# The Impact of Nonphysician Providers on Diagnostic and Interventional Radiology Practices: Regulatory, Billing, and Compliance Perspectives

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## Abstract

The numbers of nurse practitioners and physician assistants are increasing throughout the entire health care enterprise, and a similar expansion continues within radiology. Some practices have instead embraced radiologist assistants. The increased volume of services rendered by this growing nonphysician provider subset of the health care workforce within and outside of radiology departments warrants closer review. The authors evaluate the recent literature and offer recommendations to radiology practices regarding both regulatory and scope-of-practice issues related to these professionals. Additionally, billing and compliance issues for care provided by nurse practitioners, physician assistants, and radiologist assistants are detailed. An analysis of the integration of these professionals into interventional and diagnostic radiology practices, as well as potential implications for medical education, is provided in the second part of this series.

**Key Words:** Nurse practitioners, physician assistants, radiologist assistants, radiology, billing, compliance

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## INTRODUCTION

Recognized by Medicare and other payers as billing-eligible providers for many health care services, nurse practitioners (NPs) and physician assistants (PAs) have been increasing in prevalence throughout radiology departments as well as the entire health care enterprise [1-10]. Referred to by some as advanced practice providers, advanced practice clinicians, midlevel providers, or physician extenders, their scope of practice, prescription privileges, and ability to practice independently have increased but continue to vary widely among practices and states [11,12]. This variability has been cited by the Office of Inspector General as an issue that requires careful monitoring with regard to appropriate reimbursement and quality of care [13].

NPs and PAs have recently garnered substantial attention in the academic literature; however, the full impact of the increasing prevalence of NPs and PAs in radiology departments remains unclear, and their impact on patient safety, practice revenue, and radiology education thus warrants review and critique. Additionally, as their prevalence outside radiology departments continues to increase, changes in referral patterns and utilization of imaging resources may be affected as well [14]. Concurrently, an increase in the prevalence of radiologist assistants (RAs) in radiology practices has been observed. The available literature analyzing this subset of nonphysician providers, however, is limited. An analysis of this body of literature, as well as a thorough review of billing and compliance issues unique to RAs (which substantially differ from those related to NPs and PAs) is also provided herein.

The purpose of this 2-part series is to evaluate the feasibility and practicality of incorporating NPs, PAs, and RAs into radiology practices, focusing particularly on patient safety, financial performance, and their

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impact on medical education. A secondary purpose is to evaluate the potential impact of an enlarging non-radiology NP and PA workforce on diagnostic radiology practices, particularly as these professionals increasingly assume roles of primary care service providers. This first segment focuses on current regulatory and scope-of-practice issues related to employing nonphysician providers in radiology departments. Additionally, a critique of billing and compliance practices associated with both procedural and evaluation and management (E&M) services provided by this enlarging subset of the health care workforce is provided. Further analysis of the integration of nonphysician providers into interventional and diagnostic radiology practices, as well as the potential impact on medical education, is offered in the forthcoming second segment.

## HISTORY, EDUCATION, AND PRIVILEGING OF NPs and PAs

The first NP training program was founded at the University of Colorado in 1965 [15], and since shortly thereafter, most programs have offered master's degrees. More recently, doctoral degrees are becoming increasingly common [16]. First educated through traditional nursing programs, NPs come from a variety of backgrounds, and many are now trained in a variety of subspecialties, including radiology. In addition to the clinical experience obtained during their baccalaureate nursing education programs and prior registered nurse work experience, nurses in NP training programs average 17 weeks (686 hours) of clinical bedside education. NPs are licensed independent practitioners and, at the time of this writing, may operate without physician oversight in 17 states. They may obtain their own National Provider Identifier (NPI) numbers, which are used for billing Medicare and other payers. Their medication prescription privileges vary from state to state [11].

The first PA program was founded at Duke University in 1965 [17,18]. In contrast to the nursing model for NP education, PA training programs are modeled after medical student educational programs and involve, on average, 2,000 hours of clinical bedside education. PAs may also obtain their own NPI numbers and can usually bill for services rendered. The scope of practice for PAs is often determined by the local practice and hospital credentialing services and must conform to state law [12].

NPs and PAs are state licensed and must maintain national certification to remain eligible for credentialing at most institutions. Because the scope of practice for NPs and PAs varies widely by state, a thorough understanding of local rules, regulations, and customs is imperative for physician practices considering NP or PA recruitment. Currently, no nationally recognized radiology-specific training programs exist for either NPs or PAs. Radiologists employing them will thus have immense influence over the scope of practice of NPs and PAs when serving as supervising physicians. Those radiologists must individually ensure adequate training and supervision related to medical imaging and image-guided procedures. Of note, NP and PA credentialing and licensing laws allow the transfer of acquired skills to other specialties outside radiology and interventional radiology (IR) practices. Depending on individual marketplaces, the implications of such transferability should be considered by radiologists seeking to employ NPs and PAs.

## NP AND PA SALARIES

When evaluating the bottom-line implications of employing NPs and PAs in a radiology department, salary benchmarks will be useful in modeling a pro forma. According to the National Salary Survey of Nurse Practitioners, the average salary of NPs in 2013 was $98,817 [19]. A similar census report from the American Academy of Physician Assistants showed that the average salary of PAs in 2013 was $107,268 [19].

As a general rule, salaries for subspecialty-trained NPs and PAs are higher than those of their primary care counterparts [20]. But all salaries are negotiable and vary geographically. Some NPs and PAs may desire less than full-time employment, which creates flexibility for practices to create NP or PA positions specifically tailored to the unique needs of their group.

## BILLING AND CODING FOR SERVICES PROVIDED BY NPs AND PAs

Billing for services provided for NPs and PAs can be complex and has recently been targeted by the government as an area meriting heightened fraud and abuse scrutiny [21]. A firm grasp of what is (and is not) allowable is thus essential when contemplating NP or PA employment so as to simultaneously optimize legitimate revenue and minimize compliance risk.

As a general rule, NPs and PAs can perform and bill for both invasive procedures and clinical nonprocedural care. In the coding lexicon, the latter comprise E&M services. Each is discussed separately. We have focused on rules, regulations, and processes in place for Medicare. These generally apply to Medicaid and many