

CMS SUPERVISION REGULATIONS and BILLING

CMS has issued a Health Professional Taxonomy Code (HPTC) for the Radiology Practitioner Assistant (RPA), thus recognizing the RPAs as mid-level health care providers. By October 1, 2008 RPAs may obtain a CMS National Provider Identification Numbers (NPI#s), specifically identifying the RPA as a health care provider with the RPA scope of practice and CBRPA as the certification agency. While the NPI number does not allow the RPA to engage in separate billing, it is significant as an important step toward independent billing.

However, CMS does not state that an RPA cannot work as an advanced level technologist under the delegation clause of the state medical practice act (or physician's license). Each state has a physician licensing law and within that law under the delegation section, it states that a physician has the authority to delegate tasks and responsibilities to other health professionals, provided the health professional has the educational background and competency to perform the delegated tasks. The delegation section of the physician licensing law is the same statute the physician assistants (PAs) utilize to set the parameters of their practice.¹

Since RPAs do not bill for any procedures, the billing is done under the physician's provider number for 100% of the fee schedule. Section 1861(s)(3) of the Social Security Act, and the Medicare Benefit Policy Manual, Chapter 15 §80 states that diagnostic tests are payable under the physician fee schedule, provided the appropriate supervision levels are adhered to.^{2,3} The supervision levels are (1) general, (2) direct and (3) personal and apply if you work in an Independent Diagnostic Testing Facility or an IDTF. An "IDTF is a supplier of diagnostic tests that are independent of a hospital or a physician office." Therefore, most clinics and imaging centers are not considered to be IDTFs. An imaging facility that performs diagnostic tests does *not* have to register as an IDTF if: (1) the facility is owned by radiologists, a hospital or both, (2) the radiologists usually perform test interpretations at the location where the diagnostic tests are performed, (3) the facility does not usually purchase interpretations, and (4) the facility ordinarily bills globally.^{4,5}

The levels of supervision pertain only to freestanding sites. Hospitals are regulated through the JCAHO, internal hospital policies and through other

conditions of participation imposed by the Medicare program.⁵ According to clarification sought by the American College of Radiology (ACR) in a letter dated July 16, 2001 transmittal 1725, the supervision rule does not pertain to hospital inpatients or outpatients.⁶ The surgical codes are under the "personal" supervision level and require a physician to be "in attendance in the room." The phrase "in attendance in the room" is considered by some radiology groups as meaning that the radiologists must be present during the "critical" portion of a procedure and the radiologist determines when that time would be. The "critical portion" rendition is derived from a clarification announced in 1995 in the 60 Federal Register 63124, 1995 and 42 CFR §415.180, 2002 in relationship to supervision of residents. The regulation further states that the "documentation must indicate that the physician personally performed the interpretation."^{7, 8}

Recently, some attempts have been made to apply the S & I (Supervision and Interpretation) section of the Medicare regulations to the functions of the RPA. The S & I regulations describe situations wherein two *physicians* are involved in the same procedure. The regulations state that the *physician* providers then have to use a - 52 modifier code for billing, meaning that each physician bills for one-half fee for a reduced service in regard to the procedure. "Supervision (S) can be thought of as 'the person/physician who performs the procedure' or exam. The interpretation (I) should be viewed as 'the person/physician who provides the reading and generates the report'"⁹ However, RPAs do *not* bill for procedures *nor* provide interpretations, so the S & I section of the Medicare regulations do not apply. The Medicare Claims Processing Manual, Chapter 13, §80.1 clearly states that the S & I codes "are used to describe the personal supervision of the performance of the radiologic portion of a procedure by one or more *physicians* and the interpretation of findings."^{9, 10}

References:

1. "Physician Assistants and Radiology Practitioner Assistants: The Distinctions," American Academy of Physician Assistants, www.aapa.org. Accessed September 7, 2006
2. CFR , § 410.32b and the Social Security Act §1861(s)(3).
3. Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, Section 80, "Requirements for Diagnostic X-Ray, Diagnostic Laboratory and Other Diagnostic Tests."
4. Greenleaf, Tamara,, "Should You Be an IDTF?" Imaging Economics, April, 2006. Accessed on

www.imagingeconomics.com on September 7, 2006.

5. Murray, Claudia, "Medicare's Supervision Rules," Imaging Economics, September/October, 2001. Accessed on www.imagingeconomics.com on September 7, 2006.
6. ACR Bulletin, "Clarification Given By CMS on Ordering Diagnostic Tests Rule, Supervision Rule and ICD-9 Coding Guidelines," Economics and Health Policy, November 2001.
7. Smith, John J. and Leonard Berlin, "Medicare Fraud and Abuse," Malpractice Issues in Radiology, American Journal of Radiology, March, 2003.
8. 42 CFR §415.180, 2002
9. Medical Learning, Inc. Question of the Week, Section 06.19.6 Accessed on September 21, 2006 at www.medlearn.com/qa/radarchive.htm
10. Publication 100-04, Medicare Claims Processing Manual, Chapter 13, §80.1 "Radiology Services and Other Diagnostic Tests"