

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 169	Date: March 1, 2013
	Change Request 8228

SUBJECT: April 2013 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: CMS is revising the reference link in the Medicare Benefit Policy Manual for the list of hospital outpatient therapeutic services that may be furnished under general supervision or are defined as non-surgical extended duration therapeutic services (NSEDTS).

EFFECTIVE DATE: April 1, 2013

IMPLEMENTATION DATE: April 1, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/20.5.2/Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After January 1, 2010
R	6/20.7/Non-Surgical Extended Duration Therapeutic Services

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):

The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-02	Transmittal: 169	Date: March 1, 2013	Change Request: 8228
-------------	------------------	---------------------	----------------------

SUBJECT: April 2013 Update of the Hospital Outpatient Prospective Payment System (OPPS)

EFFECTIVE DATE: April 1, 2013

IMPLEMENTATION DATE: April 1, 2013

I. GENERAL INFORMATION

A. Background: CMS is revising the reference link in the Medicare Benefit Policy Manual for the list of hospital outpatient therapeutic services that may be furnished under general supervision or are defined as non-surgical extended duration therapeutic services (NSEDTS).

B. Policy:

Hospital Outpatient Therapeutic Services

CMS is updating the reference link in the Medicare Benefit Policy Manual, Chapter 6, Sections 20.5.2 and 20.7, to the list of hospital outpatient therapeutic services that may be furnished under general supervision or are defined as non-surgical extended duration therapeutic services (NSEDTS). The revised list of services reflects changes in the required supervision level for certain services in 2012 and 2013, based upon the recommendations of the Hospital Outpatient Payment Panel.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		D M E	F I	C A R I E R	R H I	Shared- System Maintainers				Other
		P a r t A	P a r t B					F I S S	M C S	V M S	C W F	
8228-02.1	Medicare contractors shall refer to Pub.100-02, Medicare Benefit Policy Manual, Chapter 6, Sections 20.5.2 and 20.7, for the updated link to the list of current services furnished under general supervision and extended duration services for the payment year.	X			X		X					COBC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC	D M E	F I	C A R R I E R	R H H I	Other
		P a r t A	P a r t B	M A C			
8228-02.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Marina Kushnirova, marina.kushnirova@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

20.5.2 - Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After January 1, 2010

(Rev. 169, Issued: 03- 01- 13, Effective: 04-01-13, Implementation: 04- 01-13)

Therapeutic services and supplies which hospitals provide on an outpatient basis are those services and supplies (including the use of hospital facilities and drugs and biologicals that cannot be self-administered) which are not diagnostic services, are furnished to outpatients incident to the services of physicians and practitioners and which aid them in the treatment of patients. These services include clinic services, emergency room services, and observation services. Policies for hospital outpatient therapeutic services furnished incident to physicians' services differ in some respects from policies that pertain to "incident to" services furnished in office and physician-directed clinic settings. See Chapter 15, "Covered Medical and Other Health Services," Section 60.

To be covered as hospital outpatient therapeutic services, the services and supplies must be furnished by the hospital or CAH or under arrangement made by the hospital or CAH (see section 20.1.1 of this chapter). The services and supplies must be furnished as an integral, although incidental, part of the physician or nonphysician practitioner's professional service in the course of treatment of an illness or injury.

The services and supplies must be furnished in the hospital or at a department of the hospital that has provider-based status in relation to the hospital under 42 CFR 413.65. For therapeutic services furnished during CY 2010, as specified at 42 CFR 410.27(g), "in the hospital or CAH" means areas in the main building(s) of the hospital or CAH that are under the ownership, financial, and administrative control of the hospital or CAH; that are operated as part of the hospital or CAH; and for which the hospital or CAH bills the services furnished under the hospital's or CAH's CMS Certification Number.

Hospital outpatient therapeutic services and supplies must be furnished under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations, and State law. They must be furnished by hospital personnel under the appropriate supervision of a physician or nonphysician practitioner as required in this manual and by 42 CFR 410.27 and 482.12. This does not mean that each occasion of service by a nonphysician need also be the occasion of the actual rendition of a personal professional service by the physician responsible for care of the patient. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, when necessary, to change the treatment regimen. A hospital service or supply would not be considered incident to a physician's service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment.

CMS requires direct supervision (defined below) by an appropriate physician or non-physician practitioner in the provision of all therapeutic services to hospital outpatients, including CAH outpatients. CMS may assign certain hospital outpatient therapeutic

services either general supervision or personal supervision. When such assignment is made, “general supervision” means the definition specified at 42 CFR 410.32(b)(3)(i), that is, the procedure or service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. “Personal supervision” means the definition specified at 42 CFR 410.32(b)(3)(iii), that is, the physician must be in attendance in the room during the performance of the service or procedure.

Effective January 1, 2011, hospitals may change to general supervision for a portion of services defined as non-surgical extended duration therapeutic services (“extended duration services”) but only as specified in this manual for those services (see section 20.7). Pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services require direct supervision which must be furnished by a doctor of medicine or osteopathy, as specified at 42 CFR 410.47 and 410.49, respectively.

The list of services that may be furnished under general supervision or that are defined as non-surgical extended duration therapeutic services is available on the OPPTS Website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html>.

Beginning January 1, 2010, according to 42 CFR 410.27, in addition to physicians and clinical psychologists, licensed clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives may furnish the required supervision of hospital outpatient therapeutic services that they may personally furnish in accordance with State law and all additional rules governing the provision of their services, including those specified at 42 CFR Part 410. These nonphysician practitioners are specified at 42 CFR 410.27(g).

Considering that hospitals furnish a wide array of very complex outpatient services and procedures, including surgical procedures, CMS would expect that hospitals already have the credentialing procedures, bylaws, and other policies in place to ensure that hospital outpatient services furnished to Medicare beneficiaries are being provided only by qualified practitioners in accordance with all applicable laws and regulations. For services not furnished directly by a physician or nonphysician practitioner, CMS would expect that these hospital bylaws and policies would ensure that the therapeutic services are being supervised in a manner commensurate with their complexity, including personal supervision where appropriate.

For therapeutic services furnished during CY 2010 in the hospital or CAH or in an on-campus outpatient department of the hospital or CAH, as defined at 42 CFR 413.65, “direct supervision” means that the physician or nonphysician practitioner must be present on the same campus where the services are being furnished. For services furnished in an off-campus provider based department as defined in 42 CFR 413.65, he or she must be present within the off-campus provider based department. The physician or nonphysician practitioner must be immediately available to furnish assistance and

direction throughout the performance of the procedure. The physician or nonphysician practitioner does not have to be present in the room when the procedure is performed.

For therapeutic services furnished during CY 2011 and following, whether in the hospital or CAH or in an on-campus or off-campus outpatient department of the hospital or CAH as defined at 42 CFR 413.65, “direct supervision” means that the physician or nonphysician practitioner must be immediately available to furnish assistance and direction throughout the performance of the procedure. As discussed below, the physician is not required to be present in the room where the procedure is performed or within any other physical boundary as long as he or she is immediately available.

Immediate availability requires the immediate physical presence of the supervisory physician or nonphysician practitioner. CMS has not specifically defined the word “immediate” in terms of time or distance; however, an example of a lack of immediate availability would be situations where the supervisory physician or nonphysician practitioner is performing another procedure or service that he or she could not interrupt. Also, for services furnished on-campus, the supervisory physician or nonphysician practitioner may not be so physically distant on-campus from the location where hospital/CAH outpatient services are being furnished that he or she could not intervene right away. The hospital or supervisory practitioner must judge the supervisory practitioner’s relative location to ensure that he or she is immediately available.

For services furnished in CY 2011 and following, a supervisory practitioner may furnish direct supervision from a physician office or other nonhospital space that is not officially part of the hospital or CAH campus where the services are being furnished as long as he or she remains immediately available. Similarly, as of CY 2011, an allowed practitioner can furnish direct supervision from any location in or near an off-campus hospital or CAH building that houses multiple hospital provider-based departments where the services are being furnished as long as the supervisory practitioner is immediately available.

The supervisory physician or nonphysician practitioner must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized therapeutic equipment, and while in such cases CMS does not expect the supervisory physician or nonphysician practitioner to operate this equipment instead of technician, CMS does expect the physician or nonphysician practitioner to be knowledgeable about the therapeutic service and clinically able to furnish the service.

The supervisory responsibility is more than the capacity to respond to an emergency, and includes the ability to take over performance of a procedure or provide additional orders. CMS would not expect that the supervisory physician or nonphysician practitioner would make all decisions unilaterally without informing or consulting the patient’s treating physician or nonphysician practitioner. In summary, the supervisory physician or nonphysician practitioner must be clinically able to supervise the service or procedure.

20.7 - Non-Surgical Extended Duration Therapeutic Services

Rev. 169, Issued: 03- 01- 13, Effective: 04-01-13, Implementation: 04- 01-13)

CMS designates a limited set of therapeutic services meeting specific criteria as nonsurgical extended duration therapeutic services (“extended duration services”), defined in 42 CFR 410.27(a)(1)(v). These are outpatient therapeutic 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 supervisory practitioner’s immediate availability to furnish assistance and direction after the initiation of the service, and that are not primarily surgical in nature. In the provision of these services, CMS requires a minimum of direct supervision during the initiation of the service which may be followed by general supervision for the remainder of the service at the discretion of the supervisory practitioner. The CMS OPPS Website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> includes a table listing the current extended duration services for the payment year.

For these services, direct supervision means the definition specified for all outpatient therapeutic services in 410.27(a)(1)(iv), that is, immediate availability to furnish assistance and direction throughout the performance of the procedure. General supervision means the definition specified in the physician fee schedule at 410.32(b)(3)(i), that the service is performed under the supervisory practitioner’s overall direction and control but his or her presence is not required during the performance of the procedure.

“Initiation” means the beginning portion of the extended duration service, ending when the supervisory practitioner believes the patient is stable enough for the remainder of the service to be safely administered under general supervision. The point of transition to general supervision must be documented in the patient’s progress notes or medical record. The manner of documentation is otherwise at the discretion of each supervisory practitioner.