CMS' 2011 OPPS Final Rule Substantially Revises Physician Supervision Requirements

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The Centers for Medicare & Medicaid Services has substantially revised its physician supervision policy by modifying the definition of direct supervision, identifying services that require direct supervision only at initiation of the service and intending to establish a process to evaluate supervision levels for specific therapeutic services.

In the 2011 outpatient prospective payment system (OPPS) final rule, the Centers for Medicare & Medicaid Services (CMS) has substantially revised its physician supervision policy by:

- Eliminating the requirement that a supervising physician must be "on the same campus" or "in the off-campus provider-based department of the hospital"
- Identifying a limited set of "non-surgical, extended duration therapeutic services" for which direct supervision is required only for *initiation of the service*, followed by a general supervision requirement for the remainder of such service
- Announcing its intent to establish an independent review process for evaluating the appropriate level of physician supervision for specific therapeutic services in the calendar year 2012 OPPS rulemaking cycle

Over the last couple years, CMS has clarified and refined the rules relating to physician supervision of hospital outpatient services. CMS currently requires direct supervision for most outpatient therapeutic services in hospital outpatient departments. Historically, direct physician supervision was assumed in on-campus settings. However, in the preamble of the 2009 OPPS rule, CMS "clarified" that assumed supervision did not mean that no supervision was required, and that hospitals had to ensure supervising physician presence and immediate availability to meet the direct-supervision requirement that applies to most outpatient therapeutic services and to many diagnostic services.

The preamble language in the 2009 OPPS rule generated numerous comments and requests for clarification, which CMS addressed in part in the 2010 OPPS final rule. (View CMS Finalizes Requirements for Supervision of Hospital Outpatient Services for more information.)

In the 2010 OPPS final rule, CMS provided a somewhat more flexible approach than the 2009 OPPS preamble, permitting supervision by certain nonphysician practitioners and interpreting direct supervision on the hospital campus or in an on-campus provider-based department (PBD) to mean that "the supervisory physician or nonphysician practitioner must be present on the same campus and immediately available to furnish assistance and

direction throughout the performance of the procedure." However, for off-campus PBDs of hospitals, CMS continued to require that the physician or nonphysician practitioner must be present in the off-campus PBD and immediately available to furnish assistance and direction throughout the performance of the procedure.

Although the 2010 OPPS rule addressed some of the provider community's concerns, many hospitals commented that, particularly in rural and critical access hospitals (CAHs), requiring a physician or nonphysician practitioner to be available at all times is excessively burdensome and difficult to staff if there is no other activity to occupy the physician in the hospital. Further, physicians or nonphysician practitioners are not always available when therapeutic services need to be provided, particularly services of long duration.

In response to these concerns, CMS is revising its definition of direct supervision for hospital outpatient therapeutic services to remove reference to "on the same campus" or "in the off-campus provider-based department of the hospital." The revised definition of direct supervision requires immediate availability, meaning the physician must be physically present, interruptible and able to furnish assistance and direction throughout the performance of the procedure, but does not include reference to a particular physical boundary. The definition will apply equally in the hospital or in on-campus or off-campus PBDs. The revised definition also applies to hospital outpatient diagnostic services that require direct supervision, except for diagnostic services provided under arrangements in non-hospital locations, where the supervising physician still will be required to be present in the office suite at the non-hospital location. The revised definition will provide relief in particular for off-campus PBDs, because a physician in an adjacent physician office now will be able to serve as a supervising physician, provided that the availability standard is met.

CMS has also identified a limited set of "non-surgical, extended duration therapeutic services" for which direct supervision is required only for *initiation of the service*, followed by a general supervision requirement for the remainder of such service. The list comprises services with lengthy monitoring components and low risk of complications that would require the assistance and direction of the supervising physician or nonphysician practitioner after assessment. Such services include a limited number of injection, infusion and observation services, but not chemotherapy or blood transfusions.

Finally, while CMS is maintaining its policy that, in general, direct supervision is required for all outpatient therapeutic services, it intends to establish an independent review process for evaluation of the appropriate level of supervision for specific therapeutic services. Such a review process may result in CMS permitting general supervision, rather than direct supervision, for certain services. Unlike direct supervision, where physician presence is required, services provided under general supervision are furnished under the overall direction and control of the physician or nonphysician practitioner, but his or her physical presence is not required during the performance of the procedure.

In calendar year 2010, CMS told its contractors not to enforce the requirement for direct supervision of outpatient therapeutic services provided in CAHs. In the 2011 OPPS final rule, CMS extended its decision not to enforce this requirement to CAHs through calendar year 2011, and expanded the scope of its decision to include small rural hospitals having 100 or fewer beds.

These changes will be applicable to services furnished on or after January 1, 2011.