Supervising Oncology Services

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The supervision of office-based and provider-based services has been a hot topic, not just in the specialty of oncology but across the healthcare spectrum. In addition to Medicare requirements that differentiate based on practice setting, differences exist between medical and radiation oncology. State laws that impact supervision and scope of practice for practitioners can also vary widely. While no single article can address the multitude of state-level regulations and scope of practice limitations, the following is a summary of the current Medicare guidelines.

Radiation Oncology: Office

Radiation oncology services performed in an office, freestanding center, or other non-provider-based facility require supervision by a qualified physician. CMS includes the *Medicare Benefit Policy Manual* on its website and Chapter 15, Section 90 states:[1]

X-ray, radium, and radioactive isotope therapy furnished in a non-provider facility require direct personal supervision of a physician. The physician need not be in the same room, but must be in the area and immediately available to provide assistance and direction throughout the time the procedure is being performed.

There are several requirements included in this manual section that may need further definition. First, a "non-provider facility" is a freestanding treatment center, physician's office, or other site of service that is not classified as a hospital or facility. According to the Social Security Act, the definition of "provider" includes:[2]

The term "provider of services" means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program…

Next, you need to know the accurate definition of "direct supervision." Although this CMS document refers to "direct personal supervision," the common term is "direct supervision." According to the Code of Federal Regulations, Title 42, Section 410.32:[3]

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 procedure. It does not mean that the physician must be present in the room when the procedure is performed.

In addition, the supervising physician must be "immediately available," which means that the supervisor must not be performing another procedure or service that renders them unavailable. In addition, CMS states that it would be inappropriate for a supervising physician to be responsible for patients and services that are outside the scope of their knowledge, skills, licensure, or privileges. The supervising physician must be prepared to step in and perform the service, not just respond to an emergency.

According to the CMS 1500 claim filing guidelines (*Medicare Claims Processing Manual,* Chapter 26), the physician reported on the claim form for each service is the physician who either personally performed or supervised the service. Specifically, the agency states:[4]

Item 24J: Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.

So how do we know which physician to list on the CMS 1500 claim form? If the service is not personally performed by a physician practice member, then the name and NPI number of the physician who supervised the service must be reported on the claim form. For example, if Dr. A supervises radiation treatment delivery in the office setting on Monday and Tuesday, Dr. A's provider information would be listed on all CMS 1500 claim lines for those delivery services.

Medical Oncology: Office

The same definitions of non-provider-based location and direct supervision apply when drug administration is performed in an office or freestanding setting. According to the *Medicare Claims Processing Manual:*[5]

Physician work related to hydration, injection, and infusion services involves the affirmation of the treatment plan and the supervision (pursuant to incident to requirements) of nonphysician clinical staff.

If the RN, LPN or other auxiliary personnel furnishes the injection in the office and the physician is not present in the office to meet the supervision requirement, which is

one of the requirements for coverage of an incident to service, then the injection is not covered.

In addition, guidelines published by the American Medical Association (AMA) in the *CPT® Manual* indicate that direct supervision is required for all infusion and injection services:[6]

Physician work related to hydration, injection, and infusion services predominantly involves affirmation of treatment plan and direct supervision of staff.

CMS provides the following information in the *Medicare Claims Processing Manual,* Chapter 12:[7]

Effective on January 1, 1998 and after, restrictions were removed on the type of areas and settings in which the professional services of NPs, CNSs, and PAs are paid under Medicare.

Although there is a restriction relating to supervision for radiation therapy, there is no requirement that a physician must supervise drug administration. However, if a midlevel provider supervises drug administration, their name and NPI must be listed on the CMS 1500 claim form. Remember that services billed in the name of the midlevel provider will be paid at 85 percent of the Medicare Physician Fee Schedule.

Oncology Services: Outpatient Hospital

For calendar year 2012, CMS continues to recognize a limited set of services with a significant monitoring component that can extend for a sizable period of time. These services, known as "extended duration services," are not surgical and typically have a low risk of complication after assessment at the beginning of the services. For these specific services, there is a requirement for direct supervision at the initiation of the service, followed by general supervision for the remainder of the service. CMS states that the point of transition from direct supervision to general supervision should be "documented prominently in progress notes or in the medical record."

Extended duration services that may be transitioned to general supervision include hydration (procedure codes **96360, 96361**) and therapeutic drug administration (procedure codes **96365-96376, C8957**).

CMS provides the following information in the 2011 Outpatient Prospective Payment System (OPPS) Final Rule:[8]

We do not believe it would be appropriate without further assessment to define chemotherapy, blood transfusion, and the recovery period for surgical services as nonsurgical, extended duration therapeutic services.

The agency further revised the definition of "direct supervision" to simply require immediate availability, meaning physically present, interruptible, and able to furnish assistance and direction throughout the performance of the procedure but without reference to any particular physical boundary. This Final Rule states:[8]

We wish to emphasize that once we remove reference to "in the hospital" or "in the provider based department," we continue to expect the supervisory practitioner to be physically present for the services he or she is supervising. As in the past, we are not defining immediate availability in terms of time or distance.

With respect to supervision by midlevel providers, the *Medicare Benefit Policy Manual* states:[9]

Considering that hospitals furnish a wide array of very complex outpatient services and procedures, including surgical procedures, CMS would expect that hospitals already have the credentialing procedures, bylaws, and other policies in place to ensure that hospital outpatient services furnished to Medicare beneficiaries are being provided only by qualified practitioners in accordance with all applicable laws and regulations. For services not furnished directly by a physician or nonphysician practitioner, CMS would expect that these hospital bylaws and policies would ensure that the therapeutic services are being supervised in a manner commensurate with their complexity, including personal supervision where appropriate.

And through calendar year 2012 (based on information in the 2012 OPPS final rule), the therapeutic supervision requirements will not be enforced in Critical Access Hospitals (CAHs) or small rural hospitals with 100 or fewer beds. While these facilities will not be penalized for violations of supervision guidelines, this is a temporary exception from the regulatory requirements.

Other Payers

CMS has published the radiation supervision requirements at a national level, but what about other payers? Most, if not all, managed care contracts and participation agreements include a "non-discrimination clause" that states patients of these insurers will not be treated in a different manner from members or beneficiaries of other plans. For example:

5.1 Nondiscrimination. *Medical Services Entity agrees that it, and each of its Qualified Physicians, shall not differentiate or discriminate in its provision of Covered Services to Enrollees because of race, color, ethnic origin, national origin, religion, sex, marital status, sexual orientation, income, disability, or age. Further, Medical Services Entity agrees that its Qualified Physicians shall render Covered Services to Enrollees in the same manner, in accordance with the same standards, and within the same time availability as such services are offered to patients not associated with MCO or any Plan, consistent with medical ethics and applicable legal requirements for providing continuity of care.*

Based on this sample contract language, all patients must receive the same level of care, including the same direct supervision of services performed.

Table 1. Supervision Requirements

SPECIALTY	SETTING	SUPERVISION REQUIRED
Medical Oncology	Office or Freestanding	· Direct Supervision · Qualified Physician or Nonphysician Practitioner
Medical Oncology: Chemotherapy	Outpatient Hospital	· Direct Supervision · Qualified Physician or Nonphysician Practitioner
Medical Oncology: Hydration & Therapeutic Drugs	Outpatient Hospital	· Direct Supervision Transitioned to General Supervision · Qualified Physician or Nonphysician Practitioner
Radiation Oncology	Office or Freestanding	· Direct Supervision · Qualified Physician
Radiation Oncology	Outpatient Hospital	· Direct Supervision · Qualified Physician or Nonphysician Practitioner

Final Thoughts

Although the cancer center may be comfortable knowing that all supervision requirements have been met or exceeded, it is essential that documentation exists that verifies physician and/or midlevel provider supervision. In an audit, a schedule or calendar listing planned supervision may not be sufficient to confirm which individuals actually provided infusion or radiation supervision on a daily or hourly basis. As a result, you may need to create a schedule that can be signed and dated by the supervising practitioner, a card swipe in/out system, or other method to document the presence of a supervisor at all times.

Cancer centers should ensure that their compliance department and/or healthcare counsel review state and federal supervision requirements to ensure compliance. According to the Advisory Board:[10]

CMS does not explicitly state that radiation therapy must be supervised by a radiation oncologist or trained NP. However, a strict interpretation of the regulation would indicate that a radiation oncologist or specially trained NP or PA would have to supervise all radiation therapy services. That said, many hospital-based cancer programs currently provide radiation therapy services without specialist supervision. The leaders of these programs should consult with their institution's legal counsel to formulate a policy that they feel is clinically defensible.

There are many different interpretations, legal and otherwise, regarding what the supervision rules actually represent and what interpretation should be applied to the CMS regulations. OI

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