Critical Access Hospital Conditions of Participation – What’s NEW?

Over the next several months we will be publishing a series of Clinical Connection Newsletters focused on the revisions in the CoPs for Critical Access Hospitals. Part Two addresses:

Do I really have to sign that?
and
Is there a Doctor in the house?

The Summary—Do I really have to sign that?

The CoPs for Critical Access Hospitals (CAH) released in April of 2015 clarify the frequency of physician review and signature in the medical record of patients cared for by a nurse practitioner, clinical nurse specialists and/or physician assistants (mid-level providers).

Here’s the summary:

1) A physician must sign the records of all inpatients managed by a mid-level provider.

2) If care was managed by a physician but the patient also received services by a mid-level provider, an additional physician review is not required.

3) A physician must review and sign a sample of outpatient records unless 100% is required by state law. If a sample is allowed, 25% is recommended, but not required. (Note: Check to see if a physician signature is required in order to bill for services.)

4) Hospital policy dictates timing of reviews – CMS only requires that the policy is reasonable based on number of patients and number of physicians on staff.

5) Physician reviews can occur off-site thru a review of the EMR or other electronic methods.

6) If you have a Rural Health Clinic, the regulations are a little different. In a Rural Health Clinic the physician assistants and nurse practitioners must participate in a periodic review of patient records. The review is meant to be collaborative (i.e. with the physician) not just a review by the physician alone. There must be evidence that the review has occurred.
CoP Excerpts—Physician Signatures (new language in italics and bold)


[The doctor of medicine or osteopathy]
(iv) Periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, or physician assistants.

(v) Periodically reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants only to the extent required under State law where State law requires record reviews or co-signatures, or both, by a collaborating physician.

All inpatient records for patients whose treatment is/was managed by a non-physician practitioner in the CAH, i.e., nurse practitioners, clinical nurse specialists, or physician assistants, must be reviewed periodically by a CAH MD/DO who must sign the records after the review has been completed. The MD/DO review is expected to cover all applicable inpatient records open at the time of the review, as well as all applicable inpatient records closed since the last review.

In the case of inpatients whose care is/was managed by an MD/DO, as evidenced by an admission order, progress notes, and/or medical orders, etc., but who also receive services from a non-physician practitioner, a subsequent MD/DO review of the inpatient record is not required.

In States where State law requires a collaborating physician to review medical records, co-sign medical records, or both for outpatients whose care is managed by a non-physician practitioner, i.e., a nurse practitioner, a clinical nurse specialist, a certified nurse midwife, or a physician assistant, a CAH MD/DO must review and sign a sample of outpatient records.

The outpatient medical record sample reviewed must be representative of all non-physician practitioners providing care to patients of the CAH. The CAH determines by policy the size of the sample reviewed and signed; however, CMS recommends, but does not require, a sample size of 25% of the records of all outpatient encounters managed by a non-physician practitioner since the prior MD/DO review. If State law requires MD/DO review or signature of a larger percentage of the outpatient records, the CAH must comply with State law.

In States where no physician record review or physician co-signature is required for patients managed by a non-physician practitioner, an MD/DO is not required to review or sign outpatient records of such patients.

Neither the regulation nor the preamble to the final rule adopting this regulation (79 Fed. Reg. 27105, May 12, 2014) specify a particular timeframe to satisfy the requirement for “periodic” review, but the CAH must specify a maximum interval between inpatient record reviews in its policies and procedures. The CAH is expected to take into account the volume and types of services it offers in developing its policy. For example, a CAH that has only four certified beds and one MD/DO on staff and which does not always have an inpatient in house would likely establish a different requirement for inpatient record review than a CAH with 25 certified beds, multiple MDs/DOs on staff and a high inpatient occupancy rate. Further, there is no regulatory requirement for the review of records to be performed on site and in person. Thus, if the CAH has electronic medical records that can be accessed and digitally signed remotely by the MD or DO, this method of review is acceptable. Therefore, CAHs with and without the capability for electronic record review and signature might also develop different policies for the maximum interval between reviews.
CoP Excerpts—Physician Review  
(new language in italics and bold)

Rural Health Clinic Condition for Certification  
§491.8 Condition for Certification: Staffing and Staff Responsibilities  

(b) Physician responsibilities. The physician performs the following:  
(3) Periodically reviews the clinic’s or center’s patient records, provides medical orders, and provides medical care services to the patients of the clinic or center.

(c) Physician assistant and nurse practitioner responsibilities  
(ii) Participate with a physician in a periodic review of the patients’ health records.

The Summary—Is there a Doctor in the house?

For most CAHs having a physician in-house or available on-call to provide medical direction isn’t an issue. However, for those who do not, the regulations provide some flexibility including technology options.

1) A physician must be present for sufficient periods of time to provide medical direction, consultation and supervision of the healthcare services the CAH furnishes. This includes supervision and review of mid-levels.

2) There must be policies specifying frequency of when a physician must be on-site based on the type of services they provide.

3) Technology, such as tele-medicine, can be combined with on-site visits.

4) A CMS memo dated June 7, 2013 (Ref: S&C: 13-38-CAH/EMTALA) clarified that a MD or DO does not need to be available, in addition to a non-physician practitioner, to respond to the emergency department. They also clarified that a MD or DO must be immediately available by telephone or radio contact but this requirement can be met by telemedicine as well as a physician who practices on-site.
§ 485.631(b)(2) A doctor of medicine or osteopathy is present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the CAH, and is available through direct radio or telephone communication or electronic communication for consultation, assistance with medical emergencies, or patient referral.

Interpretive Guidelines § 485.631(b)(2)
An MD/DO must be present in the CAH for sufficient periods of time to provide overall medical direction, consultation and supervision of the healthcare services the CAH furnishes. Being “present” in the CAH means being physically on-site in the CAH. The regulation does not specify a minimum amount of time an MD/DO must spend on-site that applies to all CAHs. Instead, CAHs have the flexibility to develop policies appropriate for their circumstances. With the development of technology such as telemedicine, a CAH may use a variety of ways and timeframes for MDs/DOs to provide the necessary medical direction and oversight. For CAHs that offer a range of more complex services, have more than one MD/DO on staff, and have busy emergency departments and/or extensive outpatient services, an on-site visit by an MD/DO only once every week or every two weeks, for example, would be grossly inadequate. On the other hand, a bi-weekly on-site visit could be unduly burdensome as well as unnecessary for a small CAH in a remote rural area that offers very limited services and has a low patient volume.

CAHs are expected to have adequate staffing to provide the services they have chosen to furnish, including staffing or supervision by MDs/DOs as applicable. CMS expects each CAH to evaluate its services and adjust its MD/DO on-site schedule accordingly, as an appropriate MD/DO schedule must reflect the volume and nature of services offered.

Note that §485.618(d) also establishes a maximum timeframe for an MD, DO, PA, NP, or clinical nurse specialist to be on-call and available to be on-site to provide emergency care, and that §489.20(r)(2) requires the CAH to maintain an on-call list of MDs/DOs who are available to be on-site as part of the CAH’s Emergency Medical Treatment and Labor Act obligations. The CAH must consider all pertinent requirements when developing its policies for MD/DO presence on site.

In addition to requiring an MD or DO to be on-site for sufficient periods of time, consistent with the requirement at §485.618(e), the CAH must also ensure an MD/DO is available through direct radio, telephone or other form of electronic communication, such as video conferencing, for consultation, assistance in handling patient medical emergencies and referral of patients to other healthcare facilities. An MD/DO providing telemedicine services to the CAH may be used to fulfill the requirement for availability via telecommunications. Further, consistent with the requirements for CAH provision of emergency services at §485.618(d), unless a, PA, NP, or clinical nurse specialist with training in emergency care is immediately available via one of these telecommunication methods and available on site within the timeframe specified at §485.618(d)(1), an MD or DO must fulfill these requirements.
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<th>Review Criteria</th>
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<td><strong>1</strong> Scope of Practice: Are your bylaws and policies within the scope of practice guidelines for PAs in your state?</td>
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<td><strong>7</strong> Inpatients: Do you have a policy for physician review and signature of ALL inpatient records, including a timeline for when it must occur?</td>
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<td><strong>9</strong> Outpatients: Do you have a policy for physician review and signature for outpatients cared for by physician assistants?</td>
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<td><strong>10</strong> Outpatients: Does the policy for physician review and signature for outpatients cared for by a physician assistant require 25% record review? If less than 25% is there a rationale for a lower percentage?</td>
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<td><strong>11</strong> Outpatients: Does the policy require physician review and signature for outpatients cared for by a nurse practitioner if required by the nurse practice act in your state?</td>
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<td><strong>12</strong> Outpatients: If physician review and signature is required for nurse practitioners, are 25% of records reviewed? If less than 25% is there a rationale for a lower percentage?</td>
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<td><strong>13</strong> Outpatients: Do you audit timeliness of physician review and signature? What is your percent compliance with your policy?</td>
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<td><strong>14</strong> Rural Health Clinic: Is there evidence of collaborative review of records with a physician and physician assistants and/or nurse practitioners?</td>
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<td><strong>15</strong> Rural Health Clinic: Is there a policy that indicates number of records to be reviewed and frequency? If less than 25% is their rationale for why there is a lower percentage?</td>
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<td><strong>16</strong> Rural Health Clinic: Do you audit the collaborative review? Is the review documented?</td>
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<td><strong>18</strong> Policy: Is there a policy in place specifying the amount of time a physician must be on-site to provide medical direction, consultation, and supervision?</td>
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How Can We Help?

Our experienced consultants help prepare your team for accreditation surveys and, more importantly, to maintain continuous survey readiness. We identify opportunities and help to mitigate deficiencies.

Our consultants survey based on your accrediting organization including: Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), Det Norske Veritas (DNV), Healthcare Facilities Accreditation Program (HFAP) and State.

We have experience in conducting surveys for various provider types including: Community Hospitals; Long Term Care; Skilled Nursing; Home Health; Hospice; Rural Health Centers and Behavioral Health.

Our services include:

- Mock Surveys
  - Tracer methodology designed to follow patients from admission to discharge
  - Review of Infection Control using the CMS Worksheet
  - Review of Quality Assurance Performance Improvement (QAPI) using the CMS Worksheet
  - Review of Discharge Planning processes using the CMS Worksheet
  - Review of medical staff credentialing and privileging including tele-medicine
  - Review of environment of care, life safety and emergency management
  - Development of a comprehensive report with recommended actions for each deficiency and measures of success

- Development of continuous survey readiness strategies
- Consultation and assistance to develop and submit a written plan of correction resulting from a state or other accreditation survey

For more information or to request a call with one of our consultants, please contact:

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If you have questions or comments about this newsletter, please contact Carolyn St.Charles, Regional Chief Clinical Officer.

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