BRIDGE

ONCOLOGY

Get Started

Radiation Oncology Supervision Survey

Disclaimer

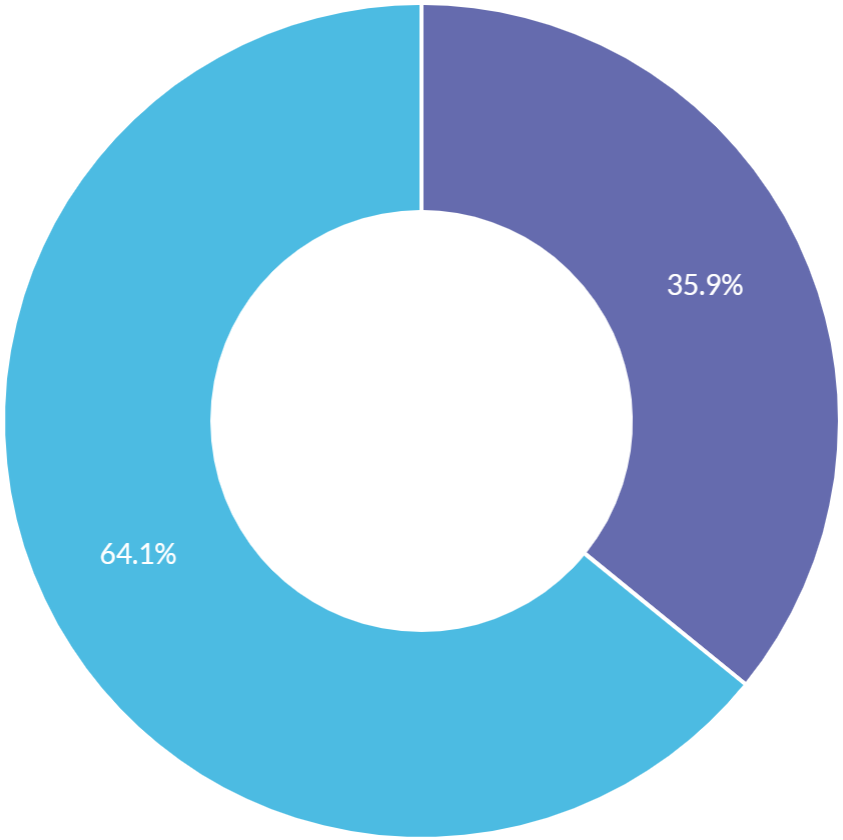
- This survey was meant to be a simple baseline survey
- There was no other data available on the subject
- Yes, additional and more clarifying questions could have been asked
- Given such an important topic the engagement rate was still low
- This survey gives clear indicators of the position on “direct supervision”

You can still complete the survey by CLICKING HERE

Q1

Do you agree with the supervision proposal that Radiation Oncology should go back 2010 Direct supervision guidelines?

Multiple Choice

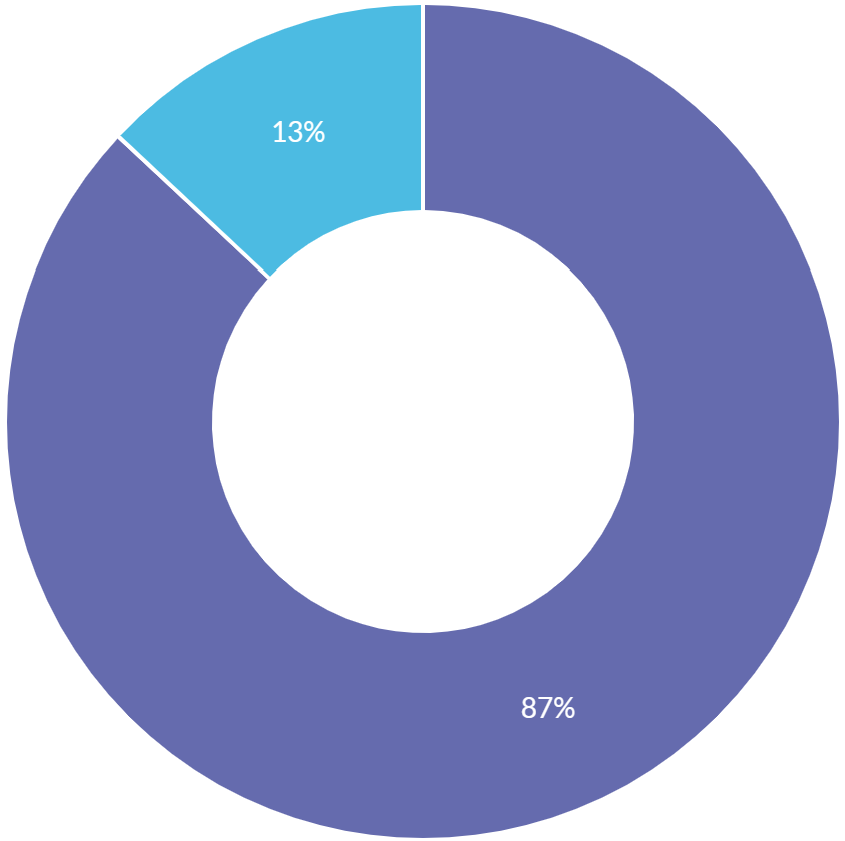


Choice	Total
Yes	33
No	59

Q2

Do your radiation oncologist currently do anything remotely or virtually like review images or check plans?

Multiple Choice

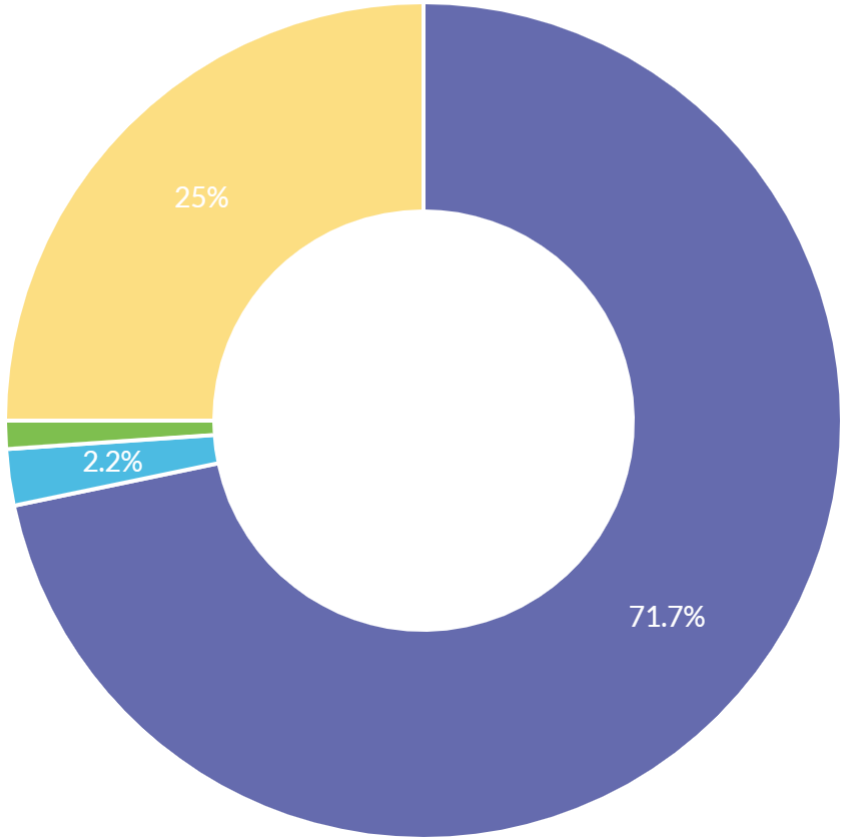


Choice	Total
Yes	80
No	12

Q3

Who detects most treatment set up discrepancies or skin/treatment reactions?

Multiple Choice

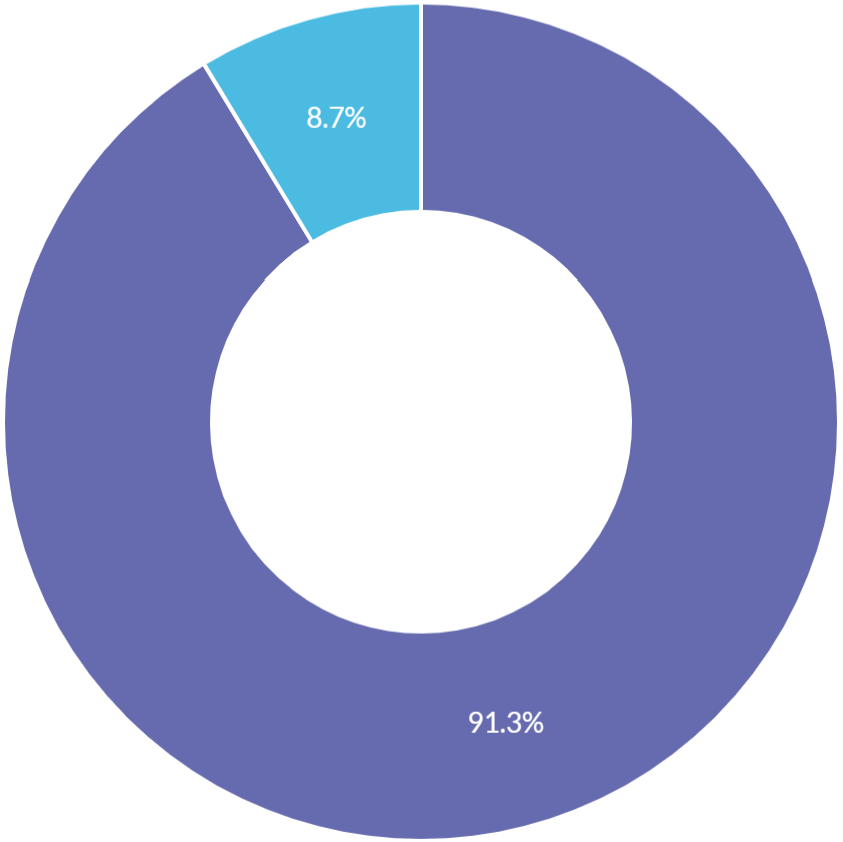


Choice	Total
Therapists	66
Nurses	2
Dosimetrists	1
Radiation oncologists	23

Q4

Do you have dosimetrist and or physicists that perform remote to tele work?

Multiple Choice

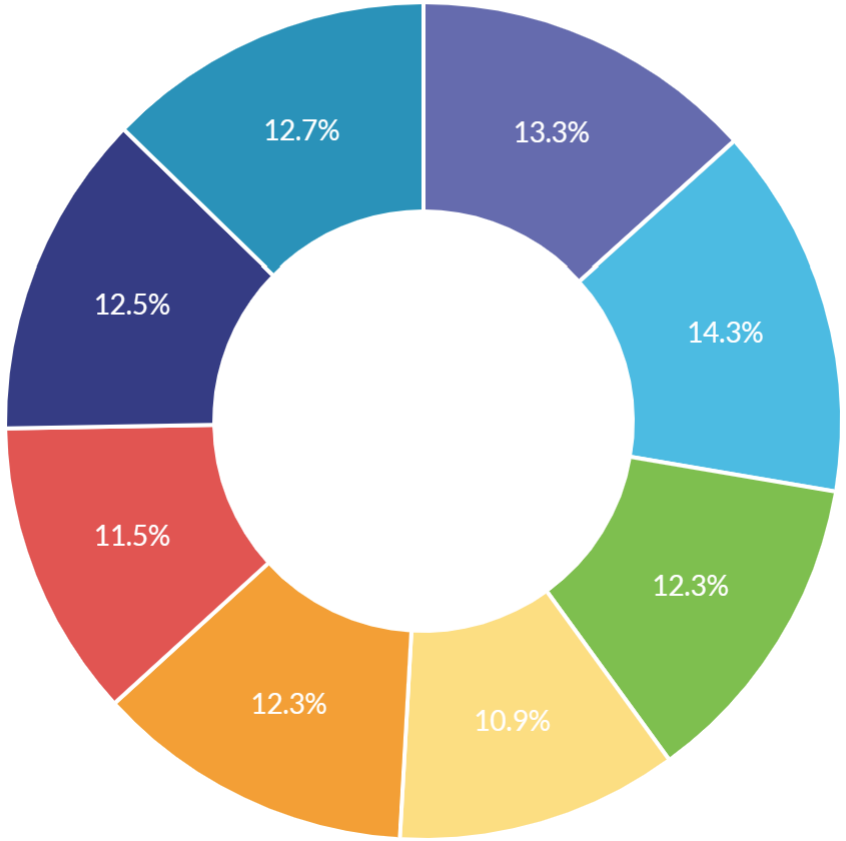


Choice	Total
Yes	84
No	8

Q5

With the radiation oncologist immediately available via audio/video, do you feel safe supervision could be provided for? (select which treatments)These are NON SRS/ SBRT

Multiple Choice

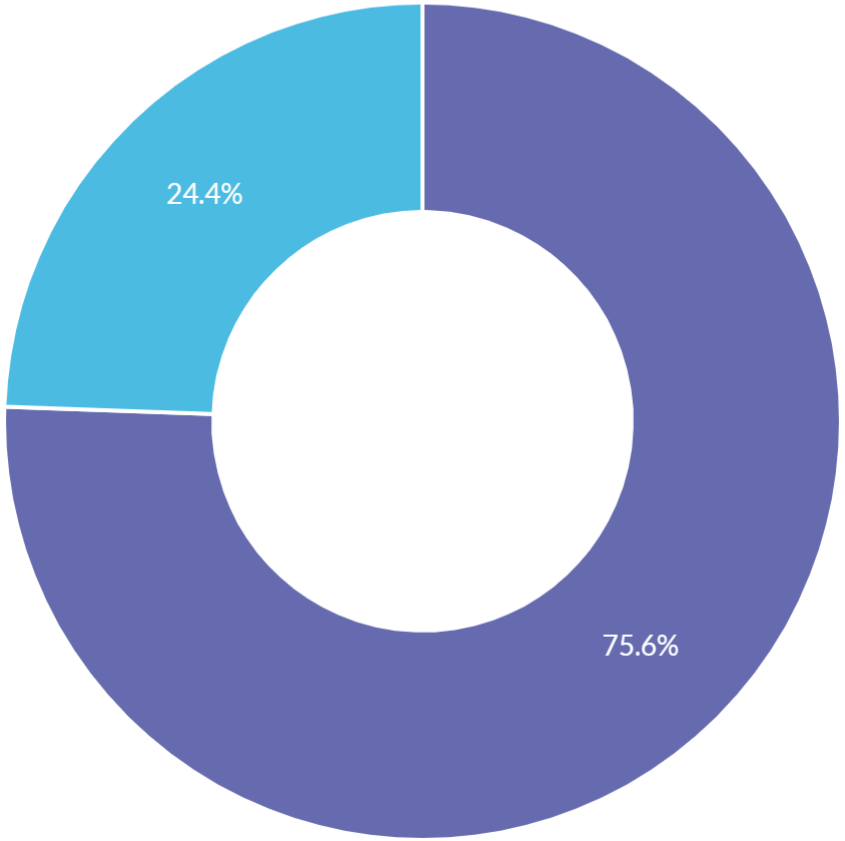


Choice	Total
Breast	66
Prostate	71
Lung	61
Head and Neck	54
Brain	61
Gyn	57
GU	62
Extremity	63

Q6

Requiring Direct Supervision, RO in clinic for ALL tasks, 5 days a week would result in center closures or increased struggles?

Multiple Choice

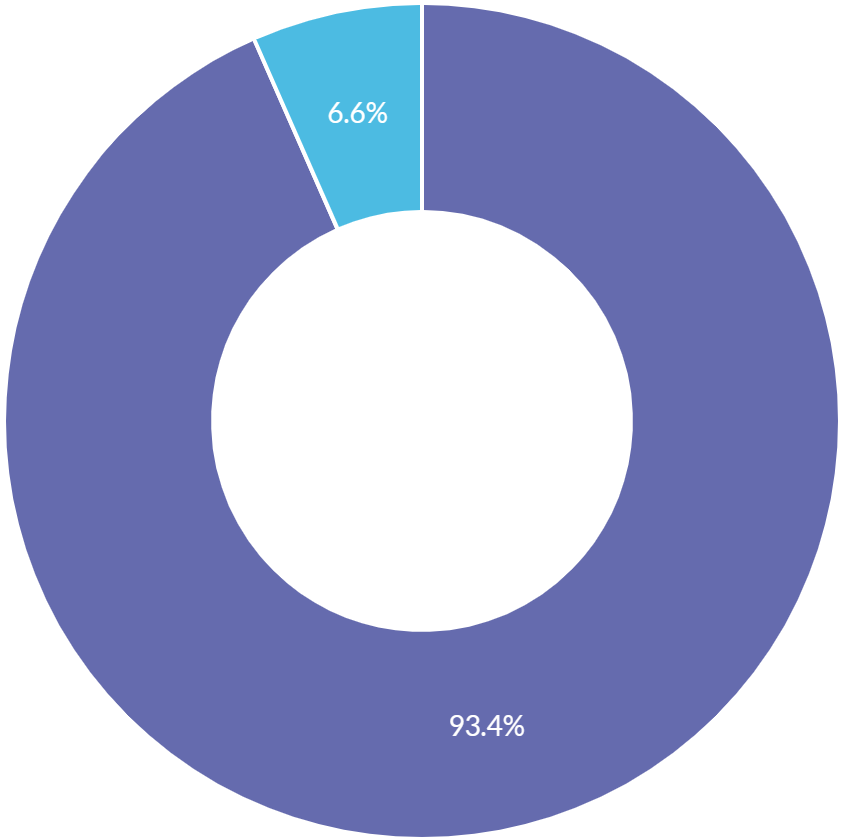


Choice	Total
Yes	68
No	22

Q7

Guardrails and safeguards that dictate what can be done remotely and via direct virtual supervision should be put in place to ensure consistency and safety.

Multiple Choice

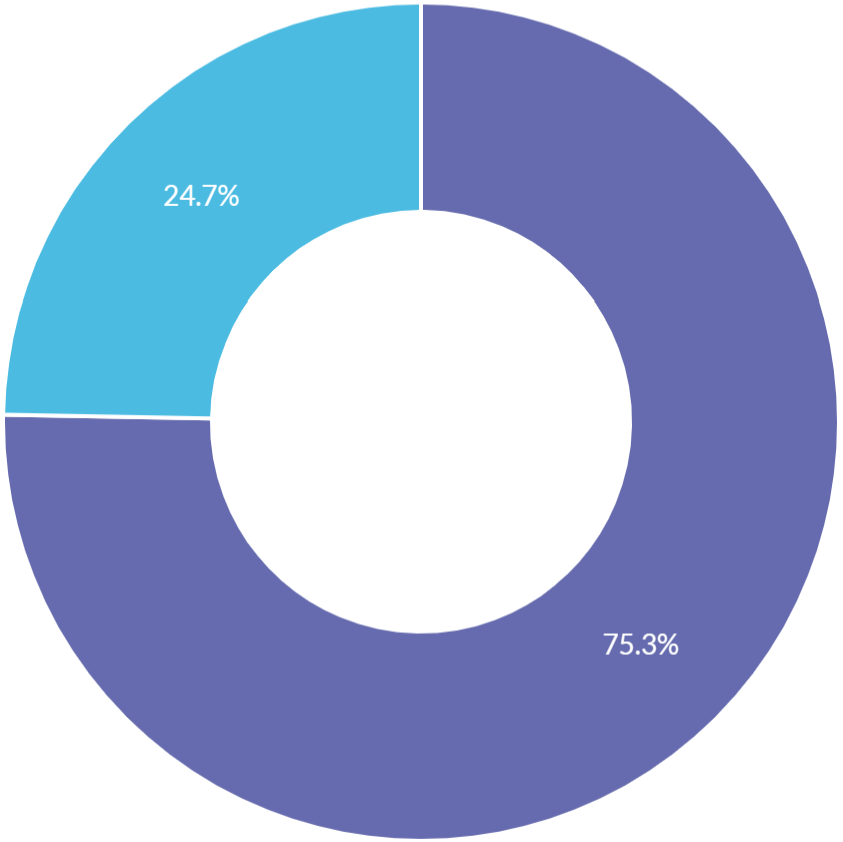


Choice	Total
Yes	85
No	6

Q8

Should accreditation be updated to account and allow for direct virtual supervision? (ACRO, APEX, ACR)

Multiple Choice



Choice	Total
Yes	67
No	22

Additional Information

ACR

February 14, 2024

ACR Urges CMS to Extend Virtual Supervision of Diagnostic Tests

Share Recommend Bookmark

The American College of Radiology® (ACR®) met with at the Centers for Medicare and Medicaid Services (CMS) leaders Feb. 12, to provide the College's views on virtual direct supervision of diagnostic tests. The College highlighted the importance of maintaining high patient safety by having specific on-site personnel. ACR voiced support for CMS to permanently extend the definition of direct supervision to permit virtual presence.

CMS allowed virtual presence during the COVID pandemic, but its allowance expires Dec. 31. CMS previously requested stakeholder feedback about whether it should extend the definition of direct supervision to permit virtual presence beyond Dec. 31. ACR previously commented in support of CMS making permanent the rule that allows virtual direct supervision of level 2 diagnostic tests via real-time audio/video communications technology by physicians, as well as non-physician providers in states with laws and scope of practice that permit them to supervise diagnostic tests.

For more information, contact Christina Berry, ACR Team Lead, Economic Policy.

ACR

Timeline:

- From 2009 through December 31st, 2019, certain CPT codes submitted for reimbursement to CMS for radiotherapy needed to be performed under Direct Supervision.
- Private insurance carriers effectively followed this policy as well.
- When this began, rural/critical access hospitals expressed concern about staffing issues with this new rule. As such, CMS enacted a policy of "non-enforcement" in 2010, creating a two-tiered system of supervision.
- MedPac released a report on this two-tiered system in 2017, finding that there was significant confusion among hospitals in regards to compliance, and that there were no safety concerns noted with either type of supervision. MedPac urged CMS to refine supervision rules so that everyone was covered under one system of supervision requirements.
- In November 2019, CMS announced that all hospital outpatient procedures (including radiotherapy) would fall under General Supervision, with the decision to craft policy requiring higher levels of supervision left up to individual hospitals. Of note, this applies only to Hospital Outpatient, not Freestanding, departments.
- General Supervision for Hospital Outpatient Departments began on January 1st, 2020.
- With the pandemic and the Public Health Emergency, CMS decided to enable "Virtual Direct Supervision", where real-time audio/visual communication would be considered sufficient to meet the Direct Supervision requirement.
- Virtual Direct Supervision has been the policy since that time, though it is considered temporary. It has been extended to December 31st, 2024 (as of March 28th, 2024).
- CMS is deliberating whether or not to make Virtual Direct Supervision permanent.

Supervision Time Warp- 2010

Hospital outpatient therapeutic services furnished in a hospital and in on-campus provider based departments (PBDs) (e.g., a facility that is not physically located within or connected to the hospital) of a hospital have a minimum requirement of direct supervision. In order to meet that direct supervision requirement the supervising physician or nonphysician practitioner must be present on the same hospital campus (including a physician's office, an on-campus SNF, RHC, or other nonhospital space) and immediately available to furnish assistance and direction throughout the performance of the procedure. 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. CMS has not specifically defined "immediate" in terms of distance but has stated that the supervisory physician or nonphysician practitioner should not be so physically far away on the main campus from the location where hospital outpatient services are being furnished that he/she could not intervene right away.

The supervising physician or nonphysician practitioner must also be a person who is clinically appropriate to supervise the services or procedures. More specifically, the current CMS regulations (410.27(f)) state that the physician or nonphysician practitioner must be available to furnish assistance and direction throughout the performance of the procedure. This means that the physician or nonphysician practitioner must be prepared to step in and perform the service, not just respond to an emergency. The supervising physician does not necessarily need to be of the same specialty as the procedure or service that is being performed or from the same department as the ordering physician. However, the supervisory physician or nonphysician practitioner must have within his or her State scope of practice and hospital-granted privileges, the ability to perform the service or procedure.

So for example, if radiation therapy services were being provided in a hospital outpatient department and the radiation oncologist who was supervising those therapeutic services left the hospital campus, a qualified physician or physician practitioner would need to be immediately available to supervise the procedures. If there is no qualified supervising physician immediately available, no radiation therapy services provided during his/her absence can be covered by Medicare. The services covered under this benefit also include materials and services of technicians.

Services furnished at PBDs must be rendered under the direct supervision of a physician. The requirement for direct supervision in a department of a hospital that has provider-based status applies to both on-campus and off-campus departments of the hospital.

In addition, it is inappropriate to allow one physician or nonphysician practitioner to supervise all services being provided in all PBDs at a particular off campus remote location. It would be highly unlikely that one physician or nonphysician practitioner would be both immediately available at all times that therapeutic services are being provided and would have the knowledge and ability to adequately supervise all services being performed at once in multiple off-campus PBDs.

Finally, CMS defines "in the hospital" to mean areas in the main building(s) of the hospital that are under the ownership, financial, and administrative control of the hospital; that are operated as part of the hospital; and for which the hospital bills the services furnished under the hospital's CCN. (410.27(g))

Even in 2010 CPT Code Clarification would have ensured the tie to the radiation oncologist

Supervision Time Warp- 2010

2. Physician Supervision of Radiation Therapy Services in an Office or Free-Standing Radiation Therapy Center

Radiation therapy services (X-ray, radium, and radioactive isotope therapy) furnished in an office or free-standing radiation therapy center have their own benefit category in Medicare. These radiation therapy services when furnished in an office or free-standing radiation therapy center require "direct personal supervision" by 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. Therefore, if the supervising physician leaves the office or the freestanding radiation therapy center, any radiation therapy services provided during his/her absence cannot be covered by Medicare. The services covered under this benefit also include materials and services of technicians.

Unfortunately, similar terms are used to describe the supervision requirements under the various benefits. As a result, the terms are often misunderstood. For example, the term "direct supervision" is used for the "incident to" and diagnostic test benefits and the term "personal supervision" is used for the diagnostic test benefit. In the case of the radiation therapy benefit, the term "direct personal supervision" is used but its definition is similar to the definition of "direct supervision" under the "incident to" and diagnostic test benefits.

As described above in section 1, Physician Supervision of "Incident to" Services in an Outpatient Hospital Setting, CMS has indicated that the supervising physician or nonphysician practitioner must also be a person who is "clinically appropriate" to supervise the services or procedures. The concept of "clinically appropriate" as described above in section 1. is not specifically addressed in CMS regulations or manual instruction for physician supervision of radiation therapy services in an office or free-standing radiation therapy center

However, in the discussion of "incident to" services in an outpatient hospital setting in the final rule, CMS states:

> "We believe it is inappropriate for a supervisory physician or nonphysician practitioner to be responsible for patients, hospital staff, and services that are outside the scope of their knowledge, skills, licensure, or hospital-granted privileges. This interpretation of the previously codified language is consistent with our longstanding application of direct supervision across settings in terms of the physical presence of the physician and what it means to "furnish assistance and direction throughout the performance of the procedure." We do not believe that allowing a supervisor to be responsible for emergencies only would satisfy the standard to "furnish assistance and direction throughout the performance of the procedure" as the language has historically been interpreted for physicians' offices and PBDs. We disagree with commenters who stated that the historical intent of direct supervision has been for a supervising physician to provide guidance and direction without expecting that professional to be able to perform the service or procedure and that performance of the procedure applies only to personal supervision. It would be unreasonable to think that a physician or nonphysician practitioner could

In light of these statements, it is ASTRO's opinion that CMS is likely to apply the requirements outlined above for "incident to" services in an outpatient hospital setting to radiation therapy services provided in an office setting. We note that the outpatient PPS final rule revised 42 C.F.R. 410.27(a)(1)(iv)(A) to define the term "direct supervision" to mean that the supervising physician is "immediately available to furnish assistance and direction throughout the performance of the procedure." This essentially tracks the language applicable in the office setting, as set forth in Chapter 15, Section 90 of the Medicare Benefit Policy Manual, which states that the supervising physician must be "immediately available to provide assistance and direction throughout the time the procedure is being performed." Moreover, as explained above, CMS stated that the position on direct supervision in the outpatient PPS rule "is consistent with our longstanding application of direct supervision across settings in terms of the physical presence of the physician and what it means to 'furnish assistance and direction throughout the performance of the procedure.'"

NOT A RAD ONC

Code Clarification NOT Supervision

Supervision Time Warp- 2010

Again, the issue is not supervision, clarify the CPT Codes. Or really do you need an RO

April 23, 2010

Common Questions about Supervision Requirements for Medicare Payment of Hospital Outpatient Services

(1) Does Medicare require direct supervision for all services provided to outpatients in hospitals?

CMS has identified supervision requirements for the provision of both therapeutic and diagnostic services furnished to hospital outpatients. Medicare requires hospitals to provide direct supervision for the delivery of all outpatient therapeutic services. Direct supervision means that the physician or non-physician practitioner is immediately available to furnish assistance and direction throughout the performance of the procedure, but it does not mean that the supervising individual needs to be present in the room when the procedure is performed.

For diagnostic services provided to hospital outpatients, Medicare requires hospitals to follow the existing supervision requirements in the Medicare Physician Fee Schedule (MPFS) Relative Value File for individual tests. The MPFS has three definitions of supervision - general, direct, and personal. General supervision means that the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Personal supervision means a physician must be in attendance in the same room during the performance of the procedure.

(5) Can an emergency department physician or non-physician practitioner directly supervise therapeutic outpatient services while in the emergency department?

In most cases, the emergency physician or non-physician practitioner can directly supervise outpatient services so long as the emergency physician in the emergency department of the campus is immediately available, meaning that, if needed, he or she could reasonably be interrupted to furnish assistance and direction in the delivery of therapeutic services provided elsewhere in the hospital. We have stated that the supervisor must be a person who is "clinically appropriate" to supervise the therapeutic service or procedure. We believe that most emergency physicians can appropriately supervise many services within the scope of their knowledge, skills, licensure, and hospital granted privileges including observation services. With regard to whether an emergency physician or a non-physician practitioner could be interrupted, such that the emergency physician could be immediately available, each hospital will need to assess the level of activity in their emergency department and determine whether at least one emergency physician or non-physician practitioner could be interrupted to furnish assistance and direction in the treatment of outpatients.

Supervision Time Warp- 2010

(6) **Does a physician need to directly supervise therapeutic services delivered to hospital outpatients or can other non-physician practitioners directly supervise as well?**
Beginning in CY 2010, non-physician practitioners, including nurse practitioners, physician assistants, clinical nurse specialists, certified nurse-midwives, and licensed clinical social workers may directly supervise the provision of all hospital therapeutic services that that they may perform themselves within their state scope of practice and hospital-granted privileges, provided that they continue to meet all the requirements for directly providing services, including any collaboration or supervision requirements. Clinical psychologists were already permitted to directly supervise hospital services provided to an outpatient, so long as those services are within the psychologist's state scope of practice and hospital granted privileges.

One more time--- It is the code..
Not the Supervision

(7) **How will the requirement for direct physician supervision of therapeutic services delivered to outpatients affect the review of claims by contractors?**
Neither supervision nor observation services are included on the Medicare Recovery Audit Contractor (RAC) list of issues for CY 2010. The focus of each year's RAC review is identified by both contractors and CMS staff and approved by CMS. CMS will ensure that the RACs, understand that an assessment of supervision will require knowledge of the level of activity in a hospital at any point in time and the hospital's staffing structure and protocols before approving any RAC audit. We will the inform MAC staff of these issues.

Only in the case of CAHs has CMS directed its contractors not to enforce the requirement for direct supervision of outpatient therapeutic services that are furnished during calendar year (CY) 2010. CMS continues to expect CAHs to fulfill all other Medicare program requirements when providing services to Medicare beneficiaries and when billing Medicare for those services.

Supervision Time Warp- 2010

(Section 20.5.1 of Chapter 6 of the Medicare Benefits Policy Manual).

We understand hospitals' concerns, and note that we would not expect that a supervising physician would operate in a vacuum, making all decisions without informing or consulting the patient's treating physician or nonphysician practitioner. This would be illogical and inappropriate for good medical practice. However, in order to furnish appropriate assistance and direction for any given service or procedure, we continue to believe the supervisory physician or nonphysician practitioner must have, within his or her State scope of practice and hospital-granted privileges, the ability to perform the service or procedure. We believe that our interpretation of the requirement means that the supervisor must be a person who is "clinically appropriate" to supervise the service or procedure. We believe it is inappropriate for a supervisory physician or nonphysician practitioner to be responsible for patients, hospital staff, and services that are outside the scope of their knowledge, skills, licensure, or hospital-granted privileges.

This interpretation of the previously codified language is consistent with our longstanding application of direct supervision across settings in terms of the physical presence of the physician and what it means to "furnish assistance and direction throughout the performance of the procedure." We do not believe that allowing a supervisor to be responsible for emergencies only would satisfy the standard to "furnish assistance and direction throughout the performance of the procedure" as the language has historically been interpreted for physicians' offices and PBDs. We disagree with commenters who stated that the historical intent of direct supervision has been for a supervising physician to provide guidance and direction without expecting that CMS-1414-FC 968 professional to be able to perform the service or procedure and that performance of the procedure applies only to personal supervision. It would be unreasonable to think that a physician or nonphysician practitioner could competently assist and direct a procedure for which they do not have sufficient knowledge and skills to perform or redirect the procedure or service.

Define Clinically Appropriate.
This is the function of guard rails….
and CLARIFYING THE CPT CODES

RadOncs use MedOncs for direct supervision coverage. Some may not agree with it, but accept that it's a common practice.

Supervision Time Warp- 2011

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 116	**Date: December 11, 2009**
	Change Request 6751

SUBJECT: January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)

20.5.2 - Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After January 1, 2010

(Rev.116, Issued: 12-11-09, Effective: 01-01-10, Implementation: 01-04-10)

Therapeutic services and supplies which hospitals provide on an outpatient basis are those services and supplies (including the use of hospital facilities) which are incident to the services of physicians and practitioners in the treatment of patients. Such services include clinic services and emergency room services. Policies for hospital services incident to physicians' services rendered to outpatients differ in some respects from policies that pertain to "incident to" services furnished in office and physician-directed clinic settings. See Chapter 15,"Covered Medical and Other Health Services," Section 60.

To be covered as incident to physicians' services, the services and supplies must be furnished by the hospital or CAH or under arrangement made by the hospital or CAH (see §20.1.1 of this chapter). The services and supplies must be furnished as an integral, although incidental, part of the physician or non-physician practitioner's professional service in the course of treatment of an illness or injury.

The services and supplies must be furnished in the hospital or at a department of the hospital which has provider-based status in relation to the hospital under 42 CFR 413.65. As specified at 42 CFR 410.27(g), "in the hospital or CAH" means areas in the main building(s) of the hospital or CAH that are under the ownership, financial, and administrative control of the hospital or CAH; that are operated as part of the hospital or CAH; and for which the hospital or CAH bills the services furnished under the hospital's or CAH's CMS Certification Number

Supervision Time Warp- 2011

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 116	**Date: December 11, 2009**
	Change Request 6751

SUBJECT: January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)

The services and supplies must be furnished under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations, and State law, and furnished by hospital personnel under the direct supervision of a physician or non-physician practitioner as defined at 42 CFR 410.27(f) and 482.12. This does not mean that each occasion of service by a non-physician need also be the occasion of the actual rendition of a personal professional service by the physician responsible for care of the patient. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen. A hospital service or supply would not be considered incident to a physician's service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment.

The physician or non-physician practitioner that supervises the services need not be in the same department as the ordering physician. Beginning January 1, 2010, according to 42 CFR 410.27(a)(1)(iv), in addition to physicians and clinical psychologists, licensed clinical social workers, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwife may directly supervise services that they may personally furnish in accordance with State law and all additional requirements, including those specified at 42 CFR 410.71, 410.73, 410.74, 410.75, 410.76, and 410.77. These non-physician practitioners are specified at 42 CFR 410.27(f).

Supervision Time Warp- 2011

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 116	Date: December 11, 2009
	Change Request 6751

SUBJECT: January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)

For services furnished in the hospital or CAH or in an on-campus outpatient department of the hospital or CAH, as defined at 42 CFR 413.65, "direct supervision" means that the physician or non-physician practitioner must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or non-physician practitioner must be present in the room when the procedure is performed. This definition is specified at 42 CFR 410.27(a)(1)(iv)(A). For pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services, direct supervision must be furnished by a doctor of medicine or osteopathy, as specified at 42 CFR 410.47 and 410.49, respectively.

For services furnished in an off-campus outpatient department of the hospital or CAH, as defined at 42 CFR 413.65, "direct supervision" means the physician or non-physician practitioner must be present in the off-campus provider-based department of the hospital or CAH and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or non-physician practitioner must be present in the room when the procedure is performed. This definition is specified at 42 CFR 410.27(a)(1)(iv)(B). For pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services, direct supervision must be furnished by a doctor of medicine or osteopathy, as specified at 42 CFR 410.47 and 410.49, respectively.

If a hospital therapist, other than a physical, occupational or speech-language pathologist, goes to a patient's home to give treatment unaccompanied by a physician, the therapist's services would not be covered. See Chapter 15, "Covered Medical and Other Health Services," §§220 and 230 for outpatient physical therapy and speech-language pathology coverage conditions.

Supervision Time Warp- 2020

January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters Number: MM11605 Revised
Related Change Request (CR) Number: 11605
Related CR Release Date: February 4, 2020
Effective Date: January 1, 2020
Related Transmittal Number: R4513CP & R267BP
Implementation Date: January 6, 2020

Specifically why ASTRO wants to revert to 2010 and not 2020.
But still have no code Clarification

7. Supervision of Outpatient Therapeutic Services

The generally applicable minimum required level of supervision for hospital outpatient therapeutic services will change on January 1, 2020, from direct supervision to general supervision for services furnished by all hospitals and Critical Access Hospitals (CAHs). General supervision is defined in regulation at 42 Code of Federal (CFR) 410.32(b)(3)(i) to mean that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure. All the policy safeguards that have been in place to ensure the safety, health, and quality standards of the outpatient therapeutic services that beneficiaries receive will continue to be in place under our new policy. These safeguards include allowing providers and physicians the discretion to require a higher level of supervision to ensure a therapeutic outpatient procedure is performed without risking a beneficiary's safety or their quality of the care, as well as the presence of outpatient hospital and CAH Conditions of Participation (CoPs), and other state and federal laws and regulations.

Also, as we noted in the CY 2020 OPPS final rule, establishing general supervision as the default level of physician supervision for outpatient therapeutic services does not prevent a hospital or CAH from requiring a higher level of supervision for a particular service if they believe such a supervision level is necessary. Providers and physicians have flexibility to require a higher level of physician supervision for any service they furnish if they believe a higher level of supervision is required to ensure the quality and safety of the procedure and to protect a beneficiary from complications that might occur.

Supervision- Novitas

Look we got it right……. Not JUST a Physician

LCD Information

Document Information

LCD ID
L36711

LCD Title
Intensity Modulated Radiation Therapy (IMRT)

Proposed LCD in Comment Period
N/A

Source Proposed LCD
DL36711

Original Effective Date
For services performed on or after 12/01/2016

Revision Effective Date
For services performed on or after 01/01/2021

- The radiation oncology physician's treatment protocol must indicate parameters under which treatment may proceed at the discretion of the qualified technical personnel, and clearly indicate situations under which the qualified radiation oncology physician must be contacted before treatment is provided.
- The qualified radiation oncology physician, if not physically present in the radiation treatment center, must be immediately available by telephone or other electronic means of communication and must be able to receive and remotely review guidance images allowing the qualified physician to provide advice and/or treatment modification before treatment is provided in situations requiring radiation oncology physician contact.
- The qualified radiation oncology physician must review and approve guidance images that were produced prior to each daily treatment within 24 hours or prior to the next treatment delivery.
- The qualified radiation oncology physician must personally evaluate each patient undergoing radiation treatment on a weekly basis, and provide direct supervision of radiation treatment delivery of all patients being treated at least twice during each calendar week of therapy.

Hence, a qualified physician for this service is defined as follows: Training and expertise must have been acquired within the framework of an accredited residency or fellowship program in the applicable specialty/subspecialty, i.e., radiation oncology. IMRT planning and Multileaf collimator device for IMRT design and construction are highly technical services and expected to be performed onl by radiation oncologists. The delivery of treatment services included in this LCD should be supervised as outlined above.

March 2024

Partial list of organizations supporting making the current levels of Supervision (per CMS definition) permanent (list not comprehensive)

National Rural Health Association

February 21, 2023

Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: End of the Public Health Emergency and Associated Flexibilities

assistant with proof of coursework towards certification.

- **HHS should modify 42 C.F.R. § 410.32(b)(3)(ii) to make virtual supervision by a physician (or non-physician practitioner [NPP] as allowable under state law) for diagnostic tests that need direct supervision available permanently at hospitals and CAHs.** Currently, this flexibility will terminate at the end of the calendar year in which the PHE ends.

Telehealth

In general, NRHA supports the expanded use of telehealth available during the PHE. We were pleased to see the extension of Medicare telehealth flexibilities through December 31, 2024, in the Consolidated Appropriations Act of 2023 (CAA, 2023), but encourage HHS to work with Congress to make such changes permanent. Notably, NRHA asks that HHS do the following:

NRHA-PHE-unwinding-letter-2-21-23.pdf (ruralhealth.us)

Telehealth

Many of the following telehealth flexibilities were extended by Congress for 151 days beyond the expiration date of the COVID-19 PHE. **We urge Congress to make these waivers permanent, as they represent critical advancements in care delivery.**

- Eliminate the originating and geographic site restrictions for all telehealth services.
- Allow rural health clinics and federally qualified health centers to continue to serve as distant sites for all telehealth services beyond mental health services.
- Expand telehealth eligibility to certain practitioners, such as respiratory, physical, occupational and speech language therapists.
- Allow providers to deliver all Medicare telehealth services (beyond mental health services) via audio-only communications when medically appropriate.
- Allow hospice and home health professionals to deliver telehealth services and qualify telehealth, including audio-only, visits to meet existing face-to-face requirements.
- Allow direct supervision through telecommunications technology for specified services.
- Allow hospital outpatient departments (HOPDs) and critical access hospitals to bill for telehealth services; or, alternatively, clarify the Health and Human Services Secretary's authority to enable hospitals to bill for outpatient psychiatry programs and other outpatient therapy services delivered through remote connection.
- Allow hospitals to bill the originating site fee when hospital-based clinicians provide telehealth services to patients at home who would normally receive services at an HOPD.

American Hospital Association™

Advancing Health in America

[Fact Sheet: COVID-19 Waivers Should Be Extended, Made Permanent or Enacted to Improve Patient Care | AHA]

AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900

September 11, 2023

In tandem, maintaining virtual direct supervision increases access to quality care. For example, virtual supervision allows physicians to supervise clinical staff across multiple campuses, which increases patient access to care; teaching physicians can access patient data during the encounter for more thorough supervision; and patients can more easily maintain continuity of care. APA conducted listening sessions with partner organizations – the American Association of Chairs of Departments of Psychiatry and the American Association of Directors of Psychiatric Residency Training – on this topic and **no departments of psychiatry that APA has yet spoken to support the removal of virtual supervision of residents.** APA

https://www.psychiatry.org/getattachment/33c95719-10d3-423d-a49d-353a0c5b7f5b/APA-Letter-CMS-2024-Medicare-PFS-QPP-Response-09112023.pdf

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CMS states it intends to monitor the use of interactive audio/video real-time communications technology to meet the direct supervision requirement through the PHE. The professional societies believe it will be evident that the quality and safety of pulmonary, cardiac, and intensive cardiac rehabilitation services are not negatively affected and, in fact, access to these services is improved with a virtual option for direct supervision.

Sincerely,

American Association for Cardiovascular and Pulmonary Rehabilitation
American Association for Respiratory Care
American College of Cardiology
American Heart Association
American Thoracic Society
CHEST/American College of Chest Physicians

https://www.acc.org//-/media/Non-Clinical/Files-PDFs-Excel-MS-Word-etc/2021/04/14/Level-of-supervision-Hospital-and-Ambulatory-Policy-Group.pdf

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@MSKCancerCenter

PRO virtual supervision

Memorial Sloan Kettering Cancer Center

Submitted electronically via regulations.gov

September 13, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS-1751-P

Expiration of PHE Flexibilities for Direct Supervision Requirements
CMS should permanently extend its policy revising the definition of direct supervision to include the virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology. Clinician judgment as to the appropriateness of virtual – rather than physically proximate – supervision will provide an important guardrail. Additional guardrails, such as identifying specific categories of services for which virtual supervision is not appropriate, may also be useful.

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American Urological Association

Virtual Direct Supervision

CMS' current policy is that virtual direct supervision will be permissible through December 31 of the year the COVID-19 PHE concludes. In preparation, the agency has requested stakeholder feedback on whether virtual direct supervision should be permitted permanently and if it should only apply to a subset of services. AUA members have been utilizing this flexibility and providing direct supervision remotely successfully throughout the COVID-19 pandemic. Specifically, they have provided virtual direct supervision for both procedures, like placing a catheter or passing a cystoscope, and E/M services, allowing those qualified health professionals being supervised to practice to the top of their licenses. According to our members, they have virtually supervised their physician assistants who are performing hospital rounds and provided direct supervision from a different office location, allowing them to expand the number of patients treated. This flexibility is a valuable tool to improve patient access, particularly in rural and underserved areas experiencing urologist shortages. While the AUA does not have any efficacy or safety data to share, our members have provided anecdotal information on instances when they have provided supervision virtually and directed patients to go from the office to the emergency room. The AUA welcomes the opportunity to work closely with CMS as a final policy is being developed.

tps://www.auanet.org/advocacy/get-involved/comment-letters-and-resources/physician-payment-and-coverage-issues/aua-comments-to-cms-on-2023
roposed-medicare-physician-fee-schedule

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American College of Allergy, Asthma & Immunology

The PHE concluded on May 11, 2023. **Under the Proposed Rule, CMS would continue to permit the use of real-time, interactive audio and video telecommunications to satisfy the direct supervision requirement through Dec. 31, 2024.** If adopted, the direct supervision requirement would be met if a practitioner is "immediately available" through real-time audio and video interactive communication. ***CMS is soliciting comments on whether this extension of the definition of direct supervision to permit virtual presence should go beyond Dec. 31, 2024.***

The Advocacy Council strongly supports this proposal and urges CMS to permanently adopt this policy. This would facilitate greater efficiencies in the workforce.

https://college.acaai.org/2024-proposed-medicare-physician-fee-schedule-impact-on-allergy-practices/

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SCAI
Society for Cardiovascular Angiography & Interventions

Submitted electronically via: http://www.regulations.gov

Physicians are clearly in the best position to determine whether virtual direct supervision can be provided safely and effectively to their patients based on their medical needs, and they should be given the flexibility to make those decisions on a case-by-case basis. Therefore, CMS should continue to allow physicians the ability to make decisions based clinical judgment as to whether a service is appropriate for virtual direct supervision.

https://scai.org/sites/default/files/2023-09/SCAI%202024%20MPFS%20comments.pdf

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At the same time, the AHA applauds CMS' proposals to extend through 2024 many of the COVID-19 telehealth flexibilities. In addition, the AHA continues to encourage CMS to work with Congress on permanent adoption of waiver provisions such as eliminating the originating and geographic site restrictions for all telehealth services and expanding telehealth eligibility to certain practitioners. We also encourage CMS to leverage its existing statutory authority to make permanent other waivers as appropriate.

https://www.aha.org/system/files/media/file/2023/09/aha-comments-on-cms-physician-fee-schedule-proposed-rule-for-calendar-year-2024-letter-9-11-23.pdf

@drbeckta / jason@coldlight.org

University Hospitals
@DrSpratticus et al

PRO virtual supervision

University Hospitals
Cleveland | Ohio

September 13, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements (CMS-1751-P)

IV. Supervision requirements: expanding permissible modalities

For the duration of the PHE, and consistent with the interim final rule making, CMS adopted a policy revising the definition of "direct supervision" to include virtual presence of the supervising physician or practitioner using interactive audio-visual real-time communications technology. In the CY 2021 PFS final rule, CMS finalized the continuation of this policy through the later of the end of the calendar year in which the PHE ends or Dec. 31, 2021. In the CY 2022 PFS proposed rule, CMS seeks comment on whether it should make this flexibility permanent. ***UH strongly urges CMS to make this flexibility permanent.***

Continuing this policy will reduce risk exposing patients and providers to infectious diseases (e.g., COVID-19, seasonal flu, and others),[19] enhance the workforce capacity of teaching in various settings, increase access to professional supervision for the future physician workforce to develop competencies and gain relevant experience,[20] and ultimately improve access to and quality of care for patients. Furthermore, it is important for medical residents and other trainees to gain experience with telehealth visits while being supervised as they will be providing telehealth services in the future to their patients when they practice on their own.

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California Medical Association

PRO virtual supervision

2. **Telehealth and Audio-Only Expansions Should be Made Permanent**

CMA strongly supports CMS' proposal to extend coverage for all services added to the Medicare telehealth services list in response to the COVID-19 PHE until the end of 2023. We also ask that the CPT codes for telephone E/M services (99441-99443), be included in the category of services which are proposed to remain on the telehealth list through 2023. In implementing the permanent telehealth services for mental health care that Congress recently enacted, CMA supports CMS' proposal to expand the definition of telecommunications system for purposes of telehealth services to include audio-only communication for mental health services.

We urge CMS to refrain from expanding the scope of practice of non-physician practitioners (NPPs) beyond that supported by their licensure, education, and training prior. We recommend that the COVID-19 PHE policy - which allows "direct supervision'' to include immediate availability through the virtual presence of the supervising physician using real-time, interactive audio/video communications technology - be made permanent.

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@Philips Healthcare

PRO virtual supervision

Expiration of Virtual Direct Supervision, PHE Flexibilities.

CMS is seeking comment on the extent to which the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology is being used during the PHE, and whether physicians and practitioners anticipate relying on this flexibility after the end of the PHE. CMS is seeking comment on whether this flexibility should potentially be made permanent.

Philips comment: Philips supports CMS' proposal to permanently amend the definition of direct supervision for telehealth services, and recommends the agency do so for hospital outpatient services and physician office services.

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AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

Ensuring Medicare Beneficiary Access: A Path to Telehealth Permanency

November 14, 2023

As telemedicine services are expanded and utilized to achieve the desired aims, it is also imperative that outcomes are closely monitored to ensure disparities in care are not widened among vulnerable populations. Policies should acknowledge the geographical and socioeconomic disparities that exist and could be exacerbated by the improper adoption of telehealth if not explicitly addressed. Access to broadband is a social determinant of health. All patients and practices should have broadband access to support delivery of telehealth services in accordance with AAFP's policy on Health Care for All. It is with these considerations in mind that the AAFP offers the following policy recommendations in response to today's hearing:

Promoting Patient-Physician Relationships

Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care, and expand access to care for rural and under-resourced communities and vulnerable populations. As discussed in the Academy's comments on the CY24 Medicare Physician Fee Schedule proposed rule and our aforementioned joint principles, **the AAFP strongly believes telehealth policies should advance care continuity and the patient-physician relationship**.

https://www.aafp.org/advocacy/advocacy-topics/health-it/telehealth-telemedicine.html

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Advocacy in action: Supporting telehealth

UPDATED DEC 8, 2023 • 4 MIN READ

COVID-19 sparked policy change and led to dramatic increases in adoption of telehealth by patients and physicians. Early in the pandemic, with strong support from the AMA, such restrictions on coverage for telehealth services were lifted by Medicare and other health plans.

That move continues to benefit patients. According to an AMA survey of more than 1,300 physicians, 80% of physicians used televisits in 2022. That's up from just 14% in 2016 and nearly triple from 2019.

Nearly 70% of doctors say they want to keep providing telehealth services. That should come as no surprise. Not only does telemedicine give more patients access to care, but research shows that telehealth and in-person diagnoses match up nearly 90% of the time,

Unfortunately, many of the telehealth flexibilities that have greatly improved patient access to care throughout the pandemic are set to expire at the end of 2024.

The AMA's position

Telehealth is critical to the future of health care, which is why the AMA continues to lead the charge to aggressively expand telehealth policy, research and resources to ensure physician practice sustainability and fair payment. And that's why supporting telehealth is an essential component of the AMA Recovery Plan for America's Physicians.

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The American Medical Association's advocacy continues to make it easier for physicians to expand care to their patients via telehealth and receive fair compensation for their services.

Expanding access, coverage, and payment:

- Telehealth availability to Medicare patients nationwide, wherever they are located including in their homes.
- Secured (PDF) legislation extending telehealth flexibilities in Medicare through December 2024 via enactment of the Consolidated Appropriations Act of 2023, which lifts geographic and originating site restrictions, extends Medicare coverage of audio-only services, delays the in-person visit requirements for tele-mental health services, and extends the Acute Hospital Care at Home program, all policies strongly supported by the AMA.
- Telehealth payment rates increased to in-person visit rates through 2023.
- Remote monitoring covered for acute and chronic conditions.

- CPT® codes for audio-only visits approved for coverage throughout COVID-19 Public Health Emergency, with payment rates equivalent to established patient visits. Advocating for this coverage to remain in place through at least 2024.
- Private payers continue to follow Medicare's guidance to ensure access to care for patients.
- Permanently expanded CMS definition of equipment that can be used for telehealth to include smart phones that are capable of two-way real-time interactive communication.

https://www.ama-assn.org/practice-management/digital/advocacy-action-supporting-telehealth

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Those Opposed x 2

ASTRO advocates for a return to direct supervision

March 1, 2024

On February 26, ASTRO submitted a comment letter to the Centers for Medicare and Medicaid Services (CMS) urging the Agency to apply direct supervision requirements (not virtual supervision) to all radiation oncology services in all sites of service. In the letter, ASTRO recognized that for many procedures and services, virtual supervision is safe and often increases access to care. However, for more intensive procedures, like radiation therapy, virtual supervision jeopardizes patient safety and quality and provides little benefit in access to care.

In prior rulemaking, CMS stated that there is an "*absence of evidence that patient safety is compromised by virtual direct supervision…,*" but ASTRO disagrees and provided real-world clinical examples demonstrating the importance of the in-person radiation oncologist in providing radiation therapy. Certainly, there needs to be flexibility for situations such as participating in tumor boards, or to ensure that patients in rural areas have access to treatments, but direct supervision is the safest approach for high-quality radiation therapy, the letter said.

Read the letter for more information.

ASTRO
AMERICAN SOCIETY FOR RADIATION ONCOLOGY

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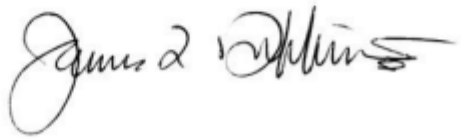
The AAPM does <u>not</u> support continued use of real-time, interactive audio and video technology once the COVID-19 public health emergency (PHE) has concluded. CMS should revert back to the pre-COVID definition and interpretation of Direct Supervision.

Appropriate payment for medical physics services, radiology and radiation oncology procedures is necessary to ensure that Medicare beneficiaries continue to have full access to diagnostic imaging and high-quality cancer treatments. We hope that CMS will consider these issues for the 2022 Medicare Physician Fee Schedule final rule. Should CMS staff have additional questions, please contact Wendy Smith Fuss, MPH at (904) 844-2503.

Sincerely,



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AGAINST virtual supervision

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BRIDGE
ONCOLOGY

Contact Us to Discuss:
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Thank You