

The use of nonphysician practitioners



Medicare Part B covers and pays for the services of physicians and certain other health care practitioners provided to beneficiaries aged 65 and older. Like any government program, these benefits have specific limitations. A limitation that is important to interventional radiologists concerns whether a particular procedure must be performed by a licensed physician, rather than a nonphysician practitioner. IRs are well served to learn and follow these Medicare rules in order to avoid costly overpayments and refunds.

In a hospital setting, nondiagnostic procedures typically performed by IRs (non-70000 CPT codes) must be performed by a physician. A physician submits claims for reimbursement for these federal programs on Form CMS-1500. Section 24J of the Form CMS-1500 requires the “rendering provider id#.” Definitions that accompany the Form CMS-1500 indicate that the *rendering provider* is the individual who provided the care and that the “Rendering Provider does not include individuals performing services in support roles, such as lab technicians or radiology technicians.”

In addition to these instructions, the Form CMS-1500 states, in pertinent part:

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me **or were furnished incident to** my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare... regulations.

In order to comply with this certification, it is important to distinguish between services performed in a hospital outpatient setting and those services performed in a physician’s own office. Although the Medicare program permits a physician to bill for services performed by nonphysician, auxiliary personnel “incident to” a physician’s professional services, this “incident to” billing rule only applies for services performed in a physician office setting.¹ Medicare Part B does not cover or pay for services performed by physician-employed, auxiliary personnel in a hospital setting, even if the physician supervises the performance of the services.² Because “incident to” services are not covered in

the hospital setting, **the physician’s personal performance of the service is required.**

When a group’s services are performed exclusively within the hospital’s inpatient and outpatient settings there is no opportunity for a radiology extender to perform procedures “incident to” a radiologist’s professional services. Only physician assistants (PAs) and nurse practitioners (NPs), who are permitted to separately enroll in the Medicare program, may perform services in a hospital setting and be billed by the physician practice for those services. The Medicare program does not recognize radiologist assistants (RAs) and radiology practitioner assistants (RPAs) as being physician extenders who may bill for their own services and be reimbursed at 85 percent of the Medicare Physician Fee Schedule. For several years, legislation has been introduced in Congress to address this specific issue.³ If such a law were passed, the Medicare program would pay for the services of an RA or an RPA in the same manner as NPs and PAs, an outcome that would benefit many IRs, RAs and RPAs, alike.

The Medicare program has also adopted rules governing the coverage and payment of diagnostic tests. Diagnostic tests must be performed under the appropriate level of **physician** supervision that is designated by the CMS.⁴ PAs, NPs, RAs, or RPAs cannot replace a physician for purposes of supervising the performance of a diagnostic test.

Although the Medicare Benefit Policy Manual states that PAs and NPs “are not permitted to function as supervisory ‘physicians’ for the purposes of other hospital staff performing diagnostic tests,” PAs and NPs can perform a diagnostic test for Medicare hospital outpatients. RAs and RPAs do not have the same legal authority. Consequently, if permitted by state law, a PA or NP (but not an RA or RPA even if permitted by state law) can **perform**, for example, the imaging guidance required for a procedure they are also performing for a Medicare hospital outpatient, providing they are not supervising a technologist in that regard.

In the physician office setting, the Medicare program pays for auxiliary personnel, such as an RA or RPA, to provide nondiagnostic procedures (i.e., physician services) to a Medicare patient if such service is “incident to” a physician’s

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service. Any services the radiologist extender performs in a physician office setting or freestanding imaging center that are not diagnostic testing services must be performed under a physician's direct supervision.⁵

In order for the radiologist extender's services to be covered "incident to" the services of a physician, the procedure must be: 1) an integral, although incidental, part of the physician's professional services; 2) commonly rendered without charge or included in the physician's bill; 3) of a type that is commonly furnished in physicians' offices or clinics; and 4) furnished under the physician's direct supervision. Direct supervision in the office setting means the physician must be present in the office suite and immediately available and able to provide assistance and direction throughout the time the service is performed. Direct supervision does not mean that the physician must be present in the same room with his or her aide.⁶

Only those procedures that are within the RA's or RPA's scope of practice (and for which the individual is qualified to perform) may be furnished as an incident to service by that radiologist extender. As noted above, RAs and RPAs may not perform

interventional radiology services that bill as physician services in a hospital setting.

The Medicare coverage and payment rules are complex—and quite arcane—but it is essential that IRs try to understand them and to be compliant in working with physician extenders. ^{IRQ}

References

1. See Medicare Benefit Policy Manual, Pub. 100-02, Ch 15, §60.1.
2. See Social Security Act § 1861(s)(2)(A).
3. See e.g. "Medicare Access to Radiology Care Act"
4. See 42 C.F.R. § 410.28(e).
5. See Medicare Benefit Policy Manual (PUB. 100-02), Ch. 15, § 60.2.
6. See *id.* at § 60.1.

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