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Via Federal Express and E-Mail (akeyser@aapm.org)

Ms. Angela R. Keyser
Executive Director
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Re: Opinion Letter

Dear Angela:

This correspondence responds to your request that we provide legal advice regarding legislative and regulatory changes necessary to create provider status for Medical Physicists ("MPs") and identify legal or regulatory impediments to direct billing. Our analysis is set forth below.

I. Current Medicare Payment for MP Services

Under the Medicare payment methodology, when the services of MPs are provided in a non-hospital setting (generally classified by Medicare as a physician's office or clinic for Medicare payment purposes), reimbursement is incorporated into the technical component of the applicable service (as identified by CPT code) under the Physician Fee Schedule. When the services of MPs are provided in a hospital outpatient setting or to a hospital outpatient, reimbursement is provided to the hospital under the hospital outpatient prospective payment system (HOPPS) based on the Ambulatory Payment Classification (APC) of the service involved.

When the services of MPs are provided in conjunction with radiation oncology or other services provided to hospital inpatients, there is no separately identifiable payment attributable specifically to the particular service involved. Rather, payment for all costs involved in the inpatient admission is reimbursed based on the diagnosis-related group (DRG) of the admission. If the patient is transported to a non-hospital facility (e.g., a freestanding radiation oncology center) for the provision of the service involved, the freestanding facility bills the hospital, and

the cost of the service is ostensibly covered by the payment received by the hospital for the admission.

If the service is rendered to a patient transported from a Skilled Nursing Facility (SNF), the payment mechanism depends upon a number of different factors. If the patient's SNF stay is covered under Medicare Part A, and the patient is transported to a hospital outpatient department for treatment, the physics services provided to the patient in conjunction with the treatment are reimbursed under the HOPPS system. However, if an SNF patient covered under Medicare Part A is transported to a freestanding facility, the freestanding facility is required to bill the SNF for all technical component services, including physics services. The SNF is expected to cover the cost of the service through the payment it receives from Medicare for the patient stay. Like under the DRG system applicable to hospital inpatient services, there is no separately identifiable amount payable for radiation oncology services provided to SNF Part A inpatients.

II. Precedent for Separate Medicare Coverage of Services Provided By Non-Physician Health Care Professionals

The governing legislation provides Medicare coverage for the professional services provided by a broad range of non-physician health care professionals, which could be cited as precedent if AAPM decides to seek separate coverage for MP services. A number of examples are described below.

A. Certified Registered Nurse Anesthetist Services

Section 9320 of OBRA 1986 provided for payment under a fee schedule to certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs). CRNAs and AAs may bill Medicare directly for their services or have payment made to an employer or an entity under which they have a contract (e.g., a hospital, physician or ambulatory surgical center). This provision became effective for services rendered on or after January 1, 1989 and is codified at Soc. Sec. Act §1861(s)(11) and (bb).

Under applicable Medicare Manual provisions, an AA is a person who is permitted by State law to administer anesthesia and who has successfully completed a six-year program for AAs, of which two years consist of specialized academic and clinical training in anesthesia. A CRNA is a registered nurse who is licensed by the State in which the nurse practices and who is currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists, or has graduated within the past 18 months from a nurse anesthesia program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification. Medicare Claims Processing Manual (CMS Pub. 100-04), §140.1 - Qualified Anesthetists.

The amount paid by Medicare for the services of a CRNA is based on a fee schedule established by the Secretary. Claims for payment may be submitted by the CRNA or by the

hospital, physician, group practice, or ambulatory surgical center with which the CRNA has an affiliation. Payment may only be made under Part B and must be on an assignment-related basis. Soc. Sec. Act §1833(l) and §1861(b)(4). A 50% discount is applied to both services if both an anesthesiologist and a CRNA are involved.

B. Occupational, Physical and Speech Therapy

The Part B program covers outpatient physical, occupational, and speech therapy services, defined as follows:

(1) *outpatient* therapy services furnished by (or under "arrangements" with) a participating provider of services, clinic, rehabilitation agency, or public health agency;

(2) physical and occupational therapy (but not speech therapy) *in the therapist's office or the patient's home,* in the case of a qualified physical and occupational therapist in independent practice (Soc. Sec. Act §1861(p).; and

(3) *inpatient* therapy services furnished by (or under "arrangements" with) a participating provider of services, clinic, rehabilitation agency, or public health agency to an inpatient of another institution such as a hospital or skilled nursing facility. Pub. 100-02, Ch. 15, §220.

Therapy services also are covered under Part B as incident to physician services provided certain conditions are met.

Significantly, certain functions must be performed by a physician before therapy services will be covered under Part B. No payment may be made for Part B physical, occupational, or speech therapy services unless: (1) a physician certifies that the therapy services are or were required by the patient; (2) the services are or were furnished while the patient was under the care of a physician, and (3) a plan for furnishing these services is or was established by the physician or by the therapist providing the services, and periodically reviewed by the physician.

C. Nurse-Midwife Services

The services of certified nurse-midwives are covered by Medicare. A "certified nurse-midwife" is a registered nurse who successfully has completed an approved program of study and clinical experience in nurse-midwifery or who has been certified by an organization recognized by the Secretary. Services covered include services furnished by a certified nurse-midwife (as well as services and supplies furnished incident to a nurse-midwife's services) to the same extent the services would be covered if furnished by a physician. The services must be authorized under state law, and most states have licensure and other requirements applicable to certified nurse-midwives. There are no restrictions on place of service. Soc. Sec. Act

§1861(s)(2)(L); (gg); 42 C.F.R. §410.77; *Medicare Benefit Policy Manual,* Pub. 100-02, Ch. 15, §180.

A nurse-midwife must be currently licensed to practice in the State as a registered professional nurse and either must be legally authorized under State law; or, if the state does not specify a program of study and clinical experience that nurse-midwives must complete to practice in that state, the nurse-midwife must:

- be currently certified as a nurse-midwife by the American College of Nurse-Midwives;
- have satisfactorily completed a formal education program (of at least one academic year) that, upon completion, qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives; or
- have successfully completed a formal education program for preparing registered nurses to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to normal newborns, and have practiced as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976, to July 16, 1982.

Most states have licensure and other requirements applicable to nurse-midwives that require specific arrangements with physicians or that specify the level of physician supervision required. These requirements must be met for the nurse-midwife to provide Medicare-covered care; however, they do not affect the nurse midwives' authority to bill on their own behalf for the services they provide.

The amount paid by Medicare for services billed by a certified nurse-midwife is based on a fee schedule established by the Secretary that, pursuant to the governing statute, allows payment rates no higher than 65 percent of the applicable physician fee schedule amount.

D. Qualified Psychologist and Clinical Social Worker Services

Clinical Psychologists ("CPs")

Effective July 1, 1990, the diagnostic and therapeutic services of CPs and services and supplies furnished incident to such services are covered and are otherwise covered if the services were furnished by a physician or as incident to a physician's services. Soc. Sec. Act §1861(s)(2)(M), (ii). The CP, however, legally must be authorized to perform the services under applicable licensure laws of the state in which they are furnished. *Medicare Benefit Policy Manual,* Pub. 100-02, Ch. 15, §160.

Covered CP services are limited to diagnostic and therapeutic services that the CP is legally authorized to perform in accordance with state law and/or regulation; any therapeutic

services that are billed by CPs under CPT psychotherapy codes that include medical evaluation and management services are not covered. Any person involved in performing the service must be an employee of the CP.

Applicable Medicare regulations specify the relationship that the CP must have with the patient's attending or primary care physician, in order for the CP services to be covered. Specifically, unless a patient is referred to the CP by the patient's physician, the CP must indicate in writing that s/he agrees that, contingent upon the patient's consent, the CP will attempt to consult with the patient's attending or primary care physician, within a reasonable time, or at a minimum notify the physician of the provision of CP services to the patient.

Clinical psychologists are paid under the physician fee schedule at the same rate as physicians for corresponding services, subject to the outpatient mental health services limitation. Payment may be made only on an assignment-related basis. Soc. Sec. Act §1833(a)(1)(L), §1833(p); 42 C.F.R. §414.62; Pub. 100-02, Ch. 15, §160.

Clinical Social Workers

The services of a clinical social worker (CSW) that are not otherwise required to be provided by a hospital or SNF in conjunction with an inpatient stay are covered by Medicare Part B. Coverage includes the diagnosis and treatment of mental illnesses that the clinical social worker is legally authorized to perform under state law and that would otherwise be covered if performed by a physician or as incident to a physician's services. Soc. Sec. Act §1861(s)(2)(N), §1861(hh); Pub. 100-02, Ch. 15, §170.

The term "Clinical Social Worker" ("CSW") is defined as an individual who possesses a master's or doctor's degree in social work; has performed at least two years of supervised clinical social work; and either is licensed or certified as a clinical worker by the state in which the services are performed; or, in the case of an individual in a state that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, skilled nursing facility (SNF), or clinic. Soc. Sec. Act §1861(hh); *Medicare Benefit Policy Manual,* Pub. 100-02, Ch. 15, §170.

The Medicare Act (Soc. Sec. Act §1861(hh)(2)) defines "clinical social worker services" as those services that the CSW is legally authorized to perform under state law (or the state regulatory mechanism provided by state law) of the state in which such services are performed for the diagnosis and treatment of mental illnesses. Services furnished to an inpatient of a hospital or an inpatient of a SNF that the SNF is required to provide as a requirement for participation are not included. The services that are covered are those that are otherwise covered if furnished by a physician or as incident to a physician's professional service.

Coverage is limited to the services a CSW is legally authorized to perform in accordance with state law (or state regulatory mechanism established by state law). The services of a CSW may be covered under Part B if they are:

- the type of services that are otherwise covered if furnished by a physician, or as incident to a physician's service;
- performed by a person who meets the definition of a CSW (see subsection A.); and
- not otherwise excluded from coverage.

Payment to CSWs is made only under assignment. The amount payable cannot exceed 80 percent of the lesser of the actual charge for the services or 75 percent of the amount paid to a psychologist for the same service. Soc. Sec. Act §§1833(a)(1)(F), 1833(p); *Medicare Claims Processing Manual,* Pub. 100-04, Ch. 12, §§150, 170.1, and 210.]

III. Legislative and Regulatory Changes Needed to Authorize Separate Payment for MPs

In order for MPs to bill for medical physics services provided to Medicare patients, it would be necessary to include at least three new provisions in the Medicare Act: (1) a provision to add MP services to the list of covered services under Medicare Part B (likely as a subsection of Social Security Act, §1861(s); (2) a provision defining the term "Medical Physicist" for purposes of Medicare coverage (likely by adding a definitional subsection to Social Security Act, §1861(x) ; and (3) a provision establishing the methodology that would be used to provide Medicare payment (likely as a subsection of Social Security Act § 1833(a)).

For example, sample provisions might be drafted as follows:

1861(s) The term "medical and other health services" means any of the following items or services:

1861(s)(2)(*) medical physicist services, as defined in subsection **;

1861(**) The term "medical physicist" means an individual who --

(A) possesses a {master's}{doctor's} degree in {medical physics}{other};

(B)

(i) is licensed as a medical physicist by the State in which the services are performed, or

> **(ii)** in the case of an individual in a State which does not provide for licensure or certification is certified by the [include appropriate certification organization(s)] and
>
> **(C)** has completed at least __ years or _____hours of [post-master's][post-doctoral] degree supervised medical physics practice under the supervision of a [include qualifications} medical physicist in an appropriate setting (as determined by the Secretary), and
>
> **(D)** meets such other criteria as the Secretary establishes.
>
> **1833(a)(1)(**)** with respect to medical physicist services under section 1861(s)(2)(*), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or ___percent of the fee schedule amount provided under section 1848 for the same service performed by a physician.

A number of observations are in order. Where, as here, a provision is added to the Medicare Act to provide coverage for the services of non-physician practitioners who are not necessarily subject to state licensure requirements, it is necessary to define by statute or regulations the education, training, and experience requirements necessary for a MP's professional services to be covered. Another approach is to specify the credential or other specialty-level certification that is necessary.

In addition, we note that the Medicare Act generally precludes separate payment for services rendered to hospital outpatients, which are ostensibly reimbursed to the hospital under HOPPS. However, CMS excluded from coverage under the outpatient prospective payment system (OPPS) those services furnished in an outpatient hospital setting that were already subject to an existing fee schedule or other prospectively determined payment rate. Professional services of physician and non-physician practitioners are paid under the physician fee schedule, and are excluded from HOPPS by regulation. For example, the regulations exclude the following services from HOPPS, and authorize separate payment; physician services that meet the requirements of 42 C.F.R. §415.102(a) for payment on a fee schedule basis; physician assistant, nurse practitioner and clinical nurse specialist services, as defined in Soc. Sec. Act §1861(s)(2)(K); certified nurse-midwife services, as defined in Soc. Sec. Act §1861(gg); services of qualified psychologists, as defined in Soc. Sec. Act §1861(ii); anesthetist services, as defined in 42 C.F.R. §410.69; and clinical social worker services as defined in Soc. Sec. Act §1861(hh)(2). In order for MPs to receive separate payment for professional services rendered to hospital outpatients, medical physics services would have to be added to this list of services excluded from HOPPS under applicable regulations.

IV. Impediments to the Establishment of a Right to Direct Billing by Medical Physicists

There are a number of significant impediments to direct billing for medical physics services that should be considered before embarking on such an initiative.

First, it is highly likely that the Congressional Budget Office would attribute a significant cost to legislation intended to establish direct billing status for medical physics services. Proponents of such legislation could argue that medical physics services are already covered as a component of hospital and freestanding centers' technical component payments and that, therefore, the establishment of direct billing rights for medical physicists would not necessarily increase aggregate expenditures—especially if the rates that are established reflect a discount from the amounts currently payable for these services. However, in our experience, the CBO generally takes the approach that aggregate expenditures grow significantly if the number of providers eligible to claim payment increases. In fact, the cost of expanded Medicare benefits (which would include changes such as adding medical physics services as a separately payable coverage category under Medicare, as described above) are generally underestimated. Actual costs generally exceed estimated costs, making CBO extremely wary of adding new benefits. This is especially true now, when some legislators are reeling from underestimates of the cost of adding prescription drug coverage to the Medicare Program.

In this regard, we note that the provisions of the Medicare Act that provide coverage for services provided by many of the non-physician medical professionals were added some time ago, when the Medicare program was under considerably less cost pressure. The types of service expansions of interest to Congress now generally relate to preventive health services, medical screening, and services in rural and other medically underserved areas.

Second, it is highly likely that hospitals and organized radiation oncology organizations would oppose the initiative. It is our understanding that medical physicists generally are not subject to state licensure and therefore are not authorized to provide professional services directly to patients, other than under the general supervision of a physician. Under these circumstances, it is especially likely that the position of the primary professional organizations representing radiation oncologists will be crucial in determining the fate of any proposed initiative.

Third, it seems unlikely that CMS would support the proposed initiative at this time. CMS, as an agency, is under considerable pressure to implement the prescription drug coverage and other provisions of the Medicare Modernization Act (MMA) in a timely manner, and generally does not favor the establishment of provider status for additional providers absent a compelling patient care justification.

Fourth, at this time, the professional services of MPs are considered to be part of hospital and freestanding centers' technical component services. A number of technical component services include not only the services of medical physicists, but also the services of other highly trained personnel, such as dosimetrists. In addition, it is our understanding that even those technical component services that primarily or exclusively involve the professional services of medical physicists, such as continuing medical physics, also require significant equipment, supplies, and other overhead expenses. In order for a medical physicist's professional services to be separately billable, the time and other resources involved in the provision of these services

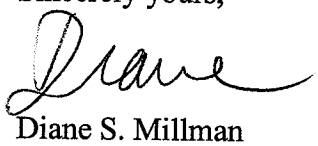
(the physicist's professional component services) would have to be segregated from the equipment, supply, overhead, and other costs associated with the service involved, which likely would continue to be borne by the facility. Under the Medicare Physician Fee Schedule, such cost segregations and valuations are performed in the first instance by the AMA RUC, which is not generally open to non-physician input.

Finally, we note that Medicare generally provides coverage for the services of non-physician health care professionals only as authorized by state law. It is our understanding that, at this time, medical physicists are not themselves subject to state licensure but are generally required by state law to provide services only under the general supervision of a licensed physician. Under these circumstances, it is unclear to us whether MPs will have sufficient leverage, as a practical matter, to insist upon direct billing independent of a supervising radiation oncologist.

* * * * *

If you have any questions, please call me.

Sincerely yours,



Diane S. Millman

DSM/