Position Statement: The Role of Physician Assistants in Interventional Radiology

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Abbreviations: IR = interventional radiology, NP = nurse practitioner, PA = physician assistant, RA = radiologist assistant, RPA = radiology practitioner assistant

DURING the past decade, interventional radiology (IR) has been transformed from a referral-based to a clinically based subspecialty. This has resulted in a fundamentally different type of workload for the practicing interventional radiologist. During this same time period, the scope of procedures provided by interventional radiologists continued to expand. A result of this decade of robust growth is a shortage of properly trained and qualified professionals. We now face a dilemma in not only how to keep up with procedural demand, but also how to provide clinical care for patients before and after procedures. It is clear that the recruitment of additional clinical support staff into the "IR team" is needed (1–3).

Today, modern IR divisions resemble surgical subspecialties, providing the full spectrum of clinical care. Patients are seen in ambulatory clinics before and after procedures and on admitting and consultation services while in the hospital. Although the care we provide to patients is similar to that in other clinical services, the personnel we utilize to provide this care is not (4,5).

The most frequently used physician extenders are physician assistants (PAs), nurse practitioners (NPs), radiology practitioner assistants (RPAs), and radiologist assistants (RAs). Each has different training, background, qualifications, and scope of practice, and not all can bill for their services (Appendix). To make matters even more complex, these differences are state-, provider-, and hospital-specific. It is therefore critical to understand these differences before deciding to hire a physician extender (6–10). This position statement will delineate the potential roles of PAs in an IR practice.

REGULATIONS

PAs must graduate from a nationally accredited PA educational program, pass the national certification examination administered by the National Commission on Certification of PAs, and obtain a state license to practice. Federally employed PAs must meet the first two criteria, but need not be licensed. PAs are eligible to obtain their own Drug Enforcement Administration number for prescription writing (11,12) and their own National Provider Identification number (as described later in the billing options for PAs). PAs on the medical staffs of hospitals are subject to similar credentialing requirements as physicians. Their responsibilities must conform to institutional policy and state regulations. State and hospital requirements vary in terms of prescriptive authority, use of ionizing radiation, level of physician supervision, and credentialing. More information regarding state laws governing PAs is available on the American Academy of Physician Assistants Web site (13).

BILLING/CODING

Employers of PAs are eligible for reimbursement from Medicare for physician services provided by PAs working with the supervision of a physician. Fees generated by PAs may partly offset or completely cover the cost of their employment (5,14,15). PAs should obtain their own National Provider Identification number for Medicare billing.

Under Medicare, PA services are reimbursed at 85%–100% of the physician fee. "Incident to" billing allows physicians to bill at 100% in the outpatient office or clinic setting provided certain physician involvement and in-

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Table 1
Medicare Policy Chart for Physician

Setting	Supervision Requirement	Reimbursement Rate	Services
Office/clinic when physician is not on site	State law	85% of physician's fee schedule	All services PA is legally authorized toprovide that would have been covered if provided personally by a physician
Office/clinic when physician is on site	Physician must be in the suite of offices	100% of physician's fee schedule*	Same as above
Home visit/ house	State law	85% of physician's fee schedule	Same as above
Skilled nursing facility/ nursing facility	State law	85% of physician's fee schedule	Same as above
Hospital	State law	85% of physician's fee schedule	Same as above
First assisting at surgery in all settings	State law	85% of physician's first assist fee schedule†	Same as above
Federally certified rural health clinics	State law	Cost-based reimbursement	Same as above
HMO	State law	Reimbursement is on capitation basis	All services contracted for as part of an HMO contract

* Using carrier guidelines for "incident to" services.
† For example, 85% × 16% = 13.6% of surgeon's fee.

creased supervision criteria are met. "Incident to" billing is not applicable in the inpatient setting.

Billing for inpatient services differs from billing for services in an outpatient office or clinic. In hospitals, if the supervising physician and the PA treat a patient on the same day, services can be billed at 100% of the Medicare fee schedule if Medicare's shared billing requirements are met, whereas it is 85% if the service is performed by the PA with no direct physician involvement. Private insurers generally cover services provided by PAs. Those services are billed under the physician's name or the PA's name depending on the particular payer's policy (16,17).

More regulatory information on reimbursement of PA, NP, and RPA services can be found on the Web sites of the American Academy of PAs (*www.aapa.org/gandp/3rdparty.html*), American Academy of NPs (*www.aanp.org*), and Certification Board for RPAs (*www.cbrpa.org/pdf/CBRPA_medicare_guide.pdf*), respectively.

As of October 25, 2002, the Centers for Medicare and Medicaid Services issued new rules providing PAs and their physicians increased latitude in hospital and office billing for Evaluation and Management services. The new requirement (Medicare Transmittal 1776) will allow PAs and physicians who work for the same employer/entity to share visits made to patients the same day with the combined work of both billed under the physician at 100% of the fee schedule. That is, if the PA provides the majority of the service for the patient and the physician provides any face-to-face portion of the Evaluation and Management encounter, the entire service may be billed under the physician. This new rule does not extend to procedures or consultations. If the physician does not provide some face-to-face portion of the Evaluation and Management encounter, the service is appropriately billed at the full fee schedule amount under the PA's National Provider Identification number with reimbursement paid at the 85% rate (18) (**Table 1**).

MEDICAID COVERAGE

Presently, all 50 states cover medical services provided by PAs under their Medicaid fee-for-service or managed care programs. The rate of reimbursement, which is paid to the PA's employer, is the same or slightly lower than that paid to physicians (19).

SCOPE OF PRACTICE

As previously discussed, the scope of practice for a PA will vary from state to state. Most states leave the determination of specific procedures deemed within the PA's scope of practice to the supervising physician and the credentialing committees of individual hospitals. States define the broad, overall practice of PAs and may regulate some specific areas, such as PA use of ionizing radiation, narcotic schedules allowed within a PA's prescriptive authority, and the responsibilities of the supervising physician. (The AAPA Web site [13] describes each state's requirements.)

In addition to the broad scope of practice for PAs defined by state law and regulations (or federal agency guidelines for federal employees), the scope of practice for an individual PA also is determined by delegation from the supervising physician and by the hospital privileging process. Hospital credentialing of PAs is similar to that of physicians. PAs must apply for privileges and submit to the same types of background checks as physicians. As a rule, hospitals will grant PAs only privileges that the supervising physician also holds. Some hospitals grant PA privileges based on the request of the supervising physician, who is responsible for the PA's performance. Others require documentation of competency via physician supervision of a specified number of each procedure before the PA is allowed to perform them without the physician present.

Before hiring a PA into a practice, it