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Critical-access hospitals at odds with supervision plan

By Jennifer Lubell
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As the CMS continues to tinker with its policy regarding physician supervision of services being provided in hospital outpatient departments, smaller providers say they may not have the manpower to comply with the latest revisions.

Hospital comments on the agency's proposed 2011 hospital outpatient reimbursement rule, due early this week, homed in on the agency's policy on physician supervision of hospital outpatient therapeutic services. Hospital industry representatives are worried that the CMS wants to require more supervision than what they believe is practical. The comment period is scheduled to end Aug. 31.

The "direct supervision requirement" was first introduced in the 2009 outpatient rule, calling for physicians to be physically present in the outpatient department of a hospital at all times when outpatient therapeutic services were provided. Although the agency has since relaxed these provisions, allowing practitioners who aren't physicians to take on these supervisory roles, new language in the 2011 proposed rule has hospital executives concerned.

No matter how the CMS tweaks this, critical-access hospitals are going to struggle with it, said Gale Walker, president and CEO of Avera St. Benedict Health Center, Parkston, S.D. Based on what the agency is planning, the hospital will need to hire at least four more midlevel practitioners or physicians to comply with the ever-changing requirement, which would cost the hospital at least $400,000 annually.

The reality is, "in rural South Dakota we don't have that kind of personnel," said Walker, who planned to visit CMS officials this week in Washington to discuss the provision. "We're going to lay out scenarios to them, telling them that this is not practical."

Specifically, the CMS identified a set of 16 nonsurgical extended duration therapeutic services—from observation services to IV hydration—and proposed a "hybrid" model of supervision, said Roslyne Schulman, the American Hospital Association's senior associate director for policy development. Under the 2010 rule, all outpatient therapeutic services require direct supervision. But there are varying degrees of supervision in the outpatient setting for diagnostic services, including: direct supervision, which requires the physician or nonphysician practitioner to be on the premises and be immediately available when the patient receives treatment, and general supervision, which means the services provided are still under the practitioner's overall direction and control, but the practitioner's presence is not required.

Under the latest proposed revision, the 16 "nonsurgical extended duration therapeutic services" would require direct supervision for the initiation portion of the service followed by general supervision once the patient has been stabilized. But "you still have to have a physician or nonphysician practitioner present for the initial observation" of a patient for these 16 specific services, Schulman explained.

The CMS in the rulemaking explained that it was proposing this amendment to offer more flexibility to hospitals in meeting the direct supervision requirement without compromising patient safety and quality. Rural or critical-access hospitals in communities with a shortage of health professionals, however, may find this a tall order to comply with, Schulman said.

Critical-access hospitals had gotten a reprieve from the direct supervision requirement only for 2010, but enforcement will start up again in 2011 unless the reprieve is extended.

From a reimbursement standpoint, “this means the service won’t be covered (under Medicare) unless a doctor is right there at the beginning,” Schulman said. Many physicians, especially those with private practices outside of a hospital campus, not to mention nurse practitioners and physician’s assistants, aren’t going to be able or willing to dedicate their entire day at the hospital’s outpatient department directly supervising patients, Schulman added.

Critical-access hospitals and other small and rural facilities will be able to furnish a supervisory figure in 30 minutes, “but not 24-7,” she continued.

Compliance will be much easier for urban hospitals that have the full-time staff, including radiologists, hospitalists, residents and other people to step in to these supervisory roles, said Terry Mills, who heads the family medicine department at the Wichita Clinic, in Newton, Kan. Even if the CMS is saying the patient doesn’t have to be supervised for the entire round of treatment, just at the outset, “all of that is splitting hairs for no consequences. If there are not enough people there or involved in other critical roles, the hospital still won’t meet that requirement,” he said.

Enforcing such a provision may be labor- intensive, but that’s the kind of thing that the CMS’ new Recovery Audit Contractors, which get paid a contingency fee for recovering improper payments, will be looking at, Schulman said.

Even with the threat of an audit hanging overhead, some hospitals are struggling just to comply with the current requirements on physician supervision. “I can tell you there are not many hospitals that are applying the rule right now,” said Felix Aguirre, vice president of medical affairs at IPC: The Hospitalist Co., headquartered in Hollywood, Calif. In the AHA’s view, the CMS should take a step back, look at all outpatient therapeutic services on a broader scale, with comment from physicians who practice in urban and rural hospital outpatient departments, and figure out which ones need direct or general supervision.