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Medical Group Pays $373,715 to Settle CMP Case on Supervision

By Nina Youngstrom

Children's Hospital Los Angeles Medical Group has agreed to pay $373,715 to settle allegations it billed for radiology services performed by residents without "appropriate" supervision, according to a civil monetary penalty settlement with the HHS Office of Inspector General (OIG). This is the latest in a series of settlements with providers for submitting claims for services that were performed by residents without the physical presence of the teaching physicians.

Teaching physician billing "is still very much a live issue," said attorney David Vernon, with Hooper, Lundy & Bookman in Washington, D.C. "Going back to the OIG Physicians at Teaching Hospitals audits 25 years ago, it has gotten the government's attention for many years as an area of potential fraud." Meanwhile, as with everything since the COVID-19 pandemic, CMS has given teaching physicians the flexibility to supervise residents virtually.

The settlement, which was obtained through the Freedom of Information Act, stemmed from a self-disclosure to OIG by Children's Hospital Los Angeles Medical Group. OIG alleged the medical group knowingly submitted claims to Medicaid for services it knew were fraudulent. From Feb. 1, 2013, through March 31, 2018, the medical group billed Medicaid for radiology services performed by a physician that allegedly "were not provided as claimed because the radiology images were reviewed and the radiology reports were prepared by residents without appropriate supervision and review" by the physician.

Children's Hospital Los Angeles Medical Group didn't admit liability in the settlement and said in a statement that it's "committed to engaging in fair and equitable billing for professional services. In the unlikely event that inaccurate billing should occur through a reporting error, the Group's policy is to move quickly to disclose it and work closely with the appropriate agencies to address the matter in the most collaborative manner possible." Otherwise, it declined to provide any details about the self-disclosure.

In the Medicare arena, a number of hospitals have settled cases over teaching physician billing. Last year, University of California Los Angeles (UCLA) Health System agreed to pay $241,033 to settle a civil monetary penalty case over a teaching physician's billing. According to the settlement, OIG alleged that UCLA Health System submitted claims to Medicare and TRICARE for services provided by a physician when allegedly the services were actually provided by "international fellows or Accreditation Council for Graduate Medical Education residents and domestic fellows, outside [the physician's] physical presence and without his supervision" between Jan. 1, 2014, and Feb. 5, 2018. The settlement stemmed from a self-disclosure.

CMS Has Relaxed Documentation Standards

Medicare allows teaching physicians to bill for services furnished in teaching settings through the Medicare Physician Fee Schedule (MPFS), including evaluation and management (E/M) services, performed by the residents they supervise, even though their hospitals already receive graduate medical education payments. To receive separate E/M reimbursement, teaching physicians must document "that you performed the service or were physically present during the critical or key portions of the service furnished by the resident and your

participation in the management of the patient," according to a March 2018 *MLN Booklet*.[1]

In the past couple of years, CMS has relaxed documentation requirements for physical presence. Teaching physicians are now free to let residents and nurses document most of their E/M services, as long as their physical presence is noted in the medical records, according to the 2019 MPFS rule. A year later, the MPFS rule said physicians, physician assistants and advanced practice registered nurses who perform and bill for their professional services only have to verify, rather than re-document, information in the chart from the members of the medical team, including residents and nurses.

With radiology, Medicare pays teaching physicians for interpreting diagnostic radiology and other diagnostic tests if the interpretation was performed or reviewed by physicians other than the resident. "The documentation has to indicate the physician reviewed the resident's interpretation," Vernon said. The physician can't take the resident's word for it.

CMS OKs Virtual Supervision of Test Interpretations

The public health emergency (PHE) has opened the door to the use of telehealth for supervision in phases. Starting March 31, 2020, as part of the first COVID-19 interim final rule with comment (IFC), Medicare paid physicians for radiology test interpretations performed by a resident when the teaching physician is present through interactive telecommunications technology, Vernon said. CMS updated the requirement in its May 8 IFC and then again in the 2021 MPFS,[2] which states that "physician fee schedule payment may also be made for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by a resident when the teaching physician is present through audio/video real-time communications technology. The medical records must document the extent of the teaching physician's participation in the interpretation or review of the diagnostic radiology or diagnostic test."

Vernon said while the MPFS change applies to all teaching settings during the PHE, the use of virtual supervision is permanent for residency training sites that are located outside of a metropolitan statistical area "to bolster rural training opportunities and rural area health care access."

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1 CMS, "Guidelines for Teaching Physicians, Interns, and Residents," *MLN Booklet*, ICN 006347, March 2018, https://go.cms.gov/2PEcUHx.
2 Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID–19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID–19, 85 Fed. Reg. 84,472 (December 28, 2020), https://bit.ly/398n6hu.