American Hospital Association

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Marilyn Dahl
Director, Division of Acute Care Services
Survey and Certification Group
Centers for Medicare & Medicaid Services
Mail Stop C2-21-16
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Dahl:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) is writing to voice concern about recently-issued interpretive guidance related to rehabilitation and respiratory care services under the hospital Conditions of Participation (CoPs). Specifically, Transmittal No. 72, issued on November 18, 2011, includes interpretive guidance that is inconsistent with regulations for ordering rehabilitation and respiratory care services found at § 482.56(b) and § 482.57(b)(3) of the CoPs. Based on feedback from many AHA-member hospitals, we believe the recent changes will significantly increase burdens on hospitals and will create barriers to care for patients in need of services from hospital outpatient departments. In addition, the new guidance creates confusion as to which practitioners may order rehabilitation and respiratory care services.

The AHA understands that the Centers for Medicare & Medicaid Services (CMS) will soon review and explain its expectations with regard to the interpretive guidance for rehabilitation and respiratory care services. **We urge CMS to clarify that:**

- **Hospitals will not be required to privilege each practitioner who orders rehabilitation and respiratory care services; and**
- **CMS will defer to state law and hospital policies with regard to which practitioners may order rehabilitation and respiratory care services.**

We ask CMS to act quickly to clear up the confusion caused by the inconsistency between the regulation and the interpretive guidance. Currently, hospitals face the dilemma of either turning patients away or possibly being cited as noncompliant with the CoPs unless they adopt burdensome new procedures.

BACKGROUND

In the preamble to the hospital inpatient prospective payment system final rule published on August 16, 2010, CMS expressed its intent to defer to state laws and regulations, hospital policies and hospital medical staffs in determining who can order rehabilitation or respiratory care services. The final regulation specified that, under § 482.56(b) and § 482.57(b)(3) of the CoPs, any practitioner may order rehabilitation or respiratory care services so long as he or she is: (1) a qualified, licensed practitioner, (2) responsible for the care of the patient, (3) acting within his or her state scope of practice, and (4) authorized to order rehabilitation services by the hospital in accordance with hospital policies and state law. A hospital may be required by state law to check that an ordering practitioner is licensed by the state before accepting that practitioner's orders for rehabilitation services in the hospital outpatient department. A hospital also may require an outpatient department to check that a referring practitioner has a national provider identifier number and is not on the Department of Health and Human Services' Office of Inspector General exclusion list.

EFFECTS OF NEW INTERPRETIVE GUIDANCE ON HOSPITALS AND PATIENTS

The interpretive guidance issued on November 18, 2011, states that the practitioner *must have medical staff privileges* to order rehabilitation and respiratory care services, as opposed to simply being authorized to order these services. This guidance would preclude a hospital from establishing a policy authorizing the orders of non-privileged practitioners to be accepted by a hospital outpatient department based on criteria set by hospital policy and state law. Instead, many hospitals would be faced with the task of privileging hundreds of practitioners who refer patients for services. As you are aware, privileging is a lengthy process that can take two to three weeks per practitioner and involves a substantive evaluation of the clinical competence and character of the practitioner. Several hospital outpatient departments reported to AHA that as much as 50 percent of their patients originate from referrals by non-privileged practitioners.

A privileging requirement could create barriers for patients who live in areas with limited services, who need specialized therapy services, and who travel to undergo medical procedures. For example, a patient who travels to a large urban medical center an hour away from home to undergo a surgical procedure may seek weekly rehabilitation services at a community hospital outpatient department near where he or she lives. If the patient's doctors lack privileges at the community hospital, the patient will be unable to receive care there. The issue is compounded if the community hospital is the only provider that offers specialized services. For example, a hospital outpatient department could have the only certified hand therapists on staff or may be the only provider with aquatic therapy facilities in the community.

Another concern with Transmittal 72 involves the types of practitioners who may order rehabilitative services at a hospital. In the preamble to the final rule issued on August 16, 2010, CMS indicated there would not be a fixed list of what type of practitioners could order services. CMS states in the final rule:

> Our intention was not to exclude other types of nonphysician practitioners such as APRNs, PTs, SLPs, or other types of rehabilitation professionals from the proposed rule provisions. . . . We point out that the proposed regulatory language does not specifically mention any 'type' of practitioner, including NPs and PAs. . . . Although NPs and PAs were the only examples of practitioner types that we used in our discussion of the proposed changes in the preamble of the proposed rule, our intention, as reflected in the proposed regulation text, is to include those qualified, licensed practitioners who meet the parameters of the proposed requirements discussed above.

In contrast, the interpretive guidance appears to spell out exactly which types of practitioners may order rehabilitative services. The guidance states, "Practitioners who may be granted privileges to order rehabilitation services include physicians, and may also, in accordance with hospital policy, be extended to Nurse Practitioners, Physicians' Assistants, and Clinical Nurse Specialists, as long as they meet the parameters of this requirement." The guidance also excludes certain practitioners who CMS states are not generally considered to be responsible for the care of the patient or qualified to order rehabilitation services, such as certified nurse midwives and clinical psychologists.

We presume the list of who may order rehabilitation services is illustrative rather than exhaustive, but it is unclear. CMS should clarify that the list contained in the interpretive guidance is not all-inclusive and that any practitioner may order rehabilitation services so long as the practitioner is (1) a qualified, licensed practitioner, (2) responsible for the care of the patient, (3) acting within his or her state scope of practice, and (4) authorized to order rehabilitation services by the hospital in accordance with hospital polices and state law.

The AHA on previous occasions has urged CMS to revise the process it uses to develop interpretive guidance to avoid the kind of confusion that this change in guidance has caused. CMS's interpretive guidance does not always align with the finalized regulatory requirements. In this instance, the new interpretive guidance represents a significant narrowing of the CoPs, and we urge CMS to only make such changes through the full and open process, inviting public review and comment.

Thank you for your consideration of our concerns, and we look forward to hearing from you soon. If you have any questions, please contact me or Evelyn Knolle, senior associate director of policy, at 202-626-2963 or eknolle@aha.org.

Sincerely,

Nancy Foster
Vice President, Quality and Patient Safety