It’s A New World: Ensuring Orders & Certification in EHRs

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Learning Objectives

• The challenges of ensuring the correct admission order (inpatient, outpatient) in an electronic health record (EHR) system

• Risks and compliance concerns with missing orders and certification with the new Two-Midnight Rule

• Process improvement recommendations to ensure compliance
Today’s Environment

• Many hospitals have EHRs
  • Some are completely electronic
  • Many are hybrids – paper and electronic

• Long-standing regulations for orders and certification documented in Conditions of Participation, CFR, state regulations
  • Audited by The Joint Commission, federal and state regulatory representatives

• CMS promulgated new regulatory guidance for orders and certification, effective for dates of service on and after October 1, 2013

Our Journey
Background

One integrated EHR and A/D/T system for our 40 hospitals (acute and CAH) in 9 states; 5 Medicare Administrative Contractors

Financial loss and increasing compliance risk over 6 months on medical necessity including issues with Level of Care (inpatient/outpatient) order

- No order documented
- Missing or conflicting documentation supporting Level of Care order
- Inappropriate changes from one Level of Care to another
- Confusion between Level of Care vs. Bed & Board moves

Multiple order types available in the EHR for documenting Level of Care orders

- Lack of standard definitions
- Inconsistent use of order types
Emergency Departments vary in the ways that they communicate the order to Registration. Typically, Registration does not wait for an order in the EHR since they work exclusively in the A/D/T system.

- Lack of Order was not identified in many hospital systems until it was too late.
- The order in the EMR may not mirror the level in the A/D/T — multiple ways to change the order without the A/D/T finding out.
Place in Inpatient

Current = 6

1. Place in Inpatient Status
2. Place in Inpatient Status from the ED
3. Behavioral Medicine Admit to Intensive Outpatient
4. Behavioral Medicine Admit to Partial Hospitalization
5. Place in Inpatient Rehab
6. Place in Inpatient Hospice Status

Future = 1

Details
• Status
  – Inpatient Acute
  – Inpatient Hospice
  – Inpatient Rehab
  – Inpatient Behavioral Med
  – Skilled Nursing (site specific)

• Attending
• Reason for Admission
• Location (ICU, Peds etc)
• Comments

Red = required field

Place in Outpatient

Current = 6

1. Place in Outpatient Status
2. Place in Outpatient Status - Ambulatory
3. Place in Outpatient Status - Ambulatory Surgery Home Today
4. Place in Outpatient Status - Ambulatory Surgery Overnight Stay
5. Place in Outpatient Status - Infusion/Transfusion
6. Place in Outpatient Status - Procedure

Future = 1

Details
• Status
  – Procedure (Example: dialysis, Radiology procedure, etc)
  – Infusion/Transfusion
  – Surgery-Extended Stay
  – Observation

• Attending
• Reason for Admission
• Location (ICU, Peds, etc)
• Comments

Red = required field
Steps Taken

- CMIO team approval obtained
- CNO and CMO calls performed
- EHR IT system support and liaison calls
- Senior leadership buy-in and approval
- Rollout

Regulatory & Operations Hurdle

CMS IP Only List

- Operational challenges:
  - Pre-registration / Registration
  - Surgical scheduling
  - IP Only List check (prior to surgery)
  - Physician order
  - Supporting documentation

Still working on this –
If anyone has solved this, please share!!!
The Two-Midnight Rule

October 1, 2013

Overview

Practitioner should order acute IP admission status if the patient’s stay is expected to exceed 1 Medicare utilization day (crosses 2 midnights) or requires a procedure listed on the IP Only List

- No change in the use of OP Observation Services
- No change with patients who have procedures on the CMS IP Only List
- Applies only to Medicare Traditional (Part A), not Medicare Managed Care
- Physician order still required for IP admission
- Physician documentation must support reasonable basis for medical necessity, the order, and expectation to stay over 2 midnights
Old Way - New Way

CMS states this is no different than what it has always required; however, it ‘feels’ different for acute care and critical access hospitals, physicians

- Regulations for orders and certification have been in CMS regulations since the start of Medicare
  - The Final Rule updated, quantified and formalized longstanding policy so it can be formally measured and assessed (audited)

Physician Required Documentation - Orders

- **Content:** Order must specify admission for IP services
  - Applies to Acute, CAH, IP Psych, IP Rehab (Rehab has additional directions to follow, specified in IRF regulations)
  - Verbal order is ok; however, it must be authenticated (signed, dated, timed) prior to discharge (or earlier if the State or hospital requires it)
  - Physician decision of less than / greater than 2 midnights
  - May be a verbal (not standing) order that identifies the qualified admitting practitioner; must be countersigned by the ordering practitioner promptly and prior to discharge

- **Timing:** Must be furnished at or before the time of the IP admission. CMS does not allow for retroactive orders or the inference of orders
  - Can be written in advance of the formal admission
Physician Required Documentation - Orders

- **Specificity:** ‘Inpatient Status’, ‘For inpatient services’, or similar language. ‘Admit to ICU’, ‘Admit to Step-down’, etc. is no longer acceptable
  - ‘Admit to ER’, ‘to Recovery’, ‘to Short Stay Surgery’, ‘Admit to Observation’ define non-IP services, and does not meet IP admission requirements

- **Ordering physician/practitioner:**
  - Authorized by the state to admit patients and has been granted admitting privileges by the hospital’s medical staff (e.g., may be the attending or the physician on call for the attending; the hospitalist; the surgeon or surgeon on call)
  - Residents and non-physician practitioners, with countersignature by ordering practitioner prior to discharge
  - ED physicians who does not have admitting privileges but authorized by the hospital to issue temporary or “bridge” IP admission orders, with countersignature by ordering practitioner prior to discharge
  - Knowledge of the patient’s hospital course

*If the order is not properly documented in the medical record, the hospital should not submit a claim for Part A payment*

Physician Required Documentation - Certification

- **Content:**
  - Reason / Diagnosis for inpatient services
  - Estimated length of time the patient needs to be in the hospital
  - Plans for post-hospital care (if appropriate),
  - CAH: Must certify the patient may reasonably be expected to be discharged / transferred within 96 hours after admission to CAH
  - Authentication of the order, certifying that IP services were ordered in accordance with the regulations governing the order

- **Timing:**
  - Certification begins with the order for IP admission
  - Certification completed and authenticated (signed, dated, timed) prior to discharge
  - CAH: Certification required no later than 1 day prior to the date on the claim
Physician Required Documentation - Certification

- The physician/practitioner signing the certification must be:
  - The physician responsible for the case; or
  - Another physician who has knowledge and is authorized to do so by the responsible physician or the hospital’s medical staff

- Recertification:
  - Psychiatric: At 12 days, then recertify per at least every 30 days
  - All other hospitals, see regulations for guidance pertaining to outliers and those not subject to PPS

- Format
  - No specific procedures or forms are required for certification or recertification
  - Must be a separate, signed statement for each certification and recertification

Next Steps
Next Steps – Part 1

EHR Changes - Orders

- Physician Order and expectation related to length of time in the hospital
- Auto-routing of all admit orders that are signed by PAs, NPs, and residents to the physician's inbox.

And…. Downtime order processes!

ADD: 2 options for “acute” status:
- Acute - Expect stay two midnights or longer
- Acute - Expect stay shorter than two midnights

“We are working on updating wording from “Place” to “Admit”.”
ADD: 2 options for “Observation” status:
Observation - Expect stay one midnight or less
Observation - Expect stay more than one midnight

ADD: 2 options for “Acute” status:
Acute - Expect stay two midnights or longer
Acute - Expect stay shorter than two midnights
“Change” to Admit to Outpatient Status Order

ADD: 2 options for “Observation” status:
- Observation - Expect stay one midnight or less
- Observation - Expect stay more than one midnight

Next Steps – Part 2

EHR Changes - Certification
- Auto pop-up of the Certification form the second time the physician signs into a patient's chart
- HARD stop so nothing can be done until the Certification is completed
Next Steps – Part 3

- **Toolkit**
  - Decision tree: Inpatient vs Outpatient
  - FAQs for physicians and key stakeholders
  - Education for physicians

- **Evaluating Pre-bill audits for cases less than 2 midnights**
  - Electronic “self-audit” options
  - Implications for days in A/R and DNFB
  - Daily monitoring reports

- **Communications**
  - Everyone involved – monthly Open Door Forum WebEx/conference calls
  - Patient communication

Concerns

- Tremendous change for physicians

- Confusion regarding time in hospital as the *only* requirement to be addressed
  - CMS confirmed that Medical Necessity is still a component of the process to determine if a patient should be IP or OP
  - The Order and Certification are to be considered along with medical record documentation to support Medical Necessity

- Challenges in communicating changes and impact to Medicare patients
Concerns

• IP Only List processes

• Internal post discharge audits
  • Resources and capabilities
  • Impact on days in A/R and DNFB

• CMS contractors
  • “Probe and Educate” audits period – extended through September 30, 2014
    • Small samples (10-25 claims per hospitals) less than 2 midnights
    • MACs citing education and further review as necessary
    • Transmittal 505 rescinded

• Lost revenue and increased compliance risk if we don’t get it right

Process Improvement Recommendations

• Work with all teams and EHRs to improve operational processes
  • Automate
  • Standardize

• Gather data and reporting volume to Finance leadership

• Create reports that each team needs
  • Distribute daily/weekly

• Use an hour every month to hold your own Open Door Forum call
  • Distribute FAQs after each call
Contact Information

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Appendix
Regulatory References

• CMS 1599-F, effective for dates of service on and after October 1, 2013 (August 2, 2013)
• Hospital Inpatient Admission Order and Certification (updated January 30, 2014)
• MLN Matters SE1333, “Temporary Instructions of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Claims” (September 26, 2013)
• CMS FAQs, “2 Midnight IP Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013” (updated February 24, 2014)
• Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims, SE1333 Revised (October 23, 2013)
• Reviewing Hospital Claims for Patient Status: Admissions On or After October 1, 2013 (updated February 24, 2014)
• Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 12013 (updated February 24, 2014)
• Medicare Inpatient Hospital Probe & Educate Statue Update (February 24, 2014)