

MEDICARE ACCESS TO RADIOLOGY CARE ACT Q&A

What specific services do RA's currently perform?

Diagnostic fluoroscopy procedures such as barium enema, upper GI, voiding cystograms. Minor interventional procedures using imaging for guidance such as biopsies (for thyroid, bone marrow, intra-abdominal masses, etc.), abscess drainages, venous access procedures (PICC lines, central lines, ports, and tunneled dialysis catheters), lumbar punctures, myelography, arthrograms, thoracentesis, paracentesis, joint injections, venograms, and others.

RA's also provide an essential role with patients by explaining risks, potential complications and benefits of the procedures. They also review prior images and pertinent lab values to assure that patients are adequately prepped and are appropriate candidates for the procedure being requested.

What level provider performs these services in the absence of an RA?

If the RA is not doing these, either a radiologist or, for some of the above procedures, another type of non-physician provider (NPP) such as an NP or PA would be performing the procedure. If an RA is doing these instead, the radiologist can focus on interpreting exams and doing more complicated procedures.

RA's are also currently the only midlevel provider adequately and expertly trained to administer ionizing radiation safely to the public.

How does the radiologist currently bill for services performed by an RA and how are they then paid for that work?

For diagnostic imaging fluoroscopic procedures' (70000 codes) technical component, if the procedure is performed in an outpatient, non-hospital setting, the radiologist submits payment under MPFS as a global bill. If the procedure is performed on hospital inpatient or outpatients, the radiologist only bills the professional component (for interpretation) and does not bill for the technical portion the RA performs.

For minor interventional procedures, the radiologist currently should not be billing the E&M at all (since the RA is not recognized by CMS as a provider who can provide these services). No one is getting reimbursement when the RA does these procedures despite states and hospitals recognizing the scope and level of supervision necessary for the RA.

Do the same billing challenges exist in the inpatient as well as outpatient setting, particularly when services formed are part of a DRG or APC?

Yes, the supervising radiologist is not allowed to bill for anything the RA does on an inpatient because incident-to does not apply to inpatients. The RA has to be recognized as a NPP before the radiologist can bill for these services.



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Does the legislation have a cost or CBO score?

The Congressional Budget Office has given the legislation a preliminary score of \$5m per year or \$50m/10 years.

However, in the hospital setting, this legislation would only have a cost to the extent that an RA is substituting for hospital personnel in the performance of procedures. If that is the case, there is a potential cost savings as Medicare would pay 85 percent of the PFS in addition to any payment made to the hospital for inpatient or outpatient services. However, if the RA is substituting for a NP, CNS or PA, these practitioners are already paid at 85 percent of the PFS so there would be no cost or savings from the provision. If the RA is substituting for a physician being paid 100 percent of the PFS, there would be savings from this provision.

In the physician's office, Medicare would be paying for the RA's service at 85 percent of the PFS amount rather than 100 percent of the PFS amount under the "incident to" benefit producing a savings in this setting.

