

Decoding the myths

Physician supervision in Medicare



Determining the appropriate level of supervision by a physician who chooses to bill Medicare for services involving ancillary personnel has become more complex as more types of personnel provide their services in the context of physician practices. In addition, Medicare recognizes some clinicians as eligible to submit

claims on their own provider numbers within a group practice but recognizes others only for billing “incident to” a supervising physician.

When these services involve designated health services under the Stark law prohibiting physician self-referral — including but not limited to imaging services and physical and occupational therapy — they also implicate both the in-office ancillary services exception and the compensation provisions of the Stark group-practice definition. Taken together, these developments have caused significant confusion and mythology among physician practice managers and physicians. The liabilities for improper handling of supervision include false claims, Stark violations and reassignment problems.

Incident-to Medicare primarily imposes supervision on physicians in the office practice by rules pertaining to “incident-to” services. These are services rendered in the office setting that are an integral — although incidental — part of the physician’s personal professional service to the patient. Consequently, an attending-physician relationship must exist before ancillary personnel may bill for patient care without physician involvement in the encounter.

Medicare sets no standards about the frequency with which the physician must interact with the patient in the course of treatment to ensure that the services continue to meet the incident-to standard,¹ although some carriers have developed local medical review policies on this.² To bill

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Medicare for these services, a physician member of the practice must be on the premises, in the office suite and immediately available to assist the ancillary personnel providing services at all times. However, under the physician-directed clinic rules, this individual need not be the ordering or attending physician. A physician member of the group in the office suite seeing other patients will suffice.³ Medicare does not permit incident-to billing by physicians in a hospital setting even if the physicians use their own ancillary personnel.

Medicare used to have a rule requiring that ancillary personnel billed incident-to be the W-2 employees of the billing practice, but that is no longer the case. Under the

State law

State law initially addresses the extent to which the physician must be on the premises, available by telephone or in formal collaborative relationships with certain types of ancillary personnel. Medicare coverage requires compliance with state licensure regulations in all respects. Consequently, knowledge of the extent to which state law addresses 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, Medicare imposes other specific requirements that vary with the context.

Reader take-away

- Learn when a physician can bill nonphysician services incident-to under Medicare, and for what services
- Learn the Stark law provisions for billing incident-to
- Learn the level of supervision Medicare requires for nonphysician providers

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2002 Medicare fee schedule, these ancillary personnel need not even be leased employees but may be independent contractors to the group.⁴ However, the practice must integrate them into the organization for their work there. These individuals may not render services away from the group practice site without physician supervision at the off-site location.

This basic aspect of incident-to billing has three exceptions:

- Services provided in hospital inpatient, outpatient and emergency department settings where ancillary personnel and a physician member of the practice share a visit;
- With respect to diagnostic testing; and
- During the global period for a procedure.

Separate from the incident-to rules, in a hospital inpatient, outpatient or emergency department setting, nonphysician practitioners who work in the same group practice as the physician may render part of an evaluation and management (E&M) service, and the physician who was not even on premises during the time those ancillary personnel were functioning may have a face-to-face encounter with the patient and perform only some aspect of the visit. Under these circumstances, the visit may be billed at 100

The Stark group-practice definition implicates some of the supervision rules in its compensation provision.

percent of the fee schedule on the physician's number. The physician encounter must be of a substantive nature, although Medicare does not define the extent of the encounter. A review of the record would not suffice.⁵ However, if the nonphysician performed the history and physical, and the physician performed the decision-making, the practice could bill the service under the physician's number.

The issues are different still for diagnostic testing. In recent pronouncements — including particularly the 2003 Medicare fee schedule — the regulators have stated that diagnostic testing is not a physician service and has separate supervision rules than those for incident-to services. The required level of supervision is that assigned to the diagnostic test by current procedural terminology (CPT) code in a quarterly updated Microsoft Excel spreadsheet available on the CMS Web site at <http://cms.hhs.gov/providers/pufdownload/rvudown.asp>. This file specifies which of the three levels of

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Level of supervision required by Medicare for nonphysician providers

Type of claim	Provider ID #	Level of supervision
"Incident-to"	Physician	In the office suite
Shared hospital visit (Transmittal 1776)	Physician	None, but face-to-face physician encounter required for physician to bill; otherwise use NPP number
Diagnostic testing	Physician or NPP who performs or to whom it is incident	General/direct/or personal per Transmittal B-01-28
NPP/OT/PT/CRNA	NPP/OT/PT/CRNA	None unless required by state law

NPP — nonphysician provider
 OT — occupational therapist
 PT — physical therapist
 CRNA — certified registered nurse anesthetist

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supervision is required for these services. These levels are defined as:

- General supervision that does not require a physician on the premises and mandates that a physician maintain overall quality control of the service;
- Direct supervision — which means the physician is on the premises and available in the office suite although not in the examination room; and
- Personal supervision, which requires the physician to be present with the patient during the diagnostic testing.

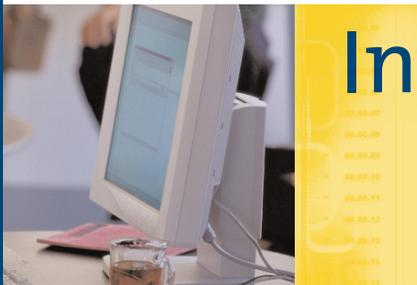
Medical group practices may choose to use a more restrictive supervision level than required for diagnostic test services. However, the minimum level of supervision is specified in the noted quarterly update and must be met to bill for the services.

During the global surgery period, a non-physician practitioner may conduct routine postoperative care without a physician

present, whether at the hospital or in the office — unless required by state law — because services included in the global surgery fee are not E&M visits.

In all of these cases, the identity of the ancillary personnel and their involvement is invisible on the claim form, since the services are billed as if rendered by the physician as an integral part of his/her services. Nonphysician practitioners, including nurse practitioners, physician's assistants and clinical nurse specialists (collectively referred to as NPPs), certified registered nurse anesthetists (CRNAs), physical therapists (PTs), occupational therapists (OTs), clinical psychologists and licensed clinical social workers may also obtain their own numbers under the Medicare program. These options have led to other confusions because the services of these professionals may be billed incident-to or not, depending on whether the requirements for such billing have been met or whether it is preferable to bill under the clinicians' own number, even in a physician practice.

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Supervision in NPP direct billing

When NPPs have their own provider numbers, work in a physician practice and assign their right to payment to the medical group, Medicare will reimburse the group for any service NPPs perform that a physician would be reimbursed for, as long as it is provided within the scope of their licensure. NPPs receive payment at 85 percent of the physician fee schedule. OTs, PTs and CRNAs receive reimbursement at 100 percent of the fee schedule.

Consequently, NPPs may see patients in the office without a physician on site, unless required by state law. They may render initial patient visits without an attending physician relationship even if no physician in the practice has ever seen the patient, and NPPs may do so even when no physician is in the office suite. NPPs may perform house calls, nursing home visits, hospital visits and consultations, order consultations, and order and perform diagnostic tests. They may not, however, supervise diagnostic tests. They may bill to the full level of the E&M code for counseling and coordination of care. PTs and OTs may function as they do in independent practice.

All of the above rules are distinct from the supervision rules when the physician is a teaching physician. In that case, the physician must personally perform the key portion of the procedure and document that s/he performed it. The only supervision that pertains to physician billing for these services is when the physician and the resident conduct hospital rounds together. No longer may the resident document that the teacher was present and supervising; the teacher must document his/her own involvement.⁶ Specific supervision rules pertain to approved primary care educational programs as well as psychotherapy services.

Stark law compensation

The Stark group-practice definition implicates some of the supervision rules in its compensation provision. The statute permits a physician to be compensated for his/her own productivity, including services incident to his/her own.

Proposed regulations generated enormous confusion by a provision that would have prohibited an ordering physician from getting direct credit for a service incident to his/her own services. Medicare rectified the problem in the final Stark II rule. The preamble to the regulations makes it abundantly clear that a physician may receive direct, dollar-for-dollar credit for services incident to his/her services to the patient.⁷ This is not a requirement but is permitted.

The level of supervision that pertains to incident-to services is the general physician-on-premises standard, or the diagnostic-testing transmittal standard. As a result, a physician may get dollar-for-dollar credit for Stark-designated health services incident to his/her services to the patient. For diagnostic testing, credit may apply even if s/he was not on the premises when the services were provided. This rule, though, would not permit credit for NPP, CRNA or PT/OT services billed on those clinicians' own provider numbers because they would not be incident to anything.

Interactions of physicians in group practice with ancillary personnel can have serious consequences for the group if not managed appropriately. This article has addressed only the supervision aspects of these relationships. An attentive practice administrator, however, can manage these moderately complex rules and should make his/her oversight an integral part of a medical group's compliance efforts. 

notes

1. Medicare Carriers Manual 2050
2. See www.lmrp.net for these policies or check your carrier's Web site
3. Medicare Carriers Manual 2050.3
4. 66 Federal Register 55267 (Nov. 1, 2001)
5. See Transmittal 1776 (Oct. 25, 2002); Medicare Carriers Manual §15501
6. Medicare Carriers Manual 15016.C
7. 66 Federal Register 909 (Jan. 4, 2001)
8. Some commentators take a more conservative approach to interpreting this excerpt from the Stark rule's preamble, arguing that it means only that a physician may receive direct compensation credit for a designated health service provided incident-to if s/he supervises the service but does not order it. 42 CFR 411.352(i)(1)

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