OPPS FINAL RULE CREATES OPPORTUNITIES AND UNEXPECTED RISKS FOR "INCIDENT TO" SERVICES

By
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On November 2, 2010, the Centers for Medicare and Medicaid Services ("CMS") issued the Final Rule with comment period (the "2011 Final Rule") for the Medicare hospital outpatient prospective payment system ("OPPS"). The changes are generally applicable for services furnished on or after January 1, 2011 but, with more than 2,400 pages of new regulations, there is "something for everyone" in the 2011 Final Rule. For example, there are new updates for ASC covered surgical procedure payment rates, changes to Whole Hospital and Rural Provider Exceptions to the Physician Self-Referral Prohibition, and new guidelines for CRNA's. Of particular importance will be new physician supervision requirements for outpatient therapeutic and diagnostic services.

The physician supervision rules all stem from the original coverage elements of the Social Security Act that provide for Medicare coverage for hospital services "incident to" physicians' services rendered to outpatients. The interpretation of the meaning of this language has taken several different forms over the years. Importantly, for the OPPS Final Rule from last year, *two* different standards were created (at least for therapeutic services) dependent wholly on whether the situs of the physician treatment were on-campus or off-campus. Essentially, "incident to" requirements in the on-campus setting required that a supervising physician or qualified nonphysician practitioner be present on the same campus and immediately available. In the off-campus setting, this presence requirement was narrowed to mean in the off-campus provider-based department of the hospital (rather than simply on campus) and immediately available.

The Final Rule expressly deletes these qualifiers. In pertinent part, CMS announced that "[t]he definition of direct supervision will be revised simply to require immediate availability, meaning physically present, interruptible, and able to furnish assistance and direction throughout the performance of the procedure but without reference to any particular physical boundary." Importantly, this relief applies to both on-campus and off-campus settings. The physician or qualified nonphysician practitioner does not have to be in the room or department when the procedure is performed although the special requirements for direct supervision by a doctor of medicine or doctor of osteopathy for pulmonary rehabilitation, cardiac rehabilitation or intensive cardiac rehabilitation services will continue to apply.

CMS did expressly decline to permit telephone supervision however maintaining that, in order to be immediately available, the supervising physician must, when required, be present in person.

Although the Final Rule does create increased flexibility for hospitals seeking to meet the "incident to" requirements, hospitals and their medical staffs should be careful when identifying supervising physicians and nonphysician personnel. The supervising personnel must know that they may be called upon to supervise particular "incident to" services, must themselves be "interruptible," and, most importantly, be "able" to furnish assistance and direction for "incident to" services. Hospitals and medical staffs are, therefore, encouraged to adopt service by service supervisory requirements, inform the supervising physicians and qualified nonphysician personnel of their supervisory roles and to review their privileging grants to ensure that all supervising physicians and qualified nonphysician practitioners are properly privileged to undertake the service that they are being asked to supervise and in which they might, by regulation, be required to intercede. To the extent that a physician or qualified nonphysician practitioner does not have the privileges necessary to perform a test for which he or she is to be listed as the supervising physician for billing purposes (as might be the case were members of a hospital's emergency department to be deemed to be acting in a supervisory capacity for a procedure down the hall from the ER), the "incident to" billing requirements will not be met and the bill will be void. Similarly, if the physician or qualified nonphysician practitioner is not interruptible such as might occur were the anesthesiologist on call at the hospital also deemed to be supervising a procedure elsewhere in the hospital, the "incident to" requirements will also not be met.

The Final Rule also contained good news for critical access hospitals ("CAH's") and rural hospital facilities. In order to give these facilities more time to prepare for and comply with the supervisory requirements under the "incident to" rules, CMS also extended its moratorium on the enforcement of the supervisory guidelines for CAH's and rural facilities at least through FY 2011.