REPORT OF THE BOARD OF TRUSTEES

B of T Report 37-A-18

Subject: Eliminate the Requirement of H&P Update (Resolution 710-A-16)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates (HOD), Board of Trustees (BOT) Report 18-A-17, “Eliminate the Requirement of H&P Update,” was referred for report back at the 2018 Annual Meeting. BOT Report 18-A-17 concerned Resolution 710-A-16, “Eliminate the Requirement of H&P Update,” which was referred during the 2016 Annual Meeting. Resolution 710-A-16, sponsored by Ohio Delegation, asked our American Medical Association (AMA) to work to change the Centers for Medicare & Medicaid Services’ (CMS) Medicare Conditions of Participation (COP) regulations governing the medical history and physician examination update and documentation requirements (H&P update) prior to surgery or a procedure as follows:

Change regulation 42 C.F.R. section 482.24 (c)(4)(i)(B) to read as follows:

When the medical history and physical examination are completed within thirty days before admission or registration, documentation of an updated examination of the patient must be placed in the patient’s medical record within twenty-four hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, only if any changes have occurred in the patient’s condition.

Change regulation 42 C.F.R. section 482.51(b)(1)(ii) to read as follows:

When the medical history and physical examination are completed within thirty days prior to admission or registration, an updated examination of the patient must be completed and documented within twenty-four hours of admission or registration only if any changes have occurred in the patient’s condition.

At the 2016 Annual Meeting, the HOD supported referral of Resolution 710-A-16 because testimony was mixed and the topic involved clinical, legal, and regulatory considerations. The sponsoring delegation testified that physicians should not have to document “no change” in the patient’s H&P update on the day of a procedure or surgery. Other testimony emphasized the importance of documenting updates on the date of surgery and potential risks associated with not documenting changes or “no change” in the patient’s condition. One speaker noted that H&P update requirements are not particularly burdensome to physicians. Additional speakers noted the complexity of the issues brought up by Resolution 710-A-16, and that patient needs may differ depending on their health and the procedures they are receiving.

BOT Report 18-A-17 recommended that Resolution 710-A-16 be adopted and noted that:
The H&P update requirement constitutes a compliance burden for physicians when a patient’s health status remains unchanged without a direct clinical benefit. It is reasonable to create a regulatory presumption that the H&P update was performed and remained unchanged if documentation to the contrary is not provided. Qualified individuals with privileges would still have to document when changes have occurred; thereby, safeguarding patient safety and ensuring a basic standard of care is met.

At the 2017 Annual Meeting, the HOD supported referral of BOT Report 18-A-17 because testimony was mixed—but mostly negative. While there was some support for the report’s recommendations, a preponderance of the testimony expressed concerns about adopting Resolution 710-A-16. Testimony emphasized the importance of documenting the H&P updates on the day of a procedure or surgery and the potential risks associated with not documenting these encounters. A speaker noted that failing to document the H&P update would be a violation of conventional risk management practices. Others questioned whether the documentation is in fact an H&P update. The importance of pre-operative visits was also emphasized, and it was noted that patients can change their minds about surgeries at the last minute. Because a preponderance of the testimony was in opposition to the report’s recommendation, the Reference Committee believed clarification was needed and recommended that it be referred for decision at the 2018 Annual Meeting.

AMA POLICY

The AMA does not have policy that is directly applicable to whether the documentation requirements of the H&P update are appropriate or not. There is, however, policy that is germane to the issue of medical record authentication in the context of physical examinations, though it provides for a streamlined approach—namely a single signature to authenticate a host of services and procedures provided to a patient. Policy H-225.965, “Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record,” reads:

The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations, and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record.

DISCUSSION

Although H&P update requirements constitute a small administrative burden for physicians when a patient’s health status remains unchanged, it is good medical practice and risk management. Also, the current regulatory requirement was issued as an alternative to a more onerous proposed Medicare requirement that would have hindered patient access to care. (See discussion below.) Furthermore, if there is a poor patient outcome, the H&P update provides compelling evidence that an H&P update (even if there is no change in status) was performed and demonstrates compliance with Medicare COP during an investigation.

In order to participate in the Medicare program, health care providers, such as hospitals, must comply with statutory and regulatory COP requirements. The COP are established through notice and comment rulemaking and represent Medicare’s minimum health and safety standards. CMS ensures compliance by conducting (or contracting with state health survey agencies to conduct) scheduled or unscheduled investigations (called surveys) to assess compliance. These surveys will include sampling and review of patient records, standard operating procedures, and associated documentation among other survey activities. Alternatively, hospitals may receive certification to
participate in the Medicare program by obtaining accreditation from an accrediting body approved by CMS. Accredited institutions are deemed to meet all of the Medicare COP, with some exceptions. Currently, CMS-approved accrediting bodies for hospitals include, but are not limited to, The Joint Commission and the American Osteopathic Association.

In 2006, CMS issued a final rule, titled: The Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations. The final rule incorporated requested changes that reduced compliance burdens on patients and physicians.

Among other things, the final rule expanded the timeframe for completion of the pre-operative H&P to 30 days and expanded the number of permissible professional categories of individuals who may perform the history and physical examination. The final rule also required that all orders, including verbal orders, be dated, timed, and authenticated by a practitioner responsible for the care of the patient. The proposed rule would have required the pre-operative H&P to be completed only by a physician credentialed by the medical staff at the admitting hospital. For many patients, this would have excluded their primary care provider, who may not be credentialed and privileged at the admitting hospital. CMS struck this requirement and put an alternative requirement in place as outlined below:

If a patient’s H&P is completed before admission to the hospital, an updated examination must be completed and documented in the patient’s medical record within 24 hours after admission, but before a surgical procedure. This update to the H&P would be completed after the patient is admitted to the hospital by a physician, oromaxillofacial surgeon or other qualified individual who has been granted these privileges by the medical staff in accordance with State law. Therefore, if the H&P was completed by the patient’s primary care provider, the H&P would be reviewed, the patient would be examined, and the H&P would be updated by an individual who has been credentialed and privileged by the medical staff to conduct an H&P. If upon review, the H&P done before admission is found to be 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 a new H&P within 24 hours after admission, but before a surgical procedure. The practitioner completing the update is responsible for ensuring that the H&P documented in the medical record is complete and accurate.

CONCLUSION

The H&P update documentation requirements are utilized to ensure that the physician performing the procedure or surgery attests that the H&P was performed properly, is accurate and up-to-date, and that the patient is deemed to be safe for the planned surgery or procedure. Seeking to reverse this regulatory concession would invite a return to the original proposed rule that the pre-operative H&P must be performed by a physician credentialed and privileged in the admitting hospital. In addition, physicians would no longer have the legal benefit that extends to physicians who are able to demonstrate through documentation that they complied with Medicare COP and accepted standards of care.

RECOMMENDATION

The Board of Trustees recommends that Resolution 710-A-16 not be adopted and the remainder of the report be filed.

Fiscal Note: None.