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Policy: Use of Patient History Form		

Purpose:

The purpose of this policy is to clarify the appropriate usage of patient history forms to improve the quality of Provider documentation to support code assignment.

Guidelines:

The review of systems (ROS) and past, family, and social history (PFSH) may be recorded on a form completed by the patient. The Provider must review the documentation and there must be a notation supplementing or confirming the information. History of Present Illness (HPI) information on the form is considered preliminary information and must be explored in the documentation by the Provider.

Policy:

- All patient history forms must be approved by the coding and billing office prior to use.
- All patient history forms must be signed and dated by the patient/caregiver when the form is completed.
- Patient history forms must be scanned to the applicable encounter in the EHR.
- If a patient history form is utilized for an encounter, documentation must reflect:
  - The Provider reviewed the documentation
  - Information must be confirmed and/or supplemented by additional information
  - If using a form filled out at a previous encounter, the Provider needs to indicate date of the original encounter, and include a statement affirming that the information has not changed since the previous encounter. This needs to be indicated within the note for each encounter that the form may be used for.
- HPI elements that are documented on the form must be readdressed by the Provider within the note.

Best Practice:

It is best practice for the Provider to sign and date the form that was completed by the patient.

References:

Palmetto GBA Jurisdiction 11 Part B- *E/M Weekly Tip: Review of systems and past/family/social history recorded by the patient* last updated on 11/05/2014.

Palmetto GBA Jurisdiction 11 Part B- *History Component* last updated on 2/21/2014