

Common Questions about Supervision Requirements for Medicare Payment of Hospital Outpatient Services

(1) Does Medicare require direct supervision for all services provided to outpatients in hospitals?

CMS has identified supervision requirements for the provision of both therapeutic and diagnostic services furnished to hospital outpatients. Medicare requires hospitals to provide direct supervision for the delivery of all outpatient therapeutic services. Direct supervision means that the physician or non-physician practitioner is immediately available to furnish assistance and direction throughout the performance of the procedure, but it does not mean that the supervising individual needs to be present in the room when the procedure is performed.

For diagnostic services provided to hospital outpatients, Medicare requires hospitals to follow the existing supervision requirements in the Medicare Physician Fee Schedule (MPFS) Relative Value File for individual tests. The MPFS has three definitions of supervision - general, direct, and personal. General supervision means that the procedure 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 a physician must be in attendance in the same room during the performance of the procedure.

For services provided by critical access hospitals (CAHs), CMS has directed its contractors not to enforce the requirement for direct supervision of outpatient therapeutic services during calendar year (CY) 2010 (please see notice at <http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/WebNotice.pdf>). CMS will revisit the rule for supervision of services in CAHs in the CY 2011 rulemaking process for the hospital outpatient prospective payment system (OPPS). CMS has only identified supervision requirements for the provision of therapeutic services to outpatients in CAHs. At this time, there is no requirement for specific levels of supervision for the provision of diagnostic services in a CAH.

(2) Why are observation services considered therapeutic and subject to direct supervision?

In Chapter 6 of the Medicare Benefit Policy Manual, section 20.6, we note that observation care is commonly ordered for patients that present to the emergency department, and that observation care is a well-defined set of specific, clinically appropriate services which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient. A patient receiving observation services presents with complex, evolving conditions that require active medical treatment and monitoring toward a decision to admit as an inpatient or discharge the patient. While we recognize that some emergent conditions progress more rapidly than others, we believe that the evolving nature of observation services and the unknown nature of the individual's condition necessitate supervision. As indicated in section 20.6, in the majority of cases, physicians can make this decision within 48 hours, and the decision is usually made in less than 24 hours. We would not expect patients to spend extended periods of time receiving observation services.

As indicated in section 20.5.2 of Chapter 6 of the Medicare Benefit Policy Manual, outpatient therapeutic services and supplies are those furnished as incident to the services of physicians and practitioners in the treatment of patients. Such services include clinic and emergency room services, and are furnished as an integral, although incidental, part of the physician or non-physician practitioner's professional service in the course of treatment of an illness or injury. Observation services include treatment comparable to an emergency department or clinic visit. Accordingly, observation services are therapeutic services. Patients receiving observation services may also receive a variety of additional diagnostic tests.

(3) Does a physician or non-physician practitioner need to be immediately available and on campus 24 hours a day, 7 days a week in order to meet Medicare's direct supervision requirements for payment purposes?

No, a physician or non-physician practitioner must provide direct supervision only when therapeutic services are being furnished to Medicare outpatients. The duration of many outpatient services is less than 24 hours, and, therefore, most services would not require 24 hours per day, 7 days per week direct supervision. Although many hospitals are continuously providing outpatient services, some small hospitals may not always be treating hospital outpatients. In these circumstances, we do not require hospitals to retain individual physicians or non-physician practitioners waiting on the campus of the hospital to supervise the therapeutic services that might be provided should a patient appear. With regard to observation services, as noted above, these are therapeutic services which must be provided under direct supervision; and we expect the treating physician or non-physician practitioner to make a decision to admit as an inpatient or discharge the patient as quickly as possible—usually less than 24 hours.

(4) Is a physician or non-physician practitioner considered immediately available as long as they are on the hospital campus? Section 42 CFR 410.27(f) sets up a two-pronged requirement for direct supervision of therapeutic services in the hospital or CAH: the physician or non-physician practitioner must be present on the same campus of the hospital and must be immediately available, meaning physically present. For the purposes of supervision of hospital outpatient therapeutic services, we recognize the 413.65(a)(2) definition of campus as "the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual basis, by the CMS regional office, to be part of the provider's campus." For payment purposes specifically, we recognize other areas or structures of the hospital's campus that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare to be part of the hospital's campus.

In the CY 2010 OPPS final rule with comment period we noted that some hospital campuses span several city blocks, and that the immediate availability requirement would limit the distance a supervisory physician or non-physician practitioner could be from the location where outpatient therapeutic services are being furnished. On small campuses, a supervising physician or non-physician practitioner typically could be anywhere on the hospital campus

and still meet the immediate availability requirement, provided that any services he or she is furnishing could reasonably be interrupted. However, that may not be the case for larger campuses.

(5) Can an emergency department physician or non-physician practitioner directly supervise therapeutic outpatient services while in the emergency department?

In most cases, the emergency physician or non-physician practitioner can directly supervise outpatient services so long as the emergency physician in the emergency department of the campus is immediately available, meaning that, if needed, he or she could reasonably be interrupted to furnish assistance and direction in the delivery of therapeutic services provided elsewhere in the hospital. We have stated that the supervisor must be a person who is “clinically appropriate” to supervise the therapeutic service or procedure. We believe that most emergency physicians can appropriately supervise many services within the scope of their knowledge, skills, licensure, and hospital granted privileges including observation services. With regard to whether an emergency physician or a non-physician practitioner could be interrupted, such that the emergency physician could be immediately available, each hospital will need to assess the level of activity in their emergency department and determine whether at least one emergency physician or non-physician practitioner could be interrupted to furnish assistance and direction in the treatment of outpatients.

(6) Does a physician need to directly supervise therapeutic services delivered to hospital outpatients or can other non-physician practitioners directly supervise as well?

Beginning in CY 2010, non-physician practitioners, including nurse practitioners, physician assistants, clinical nurse specialists, certified nurse-midwives, and licensed clinical social workers may directly supervise the provision of all hospital therapeutic services that they may perform themselves within their state scope of practice and hospital-granted privileges, provided that they continue to meet all the requirements for directly providing services, including any collaboration or supervision requirements. Clinical psychologists were already permitted to directly supervise hospital services provided to an outpatient, so long as those services are within the psychologist’s state scope of practice and hospital granted privileges.

(7) How will the requirement for direct physician supervision of therapeutic services delivered to outpatients affect the review of claims by contractors?

Neither supervision nor observation services are included on the Medicare Recovery Audit Contractor (RAC) list of issues for CY 2010. The focus of each year’s RAC review is identified by both contractors and CMS staff and approved by CMS. CMS will ensure that the RACs, understand that an assessment of supervision will require knowledge of the level of activity in a hospital at any point in time and the hospital’s staffing structure and protocols before approving any RAC audit. We will the inform MAC staff of these issues.

Only in the case of CAHs has CMS directed its contractors not to enforce the requirement for direct supervision of outpatient therapeutic services that are furnished during calendar year (CY) 2010. CMS continues to expect CAHs to fulfill all other Medicare program requirements when providing services to Medicare beneficiaries and when billing Medicare for those services.