Compliance Issues Related to Non Physician Practitioners

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Agenda

- Physician Supervision Outpatient Services
- Home Health & DME
- Documentation
- Split/Shared Services
- Residents & Medical Students
Increased Scrutiny?

  – “Incident to” services may be vulnerable to overutilization and put beneficiaries at risk of receiving services that do not meet professionally recognized standards of care.”
Physician/NPP Supervision for Provider Based Outpatient Services
Analysis

- Is the service diagnostic (paid under the MPFS) or therapeutic (any outpatient service that is not diagnostic)?
- If diagnostic, what is the level of supervision required under the MFPS (general, direct, personal)?
- Can the service be personally performed by a non-physician practitioner (clinical psychologist, LCSW, PA, NP, CNS, CNW) under state scope of practice and hospital policy?
- Are the services performed on campus or off campus?
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<td>• For <em>therapeutic</em> services, recognized NPPs, may directly supervise therapeutic services which they may personally furnish in accordance with State law and any additional requirements.</td>
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<td>• For <em>diagnostic</em> services, the NPPs can perform the tests with the state required level of supervision (e.g., they can self-supervise), but they cannot act as supervisory “physicians” for the purposes of other staff performing diagnostic tests.</td>
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Location of Supervisor: On Campus Services

- Direct supervision means that MD or NPP must be present on the same campus and immediately available:
  - Cannot be performing another procedure or services that he or she could not interrupt;
  - Cannot be so physically far away on campus from location of services that he or she could not intervene right away.
Location of Supervisor: Off Campus Services

Direct supervision means that the MD or NPP must be present in the off-campus provider based department of the hospital. It does not mean that the MD or NPP must be present in the room.
Qualifications of Supervisor: Diagnostic

The supervisory physician must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized diagnostic testing equipment, and while in such cases CMS does not expect the supervisory physician to operate this equipment instead of a technician, the physician that supervises the provision of the diagnostic service must be knowledgeable about the test and clinically appropriate to furnish the test.

The supervisory responsibility is more than the capacity to respond to an emergency, and includes the ability to take over performance of a procedure and, as appropriate to the supervisory physician and the patient, to change a procedure or the course of care for a particular patient. CMS would not expect that the supervisory physician would make all decisions unilaterally without informing or consulting the patient's treating physician or non-physician practitioner. In summary, the supervisory physician must be clinically appropriate to supervise the service or procedure. (Transmittal 128, May 28, 2010)
Can an emergency department physician or non-physician practitioner directly supervise therapeutic outpatient services while in the emergency department?

In most cases, the emergency physician or non-physician practitioner can directly supervise outpatient services so long as the emergency physician in the emergency department of the campus is immediately available, meaning that, if needed, he or she could reasonably be interrupted to furnish assistance and direction in the delivery of therapeutic services provided elsewhere in the hospital. We have stated that the supervisor must be a person who is “clinically appropriate” to supervise the therapeutic service or procedure. We believe that most emergency physicians can appropriately supervise many services within the scope of their knowledge, skills, licensure, and hospital granted privileges including observation services. With regard to whether an emergency physician or a non-physician practitioner could be interrupted, such that the emergency physician could be immediately available, each hospital will need to assess the level of activity in their emergency department and determine whether at least one emergency physician or non-physician practitioner could be interrupted to furnish assistance and direction in the treatment of outpatients.
Qualifications of Supervisor: Therapeutic (Transmittal 128, May 28, 2010)

- The supervisory physician or non-physician practitioner must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized therapeutic equipment, and while in such cases CMS does not expect the supervisory physician or nonphysical practitioner to operate this equipment instead of a technician, CMS does expect the physician or nonphysical practitioner to be knowledgeable about the therapeutic service and clinically appropriate to furnish the service.

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Q: Can the CMS requirements for supervising physician or non-physician practitioner be fulfilled using a physician assistant in the field of radiation oncology or nurse practitioner in the field of radiation oncology, or a physician that is not in the field of radiation oncology, such as a medical oncologist?

A: CMS requires the supervising physician or non-physician practitioner to be able to immediately step in and perform the procedure not just in the event of an emergency but to also be able to furnish assistance and direction throughout the performance of the procedure. CMS has indicated that the supervising physician or non-physician practitioner must also be a person who is “clinically appropriate” to supervise the services or procedures and unless a non-radiation oncologist physician or a non-physician practitioner has within his or her State scope of practice, licensure, training and hospital granted privileges the ability to perform the service or procedure, this would not meet the supervision requirements. It is ASTRO’s view that the Radiation Oncologist is always considered a clinically appropriate physician but there may be others who meet these requirements.

Q: I practice in a free standing radiation center and I am not clear on whether the physician supervision requirements allow for any MD or whether the radiation oncologist is the only one that can provide the supervision of radiation therapy services, as well as the “incident to” services.

A: ASTRO believes CMS requirements for physician supervision are the same irrespective of place of service, meaning that the supervising physician needs to be able to immediately step in and perform the procedure not just in the event of an emergency but to also be able to furnish assistance and direction throughout the performance of the procedure. Therefore it is ASTRO’s view that the Radiation Oncologist is always considered a clinically appropriate physician but there may be others who meet these requirements.
Critical Access Hospitals

- Diagnostic testing in CAH: Not applicable
- Supervision requirements for therapeutic services:
  - 2010: 3/15/10 announcement that CMS would not enforce against CAHs
  - 2011: Under proposed 2011 rules, all therapeutic services except those identified as “nonsurgical extended duration therapeutic services” at both acute care and CAH would be subject to direct supervision rules.
Who can supervise | Supervision required for provider based department (PBD) in the hospital or on-campus | Supervision required when provided in off-campus provider based department (PBD)
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## Non-Chemo Infusion Service
### 2010 Requirements

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Observation Services
Proposed 2010 Requirements

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2011 Proposed Revisions

- Non surgical extended duration therapeutic services (“NSEDTS”): observation services, infusions, injections (proposed list is in Table 37, page 424 of the Proposed Rule):
  - Direct supervision is required for the initiation (beginning portion of the service ending when patient is stable) followed by general supervision for the remainder of the service.
2011 Proposed Revisions

• “We explicitly did not include chemotherapy or blood transfusions in our proposed list of nonsurgical extended duration therapeutic services because we believe that these services require the physician’s or non-physician practitioner’s recurrent physical presence in order to evaluate the patient’s condition in the event it is necessary to redirect the service.”
Home Health and DME
Section 6407 of the Patient Protection and Affordable Care Act

- **Home Health Services**
  Prior to making a home health certification after January 1, 2010 and as a condition of Medicare and Medicaid reimbursement, the physician must document that a face-to-face encounter with the patient has been made. The face-to-face can be made by the physician; a nurse practitioner or clinical nurse specialist working in collaboration with the physician; a certified nurse-midwife; or a physician assistant under the supervision of the physician. The face-to-face encounter can be made through the use of telehealth.
Section 6407 of the Patient Protection and Affordable Care Act

- **Durable Medical Equipment**
  As a condition of Medicare and Medicaid reimbursement, orders for durable medical equipment must include physician documentation that a face-to-face encounter with the patient has been made during the 6 month period preceding the written order. The face-to-face can be made by the physician; a nurse practitioner or clinical nurse specialist working in collaboration with the physician; a certified nurse-midwife; or a physician assistant under the supervision of the physician. The face-to-face encounter can be made through the use of telehealth.
Section 6406 of the Patient Protection and Affordable Care Act

• The Secretary of HHS is authorized to revoke Medicare enrollment for a period of not more than one year each time that a physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or any other referrals which may be specified by the Secretary of HHS. This section is effective for orders, certifications and referrals made on or after January 1, 2010.
Split/Shared Services
Background

• CMS issued a revision to its Carrier Manual to address payment for Evaluation Management (E/M) services provided by physicians and non-physician practitioners (NPPs)
• Effective January 1, 2006
Billing for E/M Services
Office/Clinic Setting

• NPP Billing New Patient Visits
  • NPP can bill under his/her respective number if the collaboration/general supervision rules are met and the services are within the scope of practice of the NPP.
  • Payment made by Medicare at 85% of the physician fee schedule.

• No Shared/Split Billing for New Patient Visits
  • Example of shared visit: NPP performs a portion of an E/M encounter and the physician completes the E/M service.
  • Documentation should not reflect the performance by the physician of any portion of the E/M service.
Billing for E/M Services
Office/Clinic Setting

• NPP Billing for New and Established Patients
  • NPP can bill under his/her respective number if the collaboration/general supervision rules are met and the services are within the scope of practice of the NPP.
  • Payment made by Medicare at 85% of the physician fee schedule.

• Billing for Split/Shared Services Permitted for Established Patients if:
  • Satisfy “incident to” billing requirements; and
  • Billed under attending physician’s number.
  • Cannot bill for split/shared service for new patient because would not satisfy incident to rules.
Billing for E/M Services
Office/Clinic Setting

Established Patient Visits: Incident-to Billing Requirements

- Incident-to services are those services commonly furnished in a physician’s office that are “incident to” the professional services of a physician. In order to bill the services of an NPP such as a physician assistant or a nurse practitioner incident to a physician, there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the NPP is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician’s continuing active participation in and management of the course of treatment. In addition, the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary. If services are rendered to a new patient, there is no course of treatment already initiated by the physician, therefore, the service provided by the NPP may not be billed under the physician’s rendering provider number.
Billing for E/M Services
Hospital Inpatient/Outpatient/Emergency Department Setting

- **NPP Billing for Initial and Subsequent Visits**
  - NPP can bill under his/her respective number if the collaboration/general supervision rules are met and the services are within the scope of practice of the NPP.
  - Payment made by Medicare at 85% of the physician fee schedule.

- **Billing for Split/Shared Visits is Permitted for Initial and Subsequent Visits**
  - Applicable for initial and subsequent visits - inpatient and outpatient
  - When a hospital inpatient or outpatient visit is shared between a physician and an NPP from the same group practice and the physician *provides any face-to-face portion* of the E/M encounter, the service may be billed under either the physician’s or the NPP’s number.
Licensure/Scope of Practice
Physician/NPP Licensure Issues

- State medical boards are being more aggressive regarding physicians not supervising NPPs.
  - At its September 2010 meeting the Texas Medical Board took actions against 187 physicians, 37 of whom were from the Houston area. 6 of those 37 were cited for failure to adequately supervise those acting under their supervision, failure to supervise physician extenders, or failure to adequately supervise physician assistants.
  - September 2008, Kentucky Board of Medical Licensure issued an opinion on the minimum standards of acceptable and prevailing medical practice for physicians entering into collaborative agreements with ARNPs.
Physician/NPP Licensure Issues

- Risk Area: Prescribing controlled substances
  - Scope of practice = prescriptive authority
  - DEA registration
  - Oversight of use of controlled substances
  - Signature requirements on prescriptions
  - Scope of collaborative agreement
Physician/NPP Licensure Issues

• Risk Area: Interstate practice- the Nurse Licensure Compact does not apply to advanced practice nursing.

• NPPs providing telemedicine services must meet licensure requirements.
Resident Supervision and Medical Students
Resident Supervision and Medical Students

July 2010: Qui tam lawsuit filed in federal court in Chicago alleges that six orthopedic surgeons at Rush University Medical Center violated Medicare billing rules that require teaching physicians to be present during critical portions of the procedure. The suit alleges that supervising physicians instructed a resident to falsify the medical record.
Resident Supervision

Medical Teaching Physician Rules:

1. Teaching physician is responsible for surgical, high risk, or other complex procedures;
2. Must be present and immediately available to furnish services during entire procedure;
3. Presence must be substantiated by MD or resident notes in the medical record; and
4. If surgeries are overlapping, supervising MD must be present during critical portion of both operations and presence must be supported by documentation in the record.
Medical Students

E/M Service Documentation Provided By Students

- Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

- Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service.