Briefings on APCs

Review your electronic order templates to protect against audits and ensure compliance

by Valerie A. Rinkle, MPA

Orders for services are a vital component of ensuring Medicare coverage. With the advent of computerized provider order entry (CPOE), it is important to review order templates in the electronic medical record (EMR) and the resulting order produced or printed in the formal legal medical record to ensure the templates meet requirements.

Due to increased audit scrutiny, including resumption of inpatient status reviews by Quality Improvement Organizations (QIO) as of late September, it is vital to "audit proof" your organization's EMR and legal medical record so that the orders substantiate coverage of services. The QIOs are auditing to ensure validity of inpatient orders as well as to ensure cases meet the benchmark for at least two nights of hospital-level care. These determinations are dependent on valid orders.

CMS has published numerous resources on orders for both outpatient services and inpatient admission. Requirements for orders vary based on the type of service, such as inpatient admission, outpatient admission, observation services, diagnostic laboratory services, and other diagnostic tests. A good resource is the CMS article, "Complying With Medical Record Documentation Requirements."

Orders must be signed or otherwise legitimately authenticated. Transmittal 327 contains detailed information concerning physician signature/authentication.

Elements of a valid order

To be considered a valid order, several elements must be present. Elements required in statute or regulations by Medicare are bolded:

- Authentication of the ordering provider (signature or valid electronic signature and credentials)
- Clinical indication/justification/reason for the test, using medical terminology (e.g., sign, symptom, diagnosis) and/or ICD-10-CM codes
- Date of the order
- If a drug is ordered, the drug name, dosage, route of administration, and rate for infusions
- Name of the ordering provider?this must be a treating provider, meaning he or she has conducted an exam and intends to use the results of that exam in continued treatment of the patient
- Patient name?best practice also calls for another identifier, such as date of birth
- Test or service ordered, by name?best practice also calls for the HCPCS/CPT code of the test

Format of orders

There is no requirement regarding the format of orders. For providers not linked to a hospital's EMR, orders may continue to be delivered in writing or via facsimile. Often, the beginning of the workflow for the hospital EMR is to transcribe the order into the EMR for the patient. If this step occurs, it is vitally important that the original order be scanned and linked to the EMR to substantiate the information transcribed.

What if the staff transcribing the order incorrectly enters the information? What if the test is not logical or valid for the indication? The clinical staff providing the service should be able to view the original order and make any corrections, or obtain an updated order, as appropriate. Auditors expect to see the original order. If the order is not entered via CPOE, there will be no documentation in the EMR regarding the origination of the order, which is why scanning and not just transcribing the order is so crucial.

Orders missing elements

What does your hospital do if one of the elements is missing from the order? Ideally, if there were elements missing, no test or service would be performed. However, the current emphasis on improving patient experience may lead

hospitals to move ahead and perform the service anyway. Recall that the EMR will clearly document the time of the test and the time that the diagnosis or other information is obtained, making it very clear to auditors whether the indications for the test were missing prior to its performance.

Further, because of prior authorization requirements as well as national coverage determinations (NCD) and local coverage determinations (LCD) that establish the medical necessity for outpatient tests, diagnostic indications obtained after test performance will be questioned: Did they actually exist prior to the test being performed?

If the hospital proceeds with testing prior to obtaining all the required elements of the order, it is recommended that the original chart note of the provider ordering the test be obtained, scanned, and linked to the EMR. The original chart note should clearly document that the test is needed along with the indication for the test. Documenting this information will prevent the appearance that the indication has been added after the test solely to justify meeting prior authorization or NCD/LCD requirements. Merely updating the EMR order with a diagnosis, or calling the provider and annotating the addition of a diagnosis on a written or faxed order, will open up the account to scrutiny and allegations of invalid documentation to support services.

ED protocols

What about testing initiated via protocol in the ED prior to the patient being seen by the treating provider? Protocols need to be vetted very carefully with the medical staff and with the MAC in your region.

Typically, an order is initiated as a verbal order in the EMR based on the presenting signs and symptoms of the patient. Once the provider sees the patient and uses the test results to treat the patient, the verbal order is authenticated by the treating ED provider in the EMR.

With this workflow, the requirements for orders are met. The concern with this workflow is whether the hospital has controls in place for patients who leave without being seen (LWBS) by the provider and for tests the provider does not agree were needed.

Providers do, at times, disagree with the protocol initiated by the nursing staff. There must be a clear workflow for the provider to do one of the following:

- Not authenticate the order with which the provider disagrees.
- Authenticate the order, but annotate the tests the provider disagrees with within the order. In these cases, the disputed tests should be billed and written off as noncovered.

Also, if tests are ordered via protocol and the patient is LWBS by a provider, the tests are not usually authenticated by the provider, and they are billed and written off as noncovered.

Billing for tests and services

ICD-10-CM codes included on outpatient claims for services typically come from the provider order. For certain imaging, cardiology, and other tests (i.e., nonclinical laboratory tests) where a physician makes a separate report of interpretation, the final impression on the report may be a different diagnosis from that on the order. In this case, the coder should code the final diagnosis from the report of interpretation. This diagnosis should be the diagnosis code billed on the claim. However, a large volume of accounts are billed from the order, and there may not be a process to ensure the diagnosis from the report of interpretation is included on the claim. In the past, some billing and coding departments coded solely from the indication that patient access staff transcribed from the order onto the patient account, meaning the departments did not review the reports of interpretation.

It is critical for compliance that outpatient accounts be coded from the original order if the report of interpretation does not have a more specific diagnosis (i.e., the report states "routine" or "no finding"). Proper coding requires that the staff applying the codes either view the original order in CPOE or via the scanned image.

With today's gains in automation and productivity, more workflows now pull a code directly from the transcribed information or the data entered into CPOE to the outpatient account for billing. If this is the preferred workflow of the hospital, a sample of accounts should be audited quarterly to ensure that the codes billed match the original order and that the automated workflow is viable for compliance coding and billing and does not bypass reports of interpretation that include more specific diagnoses.

One of the best program memoranda (albeit an older one) that explains CMS policies concerning coding for diagnostic

tests is contained in Transmittal PM AB 01-144.

Including ICD-10-CM codes

There is a lot of debate regarding whether the codes themselves (versus terminology) should be included in the order. Coders typically emphasize that they can arrive at the most appropriate code if medical terminology, rather than a less specific ICD-10-CM code, is included on the order. Meanwhile, patient access staff and other employees who must apply NCDs and LCDs and check for prior authorization prefer the actual ICD-10 code to be on the order because it facilitates checking for coverage and authorization in electronic tools designed for that purpose.

CPOE can improve the specificity of orders if the drop-down menus used by providers are customized to be as specific as possible and avoid more nonspecific codes. Consider also the greater specificity present in ICD-10-CM. If certain order sets for high-volume patients include indications for drugs and other tests at their greatest specificity, documentation can be better captured in more routine workflows to support ICD-10-CM coding, thereby avoiding time-consuming provider queries.

Conclusion

EMRs enable workflows that should be scrutinized completely, from the initiation of the order with the treating provider to the order's appearance in the retained legal medical record.

Other related processes should also be scrutinized, including the workflow used to check orders for medical necessity and prior authorization, as well as the workflow used by staff and/or coders to apply the codes from the orders to the account and the resulting claim. Detailing these workflows and enhancing the processes that go along with them will ensure compliant orders.

Editor's note

Rinkle is a lead regulatory specialist and instructor for HCPro's Medicare Boot Camp® Hospital Version, Medicare Boot Camp Utilization Review Version, and Medicare Boot Camp Critical Access Hospital Version. She is a former hospital revenue cycle director and has over 30 years in the healthcare industry, including over 12 years of consulting experience in which she has spoken and advised on effective operational solutions for compliance with Medicare coverage, payment, and coding regulations,