

# MEDICARE COMPLIANCE

## CMS Proposes Killing 48-Hour Deadline for Physician Signatures on Medical Records

CMS has revamped its physician-signature requirement in a proposed update to the Medicare conditions of participation for hospitals. The 48-hour deadline for signing, dating and authenticating physician orders would be eliminated, a move that CMS trumpets as a way to cut red tape, although there are fears it may undermine compliance and patient safety.

The proposed rule also clears a path for hospital use of standing orders — with strings attached — and allows health systems to streamline their governing boards.

In the proposal, announced Oct. 18, CMS lets hospitals defer to state law or their own policies for physician-signature timeframes, and rely on a looser standard of “promptly” authenticating verbal orders.

“I am really surprised they took this position,” says Cheryl Rice, vice president and chief corporate responsibility officer for Catholic Health Partners, a Cincinnati-based health system with 32 hospitals. “They put all the ambiguity back in.” The proposal threatens to throw compliance out of whack, she says, because there won’t be a single, defined standard to enforce. “This has the potential to be a monitoring nightmare,” especially for multistate health systems, Rice says. “Whenever ambiguity or variability is added, the opportunity for noncompliance increases.”

CMS said the changes to the conditions of participation are part of a package of reforms developed in response to the Obama administration’s pledge to eliminate burdensome and unnecessary regulations and save hospitals and other providers money. Three regulations were announced together:

- (1) The proposed revisions to the hospital conditions of participation,
- (2) A proposed rule that would reduce regulatory requirements for certain providers, such as end-stage renal disease facilities, and
- (3) A final rule that modifies health and safety standards for ambulatory surgery centers.

All three are scheduled for publication in the Oct. 24 *Federal Register*.

CMS was under the gun to address the 48-hour deadline on authentication for physician signatures because its most recent regulation on the subject expires on Jan. 27, 2012. In its previous revisions to the Medicare conditions of participation for hospitals, which took effect on Jan. 27, 2007, CMS stated that all physician orders, including verbal orders, must be dated, timed and authenticated promptly by the ordering practitioner or another practitioner responsible for the patient’s care. If there’s no authentication timeframe under state law, physicians have 48 hours to get it done. But CMS set an expiration date on the 48-hour rule on the assumption that authentication problems would be solved by universal electronic health records. Because that’s still a work in progress, physician signatures are back on the radar screen. This time, CMS ditched the 48-hour deadline, saying the move brings regulatory relief without putting patients in harm’s way. “Many stakeholders in the hospital community, including The Joint Commission and the American Hospital Association, have pointed out to us that this requirement is not only a particularly burdensome one for hospitals, but also one that does not have any appreciable benefit for patients with regard to safe care,” the proposed rule states.

### All Orders Are Still Authenticated

CMS would still require hospitals to ensure all orders — written and verbal — are dated, timed and authenticated promptly by the ordering practitioner or another practitioner who is responsible for the patient’s care. But it replaces the 48-hour deadline with a new standard: deference to state law and hospital policy. If there’s no state law establishing a timeframe for signing, dating and authenticating medical records, hospitals would be permitted to set their own deadlines. As always, CMS discourages the use of verbal orders because they increase the risk of error. “When verbal orders must be used, hospitals should have their own policies in place (e.g., ‘read-back and verify’ requirements) to ensure accuracy in the transcribing of orders, particularly those involving medication dosages,” the proposal states.

San Francisco attorney Judy Waltz says hospitals will benefit from the flexibility and the authority to determine what authentication-timing standards are reasonable and consistent with state law. Hospitals can stick with a short deadline or give physicians more time to sign or authenticate orders. “48 hours is pretty arbitrary,” says Waltz, with Foley & Lardner LLP. “It’s too short. Many doctors don’t come to the hospital every day and they’re not there to sign every 48 hours.”

But Rice says the cons outweigh the pros. For one thing, abandoning the 48-hour deadline appears to conflict with the Obama administration’s push to reduce medical errors and improve patient safety and quality. The more time physicians have to sign and/or authenticate an order, the less effective it is in terms of catching errors or holding people accountable for adverse events. “Some people think 30 days is prompt enough, but if a medical mistake is made,” that’s too late to catch it, she notes. Tennessee, for example, just enacted a law requiring medical record authentication in 30 days, she says.

And CMS is deluding itself about limiting the use of verbal orders, Rice says. “Been there, done that — it doesn’t work,” she says. Verbal orders are a fact of life, even in an electronic world. “There will always be practitioners who refuse to use the technology and, as a matter of personal convenience, opt for verbal orders,” she says.

Large, multi-state health care organizations will have a hard time complying with this regulation if it’s finalized, Rice says. Either states don’t have detailed authentication deadlines or they may not comport with each other. Hospital chains and integrated delivery systems will have to abandon the systemwide, uniform training programs they had based on the 48-hour deadline and tailor compliance to either a state law or new hospital policy. The problem with this, Rice says, is that busy hospital staffers are much more compliant when the rules are clear. There are only so many policies people can memorize. It’s fine when policies are a no-brainer — don’t accept gifts from patients or vendors — but when you keep stacking up rules and regulations with varying timeframes, compliance is jeopardized, Rice says.

### State Laws Vary by Setting

“This rule kind of shoots us in the foot because it assumes everyone else — states and hospitals — will have common timeframes,” Rice says. But that’s not the case. Her cursory review of laws in states served by her health system (Ohio, Tennessee, Indiana, Kentucky) found that signing deadlines vary by the setting and by the type of entry (e.g., medication orders versus treat-

ment). Typically state rules are more liberal — they vary, with states giving physicians 24 hours, seven days, 10 days or 30 days to authenticate verbal orders.

The proposal also raises questions about the shape of Medicare audits for physician-signature failures. Hospitals around the country have received warnings from their Medicare administrative contractors about noncompliance related to signatures (*RMC 9/13/10, p. 1*) and some hospitals have faced claims denials. While missing signatures still trigger recoupment, the lack of a concrete authentication deadline may undermine the authority of auditors to deny claims for failure to promptly authenticate verbal orders.

Although the proposed regulation has changes that are “positive and true cost savings,” dumping the 48-hour deadline may turn out to be a burden in terms of implementation and retooling processes, Rice says. “CMS essentially shifted federal oversight to the states and providers.”

CMS also proposed a revision to the conditions of participation that allows hospitals to use standing orders (also known as “protocols”) under certain circumstances.

### New Path for Standing Orders

In the proposed rule, CMS green-lights pre-printed and electronic standing orders, order sets, and protocols if a hospital:

- (1) “establishes that such orders and protocols have been reviewed and approved by the medical staff in consultation with the hospital’s nursing and pharmacy leadership;
- (2) “demonstrates that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;
- (3) “ensures that the periodic and regular review of such orders and protocols is conducted by the medical staff, in consultation with the hospital’s nursing and pharmacy leadership, to determine the continuing usefulness and safety of the orders and protocols; and
- (4) “ensures that such orders and protocols are dated, timed, and authenticated promptly in the patient’s medical record by the ordering practitioner or another practitioner responsible for the care of the patient....”

Waltz says it’s a “big step forward” for CMS to accept standing orders, “even in this limited way.” The HHS Office of Inspector General’s suspicion of standing orders dates back to its compliance-program guidance for labs. OIG and CMS believe standing orders can result in unnecessary services. For example, physicians reflexively order the same lab tests for every patient who walks in the door. But CMS is floating the idea

of compliant standing orders as long as the physician customizes them for patients, she says.

While the standing orders proposal is a good idea, Rice says, CMS's criteria are too vague and may confuse operational processes. For example, CMS expects the medical staff to approve a standing order. "It could take several months to a year to get the entire medical staff to review and sign off on protocol documents," Rice says. Perhaps CMS only means a representative of the medical staff has to approve a protocol. It's unclear. And hospitals must prove they used evidence-based medicine to support a protocol. "What will be the requirement for hospitals to prove their due diligence?" These are important issues because if hospitals run afoul of the criteria, Medicare could deny all claims

for services stemming from the standing orders. "The devil will be in the details," she says.

The proposed regulation also would allow health systems to have one board of directors serve as the governing body for more than one hospital without violating the conditions of participation. That's very helpful to health systems with multiple hospitals, Waltz says. "You can improve consistency," she notes. For example, Waltz says, a single board reviewing quality outcomes at 12 hospitals can probably detect outliers in the health system more effectively than 12 separate boards would.

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