



Arizona Hospital and Healthcare Association

August 28, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1414-P, CY 2010 Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center Payment System proposed rule

Dear Ms. Frizzera:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA), thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) CY 2010 Hospital Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center Payment System proposed rule. Our comments center on the proposed changes to physician supervision of outpatient services. We appreciate the greater flexibility allowed under the proposed CY 2010 OPPS rule, but are concerned that CMS has not rescinded its earlier statement that the CY 2009 changes to physician supervision requirements were a mere clarification of existing CMS policy. Based on pre-2009 communications with Arizona's Medicare contractors and CMS documents, we believe the CY 2009 changes were new policy. To assert otherwise leaves hospitals vulnerable to unwarranted enforcement actions for 2001 through 2009. We offer the following comments for your consideration.

Beginning in CY 2010, CMS proposes that certain non-physician practitioners (NPPs) may directly supervise hospital outpatient therapeutic services – other than cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR) – if allowed within their state's scope of practice and under hospital-granted privileges. CMS states that its current policy only allows physicians and clinical psychologists to provide the direct supervision of outpatient therapeutic services. AzHHA believes CMS' proposal will improve access to services for Medicare beneficiaries, especially in rural areas. **However, we urge CMS to reconsider its decision to limit supervision of CR/ICR/PR services to physicians only.** AzHHA disagrees with CMS' interpretation that statute prescribes this limitation. While the

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) defines these as “physician supervised” services, it includes an exception clause for hospital provided services, stating “...except that, in the case of items and services furnished under such a program in a hospital, such availability [of a physician] is presumed.” For the same reasons CMS proposes to allow NPPs to supervise other outpatient therapeutic services, NPPs should be permitted to supervise CR/ICR/PR services.

With respect to outpatient psychiatric services, we recommend CMS add another discipline to the list of NPPs permitted to provide supervision. One of the most critical healthcare challenges in Arizona is access to outpatient behavioral health services, in part due to a shortage of clinical psychologists. Patients brought to emergency departments are often unable to be discharged in a timely manner because of the lack of appropriate outpatient services. This impacts the hospital’s ability to care for emergency patients who continue to present to the emergency department. Easing the restrictions on who may supervise outpatient psychiatric services will increase access to care for Medicare beneficiaries and ease pressure on emergency departments. **We urge CMS to permit clinical social workers to supervise outpatient psychiatric services.** These professionals are highly qualified and trained to detect escalation and intervene as necessary to avert a crisis. As such, they are equipped to provide supervision for outpatient psychiatric services, including working with off-site physicians who order these services.

CMS proposes to reverse a policy prescribed in the CY 2009 OPSS rule that a supervising physician be physically present in the department when outpatient therapeutic services are provided in the hospital or in an on-campus provider-based department of the hospital. Instead, CMS would define “direct supervision” in these on-campus settings to mean that the physician or NPP (1) must be present in the hospital or in an on-campus provider-based department of the hospital and (2) immediately available to provide assistance and direction throughout the procedure. For services furnished in an off-campus provider-based department, “direct supervision” would continue to mean the physician or NPP must be present in the off-campus provider-based department at all times services are provided. We believe these proposals provide a more practical approach to defining physician supervision in the hospital setting. However, we have some concerns regarding the proposed definitions.

The definition of “in the hospital” is too restrictive and would prohibit the supervising physician or NPP from being at any location that does not meet the definition, such as a physician’s office, an independent diagnostic testing facility, or hospital-operated provider or supplier, including a skilled nursing facility, home health agency or any other non-hospital space located on the hospital’s campus. Depending on the configuration and size of the hospital, these spaces may be in close proximity to the treatment area, allowing the supervising professional to quickly respond to the patient’s and performing professional’s needs. **We urge CMS to eliminate the proposed definition of “in the**

hospital” and reconsider what is truly necessary to ensure the supervising professional can provide direction and assistance throughout the performance of the procedure in a timely manner.

AZHHA is also concerned about the preamble statement, which asserts the general definition of “immediate” is “without interval of time.” This restrictive definition undermines the flexibility purported by the proposed rule. We urge CMS to establish a new definition for “direct supervision” that does not rely on the term “immediately available.” **Instead, we recommend CMS define “direct supervision” to mean that the physician or NPP is present on the hospital campus or in close proximity to the campus and able to respond in a timely manner, in accordance with hospital policies and procedures, so as to be able to furnish assistance and direction throughout the performance of the procedure.** Furthermore, “available to respond in a timely manner” should not be limited to presence at the bedside. The term should permit supervision via telephone or other technologies to maximize the use of telemedicine and other advanced technologies as appropriate and approved for the use of Medicare.

Finally, we are very concerned that CMS has chosen not to rescind its characterization of the 2009 OPPS final regulation on physician supervision as a “restatement and clarification” of long standing policy. Previous guidance given by both CMS and Arizona’s Medicare contractors contradict this characterization. The American Hospital Association and others have well documented the relevant CMS guidance, including language from 2001 OPPS preamble. With this in mind, our comments will focus on guidance Arizona hospitals have received from our Medicare contractors. This guidance gives no indication that CMS policy before the 2009 rule required the level of physician supervision prescribed in the 2009 rule, specifically the presence of the supervising physician in the outpatient department at all times that the outpatient therapeutic services are furnished – regardless of whether the services are furnished in the hospital, on the hospital campus or off-campus.

- On February 15, 2000, Blue Cross Blue Shield of Arizona issued a Limited Medicare Coverage and Billing Memorandum on outpatient therapeutic treatment (un-specific to the hospital setting), stating the procedure must be performed under direct supervision of a physician. The memorandum goes on to state that “the physician must be present in the *office suite* and immediately available to provide assistance and direction throughout the time the personnel is performing services.
- Due to confusion regarding how CMS would apply the term “office suite” to the hospital setting, Arizona hospitals sought clarification from their Medicare contractors.
- In a March 15, 2001 *Medicare B News* FAQ and a April 25, 2005 letter to an Arizona hospital, Noridian Administrative Services stated “There are no Medicare laws or regulations that define the term ‘office suite’. The *key factor* to ‘incident to’ billing is the physician’s availability to the practitioner performing the service.

Noridian uses the general rule that ‘immediately available’ means the supervising physician is able to provide assistance and direction within five minutes or less. The supervising physician must be *within the same entity* to be considered immediately available.”

- On April 24, 2008, Noridian released an Issue Brief on “Incident To” clarification. The brief states: “The policy for general supervision in the outpatient hospital setting is different from the direct supervision requirements for the office/clinic setting. Supervision requirements for outpatient hospital settings are the same as the definition at 42CFR 410.27 for services at provider based facilities. The physician/NPP supervision requirement in the outpatient hospital setting is *generally assumed to be met where the services are performed on hospital premises*. However, to assure the assumption is appropriate, there must be a physician/NPP, who is a member of the hospital staff, *on the hospital premises* at the time of the service and immediately available to render assistance and direction throughout the performance of the procedure.”
- On June 1, 2009 – after the CY 2009 OPSS final rule went into effect – Noridian issued another “incident to” clarification that stated: “When hospital personnel provide services, the following payment requirements must be met... [The services must] be delivered under the supervision of a physician who is an employee or has another contractual relationship with the hospital and is *immediately available* to provide assistance to the personnel delivering the service. “Immediately available” in the outpatient hospital setting means that the physician must be available in the same time-frame as the personnel designated to manage cardiac arrests (codes) in the hospital. *The supervisor need not be in the same department as the ordering physician/NPP or in the same department in which the services are rendered but must be on the physical premises where and when the patient receives services.*”

None of these communications indicate that the supervising physician must be in the department of the hospital where the therapeutic treatment is occurring. Instead, these communications assert the key factor prior to the 2009 policy change is the immediate availability of the physician, not the physical location of the supervising physician. We appreciate that CMS has reconsidered its policy on physician supervision, and we support the direction CMS is taking with changes in the CY 2010 proposed rule. **However, we urge CMS to rescind the physician supervision policy changes in the CY 2009 final rule, including language that characterizes the 2009 changes as a “clarification and restatement” of existing CMS policy.** Leaving this language intact makes hospitals vulnerable to unwarranted enforcement actions from 2001 through 2009.

Thank you again for the opportunity to comment on the proposed rule. If you have any questions or would like further information regarding our comments, please call me.

Sincerely,

A handwritten signature in black ink, appearing to read "John R. Rivers". The signature is fluid and cursive, with a large initial "J" and "R".

John R. Rivers, FACHE
President and Chief Executive Officer

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