



HEALTHCARE

# RISK MANAGER

VOLUME 15/NUMBER 2/2009  
GEORGETTE SAMARITAN, RN, AND  
ROSALYN R. BARNES, CPSM, EDITORS

A publication of MAG Mutual Insurance Company's Risk Management & Patient Safety Department

## Medical History: The Cornerstone of the Medical Visit

By: Teresa McMillan, RN, MSA, CPHRM, LHRM & Rodney P. Benefield, Director Practice Management Consulting, MAG Mutual

Although one of the first tasks taught during medical training is how to take a complete and accurate medical history, the poor documentation of this very task is an area that continues to be a challenge to defend during medical liability claims. According to the 2007 PIAA data, approximately 36.2% of the 119,985 claims in the top 10 most prevalent procedures/services for medical liability claims closed between 1985 and 2007; involved the performance of a *diagnostic interview, evaluation or consultation*.<sup>1</sup>

According to a study of 307 closed claims published in *Annals of Internal Medicine*, the leading reasons for the process breakdown in cases involving failure to obtain adequate medical history or physical examination included:

- Incomplete physical examination,
- Failure to elicit relevant information,
- Poor documentation, and
- Patient provided inaccurate history.<sup>2</sup>

Two particular pieces of the patient database that are recognized as areas where errors occur that can lead to patient harm are family history and medication history.<sup>3</sup> Good communication between providers and patients during the obtaining of medical history is vital. Nearly 90 percent of clinical information used in making a diagnosis is obtained from the collected history, therefore making it the cornerstone of the medical visit.<sup>4</sup>

Although there are no absolute guidelines for documenting a medical history, documenting a thorough history may reduce your liability risks, as well as reduce your risk of costly coding and billing audits by medical insurance carriers under the False Claims Act. A complete medical history should be present in the chart of all patients seen three or more times by a primary care physician or specialist.

This may be in the form of a patient questionnaire or documentation by the physician. The medical history may be provided by the physician or another clinician who saw the patient and should be updated regularly or as changes occur. If a history from an outside clinician is provided, the document should be acknowledged by the receiving physician by initialing or documenting receipt in the progress notes.<sup>5</sup>

### A complete medical history should include the following:

- Past medical history
- History of accidents
- Hospitalizations
- Immunizations
- Allergies
- Surgical history
- Family history
- Blood history
- Current medications
- Social history

### Other items that should be included are:

- A current assessment of tobacco, alcohol and substance use<sup>6</sup>
- Occupational information, identifying any possible toxic exposures or other risk factors
- The patient's present chief concerns or complaints
- History of the present illness

Due to patients' needs and circumstances, the information included in the medical history may vary, however, gathering a complete and accurate family history is becoming increasingly important as genetics explains more diseases.

Knowledge of family history can improve patient care through the early identification of families with increased risk for chronic disease such as heart disease, diabetes and certain cancers. Failure to inquire can increase your liability risks for delayed diagnosis if a positive genetic history exists. The American Medical Association and the Department of Health and Human Services have resources available as a guide to patients and providers to assist with the development and documentation of a complete family history. The information is available online at [http://www.ama-assn.org/ama1/pub/upload/mm/464/family\\_history02.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/464/family_history02.pdf) and <http://www.hhs.gov/familyhistory/>.<sup>7</sup>

Also, remember, leaving out the family history portion of a patient's medical history can be costly from a reimbursement standpoint. Higher level consultations and new patient codes require this element to be documented. For instance, documenting a detailed history instead of a comprehensive history could mean a drop in reimbursement of more than \$32 for a Medicare patient seen in Atlanta. [For more information on the importance of a comprehensive medical history in code selection for billing and reimbursement, please see our \*Physicians' Fee and Coding Guide\* available at \[www.coderscentral.com\]\(http://www.coderscentral.com\) or visit \[www.MAGMutual.com/practice-management\]\(http://www.MAGMutual.com/practice-management\).](#)

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## Medical History: The Cornerstone of the Medical Visit (continued from page one)

As medical providers, documentation is a process that truly impacts the care provided to your patients in addition to insurance reimbursement ramifications. Medical liability risks may be reduced, patient safety improved, and the risk of insurance audits mitigated by accurately documenting the medical history and utilizing the information as needed during the diagnostic process.

### Tips for Taking an Accurate Family History

1. Focus on those conditions for which (a) the disease burden is high, (b) family history can be accurately reported and is an established risk factor, (c) evidence-based interventions for prevention exist, and (d) family history alters management decisions:
  - Colon cancer
  - Coronary artery disease
  - Osteoporosis
  - Asthma
  - Breast cancer
  - Diabetes mellitus
  - Glaucoma
  - Stroke
2. A full family history for breast and colon cancer should include other associated cancers, (e.g., endometrial, ovarian, stomach, kidney, bladder, pancreatic and brain cancer).
3. Ask about all first-degree and second-degree relatives: parents, siblings, children, aunts, uncles, grandparents, nieces, nephews, grandchildren, and half-siblings.
4. Ask about the age of onset for each relative.  
Make sure patients understand not to include relatives by marriage, but to include relatives who are no longer alive, and to include paternal relatives for female conditions such as breast cancer.<sup>8</sup>

### Risk Management Tip:

Consider incorporating a statement on the information provided by the patient stating that the information provided is accurate and complete, acknowledged by the patient's signature. With accountability appropriately placed on the patient, physician liability may also be reduced.

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7. Department of Health and Human Services. Surgeon General's Family History Initiative. <http://www.hhs.gov/familyhistory/>
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## PAP Smear/Cervical Cytology, What is Current Today?

*Submitted By: Don R. Robinson, M.D.*

When we think about effective screening and disease prevention, there is hardly a more successful story to tell than that of the Papanicolou smear or Pap smear. In areas where the Pap smear has been widely utilized, cervical cancer is a rare disease. In fact, there was a time when every woman who followed suggested guidelines received a Pap smear every year during her annual exam. This has changed over recent years. The big impetus behind this change has been the growth in new technologies and the inherent cost involved. The cost of a liquid-based Pap is approximately ten times the cost of the older, Ayre-spatula-to-a-slide-and-apply-spray technique. We haven't just changed the way we collect the Pap, we have also advanced from the days when the "Cytology tech" 'screened the smears by hand,' so to speak.

Today the Pap smear material that is presented to the lab in that liquid specimen is carefully spread across the slide and passed under a computer scanner that is then backed up by the Technologist and the Pathologist. While there is debate about how much more effective the new techniques may actually be, they are becoming more and more commonly accepted. Many providers may still be

using the older Ayre spatula and spray technique and that too, is still a viable option.

The American College of Obstetricians and Gynecologists (ACOG) Committee Opinion #431, issued in May 2009, states "conventional and liquid-based techniques are both acceptable." The Opinion also states, however, that liquid-based techniques allow for reflex HPV testing. In our office, we have found that reflex testing is a very useful tool which allows us to manage the indeterminate ASC-US pap report. While changes may abound in terminology and suggested frequency, there is no doubt that it is the clinician's obligation to stay at the forefront of advances in screening.

For those of us in the trenches, the most challenging development in recent years is trying to decide when not to do Pap smears. We have been informed that cervical cancer is almost unheard of in women under 21 years of age. We have been cautioned that doing Paps too early or too frequently may result in excessive and unnecessary treatments and expense that are not in the long-term best interests of the patient.

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## PAP Smear/Cervical Cytology, What is Current Today? (continued from page one)

Human Papilloma Virus is epidemic! It is the prevalence of this infection that has led to the cautions preventing “over treatment.” Various studies indicate that 40 to 60 % of college age women are positive for HPV DNA. It becomes obvious and a matter of common sense to realize that few of these young women are actually destined to develop cancer of the cervix. Our task as health care professionals is to intervene where intervention will be of benefit and to allow healthy young women to be healthy without undue interference when we have no benefit to offer.

While we have many reasons to see our younger patients, a Pap smear may not be one of them. When we see a teenage patient, we need to help her in a number of ways. We may encounter needs for counseling, rescue from abuse, instruction in hygiene, caution in safety from sexually transmitted diseases and contraceptive planning. Pelvic exams are indicated in all sexually active women, especially teenagers!

The current guidelines however, instruct us to wait on that first Pap smear until she turns 21 or earlier if she has been sexually active for a three-year timeframe. The logic here centers on how long it can take for significant HPV-related disease to develop, while allowing for less significant infections to resolve.

Once we start doing Pap smears, they should be continued on an annual basis. False negative rates being what they are, we would be remiss if we didn't recommend such to our younger patients. Once our patients reach age 30, the suggested frequency can change. If the patient has had three consecutive normal smears, we may advance to doing Paps on an every other year to every third year frequency. If we add High Risk HPV testing in our patients over thirty and both the Pap and the HRHPV are negative, then screening every three years becomes even more acceptable. These increased intervals do not apply in women who are immunosuppressed, HIV positive, or who have been exposed to DES in utero. According to the American Cancer Society, patients who have a history of normal Pap smears may decide to not undergo further testing after the age of 70. Other national authorities are not in universal agreement with this last trend.

While the focus of this article centers on Pap smear recommendations, our true focus as clinicians must be on the results from those smears. Pap smear results should always be given primary attention. Whenever I receive a Pap result, the first thing I do is check the last few Paps the patient has undergone. To not acquaint myself with that particular patient's history, may allow for an interruption in a therapeutic plan. Like most offices, we routinely notify patients when a normal Pap returns from their annual exam.

This notification results in the patient being reminded of the need to be seen back in one year. If I am not paying careful attention while checking the current pap against the patient's history, our routine notice of a normal Pap may go out to a patient I really need to see sooner, due to her prior history of an abnormal result. A “routine” notification would be inappropriate and confusing. A general rule of value is that it is important to interpret any laboratory result in the context of the patient's history and condition. Don't be caught assuming.

Recommendations for colposcopy and follow-up for abnormal Paps are age-dependent and getting more complex all the time. In fact, the ACOG Practice Bulletin that I have referenced for this article,

#99, December 2008, “Management of Abnormal Cervical Cytology and Histology,” is 26 pages long. My advice, even for those of us who see many patients with abnormal Paps, is that we keep this Bulletin handy. It is available in the ACOG Compendium and at the ACOG website. Printing this Bulletin out and putting it in a reference file might be a helpful step.

In conclusion, I have a few principles that are worthy of thought:

- **When in doubt, do a Pap smear!** Sexually active women up to the age of 65, have the option of an annual smear. Don't be caught wishing you had done one. You can always discard it later if you so decide. You are more likely to get caught by not doing a smear than by performing one too many.
- **Always check a patient's Pap history when a new result returns.** Confirm in your own mind what an appropriate clinical path is for that particular patient.
- **Make sure you have a double-check system in place in your office.** One of our greatest liabilities can result from irresponsible patients. You may have explained everything in detail and given the appropriate hand-out. She may have looked you in the eye with understanding. And... you may never see her again! Her name should be entered on a calendar check system that notifies you when she doesn't return. You can then note her absence and make timely notification of follow-up.
- **Make sure that if you do Paps less often than annually,** the patient understands and agrees with the logic employed. and document the conversation
- **Always recommend Gardasil to your younger patients (age 9-26).** This is available, safe and protective. Stress to the patient that since there are so many varieties of the virus, the age appropriate Pap schedule **should not be altered** just because they have been vaccinated.

I often describe clinical practice as a mine field with lots of opportunities for miss-steps. It is important to maintain a team effort. Include your office nurse in the planning and the recall systems. Include your assistant by teaching her your usual steps. She may be the first to catch an oversight. It is a joy and a blessing to render medical care, don't take on the more challenging parts all by yourself. Form your office staff into a supportive and caring team and the rewards will outweigh the burdens while keeping you from burn-out.

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# Medical Assistant - Certification Programs

*Submitted By: Donald A. Balasa, JD, MBA, Executive Director, Legal Counsel American Association of Medical Assistants, Chicago, IL*

Although the laws of most states do not mandate the educational preparation for medical assistants, an increasing number of employers throughout America are preferring to hire (or insisting on hiring) medical assistants who have graduated from a postsecondary academic program accredited by either the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES). The accreditation of medical assisting programs by CAAHEP and ABHES began in 1969, and is recognized by the Council for Higher Education Accreditation. Currently, there are approximately 710 medical assisting programs in the United States that are accredited by either CAAHEP or ABHES.

Graduates of a CAAHEP or ABHES accredited medical assisting program are eligible to take the CMA (AAMA) Certification

Examination and earn the CMA (AAMA) credential. The CMA (AAMA) is accredited by the National Commission for Certifying Agencies, and the National Board of Medical Examiners serves as test consultant. CMAs (AAMA) must recertify every five years to continue to use the credential.

Employers wanting to hire CMAs (AAMA) can find CAAHEP and ABHES accredited programs at [www.caahep.org](http://www.caahep.org) and [www.abhes.org](http://www.abhes.org), respectively. Verification of currency of a CMA (AAMA) credential can be done by calling the American Association of Medical Assistants Certification Department at **1-800-228-2262**. Questions about legal scope of practice for medical assistants in all states can be obtained at [www.aama-ntl.org](http://www.aama-ntl.org) or by contacting this author at [dbalasa@aama-ntl.org](mailto:dbalasa@aama-ntl.org)

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### Alabama

- 9/17 - Huntsville-Situation Awareness in Healthcare
- 9/29 - Birmingham-Situation Awareness in Healthcare

### Florida

- 9/1 - Jacksonville-Electronic Medical Records
- 10/6 - Pensacola- Electronic Medical Records

### North Carolina

- 9/10 - Greenville-Situation Awareness in Healthcare
- 9/10 - Carey-Electronic Medical Records
- 9/15 - Greensboro-Situation Awareness in Healthcare

### South Carolina

- 10/6 - Charleston-Situation Awareness in Healthcare
- 10/20 - Columbia-Electronic Medical Records

### Virginia

- 9/22 - VA Beach-Situation Awareness in Healthcare
- 9/24 - Richmond-Situation Awareness in Healthcare

For program details and registration information:

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