requires H&P process be in MS bylaws
- This includes the requirements for completing and documenting medical histories and physical exams
- It must be done by a physician or other qualified licensed individual
- Must be licensed in according to state law and hospital policy
This standard says the medical staff oversees the quality of patient care and treatment provided by practitioners privileged through the MS process.

- EP6 MS must specify the minimal content of H&Ps
  - Can vary by setting, level of service, treatment & services
- EP7 MS must monitor the quality of the H&Ps
- EP8 Medical staff requires persons to be privileged to do H&P and also to do the required updates
EP9 The medical staff may allow individuals who are not LIPs to perform part or all of the H&P as permitted by both state law and hospital policy.

- This can be done under the supervision of, or appropriate delegation by, a qualified physician who is accountable for the patient’s H&P.

EP10 MS defines when it must be validated and countersigned by LIP with appropriate privileges.
TJC MS.03.01.01 H&P

- EP11 MS defines the scope of the medical history and physical exams when required for non-inpatient services

- TJC has a number of FAQs on H&Ps
  - Delegation of H&P
  - H&P for outpatient procedures
  - Medical students doing H&Ps
  - Delegation to PA or NP
  - Podiatrist or dentist doing H&P
  - Authentication of H&P
Delegation to PA or NP

Medical Staff (CAMH / Hospitals)

Delegation of the History and Physical Examination

Q: Can the responsibility for performing the admission history and physical examination be delegated to a practitioner such as an advanced practice nurse, physician's assistant, or registered nurse who are not licensed independent practitioners?

A: Typically, this delegation is limited to the physician’s assistant or the advance practice nurse practitioner. However, before allowing the responsibilities of an Licensed Independent Practitioner to be performed by a non-Licensed Independent Practitioner the organizations must determine and be able to demonstrate whether state laws and regulations and professional practice acts allow the such delegation and under what circumstances.

If it is determined that state law and regulation and professional practice acts allow delegation of the Licensed Independent Practitioner history and physical examination, the exam can be delegated, provided:

- the organization has appropriate policies and procedures
- such delegation meets pertinent requirements for the type of history and physical examination required by the organization
- the non-licensed independent practitioner has received specific training to perform an appropriate history and physical examination
- the organization has defined and verified that the non-licensed independent practitioner has the appropriate competence to perform a history and physical examination as defined by organization policy and procedures or other documents
- the medical history and physical examination is performed under the supervision of, or through appropriate delegation by, a specific qualified physician who countersigns in accordance with law, regulation and organizational policy, and retains accountability for the patient’s medical history and physical examination.
- the person is specifically permitted by the organization to perform the history and physical either:

  - as part of the supervising/delegating physician’s privileges, or
  - through an specific alternate process, such as that utilized by the organization for allied health practitioners.
Q. Can the organization utilize a history and physical that has been performed by someone who is not authorized/privileged by the organization?

A. The organization can have a policy that would permit the use of a history and physical examination performed by any practitioner permitted by state law.

In this situation a practitioner who is authorized/privileged by the organization, (as permitted by state law and organization policy) and familiar with the organization's policy for the defined minimal content of the H & P must:

- review the history and physical examination document;
- determine if the information is compliant with the organization's defined minimal content;
- obtain missing information through further assessment;
- update information and findings as necessary, which may include, but are not limited to:
  - inclusion of absent or incomplete required information
  - a description of the patient's condition and course of care since the history and physical examination was performed
  - a signature and date on any document with updated or revised information as an attestation that it is current.
H&P for Outpatient Procedures

History And Physical For Hospital Outpatient Procedures

Q. Do patients receiving non-inpatient services such as outpatient surgery, therapy services, laboratory and x-ray service require a history and physical?

A. In the hospital manual, MS.03.01.01 states "the organized medical staff defines the scope of the medical history and physical examination when required for non-inpatient services". The intent is that the medical staff could define only certain circumstances, such as certain type of outpatient surgeries or procedures such as angiograms, that might require a history and physical.

The medical staff can also define the scope of the assessment. For example, the pertinent relevant history for outpatient surgery for a detached retina might be defined to include only, the history of the trauma or activity that resulted in the detachment, the patient's history of cardiac and respiratory history and current medications to determine appropriate choice of anesthesia, and an assessment of the current condition of the retina and the patient's current vital signs. The pertinent, relevant history for an angiogram might be defined to include a history of cardiovascular problems including chest pain or tightness, medication history, and appropriate lab work.
A. A medical student has no legal status as a provider of health care services. The organization should have policies and procedures which address the activities of medical or other students and what documentation from students can be entered into the record.

With regard to whether a history and physical by a medical student can fulfill the requirements for a history and physical as required the history and physical entered into the record must be performed, documented and authenticated by a practitioner with privileges to do so, or delegated to a non-LIP when allowed by law and regulation (see the FAQ "Delegation of the History and Physical"). Since the medical student is not an LIP, the H & P by the medical student would not fulfill the requirements.

In addition, it may be acceptable, in accordance with organization policy and law and regulation, for students to perform certain patient care activities under the direct supervision of a qualified LIP who enters and countersigns appropriate documentation in the medical record, as required by organization policy, and accepts legal accountability for those activities and documentation.
Delegation of the History and Physical Examination

Q: Can the responsibility for performing the admission history and physical examination be delegated to a practitioner such as an advanced practice nurse, physician's assistant, or registered nurse who are not licensed independent practitioners?

A: Typically, this delegation is limited to the physician's assistant or the advance practice nurse practitioner. However, before allowing the responsibilities of an Licensed Independent Practitioner to be performed by a non-Licensed Independent Practitioner the organizations must determine and be able to demonstrate whether state laws and regulations and professional practice acts allow the such delegation and under what circumstances.

If it is determined that state law and regulation and professional practice acts allow delegation of the Licensed Independent Practitioner history and physical examination, the exam can be delegated, provided:

- the organization has appropriate policies and procedures
- such delegation meets pertinent requirements for the type of history and physical examination required by the organization
- the non-licensed independent practitioner has received specific training to perform an appropriate history and physical examination
- the organization has defined and verified that the non-licensed independent practitioner has the appropriate competence to perform a history and physical examination as defined by organization policy and procedures or other documents
- the medical history and physical examination is performed under the supervision of, or through appropriate delegation by, a specific qualified physician who countersigns in accordance with law, regulation and organizational policy, and retains accountability for the patient's medical history and physical examination.
- the person is specifically permitted by the organization to perform the history and physical either,
  - as part of the supervising/delegating physician's privileges, or
  - through an specific alternate process, such as that utilized by the organization for allied health practitioners.
Podiatrist and Dentists Doing H&P

Medical Staff (CAMH / Hospitals)

Podiatrists and Dentists Performing the Entire History and Physical for Inpatient and Outpatient Care

Q: Can Podiatrists and Dentists perform the entire history and physical for a patient admitted for inpatient and outpatient care?

A: Yes. The standard requires only that the H&P be performed by a practitioner who has been granted privileges to do so.
Provision of Care, Treatment, and Services (CAMH / Hospitals)

Authentication of the H&P in 24 Hours

Q: Does a dictated and transcribed history and physical need to be authenticated within 24 hours in order to be considered complete?

A: No. Each patient must have a history and physical performed and documented within 24 hours of admission as an inpatient. This includes weekend and holidays. History and physicals are dictated, transcribed, authenticated and placed in the medical record, based on organizational policy.

When there is a transcription delay, a handwritten note signed by the licensed independent practitioner and placed in the medical record containing pertinent findings, (i.e., enough information on the patient record within 24 hours of admission for clinicians to manage the patient and guide the plan of care) would be acceptable.
Q. What specific data must be included in the history and physical?

A. The standards do not specify the content for the H&P, this is determined by the organization's medical staff. The data should be pertinent and relevant and should include sufficient information necessary to provide the care and services required to address the patient's conditions and needs and may vary by setting or level of care, treatment, and services. As such, the specific data could be different for populations, or setting of care, treatment or services.
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The End! Questions?

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