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Outpatient supervision plan on hold until 2012 as CMS revamps policy

Heeding concerns raised by the AHA and rural hospital leaders, the Centers for Medicare & Medicaid Services (CMS) has delayed enforcing for another year its "direct" supervision requirements for outpatient therapeutic services provided by critical access hospitals (CAH) and other small rural hospitals.

In concessions to rural hospitals, the agency also an-nounced its intent to establish an advisory panel in 2012 to determine the level of supervision required for different services and broadened the definition of direct supervision to remove all reference to the physical location of the supervising professional. The policy changes are included in the final outpatient prospective payment system (PPS) rule, which CMS released Nov. 2.

The rule "reflects many of the AHA's key recommendations," said AHA Executive Vice President Rick Pollack. "The changes CMS made go a long way to ensure that patients, especially in rural America, have access to important outpatient therapeutic services."

Michael Ryan, CEO of 16-bed Hillsboro (KS) Community Hospital, was a strong critic of CMS' previous supervision policies. He called the changes in the final outpatient PPS rule a "thoughtful response to the concerns expressed by many rural providers." Ryan expressed support for extending the delay in enforcing the policy until 2012 and the revised definition of direct supervision. "That is precisely what we need to make this policy work in small, rural communities," he said.

CMS in March initially suspended implementation of its direct supervision requirement for 2010 for CAHs. The final outpatient PPS rule adds small and rural hospitals with no more than 100 beds to the mix because they have similar staffing problems. CMS said it will "revisit" the policy next year when it begins drafting outpatient payment regulations for 2012.

"The reprieve is welcome," said Daniel Kelly, CEO of 25-bed McKenzie County Health Care System in Watford City, ND. But he expressed concern that the policy, once implemented, could harm many rural hospitals, and said rural hospitals will continue to press CMS for more changes. "We look forward to an ongoing dialogue with CMS on direct physician supervision," he said.

The final rule follows CMS' July proposal of a "two-tiered" approach to super-

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AHA, others urge Congress to extend nine Medicare policies

Fourteen organizations, including the AHA, recently asked House and Senate leaders to quickly enact legislation to extend nine Medicare policies set to expire this year.

"Failure to pass legislation to extend these various Medicare policies will prompt limited access to services for beneficiaries in rural and other underserved areas, payment cuts to health care professionals, as well as the creation of an unsustainable health care environment," the groups wrote.

Among the policies are measures that provide an exceptions process for Medicare therapy caps, bonus payments for ground and ambulance services, a regulatory reprieve from stringent payment policies for long-term care hospital services and a moratorium on establishing certain new long-term care facilities, a payment add-on for psychiatric services under Medicare's physician fee schedule, and a provision allowing independent labs to bill Medicare directly for the technical component of physician pathology tests for patients.

The Nov. 1 letter calls on lawmakers to extend the outpatient "hold harmless" provision, which allows rural hospitals to receive 85% of the difference between the reimbursements they would receive under the outpatient prospective payment system and the payment they would have received under their previous cost-based system.

And the letter calls for extending the floor on geographic adjustments to the work portion of the physician fee schedule and revisions to the schedule's geographic adjustment for practice expenses. The fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense and medical malpractice insurance. These adjustments are indices that reflect how each area compares to the national average in a "market basket" of goods. Setting a floor on the physician work index increases practitioner fees in rural areas.

In addition, the groups urge Congress to extend "reasonable cost payments for clinical lab tests performed by hospitals with fewer than 50 beds in certain rural areas; and to renew the Section 508 reclassification program, which allows hospitals to seek improvements in their Medicare wage index. The Section 508 program expired on Sept. 30.

Extending these programs is a key part of the AHA's fall advocacy agenda.

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vising 16 "nonsurgical extended duration therapeutic services," which include observation, intravenous infusion and therapeutic, prophylactic or diagnostic injection. They will require direct supervision by a physician or non-physician practitioner (NPP) to begin the service, followed by "general" supervision for the remainder of the service. The transition from direct to general supervision must be documented in the physician's progress notes or in the patient's medical record. Other outpatient therapeutic services would require direct supervision throughout the entire procedure.

Under the final rule, direct supervision requires the physician or NPP to be "immediately available" to assist and direct during the entire time services are provided. The rule defines immediately available to mean "physically present, interruptible and able to furnish assistance and direction throughout the performance of the procedure but without reference to any particular physical boundary." Under general supervision, the procedure is furnished under the physician's overall control and direction, but can be performed without the physician actually present.

"It's great to see CMS suspend the physician supervision requirements for another year," said Gale Walker, president and CEO of 25-bed St. Benedict Health Center in Parkston, SD. And he welcomed CMS' broader definition of direct supervision.

CMS' decision to back away from its previous boundary requirement, suggests the agency recognizes that small rural hospitals need more flexibility in how they deliver services, Walker said. But he added that CMS needs to continue refining its supervision policy to help protect access to essential health care services in rural communities.

In the final rule, CMS said it plans to convene a panel beginning in 2012 to determine the level of supervision required for different services. CMS describes the panel as an "independent technical committee" that will be comprised of a diverse range of providers, including rural providers. The AHA had called for such an advisory committee to review each outpatient therapeutic service covered under the outpatient PPS and issue a recommendation on whether the service required direct supervision.

"We agree with commenters [on the proposed outpatient PPS rule] that there should be a mechanism for independent consideration of the most appropriate supervision level for individual therapeutic services to ensure that CMS purchases safe, quality outpatient care," stated CMS in the final rule.

Meanwhile, rural hospital leaders like Hillsboro Community Hospital's Ryan hope CMS will continue to listen to rural hospitals' concerns about the appropriate level of physician supervision "so the process works for our patients' benefit."