Background

In the 2009 outpatient prospective payment system (PPS) rule, the Centers for Medicare & Medicaid Services (CMS) “clarified” that direct supervision of outpatient therapeutic services was the standard required oversight for the provision of outpatient therapeutic services. It contended that this clarification related back to all related procedures performed as early as 2001. This policy required that a supervising physician be physically present in the department at all times when Medicare beneficiaries receive these services. This was later amended to require that the physician be “immediately available.”

In response to concerns regarding the implementation of this policy, CMS delayed enforcement of this policy for CAHs and small and rural hospitals with fewer than 100 beds through 2013 and has allowed certain types of non-physician practitioners (NPPs) to provide direct supervision for hospital outpatient services, adopted a two-tiered policy for the supervision of certain “nonsurgical extended duration therapeutic services”, and established the Advisory Panel on Hospital Outpatient Payment (HOP Panel) to recommend alternate supervision levels for individual hospital outpatient therapeutic services. The problem is that these tweaks are not enough and fail to recognize that many outpatient therapeutic services can be done safely under general supervision. CMS, in its 2014 outpatient PPS rule, ended the moratorium on the enforcement of direction supervision for CAHs.

The Legislation

- Establishes “general supervision” by a physician or non-physician practitioner for outpatient therapeutic services is sufficient to meet Medicare payment requirements for the services
- Establishes advisory panel of practitioner experts, including half practicing in rural areas, for designating therapeutic hospital outpatient services that, by reason of complexity or high risk, require “direct supervision” during initiation or for the entire service.
- Critical Access Hospitals (CAHs) deemed to have met direct supervision requirement when meeting conditions of participation requirement to have a physician on-site within 30 minutes.
- Allows non-physician practitioner to directly supervise cardiac and pulmonary rehabilitations services as long as the practitioner is acting within the scope of practice under state law.
- Defines “immediately available” to mean that the physician does not have to be physically present in the room, but could be available by phone or other means.
- Repeals CMS’s regulatory interpretation of direct supervision requirement as outlined in the 2009 Outpatient Regulations.
- Holds harmless any hospital not meeting the supervision requirement first outlined in the 2009 regulations from 2001 through the enforcement of the legislation.

IHA POSITION

IHA supports S. 257 to ensure hospitals, particularly CAHs, are able to provide quality, safe healthcare services in their communities without unnecessary restrictions imposed on the delivery.
Why Important

- Due to staffing and workforce shortages and challenges, hospitals may be forced to limit services offered in their communities to meet CMS’s imposed direct supervision requirement.
  - Due to a shortage of physicians or NPPs, particularly in rural areas, always having a physician available to provide direct supervision could unnecessarily restrict patient access to care if hospitals are unable to schedule a substitute for providers that get sick or go on vacation.
- Limiting services, especially in rural communities, will negatively impact patient access to care.
- The default requirement of direct supervision for outpatient therapeutic services is impractical and will not help improve the quality of care provided.
  - Services like continued chemotherapy sessions can safely and effectively be delivered under general supervision.
  - Several examples of chronic, repetitive situations involve a patient being seen by the same providers on a routine basis for administering necessary IV fluids, blood products, or antibiotics. These services can safely and effectively be provided under general supervision and direct supervision should not be required.
- Hospitals schedule outpatient therapeutic services to meet the patient’s needs, such as providing appointments so the patient can receive treatment before and after work, but if they must comply with direct supervision requirements, hospitals fear they may be forced to focus more on scheduling around physicians and NPPs rather than patient convenience.
  - A beneficiary’s local access to chemotherapy and/or radiation oncology treatments are a big concern when thinking about whether the hospital can continue to provide these services under CMS’ enforced direct supervision requirements due to the small number of staff “immediately available” and able to meet all of the direct supervision requirements.
- Many times, outpatient therapeutic services are offered in conjunction with Emergency Room staff that may not be immediately available if an emergency situation arises. This will further hinder available services if hospitals must provide additional staff simply to ensure direct supervision requirements can be met if an emergency arises during a scheduled procedure.

Additional Information

Under direct supervision the physician or NPP must be immediately available to furnish assistance and direction throughout the procedure, but is not required to be present in the room. With general supervision the procedure is under the physician’s or NPP’s overall direction and control, but his or her presence is not required during the procedure, however, the training of the NPP who performs the procedure and maintenance of the 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.

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