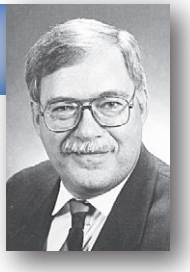

Of Physician Supervision, RAC Appeals and Cost Reports

By Duane C. Abbey, Ph.D., CFP

Physician Supervision Strikes Again

"Direct physician supervision" is a phrase frequently used by CMS as a requirement for the provision of certain healthcare services. CMS breaks the whole area of physician supervision into two parts: diagnostic and therapeutic.

Physician supervision requirements for diagnostic services are delineated through the Medical Physician Fee Schedule (MPFS). These requirements are embedded at the CPT/HCPCS code level within the MPFS itself. For selected codes, the physician supervision requirements involve three different levels: 1) general supervision, 2) direct supervision and 3) personal supervision.[1]

Recently CMS has been providing significant guidance for direct physician supervision for outpatient therapeutic services. Three fundamental questions arise:

- What is direct physician supervision?
- Who can provide direct physician supervision?
- Where and when must direct physician supervision be provided?

The general description of direct physician supervision means that the physician must be on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure.[2] While explicit definitions of *premises* and *location* would be useful, CMS does not take this discussion much further.

The question of who can provide this supervision has recently arisen and CMS did perform a careful analysis. The main question is whether a non-physician practitioner such as a nurse practitioner or physician assistant can meet the physician supervision requirement. Given the language at the Social Security Act (SSA) level, hospital services must be incident-to those of a physician.[3] The way the SSA reads and subsequent definitions for a physician, CMS concluded that non-physician practitioners do not meet the physician supervision requirements.[4] With this interpretation, hospitals must review not only their off-campus and on-campus, but out of hospital, operations.

However, there is good news! In the July 20, 2009 Federal Register, CMS is proposing to update 42 CFR §410.27 to allow nurse practitioners, clinical nurse specialists, nurse-midwives and physician assistants to meet the physician supervision standard.[5] Presuming this change takes place, as of January 1, 2010 the non-physician practitioners will be able to meet this direct physician supervision requirement. For auditors this does create a challenge because until the rules are changed, a physician must provide this supervision.

The third fundamental question concerns where and when such supervision must be provided. The general answer to these two questions appears to be

[1] See the MPFS along with the different physician supervision indicators that are used.
[2] See Transmittal 101, January 16, 2009 that updates the Medicare Benefit Policy Manual (Publication 100-02).
[3] See Social Security Act (SSA) §1861(s)(2)(B).
[4] See November 18, 2008 *Federal Register* Page 78702 (73 FR 78702).
[5] See July 20, 2009 Federal Register Page 35363 (74 FR 35363).

straightforward. Such supervision is required when Medicare beneficiaries are being provided services. Also, supervision must be provided in provider-based areas that are off-campus or on-campus, but out of the hospital itself. However, this latter statement begs the question as to whether certain hospital departments, even inside the hospital, that are provider-based may also inadvertently fall under this requirement.

Auditors need to be very cautious in reviewing all provider-based activities. Be certain to analyze completely how everything is organized. For instance, a hospital may have an off-campus facility which has an infusion center that is provider-based and also a freestanding clinic. The physicians who are in the freestanding clinic address the physician supervision requirement, but then these physicians are not on the provider-based premises which may violate the physician supervision requirement.

Auditors need to be very cautious in reviewing all provider-based activities.

All of these changes have now created the need to know exactly what is meant by the phrase *in the hospital*. CMS is currently finalizing the definition for this concept. Conceptually, identifying what is in the hospital should be simple. However, in practice identifying facilities or organizations that are in the hospital is not always straightforward. For instance, consider the infusion center that has a skywalk attaching it to the hospital building. Is this infusion center in the hospital or on the campus but outside the hospital? Depending upon the answer, the physician supervision requirements may be distinctly different. Auditors are encouraged to follow closely the final form of this important definition.

Physician supervision requirements for diagnostic services are delineated through the Medical Physician Fee Schedule.

Pursuing RAC Appeals

As the RACs start identifying overpayments and demanding recoupment, auditors are going to be drawn into technical discussion concerning coding, billing and reimbursement issues. Some of the issues will be straightforward and repayment will not be an issue. For instance, reporting two codes for a single operative procedure.

Other issues will require much greater consideration and research. Medical necessity is a subjective issue that requires clinical judgment and appropriate documentation. Additionally, there are other highly technical issues involving regulatory guidance. For instance, what if a hospital's Fiscal Intermediary provided incorrect guidance relative to a coding and billing issue? Or what if the CMS guidance for a given issue is ambiguous so that different interpretations are possible? Or the FI incorrectly paid a claim when the claim was properly coded and billed?

Auditors should be prepared to participate in the development of case files or portfolios of information that can be used to pursue RAC appeals. Developing position papers and technical analysis of issues is an area in which auditors can greatly assist in retaining payments that have already been made.

Cost Report Changes

CMS is moving to make a significant change in the cost reporting process by separating implantable devices from other types of supply items. Along with implementing a severity refinement for DRGs, CMS also changed the formulas for recalibrating the DRG weights from charge-based data to cost-based data. In order to use cost-based data, charges must be converted to costs using the hospital's cost-to-charge ratios (CCRs). These CCRs come from the cost report.

One area in which charges are developed with different markup formulas is with supply items that include implantable devices. Because there are variable markups, that is, inexpensive items are marked up more than expensive items; the CCR for supplies does not accurately reflect the proper markup for different categories of supply items. This phenomenon is called *charge compression*.

Interestingly, charge compression is recognized as a problem with DRGs, but this same situation has always been present with Ambulatory Payment Classifications (APCs). From their implementation in 2000 APCs have used cost-based data in calculating the APC weights.

Because of the lag in completing the cost reporting process, three years will be needed to implement the change to separate devices from other supply items. Thus, it will not be until 2013 that this change will go into full effect. Auditors should carefully follow how CMS defines implantable devices and then also considers expensive supply items that are used but not left in the body such as expensive catheters. Perhaps this whole process will actually define what is really meant by *implantable DME*.[6] **NP**

Duane C. Abbey, PhD, CFP is president of Abbey & Abbey Consultants, Inc., specializing in healthcare consulting and related areas. He also teaches workshops and makes presentations to hospital associations and medical societies. He is a leading expert nationally on APGs/APCs. Duane may be contacted at Duane@acciweb.com.

[6] See the May 22, 2009 Federal Register, Page 24104 (74 FR 24104).

The control center of your life is your attitude.
~Anonymous