FEDERAL ACTIONS IMPACTING ALASKA HOSPITALS – FEBRUARY 2014

96 Hour Rule

This regulation requires physicians at Critical Access Hospitals to certify at the time of admission that Medicare patients will not be there more than 96 hours. Otherwise, the hospital must transfer the patient or face non-reimbursement. Under current law, CMS has required CAHs to meet the condition of participation by maintaining a 96 hour annual average length of stay. Through recent guidance, CMS has clarified they will also begin enforcing the condition of payment that requires physician certification that each patient will stay for 96 hours or less.

H.R. 3991, the Critical Access Hospital Relief Act, has been introduced in the House to repeal the 96 hour rule. Legislation is also being proposed in the Senate to address problems with the 96 hour rule. The proposed legislation would remove the condition of payment for CAHs that requires a physician to certify that each patient will be discharged or transferred in less than 96 hours. The condition of participation requiring CAHs to maintain a 96 hour annual average per patient would remain.

Two Midnight Rule

Under the two midnight rule, a patient must stay in a hospital for two consecutive midnights before Medicare reimburses the hospital at inpatient rates. This rule applies to both PPS and Critical Access Hospitals. The change was made to dispel confusion about how to handle short-stay patients, whose treatment often triggered audits from RACs, prompting many hospitals to keep them in observation care.

The Centers for Medicare & Medicaid Services announced that it will extend the two-midnight partial enforcement delay for an additional six months through Sept. 30, 2014. Specifically, the Medicare Administrative Contractors (MAC) will continue to select claims for review with dates of admission from Oct. 1, 2013 through Sept. 30, 2014 for the Probe & Educate audits. The MACs also will continue to hold educational sessions with hospitals, as appropriate, through Sept. 30, 2014. As was the case with the previous partial enforcement delay, Recovery Auditors and other Medicare review contractors will not conduct post-payment patient status reviews of inpatient hospital claims with dates of admission on or after Oct. 1, 2013 through Sept. 30, 2014.

CMS has provided guidance on the physician order and physician certification requirements for hospital inpatient admissions. Click here.

Outpatient Therapy Cap

The statutory Medicare Part B outpatient therapy cap for Occupational Therapy (OT) is $1,920 for 2014, and the combined cap for Physical Therapy (PT) and Speech-Language Pathology Services

(SLP) is $1,920 for 2014. This is an annual per beneficiary therapy cap amount determined for each calendar year. Exceptions to the therapy cap are allowed for reasonable and necessary

therapy services. Per beneficiary, services above $3,700 for PT and SLP services combined and/or $3,700 for OT services are subject to manual medical review. CMS is not precluded from reviewing therapy services below these thresholds.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Therapists' private practices
- Offices of physicians and certain non physician practitioners
- Part B skilled nursing facilities
- Home health agencies (Type of Bill (TOB) 34X)
- Rehabilitation agencies (also known as Outpatient Rehabilitation Facilities-ORFs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Hospital outpatient departments (HOPDs)
- Critical Access Hospitals (CAHs) (TOB 85X) - (2014)

Outpatient Therapy "Direct Supervision" Policy

The Senate approved by unanimous consent legislation (S. 1954) that would extend through 2014 the enforcement moratorium on the outpatient therapy "direct supervision" policy for critical access hospitals and rural prospective payment system hospitals with 100 or fewer beds. AHA has urged CMS to extend the moratorium, which expired Jan. 1, to protect access to outpatient therapeutic services. If approved by the House, S. 1954 would give Congress more time to enact legislation such as the AHA-supported Protecting Access to Rural Therapy Services Act (H.R. 2801/S. 1143), which would adopt a default standard of "general supervision" for outpatient therapeutic services, among other provisions.

In the 2009 outpatient prospective payment system (PPS) final rule, the Centers for Medicare & Medicaid Services (CMS) mandated a new policy for "direct supervision" of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change. CMS's policy required that a supervising physician be physically present in the department at all times when Medicare beneficiaries receive outpatient therapeutic services.

Further, CMS characterized the change as a "restatement and clarification" of existing policy in place since 2001. As a result, hospitals and critical access hospitals (CAHs) found themselves at increased risk for unwarranted enforcement actions, particularly brought by opportunistic whistleblowers claiming that hospitals did not have appropriate direct physician supervision arrangements in place in some or all of its affected departments dating back to 2001.