Report on
MEDICARE COMPLIANCE
Volume 21, Number 18 • May 21, 2012

Final Medicare COPs Shift More Control to Hospitals, Drop 48-Hour Signature Deadline

CMS has ditched its 48-hour deadline for physician signatures and given hospitals a freer hand to shape their own destiny in this and other areas, according to the final update to the Medicare conditions of participation, announced May 10. While hospitals enjoy greater regulatory freedom, they take on the burden of developing new policies and procedures, compliance experts say, and may experience more claims denials if signatures are missing because physicians aren't under Medicare's 48-hour gun.

"The price of freedom is more work," says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. "Even though there is more flexibility and independence, there is more responsibility and risk for hospitals. If something goes wrong, it was the hospital making the decision," not CMS.

The new hospital conditions of participation (COPs) cover a lot of ground. In addition to the physician signature change, CMS now requires a physician on the hospital board, permits the use of standing orders, and allows hospitals to make greater use of nonphysician practitioners (NPPs). As always, CMS emphasizes it is opening the door to the flexibility rather than requiring it. For example, hospitals can choose to stick with a 48-hour physician signature deadline, but CMS is not enforcing it universally.

"I have mixed emotions," says Cheryl Rice, vice president and chief corporate responsibility officer for Catholic Health Partners, a 20-hospital system based in Cincinnati. "Obviously the changes with the boards and medical-staff leadership are all good things, but the harder parts are the authentication of orders and standing orders. On paper this looks like a good idea but in execution it creates operational and compliance issues that I don't think people thought completely through" *(RMC 10/24/11, p. 1).*

Before CMS updated the COPs this time around, it required all orders, including verbal orders, to be "promptly" signed, dated, timed and authenticated by the ordering practitioner or another practitioner responsible for the patient's care, which means 48 hours unless state law set another deadline.

While it makes permanent the part about promptly signing, dating and authenticating medical records, CMS eliminated the 48-hour deadline. When the new COPs take effect 60 days from their May 16 publication in the *Federal Register*, there will be no hard and fast CMS deadline anymore. Instead, CMS defers to hospitals and/or state laws. "CMS fully and intentionally puts everything back onto the facility to figure out how to do this," Rice says.

Hospitals may welcome this freedom, which means physicians will sign medical records and authenticate verbal orders as fast or slow as the hospital or state decides. But Rice sees trouble ahead.

"At least with the 48 hours, facilities had a defined timeframe to work toward in changing operational processes and internal controls to check for compliance," she says. Now hospitals have to take services one by one, and comb through state regulations to determine whether states are silent on signature deadlines or set a deadline. States may set different signatures deadlines for lab work, hospices and medication orders, for example, and compliance officers must nail them down. If state timeframes vary, "we are back to staff having to remember all the rules and exceptions," which prompted CMS to adopt the 48-hour deadline in the first place, Rice says. This will be tricky for health systems with facilities located in different states with different policies, she notes.

Lack of Deadline May Increase Denials

If states are silent on physician signatures, like Ohio is, hospitals will develop their own policies. They may be contained in medical-staff bylaws, which means the medical staff has to review the new policies, with approval requiring a majority voting "yes." "These policies have to be vetted by the membership and it takes time. You have to push the policy through a group of people who only meet a certain number of times a year," she notes.

Meanwhile, Medicare audits keep coming — including prepayment audits *(RMC 4/23/12, p. 1)* — and there may be unintended consequences from the revised COPs. Medicare requirements unrelated to COPs require timed, dated and authenticated physician signatures before hospitals drop claims. "If orders are incomplete and don't support why you did a test or service or admitted an inpatient and they aren't au-

thenticated before you bill, you may have a situation on your hands," Rice says.

Complicating matters, many states are considering laws that allow a 30-day period for order completion, Rice says. If hospitals face more prepayment probe audits, which involve current cases, they may lack the completed underlying documentation (e.g., signed verbal orders) required of prepayment audits. Things will only get hotter as RACs launch prepayment audits in 11 states in June or soon thereafter.

As it did with the signature requirement, CMS also put the ball in the hospitals' court on standing orders, another compliance minefield, and other areas.

Hospitals now have CMS's go-ahead to use standing orders, with some restrictions. Standing orders, which are pre-set instructions for treating certain conditions, have long troubled CMS because of the risk that medically unnecessary services would be tacked on and/or that patients wouldn't receive personalized care. But CMS said electronic and preprinted standing orders, order sets and protocols would pass muster under certain circumstances. For example, they must be consistent with nationally recognized and evidence-based guidelines, reviewed regularly and "dated, timed and authenticated promptly in the patient's medical record by the ordering practitioner." Standing orders must be developed "in consultation with [the hospital's] nursing and pharmacy leadership" in addition to the medical staff.

In its approach to standing orders, CMS has taken the middle ground in the new COPs, Waltz says. "It's not like every patient is getting the same protocol. You can use the standing order, but it's applied to a specific patient," Waltz says. "They are basically best practices that have to be approved for each patient. It's good but doesn't go as far as most people want."

CMS has also broadened the definition of "medical-staff member." In addition to physicians, hospitals can give privileges to NPPs, pharmacists and others deemed worthy. "CMS is trying to make it clear they will not prohibit it," she says. "NPPs can take some of the load off [physicians] and are often very competent and it is a way of reducing costs."

Before hospitals rush off to add NPPs to their medical staffs, Rice says they should carefully research state scope of practice laws. Be very clear what services they can perform. "A lot of states have been changing what NPPs can do," she says.

Some Administrative Burdens Were Reduced

CMS loosened the reins of nursing services in other ways. For example, orders for drugs and biologicals may be documented and signed by "other practitioners" besides physicians, including NPPs. However, CMS warns that Medicare and other insurers may not pay for drugs and biologicals not ordered by physicians. "There may be a disconnect between the COPs and payment rules. You have to keep track of both," Waltz says.

Administrative burdens were reduced by the revised COPs, CMS says. For example, hospitals no longer need a single director for outpatient services in addition to department heads. "It takes out some of the bureaucracy," Waltz says, although it doesn't apply to critical access hospitals.

And hospitals don't have to report when patients die while in soft, two-point restraints anymore. Instead, they have to maintain a log that is available to CMS on request.

But Waltz cautions that with power comes responsibility. For example, "the conditions of participation make it clear that CMS expects the medical staff to be involved and give thought to processes ahead of time. If something bad happens, someone will say, 'where was the medical staff? Why wasn't it thinking ahead?'" she says. "CMS is setting it up for people to think ahead."

Contact Waltz at jwaltz@foley.com and Rice at clrice@health-partners.org. ✧