Physician orders keep your hospital moving. Every day in every unit, many dedicated professionals are doing the jobs they’ve been trained to do with caring and expertise. Walking through a busy floor, an untrained observer might see it all as chaos. Physician orders, when they work, make sure it’s not. They give staff from various departments and ancillary areas a common communication vehicle and a shared language: they assure everyone’s on the same page, for every patient, every time.

Evolving regulations make physician order procedures more and more complicated. We may complain about the added administrative burden, but we can’t object to its purpose: to assure physicians are overseeing all that care – its appropriateness and its safety.

**Risky mistakes.**

What if physician orders aren’t delivered or documented properly? What if they’re not valid as to time or content? The consequences can be serious. Reimbursement for your services may be denied, putting your hospital at risk financially. Your procedures may not be in compliance with regulations, leaving your organization vulnerable to sanctions or decertification. And most importantly, patients may not receive the right treatments or tests, endangering their health, their safety – maybe even their lives. A recommended best practice for facilities is to receive signed orders and signs, symptoms, conditions and diagnoses at the time of scheduling to avoid medical necessity and treatment issues. See Exhibit A for an example of a typical physician order workflow.

**Do your department managers know…**

How long do standing orders stand? Some policies say they’re good for a year; others say 30 days; which is it?

Where are the guidelines?

If physicians can give verbal orders for continuing therapy?

If phone orders are still OK, what are your policies?

If you can give direction for physician orders for wound ostomy clinic patients?

**Don’t just do it; do it best.**

Hospital leadership, health information management (HIM) and quality assurance (QA) teams should concern themselves with keeping physician order policies up to date and keeping their teams informed. This paper discusses the following questions, and presents the best practice guidelines used by QHR HIM consultants to implement successful policies:

- Where do we look for guidelines and standards?
- Do our policies assure quality patient care, patient safety and timeliness of continuing physician oversight?
  - Diagnostic Testing
  - Verbal Orders
  - Continuing Therapy and Standing Orders
- How can we disseminate this information to managers and directors?
Question #1: Where do we look for guidelines and standards?

Unfortunately, there’s no one set of rules, and no one place to find them all. Many physician order guidelines or standards are both national and regional; some are included within billing guidelines. Also, within the different clinical disciplines such as physical therapy or pharmacy, there are state guidelines that regulate the scope of practice/treatment a particular clinical specialist may give. So your hospital’s policy writing team must regularly investigate multiple areas of reference. Such as…

CMS: The Centers for Medicare Services
CMS issues Regulations for Hospitals and Conditions of Participation (COP). Every hospital that accepts payment for Medicare and Medicaid patients – including Joint Commission accredited hospitals – must comply with these conditions. To determine if hospitals are in compliance with COPs, CMS also issues Interpretive Guidelines. The guidelines are instructions for surveyors on how to survey hospitals, what to look for during surveys and what questions to ask. Some refer to the guidelines as the “questions to the test.” For example, there are guidelines for laboratories under the Clinical Laboratory Improvement Amendment (CLIA) published by CMS.

JCAHO: The Joint Commission on Accreditation of Healthcare Organizations
JCAHO provides evaluation and accreditation services for multiple healthcare organizations such as general, psychiatric, children’s, rehabilitation and critical access hospitals. The JCAHO standards address the organization’s level of performance in key functions such as patient rights, patient treatment and infection control, and on its ability to provide safe, high quality care. The facility is measured on its actual performance on standards set forth in performance expectations for activities that affect the safety and quality of care – not simply on its policies and procedures. JCAHO sets an important standard for hospital compliance: the thinking is that if an organization does the right things and does them well, there is a strong likelihood patients will experience good outcomes. JCAHO develops its standards in cooperation with healthcare experts, providers, measurement experts, and consumers.

Look Here:
http://www.cms.hhs.gov/CFC'sandCOPs.
http://www.jointcommission.org
http://oig.hhs.gov
http://www.ahima.org

OIG: The Office of Inspector General
The OIG in the federal government’s Department of Health and Human Services publishes compliance program guidance for multiple sectors of healthcare and billing companies. In developing these compliance guidances, the OIG has agreed to work closely with the Health Care Financing Administration, the Department of Justice and various sectors of the healthcare industry. The first of these compliance guidances focused on clinical laboratories, and was intended to provide clear guidance to those segments of the healthcare industry that were interested in reducing fraud and abuse within their organizations. The second compliance program guidance developed by the OIG encompasses principles that are applicable to hospitals as well as a wider variety of organizations that provide health care services to Medicare and Medicaid and all other Federal health care programs. The original OIG Compliance Program for Hospitals was published in the Federal Register/ Vol. 63, No.35/Monday, February 23, 1998.

Best Practice
Know the validity of time and physician order content or format for different therapies, diagnostic testing, and continuing treatment. That means seeking out monthly updates from the sources described above. Establish a multidisciplinary team including HIM and QA professionals to maintain current policies.
Question #2: Do our policies assure quality patient care, patient safety and timeliness of continuing physician oversight?

Again, there’s no simple answer. Physician order policies vary widely; they fall into several categories. Each has its own special considerations. So to answer this question, we have to examine each type of physician order separately.

Diagnostic Testing: be on time, please
Diagnostic tests by Medicare definition include all diagnostic x-ray tests, all diagnostic laboratory tests and other diagnostic tests furnished to a Medicare beneficiary. An ‘order’ is a communication from the treating physician requesting that a diagnostic test be performed for a beneficiary/patient. The order may conditionally request an additional diagnostic test if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician, (e.g., if test X is negative, then perform test Y). An order may include the following forms of communication:

- A written document signed by the treating physician, which is hand-delivered, mailed, or faxed to the testing facility
- A telephone call by the treating physician or his/her office to the testing facility
- An electronic mail by the treating physician or his/her office to the testing facility

There are specific guidelines for Additional Diagnostic Test Exception. This allows the interpreting physician at the testing facility, because of the abnormal result of the diagnostic test performed, to determine that an additional diagnostic test is medically necessary (e.g., the last cut of an abdominal CT scan with contrast shows a mass). However, the interpreting physician/testing facility may not perform the unordered test until a new order from the treating physician/practitioner has been received.

Definitions you should know…
- A ‘treating physician’ is a physician, as defined in the Social Security Act, who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results of a diagnostic test in the management of the beneficiary’s specific medical problem. NOTE: A radiologist performing a therapeutic interventional procedure is considered a treating physician.
- A ‘treating practitioner’ is a nurse practitioner, clinical nurse specialist, or physician assistant, who furnishes, according to state law, a consultation or treats a beneficiary for a specific medical problem, and who uses the result of a diagnostic test in the management of the beneficiary’s specific medical problem.
- A ‘testing facility’ is a Medicare provider or supplier that furnishes diagnostic tests. A testing facility may include a physician or a group, i.e. radiologist, pathologist, laboratory or an independent diagnostic testing facility.

Best Practice
A best practice guideline is that in cases of diagnostic testing, the physician order is for a specific diagnostic test and should not exceed the time it takes for a diagnostic test to be scheduled, completed, interpreted, and its interpretation/result reported.

The following is from Medicare transmittal AB-02-030:
"Medicare does not require the signature of the ordering physician on a laboratory service requisition. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the service, it is not the only permissible way of documenting that the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record."
Best Practice (Continued)
Also, this is in the laboratory compliance manual published by the OIG – “Therefore, Medicare may deny payment for a test that the physician believes is appropriate, but which does not meet the Medicare coverage criteria (e.g., done for screening purposes) or where documentation in the entire patient record, including that maintained in the physician's records, does not support that the tests were reasonable and necessary for a given patient.” Although requisitions for laboratory orders are acceptable under CLIA Guidelines, QHR recommends that hospitals obtain and maintain the order to meet CMS audit requests rather than relying on a less than 10 year retention schedule as currently followed in some states for physician offices.

Verbal Orders: in case of emergency
CMS maintains [in Section 482.23(c) (2) (iii)] that verbal orders are to be used infrequently. The use of verbal orders (this includes both telephone and oral orders) should not be common practice. Verbal orders should be used only to meet the urgent care needs of the patient when it is not feasible for the ordering physician to immediately communicate the order in written or electronic form. CMS clearly states that verbal orders are not to be used for the convenience of the ordering physician. The JCAHO also urges infrequent use of verbal orders and urges that the use of verbal orders should be defined in hospital and medical staff policy.

Best Practice
A best practice is to use verbal orders only in an emergency. If the hospital allows for remote access, perhaps it should require the physician to access the system and enter the order directly. Still, there could be circumstances where this might not be feasible nor in the best interest of patient care. The policy might significantly reduce, but will not necessarily eliminate, verbal orders. A policy might direct the circumstances in which the hospital would accept such verbal orders, or how the hospital will manage physicians who do not comply with the policy.

Continuing Therapy and Standing Orders: check expiration date
There are multiple disciplines that provide continuing therapy, such as physical therapy, occupational therapy, chemotherapy, wound care/treatment and laboratory to monitor drug therapy. Although standing orders are not prohibited in connection with an extended course of treatment, too often facility policies have not addressed this issue.

While laboratory compliance plans can permit the use of standing orders executed in connection with an extended course of treatment, the compliance plan should require the laboratory and other continuing care departments to monitor existing standing orders to ensure their continuing validity.

Although standing orders are not prohibited in connection with an extended course of treatment, too often facility policies have not addressed this issue.

Best Practice
It is strongly suggested, consistent with state law requirements, that a laboratory contact all nursing homes from which it has received such standing orders and request that they confirm in writing the validity of all current standing orders. In addition, laboratories should verify standing orders relied upon at draw stations with the physician, physician’s office staff or other person authorized by law to order tests that have provided the standing orders to the laboratory. Specifically with respect to End Stage Renal Disease (ESRD) patients, at least once annually, laboratories should contact each ESRD facility or unit to request confirmation in writing of the continued validity of all existing standing orders. A tickler file should be established and all orders renewed on a 12-month basis.
Regarding physical therapy, chemotherapy and wound care/treatment, CMS has established criteria used to determine coverage, billing and payment guidelines. For example, there are criteria used to determine whether certain supplies are reasonable and necessary for a beneficiary’s ostomy treatment. State coverage of specific ostomy supplies varies. Further, Medicare coverage of ostomy supplies is different for patients who receive care under home health than for those who receive care in an outpatient setting.

**Best Practice**

Communicate with specific Fiscal Intermediaries for Local Medical Review Policies that might be in addition to National Coverage Determinations (NCDs).

For rehabilitation therapy patients, Medicare requires a complete plan of care, including:

- Patient’s significant past history
- Patient’s diagnoses that require therapy
- Related physician’s orders
- Therapy goals and potential for achievement
- Any contraindications
- Patient’s awareness and understanding of diagnosis, prognosis and treatment goals
- When appropriate, the summary of treatment provided and results achieved during previous periods of therapy services
- Specific therapy proposed (Plan of Treatment) including type, amount, frequency and duration

The rehabilitation therapy plan of care must be reviewed every 30 days. The standard for plan of care should be consistent for all payer types. Medicare wants the referring physician to be intensely involved in each case. Medicare strongly recommends that the patient should physically return to the physician for a re-evaluation 60 days after their initial visit to Rehabilitation Therapy.

**Best Practice**

With those guidelines in mind, the physician order should be specific to a certain course of therapy and should be further expanded only on a case-by-case basis. For example, if a typical PT course of treatment usually spans six weeks then the facility policy should reflect not only what is required for a complete plan of care, but how often the physician will receive an updated plan of care, progress notes, and how often the validity of the order will be reviewed. In other words, a standing order for an extended time period, i.e. 6 months, not determined to be medically necessary would be inappropriate.

**Question #3: How do we disseminate this information to managers and directors?**

By now you know physician orders aren’t just important for physicians, nurses, lab and radiology technicians. They have everything to do with patients getting the right care and hospitals getting paid for it. So when there’s a new regulation regarding physician orders, it needs to get to all the right people, and fast. To make sure that happens, develop comprehensive outpatient registration, documentation and coding policies and procedures consistent with regulatory guidance and best practices. These policies should include guidelines for physician orders, including validity of time in various settings. Oversight management should be from the compliance officer and the revenue cycle team. Then develop a plan to circulate these policies quickly, and verify they’ve been read and implemented.
**Best Practice**
Formalize the actual dissemination of national coverage and local medical review policies. To be sure they take their responsibilities seriously, have managers and directors sign that they have read the most current policies and have made changes in procedures as necessary.

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**So what?**

*Why do we have policies around physician orders? Proper physician orders help you not only deliver the right care, right on time and get paid for it… they also help you document a history of what you do for each patient. Think of them as the verbs in your medical records. And since medical records — in addition to being important clinical tracking tools — are admissible in court, they can also protect your organization in the event of a dispute. But the main reason is at the heart of what your hospital is all about: keep your policies up to date and your team informed, and you’ll do a better job of delivering quality care, every day, all day long.*

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If you have any questions about this white paper, or would like to speak with QHR about your HIM challenges, please call Devika Kumar at 1/800-233-1470, ext. 4563. To read more about how QHR has successfully helped clients address health information management issues, go to www.qhr.com, and click on the Consulting Services tab.
Note: The time validity of a physician order may be 30 days or depending on State statute and/or hospital policy.