Current Medicare Policy Limits Options for Providing Access to Quality, Safe, and Cost-Effective Medical Imaging Services

**Issue:** The rising demand and clinical need for timely medical imaging services and the increased complexity of radiologic studies have placed unsustainable pressure on our health care delivery system, limiting access to quality care for Medicare beneficiaries. The solution developed by nationally-recognized organizations – the radiologist assistant (RA) -- requires appropriate recognition by Medicare.

**Solution:** Amend the Social Security Act to (1) permit radiologists to utilize the services of radiologist assistants which the radiologist assistants are legally authorized to perform under state laws and under the conditions established by the state; and (2) reduce the professional component reimbursement to 85% of the amount otherwise applicable for services when performed by a radiologist assistant under a radiologist’s supervision.

**Background:** As far back as 1996, the U.S. Department of Defense recognized the need for an advanced practice radiologic technologist to alleviate problems caused by insufficient numbers of radiologists in the armed forces. As demand increased for radiology services and the shortage of radiologists worsened, the American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT), and the American Registry of Radiologic Technologists (ARRT) collaboratively developed the concept of the RA – a radiographer with additional education, specialized clinical training, and advanced certification.

The RA is an advanced-level radiographer who assists, but does not replace, the radiologist in the diagnostic imaging environment. The RA must complete a rigorous academic program encompassing a nationally-recognized curriculum and a radiologist-directed clinical preceptorship and must pass a nationally-recognized certification examination. An RA educational program must award a baccalaureate degree at a minimum and educate students to perform diagnostic imaging and interventional radiology procedures within the RA’s scope of practice. Today, 13 universities offer education and supervised clinical training for the RA, and 28 states license or certify RAs. An RA can be certified by the American Registry of Radiologic Technologists as a registered radiologist assistant or by the Certification Board for Radiology Practitioner Assistants as a radiology practitioner assistant. RAs always practice under the on-site supervision of a radiologist, thus ensuring high quality care. Their advanced education and training enable them to perform assessments and procedures (excluding interpretations) that traditionally are performed by the radiologist. ACR, ASRT, and ARRT have worked together to ensure consistency in education, scope of practice, and certification standards for the RA. The Society of Radiology Physician Extenders (SRPE) joined these efforts as an organization advancing continuing education and professional development for the radiologist assistant.

The following is a vivid example of how current Medicare policies limit the ability of radiologists to use RAs fully and effectively. Medicare currently requires a level of physician supervision for
many procedures that can be performed with RA involvement that is inconsistent with the RA’s education and training and with numerous states’ laws. CMS requires “personal” supervision (a physician must be physically present in the room during the procedure) for services that many states (as well as ACR, ASRT, SRPE and ARRT) have determined can be safely and effectively performed by an RA under “direct” supervision (a physician must be present and immediately available to furnish assistance and direction throughout the procedure but does not need to be present in the room when the procedure is performed). Unfortunately, Medicare’s current policy results in delays in scheduling and performing diagnostic and interventional procedures for Medicare beneficiaries, reduced access to quality care for beneficiaries (particularly in rural and underserved areas), inefficient radiology practices, and higher costs to the Medicare program.

Currently, Medicare applies the same physician supervision requirement to procedures performed by an RA that it applies to procedures performed by a general radiographer. We strongly disagree with this approach. We believe that physician supervision requirements for imaging procedures performed by RAs within their scope of practice should reflect what the RAs are permitted to do under their respective state laws as well as the states’ supervision standards where applicable. Where the state law provides that the RAs are subject to the “direct” supervision of the radiologist for certain procedures, the Medicare program should apply that supervision standard as well. This would allow the radiologist to be available for more complex procedures, consultations with referring physicians, and imaging study interpretation. Applying a reporting modifier for procedures completed with participation of an RA would distinguish them from procedures performed by radiologists and would assist with quality monitoring. In addition, applying an 85% reimbursement level for RA-performed services offers the potential for Medicare cost savings and would be consistent with how other non-physician providers have been treated under Medicare. Finally, these proposals would enable Medicare to meet an important objective of a reformed health care system, especially in light of the increased demand for services that will result from expanded insurance and Medicaid coverage – to improve patient access through the use of qualified non-physician providers where possible.