

## Medicare Physician Supervision Requirements Frequently Asked Questions

**Q:** Can the radiation oncologist be elsewhere in the facility during the delivery of the patient’s radiation therapy?

**A:** To meet direct supervision requirements, the supervising physician must be present on the same hospital campus (including a physician’s office or 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.

**Q:** Can the CMS requirements for supervising physician be fulfilled using a physician assistant in the field of radiation oncology or nurse practitioner in the field of radiation oncology, or a physician that is not in the field of radiation oncology, such as a medical oncologist?

**A:** Medicare only permits physicians to supervise diagnostic services, including image-guidance procedures, and specifically restricts non-physician practitioners such as physician assistants and nurse practitioners from providing supervision. As image guidance is integral to radiation treatment delivery, Medicare therefore effectively limits supervision of radiation therapy to physicians. The supervising physician must not only have the capacity to respond to an emergency but also have the ability to take over performance of a procedure or provide additional orders. CMS has indicated that the supervising physician must be a person who is “clinically appropriate” to supervise the service or procedure and must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure – therefore, a non-radiation oncologist physician must meet all of the above requirements to supervise radiation therapy. It is ASTRO’s view that the radiation oncologist would always be considered a clinically appropriate supervising physician; however, we recognize that some flexibility is necessary for those practices that deliver care to underserved populations who may experience access to care issues.

**Q:** When a patient undergoes a multiple fraction course of SBRT (i.e. 5 daily treatments), how often must they be seen in person by the radiation oncologist? Must the physician see the patient after each fraction of SBRT in order to be compliant? Or just after the final fraction?

**A:** The physician work for CPT 77435, Stereotactic body radiation therapy, treatment management, can be summarized as follows: “The radiation oncologist evaluates the patient prior to the procedure. Under the direct supervision of the radiation oncologist, the patient is set up on the treatment table, and all the treatment parameters are verified. Image guidance, and respiratory correlation, if required, may be achieved through a variety of methods, all of which are supervised, corrected and approved in real-time by the radiation oncologist. The radiation oncologist assesses and approves all of the ongoing images used for localization, tumor tracking, any gating application, as well as any complementary single (beam’s eye) view localization images for any of the fields or arcs that are arranged to deliver a dose. The radiation oncologist remains available throughout SBRT treatment to manage the execution of the treatment and make real-time adjustments in response to patient motion, target movement or equipment issues to ensure accuracy and safety. The physician also evaluates the patient post-procedure.

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**Q:** Is the physician required to be physically on-site at the time a treatment plan is being signed? For instance, if Dr. A performs the consultation, simulation, contouring, reviews the plan and verbally approves but Dr. A is not on-site because he's off on Friday and the patient starts on Monday, must Dr. B sign the plan to remain compliant?

**A:** In the hospital outpatient setting, the physician is not required to be physically on-site to approve and sign a dosimetric treatment plan in order to support Medicare billing. As of Jan 2020, CMS requires general supervision by an appropriate physician or non-physician practitioner in the provision of all therapeutic services to hospital outpatients. General supervision means 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. Following simulation, the components of work in the development of a treatment plan – review of the acquired image set(s), outlining and adjusting target volumes, specifying dose limits to normal organs, and evaluating and modifying the treatment plan – are performed in an iterative manner over time that may extend several days. This work, including the physician's plan approval and signature, may therefore be accomplished electronically without requiring the physician's physical presence in the same department as the technical staff while the treatment plan is being developed. *Note: This answer is only applicable to the HOPD setting. For free-standing radiation therapy centers, a direct supervision requirement applies to the development of a dosimetric treatment plan and other therapeutic services; however, plan approval and signature may be provided remotely by the ordering physician if the supervision requirement for plan development is met.*

**Q:** Can a radiation oncologist bill for the professional component (PC) of IGRT if the physician reviews the images from a location outside of the clinic?

**A:** In the hospital outpatient setting, a radiation oncologist may report the professional component (PC) of IGRT if the work is performed at a different location than where the technical component (TC) of the service was furnished. Chapter 13 of the Medicare Claims Processing Manual, [Radiology Services and Other Diagnostic Procedures](#) - with additional clarification provided by an April 2013 CMS FAQ - allows for PC and TC billing if performed at different locations. The Manual specifies that if a physician's interpretation is billed separately from the TC, modifier -26 must be appended to the reported code and the claim form must report the address and ZIP code of the interpreting physician's location. If the professional interpretation is performed at, "an unusual and infrequent location for example, a hotel, the locality of the professional interpretation is determined based on the Medicare enrolled location where the interpreting physician most commonly practices." *Note: This answer is only applicable to the HOPD setting. For free-standing radiation therapy centers, global billing of IGRT (i.e., no appended modifiers are used) is permitted if the physician reviews images at a location away from the center and if the physician and center bill under the same tax ID.*

**Q:** Can the PC component of IGRT be billed under a different physician's name from the one associated with the treatment delivery billing?

**A:** CMS classifies IGRT as a diagnostic service and therefore applies its split Professional (PC)/Technical Component (TC) billing rules that allow the PC to be performed off-site from the TC. For those diagnostic PC/TC services that require direct supervision (e.g., real-time availability to correct patient setup during IGRT, manage contrast reactions during CT imaging, etc.), CMS allows a physician employed under the same tax ID as the billing physician to provide on-site supervision while the off-site

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billing physician documents the work he/she personally performed and then bills the PC under the offsite physician's NPI.

For hospital outpatient department TC services such as treatment deliveries, the organization's (i.e, the facility's) NPI usually is entered as the billing provider on a CMS-1450 claim form. This claim form also provides a data field to enter the name and NPI of the "Attending Provider", which Chapter 25 of the Medicare claims Processing Manual defines as "the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/encounter" but does not specify if the provider is the supervising or prescribing physician. As such, either the NPI of the present physician or of the prescribing physician may be entered as the Attending Physician, provided that both physicians share the same group tax ID.