

# Supervision of Hospital Outpatient Therapeutic Services

## THE ISSUE

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.

Through multiple letters, meetings and other advocacy in the intervening years, the AHA and other national hospital and physician organizations have urged CMS to rescind or significantly modify the policy and to mitigate the new and inappropriate enforcement risks that its “clarification” created. At the urging of the AHA and others, CMS has since adopted several positive changes in the regulations. Specifically, the agency has:

- Delayed enforcement of the direct supervision policy through 2013 for CAHs and small and rural hospitals with fewer than 100 beds;
- Allowed certain types of non-physician practitioners (NPPs) to provide direct supervision for hospital outpatient services, according to their state license

and scope of practice and hospital- or CAH-granted privileges. This includes physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives and licensed clinical social workers;

- Modified the definition of direct supervision to remove all references to the physical boundaries within which the supervising professional must be located as long as he or she is “immediately available to furnish assistance and direction throughout the performance of the procedure;”
- Adopted a two-tiered policy for the supervision of certain “nonsurgical extended duration therapeutic services” such as observation services and various infusions and injections. This policy requires direct supervision only for the initiation of the service, followed by general supervision once the patient is medically stable; and,
- Established an independent review process that allows the Advisory Panel on Hospital Outpatient Payment ([HOP Panel](#)) to recommend, and CMS to adopt, alternate supervision levels, including general supervision, for individual hospital outpatient therapeutic services. CMS added four new members to the HOP Panel to represent CAHs and small and rural PPS hospitals. Based on recommendations made by five hospitals who presented at the HOP Panel’s February and August 2012 meetings, CMS reduced the level of supervision for 49 outpatient therapeutic services from “direct” to “general” supervision.

The HOP Panel’s next meeting is Aug. 26-27. **This may be the last chance to have services designated as general supervision before CMS begins enforcing its supervision requirements across the board in 2014.**

## AHA POSITION

**The AHA remains concerned that hospitals and CAHs will have difficulty implementing CMS’s supervision requirements, even with the marginal level of additional flexibility the agency has provided over the past several years. We continue to urge CMS to:**

- Adopt a default standard of “general supervision” for outpatient therapeutic services and supplement with a reasonable exceptions process with provider input to identify those specific procedures that require direct supervision;
- Ensure that for CAHs the definition of “direct supervision” is consistent with the CAH conditions of participation (CoP) that allow a physician or NPP to present within 30 minutes of being called; and
- Prohibit enforcement of CMS’s retroactive reinterpretation that the “direct supervision” requirements applied to services furnished since Jan. 1, 2001.

**These important changes are included in AHA-supported legislation, the *Protecting Access to Rural Therapy Services Act of 2013* (S. 1143/H.R. 2801).**

## WHY?

- **In an environment of continuing shortages of health care professionals, particularly in rural areas, the direct supervision requirement will be difficult to implement for hospitals and CAHs, will reduce access and is clinically unnecessary.** It would require hospitals to engage more physicians and NPPs for direct supervisory coverage without a clear clinical need and create patient access problems if hospitals were forced to discontinue or limit the hours of certain outpatient services.
- **CMS's view that this policy has applied to outpatient therapeutic services furnished since 2001 opens up the entire hospital community to misplaced enforcement scrutiny, including potential recoupments and whistleblowers who can claim that a hospital did not have appropriate direct physician supervision arrangements in place in some or all of its affected departments dating back to 2001.**
- **Direct supervision is not a requirement of the Medicare hospital CoPs and, in fact, the rules contradict the CoPs for CAHs.** One CAH CoP requires a physician or NPP to be available by phone, but not necessarily physically present on the CAH campus. In order to ensure access to hospital emergency care in these otherwise underserved areas, another CAH CoP has long required only that a physician or NPP be able to arrive within 30 minutes of a request from the staff in the facility. Therefore, CAHs may meet the CoPs yet be non-compliant with direct supervision regulations.

## KEY FACTS

Hospital outpatient therapeutic services have always been provided by licensed, skilled professionals under the overall direction of a physician and with the assurance of rapid assistance from a team of caregivers, including a physician, should an unforeseen event occur. While hospitals recognize the need for direct supervision for certain outpatient services that pose high risk or are very complex, CMS's policy generally applies to even the lowest risk services.

**The HOP Panel.** The HOP Panel is an independent review body that considers stakeholder testimony and advises CMS regarding whether it is appropriate to change the level of supervision for individual hospital outpatient therapeutic services – from direct to either general or personal supervision – so as to ensure an appropriate level of quality and safety for the delivery of patient care.

The current definitions for the three levels of supervision that are relevant to the HOP Panel are:

- **Direct supervision** means that the physician or NPP must be immediately available to furnish assistance and direction throughout the performance of the procedure. The physician or NPP is not required to be present in the room when the procedure is performed.
- **General supervision** means the procedure is furnished under the physician's or NPP's overall direction and control, but the physician's or NPP's presence is not required during the performance of the procedure. Under general supervision, the training of the NPP who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the supervising physician or NPP.
- **Personal supervision** means a physician or NPP must be in the room during the procedure.

**HOP Recommendations.** In making recommendations, the HOP Panel reviews whether there is a significant likelihood that the supervisory practitioner would need to reassess the patient and modify treatment during or immediately following the therapeutic intervention, or provide guidance or advice to the individual who provides the service. The HOP Panel considers the complexity of the service; the acuity of the patients receiving the service; the probability of unexpected or adverse patient events; the expectation of rapid clinical changes during the service; any recent changes in technology or practice patterns that affect a procedure's safety; and the clinical context in which the service is delivered. The HOP Panel meets only twice a year, in March and August.

CMS posts its preliminary decisions regarding the HOP Panel recommendations on the agency's website for a 30-day period of informal public input. After considering public comments, CMS issues its final decisions, which become effective either in July or January following the most recent HOP Panel meeting.

The [next HOP Panel meeting](#) is Aug. 26-27 in Baltimore. The number and variety of services that the HOP Panel considers will depend on how many hospitals request to testify before the HOP Panel and the services they present for evaluation. **The August HOP Panel meeting may be the last opportunity to have outpatient therapeutic services designated as general supervision before CMS begins enforcing the supervision requirements across the board in 2014.** While the AHA will continue to strongly pursue further enforcement delay, it is important to note that in the 2014 outpatient PPS proposed rule, CMS proposes to end the moratorium on enforcement of the direct supervision policy for outpatient therapeutic services provided in CAHs and small rural PPS hospitals with 100 or fewer beds.