AHIMA
Distance Education
Career-building Resources

Impact of Medicare COP Changes on HIM

Audio Seminar/Webinar

March 29, 2007

Practical Tools for Seminar Learning

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Faculty

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Ms. Clark is the Service Line Director for Health Information Services and Accreditation for Roper St. Francis Healthcare in Charleston, South Carolina. She is a past president of AHIMA and current President of the International Federation of Health Records Organizations (IFHRO). She served on the JCAHO special task force to revise the accreditation standards and process as well as the Management of Information chapter special task group. She is a frequent speaker and author on topics related to JCAHO.

Carole Gammarino, RHIT

Ms. Gammarino is a professional services consultant with Precyse Solutions, HIM Services. Ms. Gammarino is a frequent speaker and contributor to publications on APCs. She has over 10 years of experience in HIM, including extensive experience in Joint Commission preparation, tumor registry, medical staff coordinating services, unbilled accounts management, coding, and education and recruiting.

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- Update to the History and Physical
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Goals for Today

- Learn the effects of the first revision of the rule in over 10 years
- Compare the new rules to Joint Commission accreditation standards
- Recognize changes that hospital staff will need to make in documentation practices and record completion procedures
- Apply the new COP rules to case examples

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Conditions of Participation (COPs)

- November 27, 2006 changes, effective January 26, 2007
  - Completion of the history and physical examination – Medical Staff Services and Medical Record Services
  - Authentication of verbal orders – Nursing Services and Medical Record Services
  - Completion of postanesthesia evaluation – Anesthesia Services

2

History and Physical

Completion of the history and physical

November 27, 2006 *Federal Register*
beginning at page 71FR68694

Medical Staff Services §482.2 2 - (duty to adopt and enforce bylaws)

a) H&P must be completed no more than 30 days before or 24 hours after admission.

b) Must be in the medical record within 24 hours after admission and before surgery

c) **Hospital** must ensure that an updated medical record entry documenting an examination for any changes in the patient's condition is complete, and the updated examination must be completed and documented in the patient's medical record within 24 hours after admission.

3

History and Physical

Completion of the history and physical

November 27, 2006 *Federal Register*
beginning at page 71FR68694

Medical Record Services §485.24 - (all records must document)

a) A medical history and physical examination completed no more than 30 days before or 24 hours after admission.

b) Must be placed in the medical record within 24 hours after admission.

c) An updated medical record entry documenting an examination for any changes in the patient's condition when the medical history and physical examination are completed within 30 days before admission. This updated examination must be completed and documented in the patient's medical record within 24 hours after admission.

4

Joint Commission

PC.2.120 – The hospital defines the time frame(s) for conducting the initial assessment(s).

EP. 1 – A medical history and physical examination is completed within no more than 24 hours of inpatient admission.

EP. 6 – The history and physical must have been completed within 30 days before the patient was admitted or readmitted.

EP. 7 – Updates to the patient's condition since the assessment(s) are recorded at the time of admission.

IM.6.20 – Records contain patient-specific information, as appropriate, to the care, treatment, and services provided.

EP.1. Documentation and findings of assessments (refers back to PC.2.120)

5

Joint Commission

MS.2.10 – The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

EP.6 The organized medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services

EP.7 The organized medical staff monitors the quality of medical histories and physical examinations.

EP.8 The organized medical staff requires that a practitioner who has been granted privileges by the organization to do so performs a patient's medical history and physical examination and required updates.

EP.9 As permitted by state law and policy, the organized medical staff may choose to allow individuals who are not licensed independent practitioners to perform part or all of a patient's history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician who is accountable for the patient's medical history and physical examination.

EP.10 The organized medical staff defines when a medical history and physical examination must be validated and countersigned by a licensed independent practitioner with appropriate privileges.

EP.11 The organized medical staff defines the scope of the medical history and physical examination when required for non-inpatient services.

6

What do we do?

- **CMS says to follow state requirements when they have been authorized from state legislation when they differ from these federal COP requirements.**
- **Follow hospital policy if it is stricter than state or federal requirements.**
- **Follow JCAHO (or AOA) if stricter.**
- **Policy should reflect which requirements the hospital follows.**

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The "Nitty Gritty" of the H&P COP

- **Has time and date requirements.**
- **External H&Ps can not be over 30 days before admission or surgery.**
- **H&P must be placed in the record with 24 hours after admission and before surgery.**
- **Second review of the patient's condition is required at the time of admission or before surgery (if no H&P done before).**
- **Note "no changes" or what the changes are in the record.**

8

The "Nitty Gritty" of the H&P COP

- **Deleted requirement that the H&P be completed by a practitioner credentialed and privileged by the admitting hospital.**
- **An update to the H&P should be completed after the patient is admitted.**
- **The update should be completed by an individual who has been credentialed and privileged by the hospital medical staff to conduct an H&P.**
- **If H&P has been dictated and not recorded, there must be a statement to that effect and an admission note in the chart by the practitioner who admitted the patient.**
- **Applies to inpatients and outpatients (who are having surgery).**

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The "Nitty Gritty" of the H&P COP

- **Note: Practitioners do not have to be granted the privilege to conduct a medical history and physical examination by the medical staff.**
- **Added the language, "in accordance with State law and hospital policy".**

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Tips for Compliance

- **Know your state law, first!**
- **Develop a policy that complies with state law and COP.**
- **Do not have a hospital policy that is stricter than any requirement, COP, Joint Commission, state.**
- **Consider using a stamp or form (see attached) for the update.**
- **Revise policy/Medical Staff Bylaws, Rules and Regulations if appropriate.**
- **Educate the Medical, Nursing, HIM Staffs.**
- **Obtain support from Medical Staff leadership.**
- **Monitor for compliance.**
- **Take action as needed.**

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Verbal Orders

- **Nursing Services §482.23 – If verbal orders are used they are to be used infrequently. When verbal orders are used, they must only be accepted by persons who are authorized to do so by hospital policy and procedures consistent with federal and state law.**
- **Medical Records §482.24 – All patient medical record entries must be legible, completed, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the hospital policies and procedures.**

Continued

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Verbal Orders

Medical Records, Verbal Orders — Continued

- All orders, including verbal orders must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted below.
- For the five year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified and authorized to write orders by hospital policy in accordance with state law.

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Verbal Orders

Medical Records, Verbal Orders — Continued

- All verbal orders must be authenticated based upon federal and state law. If there is no state law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours.

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Joint Commission

- **IM.6.50 – Designated qualified staff accept and transcribe verbal or telephone orders from authorized individuals.**
  - **EP.1 – Qualified personnel are identified, as defined by hospital policy and in accordance with law or regulation, and authorized to receive and record verbal or telephone orders.**
  - **EP.2 – Verbal or telephone orders are dated and identifies the names of the individuals who gave, received, and implemented the order.**
  - **EP.3 – When required by law or regulation, verbal or telephone orders are authenticated within the specified time frame.**
  - **EP.4 – For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result. (Scored under National Patient Safety Goals.)**

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What do we do?

- **Use verbal orders infrequently.**
- **Hospital policy and practice should discourage the use of verbal orders as much as possible.**
- **Revisit current policy in regard to "read-back" verification process when using verbal orders. (Not included in the regulation, but expected.)**

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The "Nitty Gritty" of the Verbal Orders COP

- **Verbal orders should be used infrequently.**
- **Verbal orders must be legible, dated, timed and authenticated promptly.**
- **For the five year period following January 26, 2007, orders can be dated, timed, and signed by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified and authorized to write orders by hospital policy in accordance with state law.**

Continued

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The "Nitty Gritty" of the Verbal Orders COP ***Continued***

- **In lieu of a state law designating a timeframe for authentication of verbal orders, then authentication should occur within 48 hours.**
- **The revisions actually broaden the category of practitioner who may authenticate verbal orders, unless state law prohibits.**
- **Hospital policy must define who can accept verbal orders.**
- **The 'read-back' is expected but not included in the requirements.**

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Tips for Compliance

- Know state laws.
- Do not develop a policy that stricter than other requirements.
- Develop a policy for orders that defines:
  - A. Who can receive orders, for example RNs, PAs, PT, RT
  - B. Who can give orders, physicians, PAs, NPs
  - C. If physicians can sign for one another, and when would this occur
  - D. Verbal orders should be used infrequently
  - E. Requirements for authentication – legible, dated, timed, and authenticated; authentication must be dated and time and must be done promptly (within 48 hours), can be electronic or in writing
  - F. "Read-back" process – receiver records the order directly onto the order form or the computer, receiver dates, times, and reads back and signs the order, ordering practitioner verifies

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Tips for Compliance

- Treat telephone orders the same as verbal orders.
- Revise policy or medical staff bylaws, rules and regulations if necessary.
- Make compliance with policy part of regular record reviews and mock surveys both through observation and documentation in the medical record.
- Report findings on a regular basis by persons giving the order, taking the order, authenticating the ordering.

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Notes/Comments/Questions

Completion of the Postanesthesia Evaluation

- Anesthesia Services §485.52 –
  - Covers the delivery of anesthesia services and specifically addresses delineation of preanesthesia and postanesthesia responsibilities.
  - With respect to inpatients, a postanesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia, as specified, within 48 hours after surgery.

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Joint Commission

- Standard PC.13.40 Patients are monitored immediately after the procedure and/or administration of moderate or deep sedation or anesthesia.
  - EP.1 The patient's status is assessed immediately after the procedure and/or administration of moderate or deep sedation or anesthesia.
  - EP.4 Patients are discharged from the recovery area and the hospital by a qualified licensed independent practitioner or according to rigorously applied criteria approved by the clinical leaders. (also see IM.6.30, EP.5, 6, 7)

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What do we do?

- **Only use individual qualified to administer anesthesia to complete the postanesthesia evaluation.**
- **Must be done within 48 hours after surgery.**

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The "Nitty Gritty" of the Postanesthesia COP

- **Required any time general, regional, or monitored (includes deep sedation/analgesia) anesthesia has been administered to the patient.**
- **Monitored anesthesia care is defined using ASA guidelines.**
- **Must be performed by a qualified individual within 48 hours after the procedure.**
- **If patient is discharged less than 48 hours still must be performed.**
- **Applies to inpatients and outpatients.**
- **Stricter policy would prevail.**
- **Not clear where the evaluation should take place, but must be dated, timed and authenticated.**

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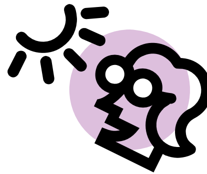
Tips for Success

- Make sure policy and/or medical bylaws, rules and regulations are in compliance with the requirements.
- Make a regular part of ongoing record review at the patient care level.
- Report findings and take action as appropriate.



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Additional COP Changes —FYI Only

- Securing medications in the Pharmaceutical Services COP
- Notice of Rights
- Exercise of Rights
- Confidentiality of patient records
- Restraint for acute medical and surgical care
- Seclusion and restraints for behavior management

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References/Resources

- **AHIMA Analysis of November and December 2006 Final Rule Changes to the Medicare and Medicaid Programs Hospital Conditions of Participation www.ahima.org**
- **Comprehensive Accreditation Manual for Hospitals: The Official Handbook, 2007**
- **E-mail: jean.clark@ropersaintfrancis.com**

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Audience Questions

Audio Seminar Discussion

Following today's live seminar
Available to AHIMA members at
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Update to the History and Physical

Must be completed if history and physical was performed prior to admission or outpatient surgery. No history and physical can be older than 30 days from admission or outpatient surgery.

- ☐ There have been no changes to the patient's condition since the last assessment.

The following changes have occurred to the patient's condition since it was last assessed.

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Physician Signature/Date ____

CROSSWALK - HIM CONDITIONS OF PARTICIPATION CHANGES AND JOINT COMMISSION

<table>
<tr><th colspan="2">History and Physical Report</th></tr>
<tr><th>CoP</th><th>Joint Commission</th></tr>
<tr><td>Medical Staff Services 482.22
a) H&P must be completed no more than 30 days before or 24 hours after admission.
b) Must be in the medical record within 24 hours after admission and before surgery.
c) Hospital must ensure that an updated medical record entry documenting an examination for any changes in the patient’s condition is complete, and the updated examination must be completed and documented in the patient’s medical record within 24 hours after admission.

Medical Record Services 485.24 (all medical records must contain)
a) A medical history and physical examination completed no more than 30 days before or 24 hours after admission.
b) Must be placed in the medical record within 24 hours after admission.
c) An updated medical record entry documenting an examination for any changes in the patient’s condition when the medical history and physical examination are completed within 30 days before admission. This</td><td>PC.2.120
The hospital defines the time frame(s) for conducting the initial assessment(s).
EP.1 – A medical history and physical examination is completed within no more than 24 hours of inpatient admission.
EP.2 – The history and physical must have been completed within 30 days before the patient was admitted or readmitted.
EP.3 – Updates to the patient’s condition since the assessment(s) are recorded at the time of admission.

IM.6.20
Records contain patient-specific information, as appropriate, to the care, treatment, and services provided.
EP.1 – Documentation and findings of assessments (refers back to PC.2.120)

MS.2.10
The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.
EP.6 – The organized medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services.</td></tr>
</table>

History and Physical cont.	
CoP	**Joint Commission**
c) updated examination must be completed and documented in the patient's medical record within 24 hours after admission.	EP.7 – The organized medical staff monitors the quality of medical histories and physical examinations. EP.8 – The organized medical staff requires that a practitioner who has been granted privileges by the organization to do so performs a patient's medical history and physical examination and required updates. EP.9 – As permitted by state law and policy, the organized medical staff may choose to allow individuals who are not licensed independent practitioners to perform part or all of a patient's history physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician who is accountable for the patient's medical history and physical examination. EP.10 – The organized medical staff defines when a medical history and physical examination must be validated and countersigned by a licensed independent practitioner with appropriate privileges. EP.11 – The organized medical staff defines the scope of the medical history and physical examination when required for non-inpatient services.

Verbal Orders	
CoP	**Joint Commission**
Nursing Services 482.23 If verbal orders are used they are to be used infrequently. When verbal orders are used, they must only be accepted by persons who are authorized to do so by hospital policy and procedures consistent with federal land sate law. **Medical Records 482.24** All patient medical record entries must be legible, completed, dated, timed, and authenticated in written or electronic form by the person responsible for providing and evaluating the service provided, consistent with hospital policies and procedures. All orders, including verbal orders must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted below. For the five year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified and authorized to write orders by hospital policy in accordance with state law. All verbal orders must be authenticated based upon federal and state law. If there is a no state law that designates a specific time frame for the authentication of verbal orders, verbal orders must be authenticated be authenticated within 48 hours.	**IM.6.50** Designated qualified staff accept and transcribe verbal or telephone orders from authorized individuals. EP.1 – Qualified personnel are identified, as defined by hospital policy and in accordance with law or regulation, and authorized to receive and record verbal or telephone or EP.2 – Verbal or telephone orders are dated and identifies the names of the individuals who gave, received, and implemented the order. EP.3 - When required by law or regulation, verbal or telephone orders are authenticated within the specified time frame. EP.4 – For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result. (scored under NPSGs)

Postanesthesia Evaluation	
CoP	**Joint Commission**
Anesthesia Services 485.52 With respect to inpatients, a postanesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia, as specified, within 48 hours after surgery.	**PC.13.40** Patients are monitored immediately after the procedure and/or administration of moderate or deep sedation or anesthesia. EP.1 – The patient's status is assed immediately after the procedure and/or administration of moderate or deep sedation or anesthesia. EP.2 – Patients are discharged from the recovery area and the hospital by a qualified licensed independent practitioner or according to rigorously applied criteria approved by the clinical leaders. (also see IM.6.30, EP.5, 6, 7)

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