I. POLICY:

Patient testing and other clinical services are provided based on the order of physicians or Advanced Practice Professionals (APP) acting within the scope of their license, certificate, or other legal credential authorizing practice in the state of Louisiana. A valid order must be present in the medical record. Valid orders include written, electronic or verbal orders and Hospital approved protocols.

Federal and State Law and regulations may dictate exceptions to this policy such as Medicare does not require an order to provide the following services:

Screening mammography
- Influenza virus vaccine and its administration; and
- Pneumococcal pneumonia vaccine (PPV) and its administration.

II. PURPOSE:

To establish billing guidelines outlining documentation for orders for Hospital outpatient tests and services in accordance with payer guidelines.

III. DEPARTMENTS AFFECTED:

All Hospital Departments performing and/or billing outpatient services. Specifically the following departments: Patient Financial Services, Patient Access, Medical Staff, Scheduling, Case Management, Nursing, Health Information Management, East Jefferson Physician Network, East Jefferson Physician Group, Outpatient Departments, Reimbursement, Administration

IV. DEFINITIONS:

1. **Authentication**: An author’s validation of his or her own entry in a document. Methods may include written signatures, faxed signatures or electronic signatures. Only the physician or APP ordering the test or service may perform authentication. State regulations and medical staff bylaws, rules and regulations specify whether APP orders require countersignature by a physician.

2. **Advanced Practice Practitioner (APP)**: Individuals such as clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners and physician assistants who furnish services that would be physician services if furnished
3. **Outpatient Services**: Outpatient services are those services rendered to a person who has not been admitted as an inpatient but is registered on the Hospital records as an outpatient and who receives clinical services (rather than supplies alone) from the Hospital. Outpatient services include, but are not limited to, observation, emergency room, ambulatory surgery, laboratory, radiology and other ancillary department services.

4. **Qualified Individuals**: Those persons qualified by specific state rules, regulations and Hospital and/or Medical Staff bylaws to accept verbal orders for outpatient tests or services. According to the EJGH Medical Staff Rules and Regulations Section 7.2.1 ‘Verbal Orders/By Whom and Circumstance’, the following individuals may take telephone or verbal orders under the described circumstances:

   “Telephone or other verbal orders may be taken only by a registered nurse or licensed practical nurse for patients under their care, except that the following personnel, if approved in accordance with hospital policy, may take verbal orders for medication, treatment and/or procedures within their respective areas of practice and which they will prepare, deliver or perform: respiratory therapists, physical therapists, registered pharmacists, occupational therapists, radiation therapist, radiological technologists, and certified social workers. Telephone orders will be accepted only from the responsible practitioner, or their designated resident, when it is not practical for the order to be given in writing.”

5. **Protocol/Clinical Pathway**: A treatment regime or standardized specifications for care of any patient having a specifically-defined care need. A protocol is developed through a formal process that incorporates scientific evidence of effectiveness with expert opinion and is agreed upon by consensus. **NOTE**: Orders for tests or services pursuant to an approved Protocol are initiated by a physician or APP and properly authenticated. A copy of the original protocol is maintained in the patient’s medical record.

6. **Standing Orders**: Orders to be initiated for all patients meeting specified circumstances or conditions (e.g. orders for patient presenting to ED with chest pain) unless the physician intervenes with different orders. Standing orders are approved in accordance with medical staff bylaws, rules and regulations, state and federal regulations, rules of accrediting agencies and hospital policy. Standing orders are entered by a clinician when the patient meets the specified circumstance or condition. They are authenticated by a physician or APP, but this may be after the order is carried out.
V. GENERAL GUIDELINES:

A COPY OF THE IMPLEMENTED STANDING ORDER IS MAINTAINED IN THE PATIENT’S MEDICAL RECORD

1. It is acceptable for a Resident physician to order a test or service provided the Hospital’s medical staff bylaws, rules and regulations authorize resident physicians to be granted the privilege of ordering tests and services.

2. It is acceptable for Nurse Practitioners and Physician Assistants to order tests or services provided they are appropriately licensed/authorized and acting within the scope of their license/authority.

3. The Hospital's Medical Staff Rules and Regulations define by position or credentials, who can relay verbal orders and who may accept and document verbal orders, which shall be in accordance with professional practice acts and state law.

4. Protocol/Clinical Pathways and Standing Orders are approved by the Medical Staff.

5. There are no Medicare rules which specify a limiting time frame for orders. The Hospital has established the following timeframes for outpatient orders based upon known regulatory guidelines. The patient’s condition can change over time, so when a timeframe is questionable, it is best practice to contact the ordering physician for confirmation or an updated order.

   Non-Scheduled Drugs/Medications: One (1) year
   Scheduled Drugs/Medications: Six (6) months
   Laboratory Test: One (1) year
   Radiology Test: Ninety (90) days (or 90 days from a future order date)
   Cardiology Test: Ninety (90) days (or 90 days from a future order date)
   Pulmonology/Respiratory: Ninety (90) days (or 90 days from a future order date)
   Physical/Occupational/Speech Therapy: Ninety (90) days (or 90 days from a future order date)

VI. PROCEDURES:

1. Patient Access and Hospital department personnel shall review outpatient orders to verify required data elements for billing are present. Protocols are considered valid orders provided they meet the requirements specified in the definition section of this policy.
2. Test or Service Order – Data elements for billing:
(Please note all elements need not be in the same document, but may be located in other areas of the medical record.)

- Patient Name
- Test or service requested (If performed as a part of a protocol or standing order, a copy of the protocol or standing order is maintained in the patient’s medical record)
- Reason for ordering test or service (i.e. diagnosis, sign, symptom, ICD diagnosis code)
- Name of Physician or APP ordering test or service, with authentication in the medical record as defined previously
- Date the order was written or received by the Hospital
- Time the service was performed may be required for certain services where billing is determined by the length of the service. Examples include observations services, infusions and physical therapy.

Verbal orders include the above elements and also the following:

- Name of qualified individual who relayed and name of who accepted and documented the verbal order
- Communication method (E.G. verbal, phone)
- Date and time order was entered into the medical record

When the above elements are present and other coverage guidelines are met, the Hospital may bill for the tests or services ordered.

3. If information from the order is missing, Team Members receiving the outpatient order shall attempt to obtain the required information. Every effort should be made to obtain all information prior to tests being performed or services being rendered. However, if patient care or the integrity of a specimen is at risk, continue processing the test(s) or performing the service(s) and subsequently obtain required elements.

4. Physician or APP authentication must be legible and obtained as defined by medical staff bylaws, rules and regulations and Hospital policy and procedure. The Hospital may code and bill the account without an authenticated order; however, the order must be promptly authenticated. Patient Access will email Health Information Management when an order is not signed prior to the test being performed so that HIM can request a signature from the ordering physician to complete the chart.
NOTE: Signature stamps must not be used in the medical record. If an order is received with a stamped signature, the Hospital shall obtain the appropriate authentication (written or electronic).

All Team Members responsible for ordering, registering, performing, charging, coding or billing outpatient tests or services are educated on the contents of this policy.

VII. RESPONSIBILITY:

Questions concerning this policy and recommended revisions shall be directed to the Director of Patient Access or designee.

VIII. REFERENCES:

EJGH Medical Staff Bylaws: Rules and Regulations

IX. APPROVAL:

Reviewed and approved by the Medical Executive Committee of the Medical Staff on the 12th day of November, 2013.