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§483.40 Physician Services

A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.

§483.40(a) Physician Supervision

The facility must ensure that--

- (1) The medical care of each resident is supervised by a physician; and**
- (2) Another physician supervises the medical care of residents when their attending physician is unavailable.**

Intent §483.40

The intent of this regulation is to ensure the medical supervision of the care of nursing home residents by a personal physician.

Interpretive Guidelines §483.40

A physician's "personal approval" of an admission recommendation must be in written form. The physician's admission orders for the resident's immediate care as required in §483.20(a) will be accepted as "personal approval" of the admission.

"**Supervising the medical care of residents**" means participating in the resident's assessment and care planning, monitoring changes in resident's medical status, and providing consultation or treatment when called by the facility. It also includes, but is not limited to, prescribing new therapy, ordering a resident's transfer to the hospital, conducting required routine visits or delegating and supervising follow-up visits to nurse practitioners or physician assistants. Each resident should be allowed to designate a personal physician. (See §483.10(d)(1).) The facility's responsibility in this situation is to simply assist the resident, when necessary, in his or her efforts to obtain those services. For example, the facility could put the resident in touch with the county medical society for the purpose of obtaining referrals to practicing physicians in the area. Facilities should share MDS and other assessment data with the physician.

Procedures §483.40

If there is a deficiency in §483.10, Resident Rights; §483.13, Resident Behavior and Facility Practices; §483.15, Quality of Life; or §483.25, Quality of Care, fully review all of the tags under this requirement.

Probes: §483.40(a)

- How was the supervising physician involved in the resident's assessment and care planning?
- If staff reported a significant change in medical status to the supervising physician, did the physician respond?
- If the supervising physician was unavailable and could not respond, did the facility have a physician on call? Did this physician respond?
- Are residents sent to hospital emergency rooms routinely because the facility does not always have a physician on call?

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§483.40(b) Physician Visits

The physician must--

- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;**
- (2) Write, sign, and date progress notes at each visit; and**

(3) Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

Intent §483.40(b)

The intent of this regulation is to have the physician take an active role in supervising the care of residents. This should not be a superficial visit, but should include an evaluation of the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regime.

Interpretive Guidelines §483.40(b)

Total program of care includes all care the facility provides residents to maintain or improve their highest practicable mental and physical functional status, as defined by the comprehensive assessment and plan of care. Care includes medical services and medication management, physical, occupational, and speech/language therapy, nursing care, nutritional interventions, social work and activity services that maintain or improve psychosocial functioning.

The physician records residents' progress and problems in maintaining or improving their mental and physical functional status. The physician need not review the total plan of care at each visit, but must review the total plan of care at visits required by §483.40(c). There is no requirement for physician renewal of orders.

In cases where facilities have created the option for a resident's record to be maintained by computer, rather than hard copy, electronic signatures are acceptable. See Guidelines for §483.75(l)(1) for information on facility safeguards concerning electronic signatures.

Physician orders may be transmitted by facsimile machine if the following conditions are met:

- The physician should have signed and retained the original copy of the order from which the facsimile was transmitted and be able to provide it upon request. Alternatively, the original may be sent to the facility at a later time and substituted for the facsimile.
- The facility should photocopy the faxed order since some facsimiles fade over time. The facsimile copy can be discarded after facility photocopies it.
- A facility using such a system should establish adequate safeguards to assure that it is not subject to abuse.

It is not necessary for a physician to re-sign the facsimile order when he/she visits the facility. When rubber stamp signatures are authorized by the facility's management, the individual whose signature the stamp represents shall place in the administrative offices of the facility a signed statement to the effect that he/she is the only one who has the stamp and uses it. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards.

Probes: §483.40(b)

- Do services ordered by a physician show a pattern of care to maintain or improve the resident's level of independent functioning? For example, how do physician orders reflect the resident's nutritional status and needs?
- Does documentation reflect continuity of care in maintaining or improving a resident's mental and physical functional status? For example, do the attending physician's rehabilitation service orders show a pattern of consistent restorative programming?

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§483.40(c) Frequency of Physician Visits

(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.

(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

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§483.40(c)(3) Expect as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.

§483.40(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.

Interpretive Guidelines §483.40(c)

“**Must be seen**” means that the physician must make actual face-to-face contact with the resident. There is no requirement for this type of contact at the time of admission, since the decision to admit an individual to a nursing facility (whether from a hospital or from the individual’s own residence) generally involves physician contact during the period immediately preceding the admission.

After the initial physician visit in SNFs, where States allow their use, a qualified nurse practitioner (NP), clinical nurse specialist or physician assistant (PA) may make every other required visit. (See §483.40(e) Physician delegation of tasks in SNFs.)

In a NF, the physician visit requirement, in accordance with the State law, may be satisfied by NP, clinical nurse specialist or PA. (See §483.40(f).)

The timing of physician visits is based on the admission date of the resident. Visits will be made within the first 30 days, and then at 30 day intervals up until 90 days after the admission date.

Visits will then be at 60 day intervals. Permitting up to 10 days slippage of a due date will not affect the next due date. However, do not specifically look at the timetables for physician visits unless there is indication of inadequate medical care. The regulation states that the physician (or his/her delegate) must visit the resident **at least** every 30 or 60 days. There is no provision for physicians to use discretion in visiting at intervals longer than those specified at §483.40(c).

Policy that allows an NP, clinical nurse specialist, or PA to make every other required visit, and that allows a 10 day slippage in the time of the visit, does not relieve the physician of the obligation to visit a resident when the resident’s medical condition makes that visit necessary.

It is expected that visits will occur at the facility rather than the doctor’s office unless office equipment is needed or a resident specifically requests an office visit. If the facility has established policy that residents leave the grounds for medical care, the resident does not object, and this policy does not infringe on his/her rights, there is no prohibition to this practice. The facility should inform the resident of this practice, in accordance with §483.10(b).

Probes: §483.40(c)

- How does the scheduling and frequency of physician visits relate to any identified quality of care problems?
- When a PA, clinical nurse specialist, or NP performs a delegate physician visit, and determines that the resident’s condition warrants direct contact between the physician and the resident, does the physician follow-up promptly with a personal visit?

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§483.40(d) Availability of Physicians for Emergency Care

The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency.

Interpretive Guidelines §483.40(d)

If a resident's own physician is unavailable, the facility should attempt to contact that physician's designated referral physician before assuming the responsibility of assigning a physician. Arranging for physician services may include assuring resident transportation to a hospital emergency room/ward or other medical facility if the facility is unable to provide emergency medical care at the facility.

Probes: §483.40(d)

- Does the facility have a physician on call for medical emergencies? Does this physician respond?
- For what reasons are residents sent to hospital emergency rooms?
- Did medical management of the emergency affect the resident's maintaining or improving their functional abilities?
- If the resident refused the physician's visit, what has the facility done to explain to the resident the results and alternatives that may be available?

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§483.40(e) Physician Delegation of Tasks in SNFs

(1) Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who--

- (i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State;**
- (ii) Is acting within the scope of practice as defined by State law; and**
- (iii) Is under the supervision of the physician.**

(2) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies.

Interpretive Guidelines §483.40(e)

"Nurse practitioner" is a registered professional nurse now licensed to practice in the State and who meets the State's requirements governing the qualification of nurse practitioners.

"Clinical nurse specialist" is a registered professional nurse currently in practice in the State and who meets the State's requirements governing the qualifications of clinical nurse specialists.

"Physician assistant" is a person who meets the applicable State requirements governing the qualifications for assistants to physician.

When **personal** performance of a particular task by a physician is specified in the regulations, performance of that task cannot be delegated to anyone else. The tasks of examining the resident, reviewing the resident's total program of care, writing progress notes, and signing orders may be delegated according to State law. The extent to which physician services are delegated to physician extenders in SNFs will continue to be determined by the provisions of §483.40(e), while the extent to which these services are performed by physician extenders in NFs will be determined by the individual States under §483.40(f).

Probes: §483.40(e)

- Do the facility's attending physicians delegate to NPs, clinical nurse specialists, or PAs?

- Do NP/clinical nurse specialist/PA progress notes and orders follow the scope of practice allowed by State law?
- What evidence is there of physician supervision of NPs or PAs? For example, do physicians countersign NP/PA orders, if required by State law?

§483.40(f) Performance of Physician Tasks in NFs

At the option of State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician.

Interpretive Guidelines §483.40(f)

If delegation of physician tasks is permitted in your State and the physician extender does not meet the qualifications listed here, cite F388.

Procedures §483.40(f)

If a nurse practitioner, clinical nurse specialist, or physician assistant is performing required physician tasks in a NF, is this allowed by the State? Is this person an employee of the facility? (Facility employees are prohibited from serving in this capacity.)

Probes: §483.40(f)

Is this person working in collaboration with the physician?