Preparing For The Future Of Virtual Direct Supervision

By **Justin Brown, Dante Lizza and Shannon Wiley** (July 7, 2023)

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Virtual direct supervision — the Medicare payment policy that allows direct supervision through real-time audio-visual technology, rather than in-person presence — has been widely used over the past several years.

A product of the COVID-19 public health emergency flexibilities, this temporary policy has allowed physicians and nonphysician practitioners to remotely supervise diagnostic tests and items and services furnished incident to their professional services.

Although May 11 marked the end of the public health emergency, virtual direct supervision is permitted at least through the end of 2023. As we approach midyear, and with several significant rules expected soon, we should learn soon whether the Centers for Medicare & Medicaid Services remains open to making virtual direct supervision a permanent payment policy.

For the many stakeholders who have relied on virtual direct supervision, CMS' decision will weigh heavily on access to and delivery of care, as well as their operations and finances.

If the policy ends, some may find that, overnight, their satellite locations are — or their entire care delivery model is — no longer viable. Worse, this news could come at the end of the year, leaving health care providers and patients scrambling.

But many hope that CMS will either make virtual direct supervision a permanent fixture of Medicare payment policy or, if not, at least extend the flexibility for another year. Extending it would allow CMS to continue studying outside the public health emergency whether and how to make virtual direct supervision permanent.

Temporary Virtual Direct Supervision Flexibilities

Medicare payment rules require physicians and nonphysician practitioners to provide direct supervision for certain items and services, including some diagnostic tests and so-called incident-to services — i.e., services and supplies furnished incident to a physician's or nonphysician practitioner's professional services.

Traditionally, at least in the office setting, "direct supervision" meant the supervising practitioner had to be physically present in the office suite, though not necessarily the same room, and immediately available to direct and assist the supervised service.

Then came the public health emergency. Concerned that requiring physical presence could impede access to care, CMS temporarily revised "direct supervision" to allow supervision through real-time audio-visual technology, rather than in-person presence.[1]

Just as in-person direct supervision does not require presence in the same room as the personnel performing the service, virtual direct supervision does not require the real-time observation of the supervised service. Instead, it requires the supervising practitioner to be immediately available to engage via audio-video technology to assist and direct the service.[2]

With this flexibility, physicians and nonphysician practitioners have been able to remotely supervise services furnished in patients' homes and satellite locations more convenient to patients. These services include not only diagnostic tests requiring direct supervision, but also items and services furnished incident to a practitioner's professional services.

Intersection with Incident-To Requirements

A statutory benefit, Medicare covers not only the services of physicians and nonphysician practitioners, but also services and supplies incident to their professional services.[3]

Aside from limited exceptions — such as designated care management services and, recently, behavioral health services — Medicare generally requires physicians and nonphysician practitioners to provide direct supervision for incident-to services.[4]

To understand the broader context, it is helpful to highlight two commonplace incident-to scenarios.

The first is when practitioners bill for items or services — such as drugs that are not ordinarily self-administered — that, absent the incident-to benefit, would otherwise not be payable under Medicare Part B.

The second is when a practitioner bills for items or services performed by other personnel — auxiliary personnel, in the incident-to parlance — in the practitioner's own name, as if they were furnished personally by the practitioner.[5]

Both scenarios reflect the realities that physician and nonphysician practitioner practices furnish items and services in addition to those of the physician or nonphysician practitioner, and practices use other clinicians to furnish items and services.

Even if state law, standards of care and other third-party payors would allow the services to be furnished without supervision or with a lower level of supervision, Medicare payment rules for incident-to services still require direct supervision — which, before the public health emergency, meant in-person presence.

As a result, an in-person direct supervision requirement naturally limits incident-to services to circumstances where a supervising practitioner can always be physically present, which is not always feasible, e.g., patients' homes.

The Future of Virtual Direct Supervision

Now, with over three years of virtual direct supervision to draw from, many stakeholders hope CMS will embrace virtual direct supervision, while others oppose it.

In recent Medicare physician fee schedule rules, CMS has solicited comments, weighing whether to extend the policy and, if it does, what safeguards it should adopt.

Although CMS has not clearly signaled whether it will extend virtual direct supervision, the main issues it appears to be grappling with relate to quality and safety concerns as well as program integrity concerns.

In terms of quality and safety, some argue that practitioner physical presence is necessary. Others argue that CMS should rely on practitioners' professional judgment to determine, in each case, whether remote supervision is clinically appropriate or whether in-person presence is required.

State licensure requirements and scope of practice limitations play an important role, they argue. Comprehensive professional licensing regimes regulate who can do what and in what circumstances, and the incident-to rules incorporate these rules by requiring the items and services to be furnished in accordance with state law.[6]

Medicare also permits some providers and suppliers to furnish services — such as home health services and home infusion therapy — without the direct supervision of physicians or nonphysician practitioners. This, some may argue, discounts broad-based safety and quality objections to permitting virtual direct supervision.

Program integrity concerns with virtual direct supervision are primarily aimed at remote supervision for incident-to services.

One concern is that allowing remote supervision will lead to overutilization of incident-to services, particularly physicians billing nonphysician practitioners' services on an incident-to basis, rather than nonphysician practitioners' services being billed in their own names.

Requiring in-person supervision does naturally limit incident-to services, because practitioners cannot be everywhere at once, at least not physically. Some argue this natural limitation is beneficial from a program integrity standpoint.

On the other hand, requiring in-person supervision may not be the best tool to limit utilization, particularly in circumstances where remote supervision is clinically appropriate.

Other incident-to requirements, after all, are rigorous.[7] Services billed incident-to must be an integral, although incidental, part of the treating practitioner's professional services for the patient. The treating practitioner — which is not always the supervising practitioner[8] — must first establish a course of diagnosis or treatment for the patient, and the incident-to service must be part of, i.e., incidental to, the course of treatment.

As such, incident-to billing is generally unavailable for new patients or existing patients with new conditions, because those services are not incident to the treating practitioner's professional services. This fundamental requirement limits incident-to services to those items and services that are, in fact, incident to the treating practitioner's professional services.

Ultimately, CMS will need to consider the favorable aspects of virtual direct supervision — such as the flexibility to expand the roles of nurses and other clinical personnel, who some predict will be increasingly important to delivering high-quality primary care and achieving health equity[9] — and weigh these against the quality and safety and program integrity concerns.

If CMS favors the former but views existing requirements as inadequate to address the latter, it may impose additional safeguards. Limiting the items or services for which practitioners can

provide virtual, rather than in-person, direct supervision is one possibility.

Another possibility is to provide guidance on the "immediately available" aspect of direct supervision in the virtual supervision context by limiting the number of auxiliary personnel a practitioner can supervise at a given time, to ensure the practitioner is, in fact, immediately available.

Yet another possibility is to extend the remote supervision flexibility for a limited time to continue studying its feasibility. This is similar to the approach MedPAC suggested for certain telehealth flexibilities,[10] and the Consolidated Appropriations Act extended many of them by statute through 2024.

A co-extensive virtual direct supervision flexibility could give CMS not only more time and data for virtual direct supervision, but also a more complete picture of the interplay between these two sets of flexibilities. This, in turn, could be invaluable to innovating care delivery through clinicians other than physicians and nonphysician practitioners.

Preparing for the Future of Direct Supervision

In today's world, where real-time audio-visual technology is used by many, clinical staffing shortages are widespread, and auxiliary personnel can play an increasingly important role in care delivery, reverting to an in-person supervision requirement could present a barrier for health care providers who have embraced virtual direct supervision.

As we approach 2024, health care providers should prepare for the possibility that CMS may not extend virtual direct supervision, or even if it does, its extension may be temporary.

Meanwhile, CMS and its contractors may more proactively monitor utilization and audit virtual direct supervision, not just as part of its routine program integrity measures, but also to gauge its continued viability. For those who rely on virtual direct supervision, we offer a few suggestions:

1. Ensure you adequately document virtual direct supervision. Maintain a record of not only who provided the service but also who provided virtual direct supervision, perhaps in a module or schedule, and document any contact between the supervising practitioner and performing personnel.

2. Depending on the size and scale of your practice, as well as the frequency of virtual direct supervision use, consider developing written policies and procedures for virtual direct supervision that demonstrate when, where, and why virtual direct supervision is clinically appropriate.

3. In anticipation of a potential reversion to in-person direct supervision, review current staffing schedules and capacity to determine needs for additional staff. Determine the financial impact and patient access issues that may arise if virtual direct supervision is no longer an option.

When the proposed Medicare physician fee schedule for calendar year 2024 is released, we encourage stakeholders to comment on virtual direct supervision. This area is one where, as CMS has indicated in prior rulemaking commentary, it would be particularly beneficial to hear from stakeholders.

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[1] CMS, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 Fed. Reg,19230, 19245 (Apr. 6, 2020).

[2] See 42 C.F.R. § 410.32(b)(3)(ii). See also CMS, Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 85 Fed. Reg. 84472, 84539 (Dec. 28, 2020).

[3] See Social Security Act, §§ 1832(2)(B), 1861(s)(2)(A).

[4] See 42 C.F.R. § 410.26(b)(5).

[5] See 42 C.F.R. § 410.26(a)(1). Auxiliary personnel can be any individual who, under state law, can perform the service under the supervision of a physician or NPP. These, for example, may be registered or licensed practical nurses, who generally cannot bill in their own names. Or they may be practitioners who can bill in their own names, such as nurse practitioners or physician assistants that, when billed incident to a physician's professional services, are paid at 100% of the physician fee schedule (rather than 85% when billed by the nurse practitioner or physician assistant).

[6] 42 C.F.R. § 410.26(b)(7).

[7] See generally 42 C.F.R. § 410.26; CMS, Medicare Benefit Policy Manual, Pub. No. 100-02, Chapter 15, § 60.

[8] See 42 C.F.R. § 410.26(b)(5) (providing that the "physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) who is treating the patient more broadly[,]" but "only the supervising physician (or other practitioner) may bill Medicare for incident to services"); Medicare Benefit Policy Manual, Chapter 15, § 60.3 (discussing incident-to billing in the physician-directed clinic context).

[9] See, e.g., National Academies of Sciences, Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care (2021), available at: https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health; National Academies of Sciences, The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity (2021), available at: https://nap.nationalacademies.org/catalog/25982/the-future-of-nursing-2020-2030-charting-a-path-to. See also CMS Strategic Plan (last mod. May 16, 2023), available at: https://www.cms.gov/cms-strategic-plan (including as "strategic pillars" advancing "health equity by addressing the health disparities that underline our health system" and driving "innovation to tackle health system challenges and promote value-based, person-centered care").

[10] See MedPAC, Report to the Congress: Medicare Payment Policy, Chapter 14, Telehealth in Medicare After the Coronavirus Public Health Emergency (Mar. 2021).