On the Line: Professional Practice Solutions (10/02)

by Beth Hjort, RHIA

Q: When are history and physical (H&P) requirements for outpatients necessary?

A: The scarcity of specific resources on this topic contributes to the difficulty of guidelines development. However, a number of standards and requirements, taken collectively, offer guidance.

The Joint Commission covers the expectation of good practice with H&P documentation for all patients in both the *Comprehensive Accreditation Manual for Hospital* (CAMH) and the *Comprehensive Manual for Ambulatory Care* (CAMAC). The intent of IM.7 through IM.7.2 states: "To establish facility consistency and continuity of patient care...Medical records contain sufficient information to: identify the patient, support the diagnosis, justify the treatment, document the course and results, and facilitate continuity of care." This is accomplished and retrospectively validated in part by pertinent initial assessment, documented in an H&P report.

CAMH standard PE.1.8 and CAMAC standard PE.1.9.1 describe the H&P before surgery for all patients this way: "the patient's physical examination and medical history, any indicated diagnostic tests, and a preoperative diagnosis are completed and recorded in the patient's medical record."

CAMH standard MS.6.3 states: "The medical staff determines those non-inpatient services (for example, ambulatory surgery), if any, for which a patient must have a medical history taken and appropriate physical examination performed by a qualified physician who has such privileges, except as provided for in MS.6.2.1 through MS.6.2.2.3 (oral surgeons, dentists, podiatrists, other LIPs)." The decision for scope of H&P assessment is a clinical one with quality of patient care as the driving force. Organization compliance with its own minimal documentation requirements shows that precautions have been taken on behalf of the patient. Notable and valuable side benefits are liability protection, evidence of medical necessity, and reimbursement impact.

Often in practice, type of anesthesia has been used as an indicator for establishing H&P scope requirements, indicating increasing procedure complexity and risk to the patient. Some organizations also factor in procedure invasiveness. CAMH standard TX.2 indirectly addresses the availability of an H&P for three categories of procedural patients: those undergoing moderate sedation/ analgesia (conscious sedation), deep sedation/analgesia, and anesthesia. In this standard, expectations are noted that include competency to evaluate patients prior to performing sedation and anesthesia. The H&P is a critical tool in the evaluation.

Medicare Conditions of Participation for Ambulatory Surgery require "complete, comprehensive, and accurate medical records to ensure adequate patient care" and define the contents of an ambulatory surgery record to include "significant medical history and results of physical examination."

When a physician group convenes to establish medical staff requirements, an important question to consider is how much risk the physicians and the organization are willing to carry. It is prudent to involve risk management and quality management in this process.

HIM professionals have significant flexibility in guiding their organizations in development of H&P requirements. Limited directives exist for H&P scope; no directives exist for format or whether reports should be written or dictated.

The Accreditation Association for Ambulatory Health Care (AAAHC) standards itinerate criteria for inclusion in the medical record such as chief complaint or purpose of visit, diagnosis or impression, and allergies. H&P inclusion in the medical record is directed.

AHIMA recommends establishment of requirements that ensure applicable H&P documentation for all outpatients. It is recommended that existing directives be extended to all patients regardless of sedation, anesthesia, or invasiveness by minimally involving clinical assessment and documentation of the area or system for which non-procedural treatment is sought or affected by a procedure, as well as any other body systems pertinent to a particular patient's welfare. Pre-formatted forms may prove helpful for documentation consistency. HIM professionals should ensure inclusion of any impacting state laws or regulations in organizational requirements.

Networking with HIM colleagues on customizable approaches can be very helpful for bringing starting options to the decision-makers. AHIMA's Acute Care Community of Practice members have discussed and shared documents on this subject within discussion groups. Use the search feature located on your personal page or within any community of practice to search across all communities. Or start a new discussion thread within a familiar community.

Whatever conclusions your organization reaches for H&P documentation requirements, be sure the expectations are recorded in the medical staff rules and regulations. Besides creating consistent documentation expectations for the medical staff, these requirements set a foundation for record analysis and performance improvement measurement.

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Article citation:
Hjort, Beth. "On the Line: Professional Practice Solutions." *Journal of AHIMA* 73, no.9 (2002): 90-1.