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Using technical safeguards to thwart phishing attacks

an interview with Adam Greene

Partner, Davis Wright Tremaine

See page 16

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Who's minding the store? Understanding supervision requirements

» Diagnostic tests have their own Medicare benefit category.
» Medicare recognizes three levels of physician supervision for diagnostic tests.
» Non-physician practitioners may not supervise performance of diagnostic tests per Medicare.
» Diagnostic and therapeutic service supervision differs in outpatient facility settings.
» Supervision requirements may differ between ACGME, Medicaid, Medicare, and state practice laws.

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When it comes to directing the care of services performed by clinical staff (e.g., qualified healthcare professionals, ancillary staff, technicians, residents, or fellows), it is important to understand the levels of physician or non-physician practitioner (NPP) supervision needed to satisfy billing and regulatory requirements. This can be much more difficult for physicians who work in large healthcare delivery systems where myriad professionals participate in patient care. Some locations in which physicians practice are provider-based settings (i.e., facility), but others are physician-based, and the payer class of the patient isn't always set in stone. If you do not understand why it is so difficult for physicians to grasp the supervision rules that govern billing of services on both the facility side and professional practice side, try walking a mile in their paper-booty-covered shoes.


Palmeter

Physicians keep many different requirements in their heads (and at times inside the pockets of their lab coats). To understand the required level of physician supervision for billing, physicians have to know whose definition applies, who is being supervised, what is being supervised, and where the service is being supervised. There are varying degrees of physician supervision dictated by Medicare, as well as state Medicaid fiscal intermediaries (whose definition may be regulated by state law), state regulations governing licensing of certain professions (e.g., Board of Medicine or Board of Nursing), and even the Accreditation Council for Graduate Medical Education (ACGME). Throw in some private payers, who may have their own definitions of physician supervision, and perhaps you will start to understand why some organizations do not have a firm grasp on these requirements.

Medicare

A critical concept when it comes to Medicare is understanding the difference between

incident-to billing and the requirements for supervision of diagnostic and therapeutic services in outpatient facility and non-facility locations. At times organizations apply Medicare incident-to billing erroneously.

In general, for services to be covered as incident-to a physician or other NPP, the services and supplies must be:

- An integral, although incidental, part of the physician's professional service;
- Commonly rendered without charge or included in the physician's bill;
- Of a type that is commonly furnished in physician's offices or clinics; and
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision.

"Direct supervision" here is defined as the physician or supervising practitioner being present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.

For professional billing, the incident-to provision is not applicable in a facility setting. In a facility setting, Medicare Part B payment is made to the facility for services rendered incident-to a physician or NPP, not to the physician, NPP, or group practice.

One area of confusion is the application of incident-to guidelines to diagnostic tests. According to the *Medicare Benefit Policy Manual*, "Carriers and intermediaries must not apply incident to requirements to services having their own benefit category. Rather, these services should meet the requirements of their own benefit category."[1]

Professional billing of diagnostic tests

Diagnostic tests are a distinct and separate benefit set forth in the Social Security Act;[2] therefore, supervision of diagnostic tests need not also meet the incident-to billing requirements. Some practices will apply the incident-to billing requirements to diagnostic tests and bill the diagnostic test as a physician service when the physician did not provide the requisite level of supervision for the test. Their rationale: "Well, the patient was established and the physician did establish a treatment plan for this problem, so the non-physician practitioner can bill the services incident-to the physician." The supervision guidelines relevant to diagnostic tests specify that only "physicians" may supervise the technical component of diagnostic tests covered under the Medicare Part B physician fee schedule. NPPs may only bill for diagnostic tests when they personally "furnish" the service (i.e., they did not simply supervise someone else performing the service).

Medicare regulations stipulate that diagnostic X-rays and other diagnostic tests must be furnished under the appropriate level of supervision by a "physician," and may not be supervised by NPPs; however, certain exceptions are afforded for some diagnostic tests furnished by some NPPs. In a nutshell, this means physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives may not supervise other staff in the performance of a diagnostic test—but when these same NPPs "perform" the tests themselves, the only level of physician supervision needed is that which is required for all services performed by that specific NPP. For example, nurse practitioners must work in collaboration with a physician, and physician assistants must practice under the general supervision of a physician.

According to the *Code of Federal Regulations*,[3] with limited exceptions, diagnostic tests covered under the Medicare physician fee schedule must be provided under some level of physician supervision or the services will not be considered reasonable and necessary. The level of physician supervision for

diagnostic tests varies, based on the complexity of the service. For most of these services, three levels of physician supervision are applicable: general, direct, and personal.

General supervision – This means the service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Direct supervision – "In the office setting" means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service; however, the physician does not need to be present in the room when the service is performed.

As you may have noted in the above definition, direct supervision is defined from the perspective of the office setting; therefore, one must determine whether the service in question is provided in an office setting (non-facility) or a facility setting. Direct supervision for outpatient facility billing is defined differently.

Personal supervision – this means a physician must be in attendance in the room during the performance of the procedure.

Outpatient facility billing

Under the Outpatient Prospective Payment System (OPPS), the level of supervision, who may supervise, and the proximity of the supervising party to the location where the service is being performed varies based on whether the service is diagnostic, therapeutic, or falls under the category of "nonsurgical extended duration therapeutic services" (NSEDTS).

Diagnostic services

Some of the rules governing supervision of diagnostic tests on the professional side also apply to outpatient facility diagnostic services (i.e., the required level of supervision must be by provided by a physician unless the NPP personally performs the diagnostic test). What's different is how "direct supervision" and "immediate availability" are defined in the outpatient facility setting.

Beginning in calendar year 2011, for services requiring direct supervision, the supervising physician may be present in locations such as physician offices that are close to the hospital or provider-based department of a hospital where the services are being furnished, but are not located in actual hospital space, as long as the supervisory physician remains immediately available. The supervising physician may be present in a location in or near an off-campus hospital building that houses multiple hospital provider-based departments where the services are being furnished, as long as the supervisory physician is immediately available.

For diagnostic services furnished in an on-campus or off-campus outpatient department of the hospital, direct supervision means the supervising physician must be immediately available to furnish assistance and direction throughout the performance of the procedure. The supervising physician is not required to be present in the room where the procedure is being performed, or within any other physical boundary, as long as he/she is immediately available. The supervising physician may be present in locations such as physician offices that are close to the hospital or provider-based department of a hospital where the services are being furnished, but that are not located in an actual hospital space, as long as the supervisory physician remains immediately available.

Immediate availability requires the immediate physical presence of the supervisory physician. CMS has not specifically defined the word "immediate" in terms of time or distance; however, an example of a lack of immediate availability would be situations where the supervisory physician is performing another procedure or service that he/she could not interrupt. Also, for services furnished on-campus, the supervisory physician may not be so physically distant on-campus from the location where hospital outpatient services are being furnished that he/she could not intervene right away. The hospital or supervisory physician must judge the supervisory physician's relative location to ensure that he/she is immediately available.

There are some other rules that apply to the coverage of physical therapy, speech-language pathology, or occupational therapy services when they are furnished "as therapy," meaning under a therapy plan of care, as well as services covered under the End Stage Renal Disease Prospective Payment System.

So in essence, for outpatient facility billing, who can supervise is the same as for professional billing, but the definition of direct supervision varies and takes into consideration the hospital campus, as opposed to an "in office" requirement because services performed in hospital-based settings are not always performed in clinic settings.

Therapeutic services

Physicians, clinical psychologists, licensed clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives may furnish the required supervision of hospital outpatient therapeutic services that they may personally furnish in accordance with state law and all additional rules governing the provision of their services. Medicare requires direct supervision of all hospital outpatient therapeutic services unless CMS makes an assignment of either general or personal supervision for an individual service. The key difference between diagnostic and therapeutic services is that NPPs may provide the requisite level of supervision for therapeutic services, but they may not do so for diagnostic services.

> …NPPs may provide the requisite level of supervision for therapeutic services, but they may not do so for diagnostic services.

For therapeutic services, direct supervision means the immediate availability to furnish assistance and direction throughout the performance of the procedure. General and personal supervision are defined above under the "Professional billing of diagnostic services" section.

For every rule there is an exception, as is the case for certain therapeutic services. For pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services, direct supervision must be furnished by a doctor of medicine or a doctor of osteopathy.

Non-surgical extended duration therapeutic services

There is a hybrid level of supervision for certain services described as non-surgical extended duration therapeutic services (NSEDTS). These include hospital outpatient therapeutic services which:

- can last a significant time;
- have a substantial monitoring component that are typically performed by auxiliary personnel;
- have a low risk of requiring the supervisory practitioner's immediate availability

to furnish assistance and direction after the initiation of the service; and
- that are not primarily surgical in nature.

In the provision of these services, CMS requires a minimum of direct supervision during the initiation of the service, which may be followed by general supervision for the remainder of the service at the discretion of the supervisory practitioner. "Initiation" means the beginning portion of the NSEDTS that ends when the patient is stable and the supervising physician or the appropriate NPP determines that the remainder of the service can be delivered safely under general supervision. The point of transition to general supervision must be documented in the medical record.

For these services, "direct supervision" means the immediate availability to furnish assistance and direction throughout the performance of the procedure. "General supervision" means the service is performed under the supervisory practitioner's overall direction and control, but his/her presence is not required during the performance of the procedure.

The list of services that may be furnished under general supervision or that are defined as NSEDTS is subject to change. The CMS website[4] is a good place to check for a list of these services.

Accreditation Council for Graduate Medical Education

In the ACGME Program Requirements for Graduate Medical Education in General Surgery,[5] residency programs must use the following classifications of supervision to ensure oversight of resident supervision and graded authority and responsibility:

- **Direct supervision**
  The supervising physician is physically present with the resident and patient.
- **Indirect supervision**
  (1) With 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.
  (2) With 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.
- **Oversight**
  The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The definition of direct supervision, as it applies to the supervision of diagnostic tests billed under the Medicare physician fee schedule, differs greatly from the ACGME's definition. The ACGME's definition of direct supervision is more in line with Medicare's definition of personal supervision. Also, the ACGME includes terms that Medicare does not recognize. In part, one of the ACGME's definitions for indirect supervision (i.e., with direct supervision immediately available) looks very similar to Medicare's definition of direct supervision—as least as far as the physician office is considered.

Residents and fellows are afforded progressive responsibility commensurate to their level of training. The level of teaching physician supervision is based on the resident's or fellow's competence and experience, as well as ACGME residency program guidelines.

The level of teaching physician supervision and participation (and documentation) needed to support professional billing may be more stringent than the levels described in ACGME residency program protocols, regardless of

the resident or fellow's experience or demonstrated competence. For example, the ACGME's Orthopaedic Surgery Review Committee for Orthopaedic Surgery[6] states that for a post-graduate year-one resident, a Foley catheter insertion may be performed under indirect supervision with direct supervision immediately available. However, under the teaching physician rules for minor procedures,[7] a teaching physician must either personally perform the procedure or must be physically present during the entire procedure in order to submit a billable charge to Medicare Part B. The teaching physician's presence and participation must also be documented in the medical record.

State Medicaid programs

Each state's Medicaid program may establish the level of physician supervision required for certain services. For example, in the *Florida Medicaid Practitioner Services Coverage and Limitations Handbook,*[8] personal supervision is required to bill Florida Medicaid for services performed by a physician assistant or advanced registered nurse practitioner under the physician's provider number. The *Florida Administrative Code*[9] defines "direct supervision" as face-to-face supervision during the time the services are being furnished; "personal supervision" is defined as services furnished "while the supervising practitioner is in the building…" As such, the state of Florida's definition of personal supervision is more in line with Medicare's definition of direct supervision.

State practice regulations

Each state's laws initially address the extent to which a physician must be on the premises, available by telephone, or in formal collaborative relationships with certain types of practitioners or ancillary personnel. Medicare coverage requires compliance with state licensure regulations in all respects. Consequently, knowledge of the extent to which a state's laws address physician supervision requirements where physicians work with nurses, laboratory technicians, physical therapists, physician's assistants, medical assistants, nurse midwives, and others in the physician practice must be considered before anything else. Thereafter, a payer may impose other specific and variable coverage requirements.

Conclusion

Supervision rules are not just a Medicare requirement. There are Medicare guidelines that differ based on professional vs. facility billing, location, type of service being supervised, and who is allowed to supervise. There may be different requirements for state Medicaid plans and even private payers. The rules for accreditation of graduate medical education programs differ from Medicare's, and lastly, there are state practice regulations which govern how professionals may practice and, at the very least, must be considered before any thought is given to billing.

So cut physicians some slack and help them navigate these complex regulations. In addition to keeping up with all of these billing and regulatory requirements, they have another very important job to perform: taking care of patients.

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