EFFICIENCY AND EFFICACY OF AN RPA

The utilization of a physician extender is radiology stems from the 1970s , when programs were developed in Kentucky, North Carolina and New York. Due to lack of support from the medical community, the movement slowly deteriorated into none existence. In medical imaging, an increased work load due to advances in technology, demands from patient-consumers and a need to provide services in rural areas, accentuated the need for a mid-level health professional in medical imaging. Radiologists found their time fractionated by several imaging modalities to the extent they have difficulty providing adequate patient care.

With the assistance of concerned and futuristic leaning radiologists, the development of the RPA program and credentialing of advance practice technologists was created. In order to keep medical imaging within the "house of Radiology," only experienced radiologic technologists were admitted to the program. The results of having an RPA within a department has been rewarding.

Efficiency

A research project was conducted by four RPAs in their respective departments (in Florida, Texas, California and Pennsylvania) in order to provide empirical data as to how an RPA can save the radiologist both time and increase revenue. Lists of procedures commonly done in departments and performed by RPAs was kept for a period of four months to provide valid data. The time needed for a radiologist to perform the procedures and the time taken for interpretation were also collected. This data was used to also determine the time saved by the RPA performing the procedures allowing more time for the radiologists to do additional interpretations. Taking into consideration the selected procedures performed in a day by a single RPA and the time saved for the radiologist who can be doing other interpretations **reveals** ***a time savings for the radiologist of 3.5 hours/day and a total of $2548.74 per day and a total of $637,185.00 per year*** as an increase in revenue. The data is attached to this paper. This study is currently being replicated for publication using a

larger population and updated data.

Efficacy and Patient Satisfaction

In a recent article published in *Radiology*, the lack of patient contact by the radiologists is becoming a looming patient care problem. In an era of instant information via smart-phones and the internet, patients are more informed and cognizant of the care they should and expect to receive. Patients are increasingly informed about diseases, treatments and the expected care regimens. Meanwhile, the radiologists' time is fractionated by the demands of several imaging modalities, referring physicians and keeping abreast with timely interpretations.

The RPA can interact with the patient, explain procedures, obtain clinical and medical information and be the liaison between the radiologist, the patient and, at times, the referring physician. This alleviates the stress on the radiologists.

In addition, with the RPA performing the fluoroscopy procedures, the imaging schedule can be adhered to more closely. Being able to meet the schedule of procedures allows the department to run more smoothly and reduces the waiting time for patients. Patient waiting time is a major complaint to hospital administrations. Numerous patient surveys conducted in facilities utilizing an RPA verifies these findings, in addition to published articles. [1,2, 3]

Employment Options for the RPA

The first option is an RPA can be the employee of the health care facility, but under the supervision of the radiologist, much like the manner in which RTs are employed. Within this scenario, the hospital is reimbursed for all procedures completed by the RPA.

A second option is the RPA is an employee of the Health care facility but is leased or contracted to the radiology group. In this situation, the radiology group is reimbursed for procedures done by the RPA and pays wages and benefits of the RPA and is also legally responsible for the RPA.

Oftentimes within this scenario, the facility continues to pay the benefit package depending on the contract with the physician group.

The third scenario is the RPA is hired by the physician group as their employee. Most radiology groups use this option for billing reasons and to provide a mechanism for delegations, which will be explained later in this document.

In all three scenarios, the RPA should undergo the scrutiny of the credentialing committee for any facility the RPA works in. Being credentialed by the committee meets the JCAHO requirements. Policies should be developed outlining the role of the RPA, such as a job description. Many hospitals group the RPA with other mid-level professionals , referred to as Allied Health Professionals, and utilize the same policy for all within the category.

Billing for RPA Services

Presently, CMS has not provided the recognition necessary for RPAs or RRAs to have independent billing privileges. The RPAs have been awarded a Health Care Provider Taxonomy Code and they can obtain NPI numbers, indicating they are recognized by CMS.. However, CMS does not state in any CMS regulations that an RPA or RA can not 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 or implies 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.[4]

Because 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. [5, 6] 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 is independent and not affilated with a hospital in any manner. 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.[7, 8]

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. [9] 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. 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, but the “critical time” usage is prevalent throughout medicine to

meet the supervision level requirement. The regulation further states that the "documentation (final report) must indicate that the physician personally performed the interpretation." [10, 11]

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 bill for one-half of the fee for each physician. "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." 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." [12, 13]

Delegation of Duties and Billing Practices

Within the licensing law for physicians in all states is a delegation clause or section which essentially states or implies that a physician may delegate to non-physician healthcare professionals, who function under the supervision of the physician, assigned tasks and responsibilities, provided the individual has the education and training to competently perform the delegated duties. In the opinion of the delegating physician the delegated task (1) can be properly and safely performed by the person to whom the medical act is delegated; (2) is performed in its customary manner (according to protocol); and is not in violation of any other state or federal statutes or hospital policy.[14]

These services are payable under the separate benefit category of diagnostic tests found at Section 1861(s)(3) of the Social Security Act (SSA) and are subject to the instructions at Chapter 15, Section 80 of the Medicare Benefit Policy Internet Only Manual (IOM). [15, 16]

In most events the physician is responsible for the delegated acts through the common law of "respondeat superior", which states that employers are responsible for the acts of his or her employees. However, there is one limited exception wherein the physician is not liable to this rule and that is when the standing orders or the protocol is not followed. However, if the physician has reason to know the health professional lacks the competency to perform the delegated acts or procedures, then the physician is liable.

Delegation of duties to a certified RPA allows the physician to bill for services as physician's professional services. Several conditions must be met to satisfy the standard: (1) the RPA must be an employee of the physician group; (2) the services must be medically necessary, within the scope of practice for the RPA and of the type normally performed at the practice site; (3) the adequate level of supervision (using the CMS definitions or hospital policies) must be provided; and (4) the physician must have contact with all new Medicare patients or Medicare patients who have new medical problems. [15]

While a RPA may greatly enhance the efficiency of the radiology services, the risk of increased liability is present if they are not properly managed and supervised. To reduce this risk the following precautions should be practiced:

1. Check the scope of practice of the RPA and make certain delegated tasks stay within the parameters of the scope and as

outlined in the health care facilitiy's credentialing process.

2. Ensure the RPAs educational background has prepared them to perform delegated tasks.
3. Ensure their licensure status and certification are up-to-date.
4. Ensure the RPA attends appropriate continuing education courses.
5. Ensure the RPA is properly supervised in accordance with CMS guidelines or hospital policies.
6. Ensure the RPA is trained with respect to the group's compliance plans for fraud or abuse, HIPPAA and other issues.
7. Make sure the group's liability insurance covers the RPA and/or he RPA has sufficient malpractice insurance coverage.
8. The RPA must always introduce themselves by their health professional status and not cause any reason for misinterpretation by the patient.

The clinical privileges and authority of any physician extender varies state by state and by billing insurance carriers. Each practice should verify the rules and/or regulations governing their jurisdiction.

Use of Modifier Codes

Information that has been placed on some professionally-related web sites concerning the S & I code and -52 modifer code is erroneous and misleading. Research of web sites for CMS, the Medicare Claims Processing Manual, the AMA CPT 2007 Professional Edition and the MLN Matters reveal when and how these codes are to be used. The inference being made to radiology groups employing an RPA is that if a RPA does a procedure, then one or both of these codes apply.

According to the Medicare Claims Processing Manual, Chapter 13, 80.1, page 37, the regulation for the S & I (Supervision & Interpretation) code states this code is

> "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. In order to bill for the supervision aspect of the procedure , the *physician*

must be present during its performance....The interpretation of the procedure may be performed later by another *physician*. In situations in which a cardiologist, for example, bills for the supervision (the "S") of the S&I code and a radiologist bills for the interpretation (the "I") of the code, both physicians should bill accordingly indicating a reduced service..."[17]

The S & I code pertains to ***physicians***, and not to non-physician personnel, such as RPAs, and should not be applied to situations using RPAs. The hospital policies govern the utilization and parameters of practice of the RPA through the credentialing process. Within IDTFs, the code-specific supervision guidelines apply.

In the CMS Change Request (CR) 4250 and Related Transmittal (CR) 804 define the usage of the -52 modifer as

"The -52 modifer is used to indicate that a service that did not require anesthesia was partially reduced *or* discontinued at the physician's discretion. ...The modifer is reported most often to identify interrupted or reduced radiological or imaging procedures..."[18]

The -52 modifer code indicates a procedure that was reduced or eliminated for a variety of reasons, and is at the physician's discretion to make this call. Since some service was technically provided, even though the result was inadequate to make a diagnostic statement, it is correct to use the -52 modifer code for the *physician's* service.[19]

The other situation that the -52 modifer code can be used is when two physicians or providers participate in a procedure, the fee is divided by utilizing the -52 modifer code. Note that the regulations state the individuals must be *providers*, meaning that CMS recognizes them as having provider numbers for reimbursement. RPAs are not considered providers, there fore the -52 modifer code can NOT be applied to functions of the RPA.[17]

NOTE: **There are over 450 RPAs working in 43 states and there has never been one complaint filed with any state or federal agency, nor has there ever been a legal complaint filed in any state.**

Results of RPA Procedure Logs

RPA	Total Cases Reported	Time Period	# of Days in Time Period**	# of Cases per day	Most common Exams Performed
RPA/Student	885	4 months	85	10.41	BE-106 SM Bowel-189 Myelo/LP-126
RPA Student	881	5 months	108	8.16	PICC-246 Thora-74 Para - 46
RPA-Certified	1764	6 months	306	5.76	Arthro-606 Thoro-276 PICC-173
RPA-Certified	1375	6 months	306	4.49	CVL/Port-507 PICC-104 Sinograms_93
Totals	4,905	5.25		7.21	

**Assumes a five day work week. Holidays and vacation days excluded.

Exams Commonly Performed by the RPA
with Average Reimbursement and Time Savings for the Radiologist

Procedure	Medicare Reimburse/ Rate	Reimburse for 7.21 cases/day	Avg Time Needed for Exam	Avg Time in minutes/day
Paracentesis	$72.36	521.72	30 min	216.3
Thoracentesis	$72.36	521.72	30 min	216.3
Small Bowel	$87.73	632.53	30 min	216.3
Barium Enema	$62.96	453.94	30 min	216.3
Athrogram	$45.44	327.62	30 min	216.3
Myelogram	$104.79	755.54	30 min	216.3
Venous Access	$150.33	1,083.88	25 min	180.25
Totals		**Avg. $ 613.85**		**Avg. 211.16 Approx 3.5 hrs/da**

Commonly Interpreted Exams and
Average Reimbursement During Time Saved by an RPA

Exams	Time needed to Interpret	Exams Read (During 211.15 minutes)	Medicare Reimburse Rate	Reimbursement for Exams read/ time period
Abdomen-2V	2 min	105.57	17.67	1,865.42
Chest-2V	2 min	105.57	17.67	1,85486
CT Head/Brain w/o contrast	5 min	42.23	92.93	3,966.66
CT Chest w/o contrast	8 min	26.39	118.56	3,128.80
CT Abdomen w/o contrast	10 min	21.12	116.17	2,453.51
CT Head/Brain w/ and w/o contrast	14 min	15.08	126.23	1,903.55
CT Chest w/ and w/o contrast	10 min	21.12	146.71	3,098.52
CT Abdomen w/and w/o contrast	15 min	14.08	139.91	1,969.93
MRI Brain	16 min	13.2	204.25	2,697.42
				Avg. Savings $2,548.74/day or $637,185.00/yr

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16. Section 1861 (s)(3) of the Social Security Act (SSA), Section 1861 (s)(3) and Chapter 15, Section 80 of the Medicare Benefit Policy Internet Only Manual (IOM).

17. Medicare Claims Processing Manual, Chapter 13, 80.1, Physician Presence, page 37.

18 Medicare Learning Network, MLN Matters, MM4250, "*Modifer -52*" January, 2006 Related CR Transmittal #804.

19 American Medical Association CPT 2007 Professional Edition, page 440.