APA Resource Document

Resource Document on Psychiatrists in a Supervisory Role

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Background

Scope of the document

The shortage of psychiatrists is expected to increase over time, despite ongoing efforts to expand the future workforce, such as increased graduate medical education (GME) slots. The increased need for access to mental health services continues, and there has been an expansion of the role of advanced practice providers to address these needs. As leaders of the psychiatric care team, psychiatrists are increasingly tasked with supervising advanced practice providers, along with leading the care team. Navigating the relationship within the clinical setting while ensuring quality patient care can be complex and complicated by regional regulatory requirements.

This document gives a general overview of considerations psychiatrists may apply to their supervision of advanced practice providers. However, this is not a definitive or comprehensive guide. Psychiatrists should work with their facility, compliance teams, and malpractice insurance carriers to clarify specific issues that need to be addressed in their practice.

Scope of the care team

The scope of practice for advanced practice providers, including psychiatric nurse practitioners (PNPs), also known as psychiatric mental health nurse practitioners (PMHNPs), and physician assistants (PAs), also known as physician associates, has undergone significant evolution within the mental healthcare system. Other members of the care team that psychiatrists may supervise, lead, or collaborate with, depending on the context, include psychologists (PhD or PsyD level), social workers (LCSWs or LICSWs), counselors (LMHCs, LPCs, LMFTs), and nurses (RNs or LPNs). By far, PMHNPs are the largest group that psychiatrists supervise.

The foundation for advanced psychiatric nursing was pioneered by early leaders such as Hildegard E. Peplau, who emphasized the importance of therapeutic relationships and the advancement of clinical nursing skills (Caldwell, 2012). These specialized advanced nurses emerged from the advanced practice registered nurse movement in the 1960s, primarily to address shortages in psychiatric care. This trend coincided with the deinstitutionalization movement, which shifted care from asylum settings to community-based settings (Nolan, 2021). Initially, the scope of practice of PMHNP was limited to specific duties, such as medication management and routine follow-up care under close supervision. Amid evolving healthcare demands and efforts to address provider shortages, the scope of practice for nurse practitioners (NPs) has expanded significantly in many states. This now includes psychiatric assessment, diagnosis, psychopharmacology, and, in some cases, leadership roles within treatment teams. While these changes have been driven by advocacy from nursing organizations and healthcare models aimed at increasing access to care, they have also raised concerns about variability in the quality of care, highlighting the importance of effective supervision and collaboration (American Medical Association, 2023).

Similarly, the PA profession originated in the mid-1960s, largely in response to physician shortages following the Vietnam War (Cawley, Cawthon, & Hooker, 2012). Early PAs were often military medics who received additional training to extend physician coverage, particularly in underserved areas. Over time, the PA role expanded across specialties, including psychiatry, where PAs now provide diagnostic evaluations, prescribe medications, and collaborate in ongoing care under

physician supervision. Although PAs remain a smaller proportion of the psychiatric workforce, they continue to play an important and growing role in expanding access to psychiatric care.

The American Psychiatric Association (APA) has long emphasized the value of collaborative practice models in psychiatry, recognizing that interdisciplinary teams, when structured effectively, produce optimal patient outcomes (APA, 2009). The nature of these collaborations, however, is complex, varies by state and region, and can evolve. Although research on this topic is limited, some evidence highlights the need for improved support and communication structures to optimize the supervisory relationship between psychiatrists and PMHNPs (Earle et al., 2011; Lee & Kim, 2022; O'Reilly-Jacob et al., 2023).

Definitions

Psychiatric mental health nurse practitioner (PHMNP): Per the Cleveland Clinic, a PMHNP, or psychiatric mental health nurse practitioner, is a type of NP who provides mental health care to adults, children and families. They assess, diagnose, and treat people with specific mental health disorders or conditions. They also work with people who have substance use disorders. Registration and licensure requirements vary by state.

Physician assistant (PA) in mental health: Per the American Academy of Physician Associates, there are currently many PAs who do inpatient psychiatric care, consult services, outpatient care, and substance abuse treatment. Many times, they work hand in hand with a team of professionals, including therapists, social workers, psychiatrists, and psychologists. As mental health treatment evolves to become more reliable and efficient for patients, PAs can continue to take on roles to lead these efforts and expand the availability of providers in this field.

Supervising physician: A supervising physician is an attending physician who is responsible for ensuring that the advanced practice provider meets the standard of care and maintains ultimate responsibility for patient outcomes. Specific requirements can vary from state to state.

Collaborating physician: A licensed medical doctor who enters into an agreement with an advanced practice provider to consult, review cases, and ensure state regulatory compliance. There is no direct oversight and specifics vary from state to state.

Education and training

The contrast in educational and training experiences between psychiatrists and PMHNPs is an important consideration when determining the appropriate degree of collaboration and supervision. A visual comparison of these pathways is included (Figure 1) to illustrate these key differences.

Physician training

Psychiatrists complete extensive medical education and clinical training, beginning with four years of traditional, classroom-based medical school and in person clinical rotations (including clinical rotations across various practice areas, such as obstetrics and gynecology, pediatrics, psychiatry, internal medicine, and surgery), followed by a one-year internship (often in pediatrics or internal medicine), four years of psychiatry residency, and often additional subspecialty fellowship training (child and adolescent psychiatry, addiction psychiatry, forensic psychiatry, consultation-liaison

psychiatry, or geriatric psychiatry). Many psychiatrists further their education through additional training opportunities including psychotherapy, research, or neurological training. Altogether, this process typically includes 10,000-16,000 hours of clinical training. During psychiatry specialization, training encompasses advanced clinical work and didactics led by clinical experts in their field, covering topics such as biological psychiatry, psychodynamic therapy, and systems-based practice. Psychiatrists must also complete multiple standardized exams, including the Medical College Admissions Test, three United States Medical Licensing Examinations (Steps 1, 2, and 3), the annual Psychiatry Resident In-Training Examination series, and ultimately the American Board of Psychiatry and Neurology Board Exam.

Psychiatric mental health nurse practitioner (PMHNP) education

PMHNPs complete advanced practice nursing education at either the master's or doctoral level following licensure as registered nurses. PMHNPs are a subset of Advanced Practice Nurse Practitioners. Clinical training hours typically range from 500-750, with some doctoral programs reaching up to 1,000 hours, and many programs offer online formats. PMHNPs receive certification from the American Nurses Credentialing Center rather than the American Board of Medical Specialties, as their training emphasizes nursing care, patient-centered health management, and systems integration specific to psychiatric and mental health populations. Their coursework and clinical experiences are often coordinated by nursing faculty affiliated with programs across a variety of sectors including standalone, private for-profit programs, hospital systems, and academic centers.

Medical school and psychiatric residency training programs are overseen by guidelines set forth by the Accreditation Council for Graduate Medical Education, whereas nursing training programs may vary in their structure and content, with some Master of Science in Nursing programs being completed fully online. These variations in training types can contribute to varying clinical acumen among practicing PMHNPs. Psychiatrists should familiarize themselves with the type of training programs completed by the PNPs whom they supervise (Wills, 2023).

Physician assistant education

PAs must complete an educational pathway that includes a bachelor's degree, followed by a master's degree from an accredited PA program, which typically spans 24 to 36 months. These programs require prior undergraduate coursework in science and healthcare-related fields and include both classroom instruction and over 2,000 hours of supervised clinical rotations across various medical specialties. Following graduation, candidates must pass the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants. Licensure is granted at the state level and generally requires graduation from an accredited program, successful completion of the PANCE, and ongoing continuing medical education (CME) to maintain certification.

Psychiatry training program recommendations

Psychiatric training is both biologically and psychotherapy-oriented, thus positioning psychiatrists to think from a multidimensional perspective with regard to clinical care. This holistic perspective

provides psychiatrists with unique expertise in supervisory and consultative roles in behavioral health. Although neurobiological phenomena can certainly result in medication treatment failures, psychodynamically driven lapses in treatment alliance all too frequently precipitate treatment failures (Chang et al., 2019). Psychiatrists undergo rigorous neuropsychopharmacological training, bolstered by a foundation in psychodynamic pedagogy, to become highly effective clinicians. This multidimensional perspective affords psychiatrists unparalleled skill in designing thoughtful biopsychosocial formulations that result in effective treatment plans.

The APA encourages psychiatric training programs to equip residents and fellows with appropriate instruction regarding effective strategies for supervising PMHNPs. As the need for psychiatric treatments grows and access to psychiatrists remains scarce, behavioral health practices can better meet the needs of their communities by including well-trained and well-supervised advanced practice providers (APPs). As a result, many clinical settings may highly encourage their psychiatrists to supervise APPs as part of their practice. Therefore, the APA strongly encourages residency training programs to incorporate specific instruction in effective strategies for supervising APPs.

PMHNP training background

APA recognizes that early career psychiatrists may begin supervising PMHNPs shortly after leaving residency. Thus, a psychiatrist may have fewer years in practice than the PMHNP whom they are supervising. However, psychiatric training is standardized to be extensive, which provides all psychiatrists with a firm foundation to supervise all levels of PMHNP's. Psychiatrists should familiarize themselves with the level of training of the PMHNP they are supervising and work to understand their level of psychopharmacological expertise to better calibrate each PMHNP's supervision needs. PMHNPs may want to consider their career stage when considering whether to pair themselves with a particular psychiatrist.

PA training background

As with PMHNPs, psychiatrists should familiarize themselves with the level of training of the PAs they are supervising to best meet the needs of the staff and patients. In general, PA students complete the same core clinical training requirements; however, there are opportunities for specialization during and after training, including a psychiatry rotation, which is typically between four and six weeks. There are also opportunities for elective rotations for more specialized clinical training, such as addiction medicine or child and adolescent psychiatry. There are also nonmandatory post-licensure training opportunities, which run for anywhere between 12 and 18 months, to give the PA more intensive clinical opportunities.

Table 1: Comparison chart of education and training

	Psychiatrist	Nurse Practitioner/Psychiatric Mental Health Nurse Practitioner	Physician Assistant
Education	4 years of medical school	Bachelor of science in nursing then either 2 year masters or 4 years doctorate program	2 to 3 years of postbaccalaureate PA program
In-person clinical training hours	10,000-16,000 hours	500-750 hours	2000 hours
Residency	3 to 7 years, with an additional 1 to 3 years for subspecialty fellowship	No residency required	No residency required
Continuing education	CME hours vary by state, license renewal periods are 3 years, and recertification is every 10 years	Psychiatric Mental Health Nurse Practitioner-Board certified credential is valid for 5 years	CME varies by state; recertification is required every 10 years

Supervision

Supervision via tele-technologies

Online supervision in psychiatry offers significant benefits, such as flexibility, accessibility, and cost-effectiveness, but it also presents challenges that require careful management. The ability to connect remotely allows psychiatrists and mental health professionals in underserved areas to access supervision without the constraints of geography, and the flexible scheduling accommodates busy clinical practices. Additionally, online supervision enables access to specialized expertise, expanding learning opportunities in areas such as forensic psychiatry and addiction.

However, several challenges must be addressed. Technological reliability is crucial, as supervisors and supervisees need stable internet connections and secure platforms for videoconferencing and file sharing. Confidentiality and data security are key concerns, requiring encrypted platforms and strict protocols to comply with regulations such as the Health Insurance Portability and Accountability Act. The potential loss of nonverbal cues in online interactions can also make it harder to assess supervisee performance, and live observation of clinical work is more difficult to conduct remotely, often requiring recorded sessions with patient consent.

Maintaining professional boundaries in online supervision is essential, as remote settings can blur lines between personal and professional spaces. Supervisors and supervisees must remain

focused and conduct sessions in appropriate environments to uphold professionalism. Additionally, supervising across disciplines online demands careful consideration of each professional's scope of practice, ensuring feedback aligns with their legal and professional responsibilities.

Ethical considerations, particularly around confidentiality and informed consent, must be prioritized in online supervision, especially when patient information is shared electronically. Finally, clear distinctions between supervision and consultation are necessary to avoid confusion and ensure proper accountability in remote settings.

While online supervision offers notable advantages, it requires addressing technical, ethical, and professional challenges to ensure its effectiveness in supporting psychiatric practice.

Collaborative relationships

Collaborative agreements are contracts between physicians and APPs to provide practice oversight. These agreements mainly occur in states in which the APP does not have full practice authority. States vary regarding the level of involvement of the physician in a collaborative agreement, but that is not the only consideration for the scope of the agreement. Psychiatrists should also consider the scope of practice for the APP in that state, the practice setting, experience and training of both the psychiatrist and the APP, and the needs of the patients in the practice.

Hierarchy and final determinations

Supervision rules for NPs and PAs vary widely by state. Some states require **direct supervision**, but this can be even further parsed out. Physicians must be physically present in some states, while others allow supervision to occur remotely through periodic chart reviews or consultations. **Collaborative agreements** exist in states with less stringent supervision requirements, where NPs and PAs, albeit more rarely with the former, can practice more independently. (AMA PA Scope of Practice 2018) Further, NPs may have **full practice authority** in some states, meaning they can diagnose, treat, and prescribe medications without physician oversight. In contrast, PAs more often require some level of supervision or delegation from a physician.

Nurse practitioner supervision requirements by state:

A) States with full practice independence:
   - Alaska, Arizona, Colorado, Connecticut, Hawaii, Idaho, Iowa, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oregon, Rhode Island, South Dakota, Vermont, Virginia*, Washington, Wyoming, and Washington, DC

* Full practice authority after meeting an equivalent of five years of full-time practice experience with a collaborating physician

B) Reduced practice states:

- Alabama, Arkansas, Delaware, Illinois, Indiana, Kansas, Kentucky, Louisiana, Mississippi, New Jersey, New York, Ohio, Pennsylvania, Utah, West Virginia, and Wisconsin

C) Restricted practice states:

- California, Florida, Georgia, Michigan, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas

Clinical Practice Concerns

When members of the care team are unclear about their scope and role, there can be increased burdens, increased response times, and a potential increase in medical errors. Optimal role delineation can reduce confusion and conflict and needs to be clearly defined throughout the practice relationship.

Practice setting

Depending on the practice setting, psychiatrists need to also take into account workload and the additional time quality supervision requires on top of the psychiatrist's patient workload. Additional training should be provided to support collaborations, communications, and implementation into the workflow. A focus on cultural awareness listening skills has also shown to improve the supervisory experience (Rotherwell, 2021). Psychiatrists in supervisory roles must also be empowered to facilitate opportunities to upskill supervisees who are underperforming. Those conversations can be challenging or uncomfortable, leading to increased distrust, poor communication, and decreased performance by both the supervisor and supervisee.

Patient acuity

Patient acuity in psychiatric care refers to the severity, complexity, and dynamic nature of a patient's mental health condition, which directly impact the intensity and immediacy of clinical intervention required (Smith & Jones, 2018). High-acuity patients often present with acute psychiatric crises, complex comorbid conditions, and elevated risk profiles that demand continuous monitoring and rapid clinical responses (Brown & Davis, 2015).

Defining patient acuity

Severity and complexity:
Patient acuity encompasses not only the intensity of symptoms but also the presence of additional complicating factors such as co-occurring medical or psychosocial issues. High-acuity cases necessitate a proactive approach where timely and decisive interventions are paramount (Smith & Jones, 2018).

Resource and monitoring needs:
The level of acuity determines the required intensity of oversight. Lower-acuity patients may be managed with routine follow-ups and periodic evaluations, while high-acuity patients

require more frequent, in-depth supervision, including real-time consultations and immediate intervention when clinical deterioration is detected (Brown & Davis, 2015).

Dynamic clinical status:
As patient conditions can fluctuate rapidly, supervisory models must be adaptive. Continuous reassessment allows for dynamic adjustments in supervision intensity, ensuring that emerging crises are met with prompt and effective responses (Smith & Jones, 2018).

Impact on supervisory practices

Tailored oversight and risk management:
For high-acuity cases, intensive supervisory strategies are essential. These include frequent case reviews, direct observation, and immediate access to the supervising psychiatrist for crisis intervention. Such an approach helps mitigate risks, such as treatment nonadherence or emergent psychiatric emergencies, thereby enhancing patient safety (Brown & Davis, 2015).

Clinical decision-making support:
Supervising psychiatrists play a crucial role in guiding treatment decisions for complex cases. Their expertise assists in refining diagnostic formulations and balancing pharmacological with psychotherapeutic interventions, thus ensuring that high-acuity patients receive comprehensive care (Smith & Jones, 2018).

Integration of tele-supervision:
With the growing adoption of tele-technologies, remote supervision has become an invaluable tool in managing high-acuity patients. Secure video consultations and electronic monitoring can support continuous assessment and rapid response, although protocols must ensure that the quality of supervision is maintained at the same level as in-person oversight (Lee, Kim, & Park, 2020).

Adjusting supervisory models

Setting-specific considerations:

- **Inpatient settings:** These environments often manage higher patient acuity, requiring direct supervision, immediate availability of the supervising psychiatrist, and coordinated multidisciplinary interventions.
- **Outpatient settings:** Although patient acuity may vary more widely, these settings still benefit from adaptive supervisory models that allow for escalation of oversight when a patient's condition deteriorates (Anderson et al., 2016).
- **High-risk patient lists and weekly supervision:**
  An effective strategy to enhance patient safety involves preparing a high-risk list that identifies patients within a caseload who exhibit elevated acuity. This list allows

supervisors to flag individuals requiring extra attention and can serve as a focal point during weekly supervisory meetings. Regularly discussing these high-risk cases enables timely interventions and ensures that supervisory resources are targeted where they are most needed (Anderson et al., 2016).

Optimizing caseloads

The overall acuity of a patient panel should directly inform the supervisee-to-supervisor ratio. High-acuity settings may require fewer supervisees per psychiatrist to maintain effective oversight and ensure optimal patient care (Anderson et al., 2016).

Integrating patient acuity into supervisory practices is vital for enhancing patient safety and improving clinical outcomes in psychiatric care. By tailoring supervision intensity to the complexity of patient presentations—whether in-person or via tele-technologies—psychiatrists can ensure that both high- and low-acuity patients receive the appropriate level of care, ultimately supporting better treatment outcomes and fostering the professional development of mid-level practitioners (Smith & Jones, 2018; Brown & Davis, 2015; Lee, Kim, & Park, 2020; Anderson et al., 2016).

Appropriate number to supervise

There is no exact number that is appropriate for every psychiatrist, but there are considerations that must be taken into account. In addition to legal requirements (39 states have established limits on the number of PAs that physicians can supervise or collaborate with (AMA), the psychiatrist must consider facility or system requirements, the experience level of both the psychiatrist and the APP, and the time available to the supervising psychiatrist while balancing the ability to provide quality care to patients.

Billing practices

“Incident-to" provision

"Incident-to" billing allows services provided by nonphysician practitioners (NPPs) to be billed under a supervising psychiatrist’s National Provider Identifier (NPI) at the full 100% Medicare Physician Fee Schedule (MPFS) rate, rather than the 85% rate applicable when billed under the NPP’s own NPI. Services provided incident to a psychiatrist's professional services must be considered integral, though incidental, to the physician’s personal care in diagnosing or treating a patient’s condition. Incident-to billing allows psychiatrists to receive full Medicare reimbursement for services provided by supervised NPPs, increasing efficiency and revenue while maintaining oversight of patient care. However, strict requirements must be met to qualify.

Key requirements of incident-to billing:

Incident-to billing requires that the psychiatrist perform the initial evaluation and establish a treatment plan, with follow-up services by the NPPs aligning with that plan and consisting of mental health services typically provided in a psychiatric office. During these follow-up visits, the psychiatrist must provide direct supervision, meaning they are physically present in the office suite and immediately available to assist if needed. However, they do not need to be in the same room.

The psychiatrist must also remain actively involved in the patient's care, reviewing progress and updating the plan as necessary as part of their supervision responsibilities.

Incident-to services must take place in a clinic or office setting and are not permitted in hospitals or skilled nursing facilities. Proper documentation in the medical record is essential for compliance with incident-to billing rules. The note must indicate that the service was incident-to and that all requirements have been met, including that the psychiatrist performed an integral, though incidental, part of the overall care. Only established patients with an existing plan of care qualify for incident-to billing, and the services must be provided without separate a charge or included in the psychiatrist's bill. The NPP must also work within their legal scope of practice as defined by state law.

New patient visits or visits involving changes to the treatment plan are not eligible for incident-to billing and must be submitted under the NPP's NPI. Improper use of incident-to billing can result in Medicare overpayments and potential audits.

Eligible practitioners under incident to provision:

Services may be delegated only to individuals within the following licensed categories, when practicing within their state-authorized scope:

Table 2: Covered services by practitioner type

Practitioner Type	**Approved HCPCS Codes**
Doctorate or Master's Level Clinical Psychologist	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90880, 90899
Doctorate or Master's Level Clinical Social Worker	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90899
Clinical Nurse Specialist (CNS)	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90899
Nurse Practitioner (NP)	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90899
Marriage and Family Therapist (MFT)	90832, 90834, 90837, 90839, 90840, 90846, 90847, 90849, 90853, 90899, 96105, 96112, 96113, 96116, 96121, 96130, 96131, 96136, 96137, 96138, 96139, 96146, G0451
Mental Health Counselor (MHC)	90832, 90834, 90837, 90839, 90840, 90846, 90847, 90849, 90853, 90899, 96105, 96112, 96113, 96116, 96121, 96130, 96131, 96136, 96137, 96138, 96139, 96146, G0451

These professionals may bill designated HCPCS codes when providing covered services under a supervising provider's plan of care. For example, a psychiatrist may hire a licensed clinical social worker to deliver services included in the permitted code list. However, these individuals do not need to be separately enrolled in Medicare as independent practitioners when billing under the incident to rule. Services must be rendered under general supervision, meaning the supervising psychiatrist must direct and oversee care. However, physical presence during the procedure is not required.

Setting requirements

In private practices, services and supplies must be provided under general physician supervision. In physician offices located within institutions, auxiliary personnel must be part of the physician's office staff, not the institution's staff. For services provided in a home or noninstitutional setting, general supervision by the physician is still required. Services provided in hospitals or skilled nursing facilities during a covered stay are not eligible for incident to billing under Part B and must be billed by the facility under Part A.

Non-covered scenarios

Medicare does not cover psychological services furnished incident to by individuals outside the approved categories or without proper licensure, training, or supervision. These higher credentialing standards reflect the necessity for services billed under Part B to match the quality of the physician's care.

Rates

Medicare fee schedule rates by professional

Medicare allows NPs and PAs to bill under a supervising physician's provider number if certain criteria are met through incident to billing. When services are provided by an NP or PA incident to under a physician, Medicare reimburses at 100% of the physician fee schedule rate. However, if the NP or PA bills uses their own provider number, Medicare would reimburse at 85% of the fee schedule rate. MedPAC reports that a significant portion of services delivered by NPs and PAs to Medicare beneficiaries are billed under the incident to provision (Chernew, 2024). Additional fee schedule rates by provider type are listed in the chart below for comparison.

Table 3: Medicare Provider Rates

Eligible Professionals	Medicare Physician Fee Schedule Payment Rates
Physicians (MDs and DOs), particularly psychiatrists	Paid at 100% under the physician fee schedule (PFS)
Clinical psychologists (CPs)	Paid at 100% of assigned services under the PFS*
Clinical social workers (CSWs)	Paid at 80% of the lesser of the actual charge for the service or 75% of the clinical psychologist's PFS*
Clinical nurse specialists (CNSs)	Medicare pays for services at 80% of the lesser of the actual charge or 85% of the amount a physician gets under the PFS*

Nurse practitioners (NPs)	Medicare pays for services at 80% of the lesser of the actual charge or 85% of the amount a physician gets under the PFS*
Physician assistants (PAs)	Services at 80% of the lesser of the actual charge or 85% of the amount a physician gets under the PFS*
Independently practicing psychologists	Paid at 100% under the PFS for diagnostic tests**
Marriage and family therapists (MFTs)	Medicare pays for services at 80% of the lesser of the actual charge or 75% of the amount a CP gets under the PFS*
Mental health counselors (MHCs), including certified alcohol and drug counselors	Medicare pays for services at 80% of the lesser of the actual charge or 75% of the amount a CP gets under the PFS*

*Medicare pays only on assignment

**Medicare doesn't subject diagnostic, psychological, and neuropsychological tests to assignment; however, on the claim, include the name and address of the physician or NPP who orders the tests.

Incident-to clinical example

In an outpatient psychiatric clinic, Dr. Smith, a psychiatrist, supervises a PMHNP. A new patient presents with symptoms of depression. Dr. Smith conducts the initial comprehensive evaluation (90792), establishes a diagnosis of major depressive disorder, and creates a treatment plan that includes starting a selective serotonin reuptake inhibitor (SSRI) and scheduling weekly follow-up visits. She documents this plan thoroughly and notes in the medical record that the NP may conduct follow-up visits under her supervision.

One week later, the PMHNP sees the patient for her first follow-up. The patient reports tolerating the SSRI but continues to feel down. The NP reviews her symptoms, provides supportive psychotherapy, and encourages continued medication adherence. During this visit, the psychiatrist is physically present in the office suite and immediately available should any issues arise. The PMHNP follows the treatment plan initiated by Dr. Smith without changing the care plan or treating a new presenting problem.

Since all requirements for incident-to billing are met, the follow-up visit is billed under Dr. Smith's NPI using the appropriate Current Procedural Terminology (CPT) code for an established patient's office visit (such as 99213). Medicare reimburses the visit at 100% of the physician fee schedule because it qualifies as an incident-to service.

For the billing to be compliant, Dr. Smith must have personally performed the initial service and established the treatment plan, remained actively involved in the patient's care, ensured that the NP followed the established plan, and provided direct supervision by being physically present in the office suite during the follow-up visit.

If any of these conditions are not met, for example, if the patient presents a new problem or if Dr. Smith is not in the office suite, then the visit could not be billed as incident to. Instead, it would need to be billed under the NP's NPI at 85% of the physician rate. This scenario demonstrates how

psychiatrists may leverage incident-to billing when supervising NPPs, provided that all supervision and documentation requirements are strictly followed.

Supervisory billing

Supervisory billing is a practice in which a licensed mental health provider bills for services that are actually delivered by a less-experienced or unlicensed provider, such as an intern, associate, or trainee pursuing licensure, who is working under the psychiatrist's supervision. This arrangement is often used in mental health settings to allow pre-licensed professionals to provide care and gain necessary clinical experience while receiving guidance from a fully licensed clinician.

In this model, the supervising provider is responsible for ensuring that services meet professional and ethical standards. Supervision may include reviewing session notes, observing client sessions, and holding regular meetings to discuss cases and maintain the quality of care. Because pre-licensed providers generally cannot bill insurance directly, the services they provide are billed under the licensed psychiatrist's NPI, as if the supervising clinician had rendered the service themselves.

Insurance coverage for supervisory billing varies, and not all payers accept it. For instance, Cigna and Aetna allow supervisory billing in all states, while Optum and United Healthcare allow supervisory billing only in California, Colorado, Iowa, and Massachusetts. This billing method is frequently used in private practices, outpatient clinics, and academic training programs. However, practices must verify whether each insurer allows this arrangement and ensures they understand any specific insurer requirements.

Of note, supervisory billing carries a higher risk of audit because claims appear as though the licensed provider performed the service, even though it was delivered by a supervisee. Maintaining thorough documentation is essential to demonstrate compliance and reduce potential liability.

Primary Care Exception

Under the standard teaching physician rules in psychiatry, Medicare requires that the teaching physician be physically present during the key portions of the service, or for the entire service in the case of certain procedures, to bill under their NPI. The resident may perform portions of the encounter, but the teaching physician must personally participate in the patient's care, verify the history, examination, and medical decision-making, and document their own involvement in the medical record. This rule applies in both inpatient and outpatient psychiatric settings, and there is no restriction on patient type or visit complexity as long as the required level of presence and participation is met.

Under the evaluation and management (E/M) services Primary Care Exception, low to moderate complexity patient visits (99202-99203 and 99211-99213) and some preventive services can be billed by the resident without the teaching physician being in the room. The Primary Care Exception applies to outpatient psychiatry clinics recognized as Centers for Medicare & Medicaid Services (CMS)-approved primary care centers that provide comprehensive care to chronically mentally ill patients. The teaching physician must be immediately available in the clinic to provide direct supervision, review the resident's work, confirm the medical necessity, and sign the note. They are only allowed to supervise up to four residents at a time to ensure these responsibilities are met. The

encounter must be billed under the teaching physician's NPI with the GE modifier to indicate the use of the exception. Residents must first complete more than six months of an approved residency program in order to provide billable patient care without the physical presence of a teaching physician.

Split (or shared) E/M visits

While Medicare explicitly uses and defines incident-to billing, commercial insurers may permit billing under similar supervision structures but with different requirements and terminology, often referred to as "split/shared" services. Providers should verify each commercial insurer's policy individually, as supervision levels, reimbursement rates, and documentation expectations can vary significantly.

Split (or shared) visits involve both a physician (e.g., psychiatrist) and an NPP contributing to a single (E/M service during the same patient encounter. These visits can be billed under either provider, depending on who performs the substantive portion of the service (defined as more than 50% of the total time spent by both clinicians jointly furnishing the visit). Time includes activities such as taking patient history, performing exams, counseling, and documenting in the record. Split/shared visits are only allowed in facility settings (e.g., hospitals, outpatient departments, skilled nursing facilities) and are not permitted in office or clinic settings.

Split/shared billing allows psychiatrists to collaborate with NPPs in delivering care while still billing under their own NPI at the full physician rate, enhancing flexibility by allowing team-based care, improving efficiency by dividing responsibilities, and maximizing reimbursement through higher payment rates than if billed solely under the NPP's NPI.

Of note, both the psychiatrist and the NPP must be part of the same group, and both clinicians must see the patient on the same calendar day. The psychiatrist and NPP must each provide a personally performed, medically necessary part of the visit. No specific level of supervision (general, direct, or personal) is required beyond this co-participation. The psychiatrist does not need to be physically present during the NPP's portion, unless required by other state regulations.

The medical record must clearly identify the total time spent and the practitioner who provided the substantive portion. Each provider must document their own contribution, while the billing provider must sign and date the note. Claims must include modifier FS to indicate that the visit was split/shared.

Billing considerations

Split/shared billing applies only to E/M services, and not to psychotherapy codes or procedures. Psychiatric services such as psychotherapy (90833, 90836, 90838) generally cannot be billed as split/shared. If the psychiatrist does not meet the "substantive portion" threshold, the service must be billed under the NPP's NPI at 85% of the Medicare rate.

In accordance with the CPT E/M Guidelines, only distinct time can be counted. When practitioners meet jointly with or discuss the patient, only the time of one of the clinicians can be counted.

Example: If the NPP first spent 10 minutes with the patient and the psychiatrist then spent an additional 15 minutes, their individual time would be added together for a total of 25 minutes. The psychiatrist would bill for the visit, as they provided more than half of the total time (15 out of 25 minutes). If, in the same scenario, the psychiatrist and NPP also spent five minutes together

discussing the patient's treatment plan, that shared time would only be counted once when determining the total time and identifying who performed the substantive portion of the visit. The total time would then be 30 minutes, and the psychiatrist would still bill for the visit, having contributed 20 of the 30 total minutes.

Split (or shared) visit clinical example

In a hospital outpatient department, Dr. Lee, a psychiatrist, and a PMHNP, work together to manage the care of an established patient admitted for medication stabilization. The PMHNP begins the visit by reviewing the patient's current mental status, assessing medication adherence, and updating the clinical notes. Later that same day, Dr. Lee sees the same patient, performs a psychiatric evaluation that includes decision-making on medication adjustments, and independently documents her portion of the visit. Both clinicians provide substantive portions of the visit, contributing to the history, examination, and medical decision-making.

Because they each performed components of the visit and documented their involvement in the medical record, the visit qualifies as a split (or shared) service under Medicare rules. Dr. Lee reviews the NP's documentation, confirms it accurately reflects the care provided, and finalizes the note by indicating that the visit is being billed as a split/shared service. Since both the psychiatrist and NP together performed the substantive portion of the visit and Dr. Lee is the billing provider, the claim is submitted under Dr. Lee's NPI, allowing reimbursement at the physician rate (100% of the fee schedule). To comply with supervision and billing requirements, Dr. Lee must ensure that the services provided by the PMHNP were medically necessary, that her distinct portion of the care is clearly documented, and that the documentation reflects the collaborative nature of the visit.

Liability

Exposure to liability can occur under several different avenues. (Hickman, 2021). In response to a directive by the executive branch, CMS published a rule deferring to the states to define the physician-PA relationship and any oversight requirements for that relationship (CMS MPFS CY, 2020).

Most states, through statutory or common law, recognize the physician-PA relationship as an agency. An agent (the PA) is one who acts on behalf of the principal (the physician), and the principal can control the actions of the agent. PAs, therefore, work as agents of the physician. The common law of agency is a fiduciary relationship produced by the assent of both parties, in which the agent will represent the principal, subject to the principal's control.

Under the theory of agency, principals can face direct liability for their direct actions and indirect liability for the actions of agents under theories of vicarious liability (Hickman, 2021, table 1). The physician's direct liability can arise from:

- Negligent hiring and credentialing of the PA
- The physician not adhering to state oversight law and regulations
- The physician's own medical decision-making, in which the PA may or may not participate.

Agents can exercise professional judgment on behalf of the principal while legally maintaining their own identities. When the principal is not aware of or cannot exercise control over the professional judgment, the courts have generally not found the principal liable for the agent's actions, as demonstrated in *Blatchley v. Cunningham*, US District Court for the District of Colorado. An employer's expectations for supervision should be laid out in writing in your employment contract. Supervision requirements are sometimes addressed in contract addenda; these should be carefully reviewed before signing.

Ethics

As licensed medical practitioners, psychiatrists and PMHNPs are expected to guide their practices by the core medical ethics tenets of autonomy, beneficence, non-maleficence, and justice. In addition, they must follow the codes of ethics outlined by their state medical license boards, specialty certification organizations, and practice privilege-granting institutions. Before beginning clinical supervision, it is worth reviewing these organizational guidelines with potential PNP supervisees and discussing how these principles are incorporated into your practice. This discussion should also include an overview of how the unique ethical challenges in psychiatry, such as restriction of services, patient confidentiality, and treatment over objection, are handled in your practice (Levit et al., 2024).

Besides establishing an understanding of the ethical framework of a practice, several other important factors must be prioritized to enable effective clinical supervision. These include confirming there is adequate time in each party's schedule for supervision meetings, training, and professional development. There should also be a process for conflict resolution and opportunities given to question clinical decisions. Last, attention must be given to the PNP's caseload volume and complexity to ensure work is equitable and there is appropriate professional independence and clinical oversight.

Scheduling and preparing regular discussions on individual cases and ethical and legal issues are core components of clinical supervision. State or organizational regulations may define the minimum frequency of PNP consultations, education, and training. If not, psychiatrists should agree with PNP supervisees on the appropriate frequency, duration, and goals for clinical supervision sessions before working together. This facilitates professional accountability so neither party feels their time is undervalued.

Moreover, psychiatrists are responsible for promoting continuous learning in medicine. This can be accomplished through psychiatrists seeking opportunities to enhance their own knowledge and teaching effectiveness through conferences, workshops, and online courses. At least one of these professional activities should focus on aspects of clinical supervision annually. Psychiatrists should also recommend professional activities for PNP supervisees that they believe will add to the PNP's clinical expertise and overall professional growth.

Fostering a space where PNP supervisees feel comfortable discussing concerns or mistakes encourages transparent communication. This creates an atmosphere in which PNP supervisees feel safe sharing ethical concerns or disagreements without fear of retaliation (Rothwell et al., 2021). Psychiatrists can promote such open lines of communication by being available outside scheduled clinical supervision meetings. They can also establish trust by sharing their own ethical

dilemmas and errors, giving time for reflective learning, and encouraging constructive feedback (Rothwell et al. 2021). Developing a clear and fair process to manage conflicts before working together will also reduce hesitancy to discuss disagreements in supervision.

Psychiatrists have the ethical responsibility to monitor PNP supervisees' caseload volume and complexity and to keep meetings concise and relevant to clinical work to prevent clinician fatigue and burnout or disruption of workflows. This includes paying close attention to the volume and complexity of patient panels. The psychiatrist should work with the PNP supervisees to make sure they have a caseload that gives them enough time to safely care for patients and avoid ethical violations. In addition, their caseloads should enable them to function independently and at the highest level of their professional licenses. The determination of the number of cases that PNP supervisees manage should be influenced by their years of experience, clinical expertise, and scope of practice per state regulations.

Care delivered by PNPs under the supervision of a psychiatrist should adhere to the same core bioethical principles that underlie all medical care and medical decision making. These core bioethical principles ensure that clinical standards of care are maintained across and within all systems of care (Roberts & Dyer, 2004). However, a 2010 study by Grady et al. showed that only 57% of the nurse and social worker respondents in their study had ethics education in their basic or advanced professional programs (Grady et al., 2010). Due to this variation in ethical training, the psychiatrist supervisor must assess the PNP's level of ethical clinical training to understand areas of strength and weakness.

Psychiatric care commonly illustrates bioethical complexities. Psychiatrists in practice must often employ advanced clinical and ethical problem-solving techniques, as defined by Roberts and Dyer, to resolve complex clinical issues that commonly arise in psychiatric clinical encounters. (Roberts & Dyer, 2004, pp. 255-256.) Complex ethical decision-making underscores common clinical issues around patient autonomy, patient safety, confidentiality, nonmalfeasance, and beneficence. Controlled substance scenarios often raise ethical questions around patient safety, beneficence, and nonmaleficence when patients request doses beyond what is clinically indicated. Issues related to veracity, fidelity, and integrity also arise when considering conflicts of interest created by financial incentives around clinical care delivery. Bioethical education is necessary to address all such ethical challenges that emerge in the practice setting.

Ulrich et al. demonstrated that a focus on ethics education for NPs promoted a sense of better preparedness (Ulrich et al., 2010). Given the ever-present need for bioethical reasoning in clinical care, psychiatrist supervisors must be prepared to guide PNP supervisees in identifying common, complex ethical scenarios that require additional supervision to appropriately resolve. Therefore, psychiatrists should include bioethical decision-making in the supervision process to better help PNP supervisees provide the highest standard of clinical care.

Psychiatrists are especially poised to impart ethical questioning and reasoning into the supervision process. The supervision and consultation paradigm embedded in psychiatric residency is one that requires self-reflection and analysis of the therapeutic and clinical situation. Psychiatric training exposes the ethical complexities that result from various forms of transference and countertransference. Both negative and positive countertransference can create the groundwork

for ethically driven therapeutic errors. Therefore, it is the ethical duty of the psychiatrist supervisor to help unveil these circumstances in real time to ensure high-level clinical care (Thomas, 2010).

Additionally, financial conflicts of interest can arise between psychiatrists and supervisees when psychiatrists receive remuneration directly from the NP for supervision provided (Bakanas, 2010). Conflicts of interest must be addressed, and earnest discussions around these conflicts are imperative in the relationship between supervisor and supervisee. Psychiatrists should not allow their own financial incentives to create ethical lapses in care.

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