

Briefings on APCs

CMS tears down walls for physician supervision

New definition of 'immediately available' eases burden, creates new challenges

More physicians should be able to provide supervision for outpatient procedures after CMS finalized a change to its physician supervision requirements in the 2011 OPPS final rule, released November 2, 2010.

Beginning this year, CMS is removing the words "in the hospital" from the definition of "immediately available," meaning CMS will no longer require physicians to be present in every off-campus provider-based department (PBD).

The meaning of the phrase "immediately available" will not change per se, says **Debbie Mackaman, RHIA, CHCO**, regulatory specialist for HCPro, Inc., in Danvers, MA. CMS clarified in the rule that it continues to mean physically present, interruptible, and able to furnish assistance and direction throughout the performance of the procedure. "The change is that the walls have come

down and the same rules will apply to on-campus and off-campus services," Mackaman says.

New flexibility

That change offers a lot of flexibility to hospitals, says **Kathy Dorale, RHIA, CCS, CCS-P**, vice president of HIM at Avera Health System in Sioux Falls, SD. Avera includes 28 hospitals, 24 of which are critical access hospitals (CAH).

"It honestly does help us by loosening those boundaries of what it does mean to be immediately available,"

Dorale says. Now a physician can supervise a service in the department off the campus of the hospital, such as a clinic across the street. Avera

and many Midwest CAHs use that type of setup, so the change will help those hospitals, she says.

Facilities with off-campus cardiac and pulmonary rehab programs will also benefit from the change, says Dorale. The statutory language does not provide flexibility on the type of practitioners required to provide the supervisory function for the cardiac and pulmonary rehab programs, but it does allow the flexibility of location regarding where the physician can be located.

For the hospitals that buckled down in 2010 and really looked at who they had on staff designated as the supervising physician or nonphysician practitioner (NPP) and where they were located for on-campus services or services provided in the hospital, loosening the boundary won't have as much of an impact as it will for off-campus departments where additional staff may have been put in place in 2010 to meet the requirement of the

"The change is that the walls have come down and the same rules will apply to on-campus and off-campus services."

—*Debbie Mackaman, RHIA, CHCO*

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HCPro

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physician or NPP needing to be in the department, says **Jugna Shah, MPH**, president of Nimitt Consulting in Washington, DC. Facilities that weren't meeting the requirements for 2010 should consider themselves behind the eight ball, says Shah, because the 2011 final rule primarily reiterates CMS' expectation that direct physician supervision is required. However, facilities struggling to meet the off-campus requirement should find some relief from the changes for 2011.

"Everyone who had their ducks in a row in 2010 can now take a step back and use the changes CMS has finalized for 2011 to reevaluate what they have in place and if they have opportunities to make different staffing decisions," says Shah. "For folks who have been struggling to comply, this rule should make clear that CMS is sticking to its guns, and that means they need to shore things up because we can expect this issue to come under review in

future audits. Rest assured that while CMS may look the other way with respect to monitoring compliance with its direct physician supervision rules for time periods prior to 2009, there is definite risk for 2010 and 2011."

Prior supervision requirements

CMS previously made several changes to its physician supervision requirements in the 2010 OPSS final rule. In it, CMS permitted NPPs (e.g., physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, clinical social workers, and clinical psychologists) to provide direct supervision for hospital outpatient therapeutic services when their state license allows them to do so. This provision continues to apply in 2011.

The 2010 definition of "immediately available" required a physician or NPP to be in the department for off-campus PBDs, such as an off-campus wound care clinic. RNs with special training usually performed the wound care; however, CMS required a physician or NPP to be in the department. They could be seeing other patients or doing paperwork, for example, as long as they could be immediately available. But for many providers, this was likely an additional cost given that each off-campus PBD was required to have a physician or NPP available, which in many cases may have meant the individual was unable to provide other services.

For off-campus PBDs with a number of departments, to meet the letter of the law, a supervising physician had to be present in each of those departments. For those off-campus PBDs, the elimination of any reference to a physical boundary within which the physician or NPP must be could free up certain staff, resulting in cost savings, so this is truly an opportunity for hospitals to think differently about staffing and achieves CMS' desire to provide some additional flexibility to hospitals, Shah says.

For example, if a hospital has seven departments in an off-campus location, to meet the supervision requirements for 2010, the supervising physician or NPP had to be in each department. "With the changes

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for 2011, instead of having seven different people providing direct supervision, the facility may be able to have three or four people," Shah says.

New supervision requirements

The change in the definition of "immediately available" gives hospitals more leeway in scheduling physicians and NPPs for those off-campus departments. However, the physician or NPP responsible for providing supervision still needs to be immediately available. The physician or NPP needs to know what services he or she is supervising, who is providing the service, and when that service is being performed.

Communication with the supervising practitioner at off-campus locations will be critical, says Mackaman. Facilities will need to put some type of organizational scheduling in place so that staff members don't simply assume a physician in another department is providing supervision. Schedulers will also have to look at what types of procedures are planned when a physician is responsible for providing supervision.

"They cannot be scheduled for a procedure that can't be interrupted during the time the wound care is being provided or they cannot be so far off campus—for instance, at the gym 10 miles away with the cell phone turned off—that they cannot respond 'without lapse of time,'" Mackaman says.

Strategies for meeting the requirements

CMS' decision to back away from the boundary requirement provides hospitals with more options for how and when they deliver services. However, the onus is still very much on hospitals because, if audited by CMS, RACs, or others, they will need to be able to prove who the supervisory physician or NPP was and how that person met the requirement of being immediately available, including that he or she could in fact be interrupted.

In order to meet the challenges of 2010 final rules, the medical staff and compliance officers reviewed scheduling patterns to come up with staffing solutions that would not compromise the delivery of patient care while

meeting the CMS regulations, Dorale says. Quite honestly, sometimes this was difficult, but especially in a CAH setting. Luckily, CAHs received an exemption in 2010 that has been extended into 2011. With CMS removing the words "in the hospital" from the supervision requirements, facility staff members will be able to see who is available in the clinic setting as well, Dorale says. This is a big win for all hospitals, but especially for CAHs and small rural hospitals.

Each facility will have different criteria and different staffing situations, so no one-size-fits-all solution exists. When determining whether the facility is meeting the supervision requirements, Mackaman suggests considering the following areas, among others:

- Who is responsible and on which days?
- What are the department's hours of operation?
- How will staff contact the supervising practitioner if he or she is not in the department?
- What is the expected response time?
- What are the limitations of where the supervising practitioner can go when he or she is responsible for supervision?

Immediately available

CMS' decision to remove the words "in the hospital" from the physician supervision requirements provides additional latitude with staffing, but "CMS still does not define 'immediately available' with respect to time or distance, which is a good thing," says Shah.

"Because CMS is not defining 'immediately available' in terms of a particular location or duration, each individual hospital is going to have to decide how that is defined," Dorale says. "They are going to have to look at where their supervisory physicians would be located and if they feel that meets the requirements of the final rule."

However, HIM and compliance staff can find clues regarding CMS' expectation around what "immediately available" means. For that reason, Shah recommends that compliance staff at every facility should read the actual language in the rule.

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New definition

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For example, CMS states that it would be “neither appropriate nor immediate” for the supervising physician or NPP to be so physically far away that he or she could not intervene right away.

“CMS references the idea that the physician or NPP should be able to intervene right away several times and in different ways, which is a clue,” Shah says. “I think it’s a pretty strong statement when CMS says it would be neither appropriate nor immediate if the designated supervising individual could not intervene right away.” These statements are just another example supporting CMS’ direct comment about how it is not relaxing the requirements around immediately available.

CMS is not going to define time or distance, so everyone needs to use common sense. Staff members know where the departments are and what the physical space looks like, so they should be able to determine what meets this litmus test of being available right away.

“Hospitals need to ask, ‘If we were audited, could we prove who the supervisory physician or NPP on staff was at the time and defend that these people were immediately available in the sense that they were able to intervene right away?’ ” Shah says. “I think there is going to come a day when hospitals are going to have to defend it.”

ED physicians providing supervision

Over the years, many have assumed that ED physicians in the hospital would simply be able to provide the necessary direct supervision. In the 2011 OPPI final rule, CMS talks about how an ED physician could be the one who is providing the direct supervision, but that each hospital needs to evaluate this. CMS is allowing flexibility, but hospitals need to be very careful, says Shah. “This is not something automatic, so no one should just assume their ED staff are always immediately available per CMS’ guidance on what that means.”

If it’s a small hospital with one ED physician on staff and an ambulance pulls up in the middle of the night, that person is now tied up and likely not able to interrupt

what he or she is doing to provide direct supervision to an observation patient who has turned for the worse or another patient who has a reaction to medication, Shah says. Depending on the services your facility provides, the hours it provide them, existing staff, and the capacity of the ED and other departments, you may be able to designate someone in the ED as the supervisory physician or NPP, especially after hours. But during the day, the ED may be too busy to respond to requests from other departments to provide the necessary supervision.

“Some key decision-making items include what your book of business is, the hours you are open, and the overall volume of business you have,” says Shah.

Patients receiving infusion therapy could have a reaction to a medication. The nurse must be able to pick up the phone and call the supervising physician or NPP. That person would need to be available to attend to the patient in person and possibly change the course of treatment. “If a physician in your ED is tied up with an emergency and can’t interrupt what he or she is doing and cannot intervene right away, then you have a problem,” Shah says.

So staff members need to know who else is available. Since the physician or NPP does not have to be in the department at all times, hospitals have some flexibility with where they are located, as long as they are immediately available and interruptible. “These are the two keys now that guide everything with respect to direct physician supervision requirements for the vast majority of outpatient therapeutic services,” says Shah.

For a CAH or small rural hospital, the opportunity will now exist for hospital staff to initiate their policies and procedures for contacting additional physician and non-physician staff to be called in, no matter where their location, as long as they are “immediately available” and can be physically present to furnish assistance, Dorale says. “The physician could be two blocks from the main campus, in their own home, and still be immediately available. This is the reality of rural America.” ■

CMS expands suspension of physician supervision rules

The changes CMS made to the supervision requirements will delay but not eliminate the problems critical access hospitals (CAH) and small rural hospitals have with after-hours care. Many CAHs and small rural hospitals do not have physicians in the facility 24 hours per day. However, the supervision changes will not affect CAHs in 2011 because CMS will not evaluate or enforce the “direct supervision” requirement for therapeutic services furnished to outpatients in CAHs and rural hospitals.

CMS initially suspended enforcement of these requirements in March 2010 for CAHs only, after CAHs made compelling arguments that CMS needed to study this area more carefully before requiring direct supervision. CMS continues to assert that CAHs cannot operate under their *Conditions of Participation (CoP)* alone, but should be required to also follow CMS’ physician supervision rules.

In 2011, CMS also is suspending the direct supervision requirement for small and rural hospitals with 100 beds or less that are paid under OPPS.

“This surprised me because CMS was very adamant that all beneficiaries should expect to receive the same level of quality and safety, regardless of what type of hospital they go to,” says **Debbie Mackaman, RHIA, CHCO**, regulatory specialist for HCPro, Inc., in Danvers, MA. “It surprised me even more that, after all this discussion, they expanded the nonenforcement out even further to include more hospitals.”

CoPs vs. OPPS

CMS devoted a considerable section of the 2011 OPPS final rule to discussing the idea that the *CoPs* are for licensure and do not dictate payment policies. CMS believes that the *CoPs* set minimum requirements for CAHs and that CAHs are required to follow all other policies that pertain to payment. Therefore, when the payment policies are stricter than the *CoPs*, CMS stated that CAHs are held to the stricter standard.

The *CoPs* are probably the No. 1 item that hospital administrators and legislators are looking at when they

consider a legislative fix to the supervision requirements for CAHs, says **Kathy Dorale, RHIA, CCS, CCS-P**, vice president of HIM at Avera Health System in Sioux Falls, SD. Avera includes 28 hospitals, 24 of which are CAHs.

“I would guess that if we take this forward legislatively, that would be one of the things that our legislators would go for is that the *CoPs* were put in place specifically because rural healthcare for CAH is different,” Dorale says.

CMS received numerous inquiries from providers asking where quality has been a concern. In the 2011 OPPS final rule, CMS stated that it did not have any quality or safety concerns to base its argument on, Dorale says.

Dorale and other members of the Avera staff, including two of Avera’s physicians, a hospital CEO of a CAH, and the vice president of public policy, visited CMS in August and met with Jonathan Blum, director of the Center for Medicare Management. During the discussion, Herb Saloum, MD, family physician of rural South Dakota, told the CMS representatives that during his 35 years of practice, he has never seen a hemolytic response reaction to a blood transfusion. While patient reactions to blood frequently occur, CAHs has protocols for handling all these situations including contacting the physician who is immediately available under the new definition, says Dorale.

“The physicians tried to help CMS representatives understand what it means to be available in a small rural setting. Because of the *CoP* that has been written, we have followed those rules and Dr. Saloum has never experienced a problem in his 35 years of practice, so why the change?” Dorale says.

The change in definition of “immediately available” does reduce or perhaps eliminate the concerns for some CAHs and small rural hospitals. “We would like to think that our visit to CMS had some impact on the rulemaking process and that speaking up for what is important can make all the difference,” she says.

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CMS expands suspension

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After-hours care

Dorale is still concerned about after-hours care for some CAHs. In the 2011 OPPTS final rule, CMS stated that given the fact that CAHs are reimbursed based on their reasonable costs, a CAH might be better able than a small rural PPS hospital to hire staff to provide direct supervision. CMS also stated that it did not receive comment as to why this was the case. That piece may not have been covered well enough by hospitals, but CMS did receive comment in person and through public comment, says Dorale. "We should provide additional comments to explain our position," she says. "If our Medicare population is 40%, that is the 40% that is covered and paid cost. The other 60% of the costs remains noncovered costs to the organization."

CAHs could also face additional problems recruiting qualified physicians or nonphysician practitioners to their facilities to cover supervision at night if that provider is present only to provide supervision. That staffing

challenge is one reason CAHs have qualified staff such as nurses monitoring patients. In addition, CAHs have protocols for required response time for all physicians.

"We feel we're well covered in those areas," Dorale says. "We just find it tough having to jump through all these hoops and force ourselves to spend valuable time on rules that have not caused our hospitals any quality or safety concerns. We have so many other important things we could be doing to prepare for healthcare reform."

One of the most important things for CAHs and small rural hospitals is to communicate our concerns to CMS, say Dorale. "We need to help CMS and legislators understand what it means to be a CAH hospital in rural America. If we sit by and do nothing, we are going to end up with costly rules that we are going to have to live with. Unfortunately, not enough people take the time to analyze and understand the impact of these rules on their organizations and the patients they serve until it is too late." ■

CMS finalizes list of 16 extended-duration services

As part of the 2011 OPPTS final rule, CMS identified a limited set of services as "non-surgical extended duration therapeutic services," requiring direct supervision for initiation of the service followed by general supervision for the remainder of the service. "General supervision" means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. CMS identified 16 services to fall into this new category in the proposed rule and finalized the list for 2011 in the final rule, despite receiving comments from numerous providers about holding off on this type of decision.

"This is clearly directed at observation services and, in particular, the difficulty critical access hospitals [CAH] had with covering these services at night," says

Kimberly Anderwood Hoy, Esq., CPC, director of Medicare and compliance at HCPro, Inc., in Danvers, MA.

But since CAHs and rural hospitals with fewer than 100 beds are exempt from the direct supervision guidelines for 2011, finalizing this list of services seems premature and perhaps even irrelevant for most other hospitals.

"The most significant thing about CMS having finalized such a list is that it sets a precedent for where the agency is headed in the future in terms of evaluating more and more services to determine whether they could go from direct to general or vice versa," says **Jugna Shah, MPH**, president of Nimit Consulting in Washington, DC. "I think it's also a clue that CMS is very serious about starting CAHs and rural hospitals with less than 100 beds to meet the direct physician supervision requirements for outpatient therapeutic services similar

to all other hospitals in very short order, and such a list can help provide these types of hospitals with the flexibility they need. If there were any doubts in our minds about their seriousness about folding the other types of hospitals in, there shouldn't be."

Included services

CMS selected 16 services to constitute the new category, including observation, IV infusion, subcutaneous infusion, and therapeutic, prophylactic, or diagnostic injections. To be considered for the new category, a service must:

- ▶ Be of extended duration, frequently extending beyond normal business hours
- ▶ Largely consist of a significant monitoring component, typically conducted by nursing or other auxiliary staff
- ▶ Be of sufficiently low risk, such that the service typically would not require direct supervision
- ▶ Not be a surgical service that includes recovery time

Those hospitals that choose to use the direct to general supervision transition for those services will need to develop written protocols, policies, procedures, and documentation guidance to put this in place. Alternatively, a hospital could choose to disregard this flexible methodology and instead require direct supervision for all services of its outpatient therapeutic services, including these 16 extended-duration services.

The transfer from direct to general supervision should only happen after the patient is stable, but CMS leaves this determination to the provider and requires the provider to document the transition in the medical record or progress notes. The fact that CMS leaves these things up to the discretion of the provider is a good thing, says Shah, but that means the onus is on the provider to have strong policies and procedures in place.

"The question on the mind of many is whether being able to downgrade from direct to general physician supervision for these 16 services is that important for non-CAH and small rural hospitals, given that it will likely be easier to meet the direct physician supervision requirements than to take on the burden of being able to downgrade some services from direct to general supervision given the burden of proof of documentation," Shah says. In most cases, larger hospitals will have no problem shoring up their processes to have a supervising physician or nonphysician practitioner (NPP) immediately available to provide the necessary direct physician supervision, either from their ED or another department.

Excluded services

CMS excluded all surgical services—including recovery time—from the new category because, although monitoring of any patient in recovery is a key component of surgery, it is not the focus or a substantial component of the

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service. In addition, CMS states that it believes the surgeon should personally evaluate the patient's medical status during the recovery period.

In the 2011 OPPTS final rule, CMS discussed comments regarding additional services some providers believed should be added to the list, including blood transfusions and chemotherapy. CMS declined to expand the list of services.

"That was upsetting to us, especially in critical access hospitals," says **Kathy Dorale, RHIA, CCS, CCS-P**, vice president of HIM at the 28-hospital Avera Health System in Sioux Falls, SD. "Physicians will tell you that blood transfusions are safely provided in a hospital setting without direct supervision. Again, policies and procedures for blood administration have long guided our critical access hospitals and small rural hospitals no differently from large urban hospitals. CMS did not add blood administration or chemotherapy to the list of 16, but I would suspect more discussion on these topics once a review panel is created."

CMS defines "initiation of the service" as the beginning portion of a service, ending when the patient is stable and the supervising physician or appropriate NPP believes the remainder of the service can be delivered safely under his or her general direction and control, without the physician's physical presence on the hospital campus or in the provider-based department of the hospital.

This is an interesting change in how the supervising physician is viewed, says Hoy. In the past, the supervising physician needed to be immediately available to step in and provide direction and assistance but did not have to see the patient. "The new guideline seems to presuppose at least some face-to-face service between the supervising physician and the patient because the supervising physician is the one to determine that the patient is 'sufficiently stable' to 'transfer to general supervision,'" says Hoy.

Some services, such as blood transfusions and recovery from surgery, could go either way, says **Debbie Mackaman, RHIA, CHCO**, regulatory specialist for HCPro, Inc., in Danvers, MA. For blood

transfusions in the ED or post surgery, CMS would probably require direct supervision for the entire procedure. For scheduled outpatient blood transfusions because the patient is anemic, this might be considered for a "transition" procedure under normal circumstances, Mackaman says.

The new panel

Commenters also suggested that CMS not decide supervision levels in a vacuum. CMS agreed and, as a result, will form a panel to review the supervision requirements for all outpatient services. CMS is seeking comments on who should make up the advisory group and the criteria that they should use when determining supervision levels for outpatient services. "The fact that they are setting up that panel means that they are going to look at other services over time that could go from direct to general or, as they say in the rule, 'vice versa,'" says Shah.

The panel adds another layer to the rulemaking process, but it allows providers and others to make suggestions about what should be considered, says Mackaman. "I think this committee should be independent of CMS payment policies and should be looking at quality care, safety, and clinical circumstances," she says. "This process may work very well—sort of a go-between."

In the final rule, CMS discusses the possibility of using the current APC Advisory Panel. Although Dorale says that idea is okay, she believes CMS needs to add members to the panel to represent smaller hospitals.

Shah agrees and also believes the panel needs to be able to focus on services being rendered in hospital outpatient departments by both physicians and NPPs rather than services being provided and paid for under the physician fee schedule.

The physicians who currently serve on that panel are highly specialized and serve in large urban areas. That's part of the reason CAHs and the small rural hospitals have been so disappointed with the recent CMS rules. CAHs have had difficulty expressing their concerns and

explaining how they operate in small rural communities, Dorale says. "I think CMS, to its credit, is doing the best it can to understand the concept of rural health, but somehow I still believe they are missing the operations piece of CAHs to some extent," she says.

If this committee does get involved in payment recommendations, Mackaman says it is possible that CMS will decrease payments for services that are on the transition list. If a physician or qualified NPP isn't present for the entire procedure, it does not cost the hospital as much to provide that care, she explains. CMS may decide that instead of providing a \$100 payment for a service, it will only reimburse a facility \$75.

"I think it should include, at a minimum, physicians, clinicians, quality and risk management members who come from the healthcare environment, in addition to whoever CMS would also identify as necessary members," says Mackaman. "To get an unbiased list, I think it is important to have members who understand how it actually works in the hospitals. Sometimes it seems that the CMS regulations are far removed from the reality of the trenches."

That is especially true when it comes to small rural hospitals and CAHs, so Dorale says it is essential that these smaller providers gain a voice on the committee. "They'll miss us entirely again if we don't have representation on that panel," she says. ■

2011 OPPS and physician fee schedule update

Critical care coding changing, cancer center payment isn't

As part of the 2011 OPPS final rule, CMS finalized changes to critical care coding and shelved a proposal to change the way cancer centers are paid.

A change by the CPT Editorial Panel led to the revision in critical care coding. The CPT panel revised its guidance for critical care codes 99291 and 99292 to specifically state that, for hospital reporting purposes, critical care codes do not include the specified ancillary services.

The good news is that, beginning this year, hospitals can and should follow the CPT guidelines that will allow separate reporting of ancillary services and associated charges when provided in conjunction with critical care. These ancillary services include but are not limited to EKGs, chest x-rays, and pulse oximetry.

The bad news is that hospitals will not receive separate payment right away for those services. This is because CMS said it has already factored the costs of ancillary services into the 2011 critical care APC payment rate, based on 2009 claims data where the cost of these services was included in the critical care charge.

"Despite not receiving separate payment right away for these ancillary services, this change is a win for the hospital community because they have been trying

individually through comment letters and through the American Hospital Association to get CMS and/or the AMA, through the CPT Editorial Panel, to realize that hospitals should be allowed to report and obtain payment for these ancillary services in addition to the reporting and payment for critical care," says **Jugna Shah, MPH**, president of Nimitt Consulting in Washington, DC.

CMS is requesting comments on this issue, so hospitals should provide feedback on how the agency should treat the revision of the CY 2011 critical care codes for the future, especially with respect to generating separate payment in the future, because eventually hospitals should see separate payment for the associated ancillary services in addition to the critical care service.

Cancer center reimbursement

In the 2011 OPPS proposed rule, CMS proposed to bring the payment levels for cancer centers more in line with other hospitals. A CMS study shows that certain cancer hospitals are more costly than other OPPS hospitals, but many commenters expressed the opinion that CMS' proposed solution didn't fix the problem for cancer

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Critical care coding

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hospitals and it seemed to negatively impact the bottom line of other hospitals and also harm beneficiaries, so the delay may be warranted in order to find a better solution.

In the final rule, CMS refers to the comments it received in a general sense but doesn't respond to each one individually or indicate whether it agrees with the comments. "CMS just states it received a number of comments and believes this issue is critical enough to review further," Shah says.

Laboratory signature requirements

CMS finalized a provision in the CY 2011 Medicare Physician Fee Schedule final rule to require a physician signature on all lab requisitions. CMS made the change in an effort to eliminate uncertainty over what qualifies as a requisition versus an order. The facility performing the ordered service must maintain the documentation.

Hospital-based or independent labs that already have a signature requirement in place, regardless of the document, are already meeting the requirement. Labs that have combined the lab order and requisition into one form and have signatures are already meeting the requirement as well. However, labs that rely on ordering physicians or nonphysician practitioners (NPP) to maintain the documentation in their medical records must now require a signature for all services provided, says **Debbie Mackaman, RHIA, CHCO**, regulatory specialist for HCPro, Inc., in Danvers, MA.

Requiring signatures on requisitions because will better protect hospitals in the future if audited for signed orders, says Shah.

Diagnostic supervision requirements

CMS changed the physician supervision requirements for outpatient therapeutic services by removing the boundary requiring physicians to be "in the hospital." CMS will adopt a similar definition of direct supervision for outpatient diagnostic services, with one exception. For diagnostic services furnished under arrangement in

nonhospital locations, direct supervision will continue to mean physical presence in the office suite. For all other outpatient diagnostic services, direct supervision will now mean immediately available, without reference to any physical boundary.

"This is great news for hospitals as they are no longer tied to a physical space for therapeutic and most diagnostic outpatient services; however, they will continue to be held responsible to provide that assistance 'without lapse of time,' " says Mackaman.

Partial hospitalization programs

CMS is establishing four separate partial hospitalization APC per diem payment rates, two for community mental health centers (CMHC) partial hospitalization programs (PHP) and two for hospital-based PHPs, which are based on the data for each provider type. CMS will phase in the CMHC payment rates over two years.

CMS also implemented a change to the definition of a CMHC, requiring it to provide at least 40% of its services to non-Medicare beneficiaries. The rulemaking also implements a change to the definition of a PHP (CMHC or hospital-based), excluding services furnished in a beneficiary's home or an inpatient or residential setting. CMS will continue the CMHC outlier threshold at 3.4 times the APC payment amount for APC 173, the higher intensity APC, for 2011.

Healthcare reform changes

Under the Patient Protection and Affordable Care Act (PPACA) and announced in the OPSS final rule, the beneficiary's copay will be waived for the preventive services that Medicare covers. CMS will provide the full payment for these services and the patient will have no out-of-pocket expenses. In addition, PPACA extends the preventive focus of Medicare coverage to provide coverage for annual wellness visits when beneficiaries receive personalized prevention plan services (PPPS). Specific documentation will be required in order to bill

for the PPPS, similar to those for the initial preventive physical exam, or “Welcome to Medicare” physical.

Inpatient-only list

CMS is removing three procedures from the inpatient-only list. The inpatient-only list specifies those services for which the hospital will be paid only when provided in the inpatient setting because of the nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. The procedures CMS removed from the list are:

- 21193, reconstruction of mandibular rami; horizontal, vertical, C, or L osteotomy; without bone graft
- 21395, open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)

- 25909, amputation, forearm, through radius and ulna; reamputation

All three have a T status indicator (significant procedure subject to multiple procedure discounting that is paid by APC).

Drug reimbursement

In the 2010 OPSS final rule, CMS finalized a new method for calculating payment for separately payable drugs and redistributing approximately \$150 million of the costs associated with HCPCS-coded packaged drugs with average sales prices (ASP) to separately payable drugs.

CMS continued with the same calculation method for 2011, but the result is that CMS will reimburse hospitals for all separately payable drugs at ASP plus 5%. ■

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