

APC PAYMENT INSIDER

Independent news & guidance to comply with Medicare coding & billing rules

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 OPSS 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 HCP Pro, 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

"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

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 flexibility regarding where the physician can be located.

For the hospitals that buckled down in 2010 and looked at whom 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

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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 OPPI 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, a supervising physician had to be present in each of those departments to meet the letter of the law. 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. This is an opportunity for hospitals to think differently about staffing, and it 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, the supervising physician or NPP had to be in each department to meet the supervision requirements for 2010. "With the changes 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 off-campus departments. However, the physician or NPP responsible for providing supervision still

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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,'" says Mackaman.

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 be interrupted.

In order to meet the challenges of 2010 final rules, the medical staff and compliance officers at Avera 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, 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 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 of what "immediately available" means. For that reason, Shah recommends that compliance staff at every facility should read the actual language in the rule.

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

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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 simply assumed that ED physicians in the hospital would be able to provide the necessary direct supervision. In the 2011 OPPTS final rule, CMS talks about how an ED physician could be the one who is providing the 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 an ambulance pulls up in the middle of the night to a small hospital with one ED physician on staff, 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 a patient who has a reaction to medication, Shah says. Depending on the services your facility provides, the hours it provides them, the 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 individual 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.

As a result, 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 nonphysician staff, no matter where their location, as long as they are “immediately available” and can be physically present to furnish assistance, says Dorale. “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.” ■

Questions? Comments? Ideas?

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This Month's Coding Q&A

Declotting code describes service

Q There is a new method of administering declo-
tting medication, via an infusion instead of an injec-
tion. When declotting a vascular access device (VAD)
during a two-hour infusion, is charging for IV infusion
16–90 minutes and IV infusion, additional hour appro-
priate? Or should we charge only declotting VAD code
36593?

A Examples of thrombolytic agents include Activase®,
Eminase®, Retavase®, and Streptase®.

Instructions for use of the *CPT Manual* state in the
introduction on p. x that CPT codes are determined by
“[s]elect[ing] the name of the procedure or service that
accurately identifies the service performed.”

When a VAD or catheter is declogged during a two-
hour thrombolytic infusion, the CPT code that most
accurately describes the service is 36593, not 96365
or 96366. It is important to note that the descriptor

for code 36593 (declotting by thrombolytic agent of
implanted access device or catheter) does not state that
it is an infusion or injection, which allows the coder to
use it for either methodology.

If sequential administration of the thrombolytic agent
occurs during the same treatment session, 36593 is a sin-
gle line-item charge; however, “36593 ... may be reported
more than once per day with modifier -59 when defined
separate declots take place” (*CPT Assistant*, December 2009,
Vol. 19, No. 12, p. 11).

Refer to your current *CPT Manual* for complete code
modifiers and descriptors.

Procedures performed during observation

Q When counting observation hours on the facility side,
are hospitals required to deduct time when a patient
goes to radiology for a CT scan? Must hospitals deduct IV
infusion time or any other procedure time?

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Q&A

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 The requirement to deduct time from the total time a patient spends in observation under active evaluation, monitoring, and diagnostic workup is not as cut-and-dry as most would prefer.

The *Medicare Claims Processing Manual*, Chapter 4, §290.2.2, "Reporting Hours of Observation," addresses this matter. In situations where a patient undergoes diagnostic testing in an outpatient hospital department, preparation services furnished prior to testing and recovery afterward are included in the payments for the diagnostic services. The manual further states that observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals should record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to calculate the total number of units reported on the claim for the hourly observation services HCPCS code G0378.

Access the manual at <https://www.cms.gov/manuals/downloads/clm104c04.pdf>. Refer to p. 185/213.

Also refer to CMS FAQ 9974, published January 26 and updated July 7. The question asks whether a hospital may report drug administration services, such as therapeutic infusions, hydration services, or IV injections, furnished during the time period when observation services are being reported. Not surprisingly, CMS' answer is not as straightforward as most would prefer.


The answer to whether the time devoted to providing diagnostic or therapeutic services must be subtracted from the total calculated time for observation reporting hinges on whether the provided service requires active, separate monitoring. CMS' answer indicates that in the case of drug administration services, active monitoring depends on the type of drug administration service, the specific drug administered, or the needs of the patient.


Access the FAQ at https://questions.cms.hhs.gov/app/answers/detail/a_id/9974/~/may-a-hospital-report-drug-administration-services-such-as-therapeutic.

In general, the determination of whether you should carve time devoted to diagnostic or therapeutic services from the calculation of the total time the patient spends in observation rests with the provider.

Create a hospital-specific policy for staff regarding the need to record time spent performing diagnostic or therapeutic services that meet the definition of active monitoring and should be deducted from the total patient calculated time spent in observation.

Billing for insulin sometimes permissible

 I know insulin is a medication that patients give themselves at home; however, may we bill for insulin administered to an ED patient by an ED nurse? Please explain.

 A self-administered drug is one furnished to a patient in the outpatient setting for therapeutic purposes that is usually administered by the patient and is not integral to the performance of a treatment or a procedure. Typically, insulin is considered one of these self-administered drugs and would be excluded from Medicare coverage.

In CMS' *Transmittal CR 6950*, effective July 30, 2010, CMS has updated the information related to determining self-administration of drugs and biologicals. In this transmittal, CMS has indicated that, without evidence to the contrary, MACs should presume that drugs delivered by subcutaneous injection are self-administered by the patient and consequently would not be covered by Medicare. Access the transmittal at www.medicarefind.com/searchdetails/Transmittals/Attachments/R123BP.pdf.

However, if a patient presents to the ED in a diabetic coma, billing for the insulin and the administration may be permissible. *Medicare Alert Bulletin 2164*, published by BlueCross BlueShield of Georgia February 1,

2006, includes a corrected response to a question in the Frequently Asked Questions section in *Medicare Alert Bulletin 2160*, issued October 24, 2005:

When can insulin be covered in the emergency room and when is it considered a self-administered drug?

The only situation where insulin can be covered is if a patient enters the emergency room in a diabetic coma and needs and receives insulin. Providers should bill Medicare with A4

value code and its related dollar amount; bill the insulin under revenue code 0637 and bill the injection with revenue code 0450 using CPT code 90782. Otherwise, insulin would be considered a self-administered drug.

Each MAC is required to publish a list of which drugs it considers self-administered, along with the rationale used to make that determination. Consult your MAC's website for additional information about this topic. ■

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