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THE LEXICON OF SUPERVISION: CMS VERSUS ACGME DEFINED TERMS

BACKGROUND.

Health care procedures and services often must be appropriately "supervised" to ensure quality of care and safety for patients. In recent years, the Centers for Medicare and Medicaid Services ("CMS") has clarified its defined levels of supervision (general, direct and personal) applicable to the provision of hospital outpatient diagnostic and therapeutic services. Under those Medicare coverage rules, the correct level of physician or non-physician practitioner supervision must be provided for the service to be a covered (i.e., payable) service to Medicare beneficiaries.

Effective July 1, 2011, the Accreditation Council for Graduate Medical Education ("ACGME"), as part of its update to the "duty hour rules,"1 clarified its position with respect to the amount of teaching physician supervision required for residents. Accordingly, the ACGME adopted its own, different "supervision" vocabulary, also identifying three levels of resident supervision (oversight, indirect and direct).

In light of the recent spotlight focused on the supervision of hospital outpatient therapeutic services pursuant to 2009/2010 CMS guidance and the new ACGME positions, there is the possibility for confusion at teaching hospitals as to the correct level of supervision that is required for different purposes. This article offers a guide to sort out the CMS and ACGME vocabulary.

TWO CONTRASTING SUPERVISION FRAMEWORKS.

CMS identifies three levels of supervision to be provided depending on the complexity and risk associated with the performance of a particular clinical service or procedure:

1. "Personal Supervision": The physician is present in the room when the service is being performed.

2. "Direct Supervision": In the outpatient hospital setting, the physician2 is "immediately available" or "physically present, interruptible and able to furnish assistance and direction throughout the performance of the procedure"; the physician does not have to be present in the same room when the procedure is being performed or within any particular hospital boundary, such as the confines of the hospital campus.3 Of note, CMS revised this definition in the 2011 Hospital Outpatient Prospective Payment System Final Rule to remove a requirement that the supervising physician be located "on the same campus" or "in the off-campus provider-based department of the hospital" when he or she is supervising an outpatient hospital therapeutic or diagnostic service.4

3. "General Supervision": A service is furnished under the overall direction and control of the supervising physician, but his or her physical presence is not required during the performance of the procedure.

The ACGME also identifies three levels of supervision but uses different terminology for supervising residents:

1. "Direct Supervision": The supervising physician is physically present with the resident and the patient.

2. "Indirect Supervision" is broken down into two levels:

   a. "Direct Supervision Immediately Available": The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide direct supervision.

   b. "Direct Supervision Available": The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision.

3. "Oversight": The supervising physician is available to review procedures and encounters and to offer feedback after care is delivered.5

A careful parsing of the two supervision frameworks reveals that some of the same terms have different meanings. For example, the CMS definition of "personal supervision" (physician is present in the room) corresponds to the ACGME definition of "direct supervision" (supervising physician is physically present with the resident and patient), yet the CMS definition of "direct supervision" does not require the supervising physician to be in the same room/physically present with the patient.

Likewise, the CMS definition of "direct supervision" (physician must be immediately available to assist) is similar to the ACGME definition of "direct supervision immediately available." The ACGME definition of "direct supervision available" (no physical presence but available by telephone or electronic modalities) has no counterpart in the CMS system except, arguably, CMS "general supervision," to the extent CMS general supervision requires no physical presence.

Finally, the CMS definition of "general supervision" (only requiring overall physician direction and control) is closest to the ACGME definition of "oversight" (requiring only that the resident's supervisor is available to review encounters and offer feedback after care is delivered).

In sum, while both CMS and the ACGME offer a similar three-tiered structure to define physician supervision, the terms used by each differ and even contradict each other. The following chart provides a ready reference for comparing the two systems.

Comparison of ACGME and CMS Supervision Requirements

CMS: Personal Supervision	Supervising physician is present in the room with the patient.
ACGME: Direct Supervision	Supervising physician is physically present with the resident and patient.
CMS: Direct Supervision	Supervising physician is immediately available to furnish assistance and direction throughout the performance of the procedure; however, the physician does not have to be present in the same room when the procedure is being performed.
ACGME: Indirect Supervision: Direct Supervision Immediately Available	Supervising physician is physically present within the hospital or other site of patient care, and is immediately available to provide direct supervision.
ACGME: Indirect Supervision: Direct Supervision Available	Supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision.

CMS: General Supervision	A service is furnished under the overall direction and control of the supervising physician, but his or her physical presence is not required during the performance of the procedure.
ACGME: Oversight	Supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

AND WHILE WE'RE ON THE SUBJECT OF SUPERVISION - SOME IMPORTANT RECENT CMS GUIDANCE CONCERNING THE SUPERVISION OF HOSPITAL OUTPATIENT THERAPEUTIC SERVICES.

With respect to the delivery of hospital outpatient therapeutic services, not only must there be "direct supervision" by a supervising physician, but that physician must be "clinically appropriate." Unfortunately, CMS's position on which physicians are clinically appropriate is less than clear. CMS has said that while it need not be a physician in the same specialty or even in the same department as the physician ordering the service, it would be "inappropriate for a supervisory physician . . . to be responsible for patients, hospital staff, and services that are outside the scope of [the physician's] knowledge, skills, licensure, or hospital-granted privileges"6 (emphasis added). One approach may be to leave it up to the designated supervising physician to decide whether she or he is clinically appropriate, at the time designated as the supervising physician.

CMS also has suggested that physicians ordering hospital outpatient therapeutic services must continue to stay involved in the actual performance of the services. "A hospital service or supply would not be considered incident to a physician's services 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."7 We believe CMS has articulated a new position with respect to the role of the ordering physician, and that this, potentially, may result in a narrower scope of Medicare coverage than the industry has experienced in the past.

Practical Considerations.

Teaching hospitals should take note of the different supervision frameworks and their corresponding defined terms. With the expected heightened level of attention to the duty hours issue in light of the changed standards, teaching hospitals may need to track supervision differently under the differing standards, as attention to supervision requirements for ACGME and Medicare outpatient therapeutic services occurs. Hospitals must be wary of exercising and, when needed, documenting the right level of supervision for the right circumstances, to comply with applicable rules and to ensure available reimbursement for furnished services.

If you have any questions or would like additional information about this or related topics, please contact your regular Hall Render attorney or:

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[1] The duty hour rules set forth the number of hours residents may work on clinical and academic activities and the supervision framework.

[2] In appropriate cases, a non-physician practitioner also can provide direct supervision of an outpatient therapeutic or diagnostic service.

[3] 75 Fed. Reg. 72008 (Nov. 24, 2010).

[4] For additional information on supervision requirements for hospital outpatient services, please see Hall Render's Health Law News of November 22, 2010

[5] ACGME resource: Resident Duty Hours in the Learning and Working Environment, ACGME website: http://www.acgme.org/acWebsite/dutyHours/dh-ComparisonTable2003v2011.pdf

[6] 74 Fed. Reg. 60584 (Nov. 20, 2009).

[7] 75 Fed. Reg. 72006 (Nov. 24, 2010). Under Medicare coverage rules, hospital outpatient therapeutic services are only covered if they are "incident to" the services of a physician in the treatment of the patient.