Clarification of the "Incident to" Rule as it Applies to the Radiologist Assistant and Other Non-Physician Practitioners

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Radiologist Assistants (RA) furnishing services under the supervision of a radiologist will be providing services that are classified as diagnostic services (generally services with separate distinct professional and technical components) and other services that may be part of a diagnostic service but are classified as non-diagnostic (generally injection procedures). In the CY 2019 Physician Fee Schedule (PFS) final rule, the Centers for Medicare and Medicaid Services (CMS) recognize RAs as radiologist staff who can provide services to Medicare patients under revised supervision levels. Effective January 1, 2019, RAs now may perform under direct supervision technical component services requiring personal supervision under the PFS. The radiologist no longer needs to be in the room as a condition of payment for Medicare to pay either the hospital or the radiologist for the technical component of the diagnostic imaging service.

However, the challenge remains as to whether the radiologist can meet the requirements to bill for the non-diagnostic service when the RA provides the service in the office setting.

In CMS' code of federal regulations (CFR) there are nine criteria that must be met in order to qualify for "incident to" billing in the office setting:

42 CFR section 410.26, 9 Requirements for a Service to be Paid under the "incident to" Rules
(1) Services and supplies must be furnished in a noninstitutional setting to noninstitutional patients.
(2) Services and supplies must be an integral, though incidental, part of the service of a physician (or other practitioner) in the course of diagnosis or treatment of an injury or illness.
(3) Services and supplies must be commonly furnished without charge or included in the bill of a physician (or other practitioner).
(4) Services and supplies must be of a type that are commonly furnished in the office or clinic of a physician (or other practitioner).
(5) In general, services and supplies must be furnished under the direct supervision of the physician (or other practitioner). Designated care management services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided incident to the services of a physician (or other practitioner). The physician (or other practitioner) supervising the auxiliary personnel need not be the same physician (or other practitioner) who is treating the patient more broadly. However, only the supervising physician (or other practitioner) may bill Medicare for incident to services.
(6) Services and supplies must be furnished by the physician, practitioner with an incident to benefit, or auxiliary personnel.

(7) Services and supplies must be furnished in accordance with applicable State law.
(8) A physician (or other practitioner) may be an employee or an independent contractor.
(9) Claims for drugs payable administered by a physician as defined in section 1861(r) of the Social Security Act to refill an implanted item of DME may only be paid under Part B to the physician as a drug incident to a physician's service under section 1861(s)(2)(A). These drugs are not payable to a pharmacy/supplier as DME under section 1861(s)(6) of the Act.

When a RA provides a service that CMS classifies as non-diagnostic in the office setting under direct supervision, there are a few criteria where the RA and radiologist come up short of meeting the "incident to" rules. Under criteria #2, *services must be an integral part of a physician's service in the course of diagnosis or treatment of an injury or illness*. This criterion suggests that the radiologist is in control of not only the diagnosis but also treatment of the patient. In the Medicare Benefit Policy Manual, Chapter 15, section 60.2, CMS states that to meet the "incident to" requirement:

> There must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the nonphysician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment.

This implies that the radiologist spent face-to-face time with the patient and where other physician services such as evaluation and management (E/M) codes were billed. For many interventional radiology services, criteria #2 can be met with such additional physician services, but this is not the case for a patient simply receiving a stand-alone service. When a radiology practice is performing only an ordered interventional radiology procedure or diagnostic test, radiology practices would not meet the requirements of the "incident to" rules and would be unable to bill Medicare for RAs' services under the PFS. The service that is performed by an RA "incident to" the physician's service occurs when it is a part of the physician's overall care provided for the patient. Follow up physician services are also necessary.

Medicare does not permit PFS billing under the "incident to" rules in the hospital setting. This means that physicians must either personally provide the services of the procedural code or not bill it at all. Again, this is where Medicare's regulations present a grey area and billing for the RA providing procedural services (e.g. CPT codes 19999-69999) in the hospital inpatient and outpatient setting are not permissible.

The Intersocietal Commission of the Radiologist Assistant (ICRA) has identified these problem areas. ICRA is working through the Medicare Access to the Radiology Care Act (MARCA) to change the law so that radiologists can bill for non-diagnostic services performed by RAs they employ and directly supervise in both the hospital and office setting. If passed, this bill would provide for a new benefit category where the "incident to" requirement does not need to be met for the non-diagnostic service to be billed in the office setting. It would further allow the non-diagnostic service to be billed in the hospital if the RA is employed by and working under the direct supervision of the radiologist. Until the passage of MARCA, radiology practices should be mindful of the "incident to" criteria in the office setting and lack of ability to bill for RA services under the PFS in the hospital setting. ICRA continues to work to remedy this payment

policy problem so that RAs can be fully utilized in radiology practice as soon as possible. Please consult with a qualified health care attorney in your jurisdiction for specific legal advice on properly working with RAs. You may check ACR's Legal Office attorney referral list at:

https://www.acr.org/Practice-Management-Quality-Informatics/Legal-Practices/Attorney-Referral.