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§482.61(a)(5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

Interpretive Guidelines §482.61(a)(5)

Upon admission the patient should receive a thorough history and physical examination with all indicated laboratory examinations. These investigations must be sufficient to discover all structural, functional, systemic and metabolic disorders. A thorough history of the patient's past physical disorders, head trauma, accidents, substance dependence/abuse, exposure to toxic agents, tumors, infections, seizures or temporary loss of consciousness, and headaches, will alert the physician to look for the presence of continuing pathology or possible sequelae any of which may turn out to be significant and pertinent to the present mental illness. Equally important is a thorough physical examination to look for signs of any current illness since psychotic symptoms may be due to a general medical condition or substance related disorder.

The screening neurological examination

As part of the physical examination, the physician will perform a "screening" neurological examination. While there is no precise definition of a screening neurological examination in medical practice such examination is expected to assess gross function of the various divisions of the central nervous system as opposite to detailed, fine testing of each division. Gross testing of Cranial Nerves II through XII should be included. Statements such as "Cranial Nerves II to XII intact" are not acceptable. These areas may be found in various parts of the physical examination and not just grouped specifically under the neurological. In any case where a system review indicate positive neurological symptomatology, a more detailed examination would be necessary, with neurological work-up or consultation ordered as appropriate after the screening neurological examination was completed.

Complete neurological examination.

A complete, comprehensive neurological examination includes a review of the patient's history, physical examination and for psychiatric patients, a review of the psychiatric evaluation. The neurologist/psychiatrist himself/herself also takes a history to obtain the necessary information not already available in the medical record or referral form. The neurological examination is a detailed, orderly survey of the various sections of the nervous system. As an example, whereas a simple reading of a printed page will be sufficient to assess grossly the patient's sight (cranial nerve II) in a complete neurological examination, the neurologist may test visual acuity with a snellen chart, perform a fundoscopic examination of both eyes (sometimes after dilating the pupils) and he/she will examine the patient's visual fields. In the examination of the motor system, the power of muscle groups of the extremities, the neck and trunk are tested. Where an indication of diminished strength is noted, testing of smaller muscle groups and even individual muscles are tested. In a complete neurological examinations all the systems are examined, but the physician will emphasize even more the areas pertinent to the problem for which the examination was requested.

Survey Procedures §482.61(a)(5)

Did the presence of an abnormal physical finding or laboratory finding justify the need for further diagnostic testing, or for the development of an intercurrent diagnosis? If the finding justified further follow-up in either situation, was such follow-up done?

Is there evidence that a screening neurological examination was done and recorded at the time of the physical examination?

Was the screening neurological or history indicative of possible involvement (tremors, paralysis, motor weakness or muscle atrophy, severe headaches, seizures, head trauma?

If indicated, was a complete, comprehensive neurological exam ordered, completed and recorded in the medical record in a timely manner?