Consistent Interpretation

Joint Commission Surveyors' Observations Related to Timely Completion of Inpatient History and Physicals

The **Consistent Interpretation** column helps organizations to comply with specific Joint Commission requirements. Each installment of the column draws from a database of surveyors' de-identified observations (left column) on an element of performance (EP)—as well as guidance from the Standards Interpretation Group on interpreting the observations (right column).

The requirements in this column are not necessarily those with high rates of noncompliance. Rather, they have the potential to negatively affect care or create risk if out of compliance. That is, they may appear in the upper right corner of a *Survey Analysis for Evaluating Risk*® (*SAFER*®) Matrix if cited on survey. Featured EPs apply to hospitals; however, the guidance may be extrapolated to apply to other accreditation programs with similar services and populations served.

This month, **Consistent Interpretation** focuses on the medical history and physical examination process.

Note: *Interpretations are subject to change to allow for unique and/or unforeseen circumstances.* P

Noncompliance Implications	Obtaining a medical history and conducting a physical examination when providing care, treatment, and services establishes a patient's overall state of health and informs a plan of care. The history and physical process should identify any underlying conditions and/or comorbidities that may affect the planned course of care, treatment, and services. When completed no more than 30 days prior to inpatient admission or registration (for example, outpatient services), an updated history and physical are required within 24 hours after admission to determine any changes in the patient's condition and to ensure that the most current information is available to the patient care team. If surgery or other procedure requiring anesthesia services is planned, the history and physical and/or update must be completed prior to such procedures. To comply with accreditation and regulatory requirements, the history and physical and/or update must meet the following required elements: ● Include the elements as defined by the medical staff, law, and regulation ● Entered into the medical record ● Available to patient care team members For more information, *see* the following Joint Commission Frequently Asked Questions (FAQ)—History and Physical: ● Understanding the Requirements ● Update Requirements ● Update Requirements When Procedures Are Performed During Inpatient Stay ● Prenatal Record ● Dictated Not Transcribed

Provision of Care, Treatment, and Services (PC) Standard PC.01.02.03: The hospital assess and reassesses the patient and the patient's condition according to defined time frames.	
EP 4: The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. R **Note 1:** ***For hospitals that use Joint Commission accreditation for deemed status purposes:*** *Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead.* **Note 2:** *For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.* (*See also* MS.01.01.01, EP 38; MS.03.01.01, EPs 6, 19; RC.02.01.03, EP 3)	
Compliance Rate	In 2022, the noncompliance percentage for this EP was **10.25%**—that is, **155** of **1,512** hospitals surveyed did not comply with this requirement.

Surveyor Observations	Guidance/Interpretation
• A history and physical were completed more than 30 days prior to admission or registration. • A history and physical were not completed within 24 hours of admission or registration. • A new history and physical were not performed for a patient whose electroconvulsive therapy (ECT) treatments exceeded 30 days.	• For obstetrical patients, the prenatal record may be used as the history and physical if it is updated to reflect the patient's condition at admission or prior to a high-risk or operative procedure. *See* the Prenatal Record FAQ for more information. • Organizations that permit an assessment in lieu of a history and physical for outpatient procedures also must demonstrate compliance with Medical Staff (MS) Standard MS.01.01.01, EP 38,* and MS.03.01.01, EP 19.† • Cite at MS.03.01.01, EP 19, if the organization does not have a policy identifying specific patients for whom an assessment may be used in lieu of a history and physical for an outpatient procedure. • Cite at MS.01.01.01, EP 38, for medical staff bylaws that do not specify that a patient assessment is completed and documented after registration—but prior to surgery or a procedure requiring anesthesia services—when the patient is receiving specific outpatient surgical or procedural services. • Cite at PC.01.02.03, EP 7,‡ for failure to complete and document the patient's assessment after registration/arrival. • A new history and physical are required for patients receiving ECT treatments for more than 30 days. • Cite at MS.01.01.01, EP 5,§ when the history and physical on the medical record are missing required elements as defined by the medical staff bylaws and law and regulation. • Cite at Record of Care, Treatment, and Services (RC) Standard RC.01.03.01, EP 3,¶ when a history and physical are performed within 24 hours of a patient's admission but are not in the medical record.

* Standard **MS.01.01.01, EP 38**: **For hospitals that use Joint Commission accreditation for deemed status purposes:** When the medical staff has chosen to allow an assessment, in lieu of a comprehensive medical history and physical examination, for patients receiving specific outpatient surgical or procedural services, the medical staff bylaws specify that an assessment of the patient is completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the patient is receiving specific outpatient surgical or procedural services.

Note: *For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(i), (ii), (iii), and (v). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.*

(*See also* PC.01.02.03, EP 4)

† Standard **MS.03.01.01, EP 19**: **For hospitals that use Joint Commission accreditation for deemed status purposes:** If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply, in lieu of a comprehensive medical history and physical examination, the policy is based on the following:

- Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure
- Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures
- Applicable state and local health and safety laws

Note: *For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.*

(*See also* PC.01.02.03, EPs 4, 5)

‡ Standard **PC.01.02.03, EP 7**: **For hospitals that use Joint Commission accreditation for deemed status purposes:** When the medical staff has chosen to allow an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the assessment of the patient is completed and documented after registration but prior to surgery or a procedure requiring anesthesia services when the patient is receiving specific outpatient surgical or procedural services. (For more information, refer to Standard MS.03.01.01)

Note: *For further regulatory guidance, refer to 42 CFR 482.24(c)(4)(i)(A) and (B), 482.51(b)(1)(i) and (ii), and 482.22(c)(5)(v). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.*

§ Standard **MS.01.01.01, EP 5**: The medical staff complies with the medical staff bylaws, rules and regulations, and policies.

¶ Standard **RC.01.03.01, EP 3**: **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital records the patient's medical history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services.

EP 5: For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. **R**

Note 1: ***For hospitals that use Joint Commission accreditation for deemed status purposes:*** *Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead.*

Note 2: *For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.*

(*See also* MS.03.01.01, EP 19; RC.02.01.03, EP 3)

Compliance Rate	In 2022, the noncompliance percentage for this EP was **6.08%**—that is, **92** of **1,512** hospitals surveyed did not comply with this requirement.

Surveyor Observations	**Guidance/Interpretation**
● There was no evidence that the history and physical completed prior to admission had been updated within 24 hours of admission. ● There was no evidence that a surgical patient's history and physical completed prior to admission were updated prior to surgery.	● An updated patient examination, including any changes in the patient's condition, must be completed and documented in the medical record when a history and physical are completed prior to admission or registration. ● Cite here, at Standard PC.01.02.03, EP 5, if there is no evidence that an updated examination was completed and entered into the medical record within the required time frame. ● The organization determines the required elements of an updated examination and where this information is documented; for example, a progress note, an addendum to the history and physical, a separate document, and so on. ● For inpatients with extended stays, the daily progress notes serve as the update to the history and physical. A separate update is not required in these cases. For example, a patient has a colon resection on day 4 of the admission.
● Anesthesia providers are not granted permission to conduct the history and physical update prior to surgery according to the organization's medical staff bylaws or rules and regulations. However, prior to surgery, an anesthesia provider completed the update of the history and physical that were performed prior to admission.	● Anesthesia providers may be permitted to perform a history and physical update if the following applies: ❍ The anesthesia provider is privileged to perform histories and physicals (*see* MS.01.01.01, EP 16,* and MS.03.01.01, EPs 2,† and 8‡). ❍ The anesthesia provider documents the minimum required elements as defined by the organization (*see* MS.03.01.01, EP 6,§ and the US Centers for Medicare & Medicaid Services Conditions of Participation beginning with 482.22(c)(5)). ❍ Completing a history and physical/update is within the scope of practice for the anesthesia provider as defined by state law and regulation. ❍ The organization recognizes the anesthesia provider and their documentation as the practitioner eligible to conduct the update.

* Standard **MS.01.01.01, EP 16**: **For hospitals that use Joint Commission accreditation for deemed status purposes:** The medical staff bylaws include the following requirements: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy.

Note: *For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6–11. For more information on completion time of the history and physical examination, refer to Standard PC.01.02.03, EPs 4 and 5.*

† Standard **MS.03.01.01, EP 2**: Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

‡ Standard **MS.03.01.01, EP 8**: The medical staff requires that a physician or other licensed practitioner who has been granted privileges by the hospital to do so performs a patient's medical history and physical examination and required updates.

§ Standard **MS.03.01.01, EP 6**: Ⓓ The organized medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services.

(*See also* PC.01.02.03, EP 4)