REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-16

Subject: Virtual Supervision of "Incident to" Services (Resolution 713-A-15)

Presented by: Robert E. Hertzka, MD, Chair

Referred to: Reference Committee G (Steven Hattamer, MD, Chair)

At the 2015 Annual Meeting, the House of Delegates referred Resolution 713, "Include Telemedicine in the Definition of Direct Supervision," which was sponsored by the New Mexico Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2016 Annual Meeting. Resolution 713-A-15 asked:

> That our American Medical Association (AMA) request that the Centers for Medicare & Medicaid Services update its direct supervision requirements to change the definition of direct supervision to include supervision via real-time telemedicine-based visual and audio interaction, rendered in accordance with applicable federal and state laws and regulations.

This report outlines the requirements of the various levels of physician supervision, highlights developments in "incident to" billing requirements included in the 2016 Medicare Physician Payment Schedule final rule, summarizes relevant AMA policy, and presents policy recommendations.

LEVELS OF PHYSICIAN SUPERVISION

Physicians can provide varying levels of supervision of services and procedures furnished by non-physician practitioners and employees. "Personal supervision" has been defined by the Centers for Medicare & Medicaid Services (CMS) as requiring physicians to be in the room during the provision of the service or procedure. "General supervision" means that the physician does not need to be in the room during the provision of the service or procedure; however, the service or procedure must be performed under the physician's overall direction and control.[1]

Resolution 713-A-15 asked that our AMA request that CMS update its direct supervision requirements to include supervision via real-time telemedicine-based visual and audio interaction. After debate in the reference committee hearing and on the floor of the House of Delegates, it was clarified that the sponsor of Resolution 713-A-15 supported the amended language offered by the reference committee. As such, the sponsor of Resolution 713-A-15 supports revising the direct supervision requirement for physicians to bill "incident to" to include virtual supervision via real-time visual and audio interaction between the supervising physician and the non-physician providing patient care services, if rendered in accordance with other applicable federal and state laws and regulations.

For services and supplies that are provided in a physician's office, a patient's home or other institution excluding a hospital and skilled nursing facility, the Medicare Benefit Policy Manual

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states that, in order "to be covered incident to the services of a physician or other practitioner, 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 are commonly furnished in physician's offices or clinics; and
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision."[1]

While Council on Medical Service Report 8-A-16, also being considered at this meeting, more comprehensively examines the billing of "incident to" services, this report is specifically addressing the requirement by CMS that a physician must provide direct supervision of "incident to" services. CMS has clarified that direct supervision does not mean that the treating physician or any physician in the physician's group must be in the same room as the non-physician practitioner providing the service. Rather, a physician must be present in the larger office suite and immediately available to provide assistance and direction during the provision of "incident to" services. In addition, the physician billing "incident to" must have first seen the patient and initiated the course of treatment, and provided subsequent services at a rate that shows active participation in and management of the course of treatment. If services provided by non-physician practitioners do not meet the requirements of "incident to" billing, non-physician practitioners would bill under their own national provider identifier (NPI) number; the payment for most non-physician practitioners (except nurse-midwives and nurse anesthetists) is a percentage (65 to 85 percent) of the physician rate.

There are some differences in supervision requirements depending on the site of care. For those services and supplies that are provided incident to a physician's service in a physician-directed clinic, several physicians may provide supervision for "incident to" services versus an individual attending physician. There are also some exceptions to the direct supervision requirement for a limited set of services provided to homebound patients in medically underserved areas, and when services provided to homebound patients comprise an integral part of the physician's professional services to the patient, provided by personnel meeting relevant state requirements. In these exceptions, general physician supervision is required, which means "that the physician need not be physically present at the patient's place of residence when the service is performed; however, the service must be performed under his or her overall supervision and control."

In determining whether direct supervision exists, CMS has stated that the availability of the supervising physician by telephone and the presence of the physician somewhere in the institution (beyond the larger office suite) does not meet the direct supervision standard.[1] Therefore, when physicians have offices in institutions including skilled nursing facilities, the "office must be confined to a separately identifiable part of the facility and cannot be construed to extend throughout the entire facility."[2] Addressing the requirement for direct supervision that physicians must be immediately available to provide assistance and direction during the provision of "incident to" services, CMS included the following language in its Medicare Benefit Policy Manual addressing hospital services covered under Part B:

> "Immediate availability requires the immediate physical presence of the supervisory physician or non-physician practitioner. 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 or non-physician practitioner is performing another procedure or service that he or she could not interrupt. Also, for services furnished on-campus,

> the supervisory physician or non-physician practitioner may not be so physically distant on-campus from the location where hospital/CAH outpatient services are being furnished that he or she could not intervene right away. The hospital or supervisory practitioner must judge the supervisory practitioner's relative location to ensure that he or she is immediately available. The supervisory responsibility is more than the capacity to respond to an emergency, and includes the ability to take over performance of a procedure or provide additional orders."[3]

THE 2016 MEDICARE PHYSICIAN PAYMENT SCHEDULE FINAL RULE

In the 2014 Medicare Physician Payment Schedule (MFS) final rule, CMS set explicit requirements that "incident to" services must be furnished consistent with applicable state law, including state licensure and other requirements for the "auxiliary personnel" providing the services. In the 2016 MFS, CMS modified existing language around its requirement that "the physician or other practitioner who bills for incident to services must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident to services." The change removed a sentence explaining that the physician supervising the services did not need to be the physician who initiated the patient's treatment and is overseeing their general care. The AMA and other physician groups argued that this change could be interpreted as prohibiting this practice which is common for certain types of services such as periodic drug injections or infusions where one physician is managing the overall plan of care but another may supervise the provision of individual services during the course of that care. Fortunately, CMS clarified in the MFS that the supervising physician (or practitioner) for a particular incident to service does not have to be the same person who is "treating the patient more broadly" and added clarifying regulatory language to that effect.

RELEVANT AMA POLICY

Policy H-360.988 supports the provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician's supervision and direction regardless of whether such services are performed where the physician is physically present, so long as the ultimate responsibility for these services rests with the physician and so long as the services are provided in conformance with applicable state laws. While the policy stipulates that the supervision of physician assistants in most settings includes the personal presence or participation of the physician, the policy also recognizes that the physician assistant may function apart from the supervising physician in certain practice settings, if permitted by state law. The policy states that such remote function should be approved by the state medical licensing board on an individual basis, and that the approval for remote function should include requirements for regular reporting to the supervising physician, appropriate site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times.

Policy H-160.950, which outlines guidelines for integrated practice of physicians and nurse practitioners, states that physicians are responsible for the supervision of nurse practitioners and other advance practice nurses in all settings, and that at least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner. Policy H-160.947 states that physicians are responsible for the supervision of the physician assistants in all settings, and must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means. Policy H-35.992 states that reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel, and such personnel should be under the supervision of practicing physicians. Policy H-465.986 encourages state medical associations to

carefully evaluate the relevant practice acts in their jurisdictions to identify any modifications needed to allow the most effective use of mid-level practitioners in improving access to care, while assuring appropriate physician direction and supervision of such practitioners. Policy D-390.959 states that our AMA will work with key stakeholders to make general supervision, rather than direct supervision, the requirement for Medicare payment for most, but not all, outpatient therapeutic services.

DISCUSSION

The Council recognizes that payment resulting from "incident to" services can be an important revenue source for physician practices that choose to fulfill the conditions and administrative requirements to do so. That being said, allowing for services provided by non-physician practitioners and employees to be billed incident to a physician's professional services if a physician provides virtual supervision via real-time visual and audio interaction requires additional testing before full implementation. Allowing physicians to provide virtual supervision to meet the direct supervision standard in order to bill "incident to" could enable physicians to receive payment for supervision they already provide via a real-time visual and audio interaction. However, a chief premise of the direct supervision requirement in order to bill "incident to" is that a physician must be immediately available to provide assistance and direction during the provision of the services. In the case of virtual supervision, the capacity for physicians to provide said direction and assistance would be limited, since they would not be physically present.

While the Council is not in support of making the requirements for virtual supervision of "incident to" services more onerous than traditional direct supervision, additional safeguards must in place to ensure patient safety and quality of care in the provision of "incident to" services with virtual supervision, and prevent these services from undergoing serious scrutiny for fraud and abuse. As such, the Council is supportive of CMS initiating pilot programs in the Medicare program to enable virtual supervision of "incident to" services that require direct supervision. The physician billing "incident to" and providing virtual supervision of "incident to" services must otherwise fulfill all other requirements to bill "incident to." Before virtual supervision of "incident to" services can be permitted, the Council believes that physicians providing virtual supervision of "incident to" services should visit the sites in person where patients receive procedures from non-physician practitioners or employees. Also, patients receiving "incident to" services that are virtually supervised must have access to the certification, licensure and/or board certification qualifications of the health care practitioners who are providing and supervising the care in advance of their visit. During the course of the encounter, virtual supervision of "incident to" services must require the physician to be connected through real-time audio and video technology with the room in which the "incident to" service is provided, to ensure that the physician is immediately able to provide assistance and direction during the provision of the service.

The Council recognizes that virtual supervision of "incident to" services and procedures may not be appropriate for all services and procedures. It is paramount that virtual supervision of "incident to" services follows evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. The Council notes that national medical specialty societies may have a role in outlining what services and procedures could be safely and effectively overseen with virtual supervision. As such, national medical specialty societies should develop best practices and protocols for virtual supervision of "incident to" services, including specifying which services and procedures would not qualify for this practice.

One of the chief responsibilities of physicians billing "incident to" is to respond to an emergency if it occurs during the provision of "incident to" services, and to take over the provision of the service

or procedure if necessary. As physicians virtually supervising "incident to" services would not be physically present to assist in that capacity, the Council believes that physicians providing virtual supervision of "incident to" services must establish protocols for emergency services if needed during the provision of said services. Finally, they must have an agreement with a physician at the site at which "incident to" services are provided, to ensure the provision of immediate assistance.

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 713-A-15, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) supports pilot programs in the Medicare program to enable virtual supervision of "incident to" services that require direct supervision if they are developed with specialty society input and abide by the following principles:

    a) The physician billing "incident to" must fulfill other requirements of direct supervision of "incident to" services, including first seeing the patient and initiating the course of treatment, and providing subsequent services at a rate that shows active participation in and management of the course of treatment.
    b) The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services.
    c) Non-physician practitioners and employees providing "incident to" services must follow existing requirements for the provision of "incident to" services, including abiding by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
    d) The delivery of "incident to" services must be consistent with state scope of practice laws.
    e) Virtual supervision of "incident to" services must require the supervising physician to be connected through real-time audio and video technology with the room in which the "incident to" service is provided, to ensure that the physician is immediately able to provide assistance and direction during the provision of the service.
    f) Virtual supervision of "incident to" services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
    g) Physicians providing virtual supervision of "incident to" services should visit the sites in person where patients receive procedures from non-physician practitioners or employees.
    h) Physicians providing virtual supervision of "incident to" services must establish protocols for arranging for emergency services, including having an agreement with a physician at the site at which "incident to" services are provided, to ensure the provision of immediate assistance.
    i) Patients receiving "incident to" services that are virtually supervised must have access to the certification, licensure and/or board certification qualifications of the health care practitioners who are providing and supervising the care in advance of their visit.
    j) Patients receiving "incident to" services that are virtually supervised must have a choice of provider, as is required for all medical services. (New HOD Policy)

2. That our AMA encourages national medical specialty societies to develop best practices and protocols for virtual supervision of "incident to" services, including specifying which services and procedures would not qualify for this practice. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual, Chapter 15: Covered Medical and Other Health Services. Revised November 6, 2015. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.
[2] Centers for Medicare and Medicaid Services. MLN Matters SE0441. "Incident to" Services. April 9, 2013. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf.
[3] Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual, Chapter 6: Hospital Services Covered Under Part B. Revised December 18, 2015. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf.