HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

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COMPLIANCE ALERT 10-48

CMS Finalizes Changes to Physician Supervision Requirements and Ancillary Services for Critical Care

CMS released the 2011 OPPS final rule on November 2. Key changes were finalized regarding physician direct supervision and billing for ancillary services with critical care.

Physician Direct Supervision: Overall, the Final Rule maintains the general requirement for direct supervision of all outpatient therapeutic services. However, the 2452-page document includes four key changes to the physician supervision requirements:

- Changed the definition of "immediately available"
- Delayed enforcement of supervision requirements for rural and critical access hospitals (CAHs)
- Announced its plan to convene a panel beginning in 2012 to determine the level of supervision required for different services
- Finalized a new category of "nonsurgical extended duration therapeutic services" that require direct supervision during an initiation period, followed by a minimum standard of general supervision

I. Defining Immediately Available. Beginning in 2011, physicians will no longer be required to be present in every off-campus provider-based department. Now, the definition of "immediately available means…."physically present, interruptible, and able to furnish assistance and direction throughout the performance of the procedure but without reference to any particular physical boundary."

Compliance Guidance: Hospitals will still need to provide documentation, if audited, as to: 1) who was the supervisory physician, and; 2) how the physician

was immediately available and interruptible.

II. Delaying Enforcement of Supervision for CAHs. CAHs (and small rural hospitals with under 100 beds) will not be evaluated against the "direct supervision" requirement and CMS will not enforce the requirement for therapeutic services furnished in 2010 and 2011. CMS will consider hospitals to be rural if they are either geographically located in a rural area or are paid through the outpatient PPS with a wage index for a rural area. This extension will allow CAHs and small rural hospitals to prepare to meet this definition of direct supervision in CY 2012.

Compliance Guidance: CAHs should prepare for the eventual requirement of direct supervision for therapeutic outpatient services as CMS remains committed to the concept and requirement.

III. Convening a Panel to Determine Supervision Requirements. In the CY 2012 OPPS rulemaking cycle, CMS will establish an independent review process that will allow for an assessment of the appropriate supervision levels for individual hospital outpatient therapeutic services.

IV. New Category of Nonsurgical Extended Duration Therapeutic Services Require Direct Supervision. CMS also finalized its proposal to permit a two-tiered approach to supervision for a few specified hospital outpatient therapeutic services. CMS identified a set of 16 "nonsurgical extended duration therapeutic services" to which this revised policy will apply, including observation services, various intravenous and subcutaneous infusions and various therapeutic, prophylactic or diagnostic injections.

Consequently, before the new panel mentioned above is convened), CMS has established a new category of "nonsurgical extended duration therapeutic services" that require direct supervision as defined in §410.27(a)(1)(iv) during an initiation period, followed by a minimum standard of general supervision as defined in §410.32(b)(3)(i) for the duration of the service.

The extended duration services will include the following limited set of procedures identified in the final rule:

HCPCS Code	Long Description
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump
G037	Hospital observation service, per hour

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G0379	Direct admission of patient for hospital observation care
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion ite(s)
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each dditional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
96376	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each dditional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for

CMS is defining "nonsurgical extended duration therapeutic services" as "services that can last a significant period of time, have a substantial monitoring component that is typically performed by auxiliary personnel, have a low risk of requiring the physician's or appropriate nonphysician practitioner's immediate availability after the initiation of the service, and are not primarily surgical in nature. In new §410.27(a)(1)(v)(B), we are finalizing our definition of "initiation of the service" as the beginning portion of a service ending when the patient is stable and the supervising physician or appropriate nonphysician practitioner

believes the remainder of the service can be delivered safely under his or her general direction and control without needing his or her immediate availability."

Changes for Billing of Ancillary Services with Critical Care: In addition to the above, the CPT Editorial Panel is revising guidance for critical care codes 99291 and 99292 so that these codes do not include the specified ancillary services. So beginning in 2011, hospitals "can and should report in accordance with the CPT guidelines that will allow the separate reporting of ancillary services and associated charges when provided in conjunction with critical care. These ancillary services include, but are not limited, to electrocardiograms, chest X-rays, and pulse oximetry." (HCPRO News Release, 11/3/1010).

More specific information can be found by reviewing the final rule located in the web link below.

Source: **http://www.ofr.gov/OFRUpload/OFRData/2010-27926_PI.pdf**
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