

# Direct Billing for Medical Physics Procedures: Implementation

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## INTRODUCTION

Direct Billing (being a “provider”) is the privilege to charge patients and/or their insurance carriers directly for medical services rendered. It is the essential factor that distinguishes between professional and technical staff. Tim Williams, MD, the editor of ASTROnews and candidate for president of ASTRO, sees similarities between practicing without direct billing and hanging drywall for a living (ASTROnews April-June 2005, pp. 1). John Barsotti, MD, a radiologist turned consultant, identifies our inability to directly bill patients as the reason why medical physicists are not treated as professionals, and are not necessarily considered as members of the treatment team. Recognizing the importance of direct billing, a nearly 2/3 majority (64%) of the AAPM membership expressed their desire to attain that privilege for physics services in radiation therapy.

In response to these wishes, the professional council has organized this symposium, in which the various aspects of provider status for physicists will be discussed. This presentation will concentrate on key issues that have to be addressed to make provider status a reality. It will demonstrate how we can make it into a win-win situation for all parties involved, including physicists, radiation oncologists, administrators, and above all, our patients.

### **Medical physicists are medical specialists deserving provider status**

Qualified medical physicists, i.e., those certified by ABR (or having a certificate of equivalence if ABMP certified), are listed by the American Board of Medical Specialties at par with neurosurgeons, urologists, radiation oncologists and others. This listing is proof of our accomplishments in the medical field, and does not diminish our standing as physicists.

Furthermore, medical physicists are directly involved in patient care, and assume full responsibility for their area of expertise. The Chairman of the Board of ASTRO (American Society for Therapeutic Radiology and Oncology) summarized our role in cancer care in a letter to HCFA (now CMS), stating “... physicists orchestrate the entire treatment process ...” According to the Guide To Radiological Physics Practice, American College of Radiology (ACR), 1990, p.1 and p. 18, “The radiological physicist is a colleague of the radiologist.” Medical physicists have as much or more patient contact than many other providers, including pathologists and some diagnostic radiologists, especially teleradiologists, who know their patients only from their x-ray images.

Yet, despite their length of training, patient contact and responsibilities, which are at par with other medical specialists, medical physicists are singled out as the only group not entitled to direct billing.

## **OVERCOMING IMPEDIMENTS**

To estimate the feasibility of direct billing, AAPM has hired a law firm to identify specific changes in law that would be necessary, as well as potential impediments. The law firm suggested asking Congress to make changes to the Social Security Act § 1861, adding medical physicists to the list of non-physician providers like nurse anesthetists and clinical social workers. Radiation oncologists, hospital administrators and reluctance by Congress were mentioned as potential impediments. In the following I will propose a path to circumvent the impediments in a manner that is beneficial for all parties involved.

### **Radiation Oncologists**

There was never any doubt that we need radiation oncologists on our side if we want to obtain direct billing. In that regard, the law firm did not point out any unanticipated potential hurdles. To secure the support of radiation oncologists, we have to be creative and honest.

1. Never make any proposal that would take money from existing professional codes.

The American College of Radiation Oncology (ACRO) stated explicitly that they are not opposed to direct billing by physicists, provided that the money does not come from their members' income. As an early member and fellow of ACRO, I have asked for support from this organization, and believe this position is as fair as anybody can expect.

Considering that the income of medical physicists “pales compared to that of radiation oncologists and some administrators”, as the president of ASTRO noted in a letter, it is quite obvious that additional funds from Medicare have to be secured. Fortunately, the Balanced Budget Act of the late 1990s, which required any new expenditure in the federal budget to be offset by equal cuts in other areas, is no longer valid. It was soon replaced by the Refined Balanced Budget Act, which allowed some increases, and has lost its meaning when Congress recognized that even 400+ billion deficits are acceptable in times of need. Health care expenditures were recently allowed to exceed 15% of the GDP. Abolishment of the Balanced Budget Act forestalled the predicted turf battles between urologists and radiation oncologists when prostate brachytherapy became popular, allowing payment to both groups of medical specialists. There are many other medical procedures that require more than one specialist, and all are getting reimbursed directly for their efforts. Therapeutic radiology, which requires the services of the medical physicist and the radiation oncologist, is just one of those procedures.

Another potential battle was avoided by the diplomatic skills of optometrists. For prescription of glasses, Medicare used to pay optometrists only a fraction of the amount it paid ophthalmologists. When optometrists pointed out this discrepancy, Medicare tripled their reimbursement, reasoning that there was no demonstrated difference in quality between the two professions for this service. Had optometrist used a “balanced budget approach”, i.e., suggested to reduce reimbursement of ophthalmologists to achieve equity, a battle would have ensued, with optometrists gaining much less. The method they used produced a win-win situation for both parties. I now walk across the street to an ophthalmologist, who gained a new patient, since

driving across town to my optometrist no longer saves money. Whatever income the optometrist lost on business from me, he gained many times from the higher fees from patients who stayed.

Medical physicists need to take the same approach. IMRT, for example, is a new technology which provides reasonable payment for technical services, but forgets about the professional medical physicist. A CPT code providing reimbursement for the professional services of the physicist in IMRT verification needs to be the first one to be established. Recent misadministrations have shown that individual verifications are absolutely necessary for quality patient care, yet are often omitted due to absence of specific reimbursement. The initial minuscule increase in cost would be recovered many times by a decrease in health care cost resulting from tumor recurrences and other complications. A higher life expectancy for patients would be an additional bonus. (An article in the New England Journal of Medicine 1992, Vol. 327, pp. 1499, indicates a correlation between survival and medical physics hours spent per patient.)

## 2. Forge closer ties between AAPM and the various radiation oncology societies, especially ASTRO and ACR

The radiological societies RSNA, ASTRO and ACR offer gold medals and other special awards for deserving medical physicists, whereas AAPM does not provide for similar recognition of deserving radiation oncologists. Furthermore, courses intended primarily for radiation oncologists typically give special discounts to physicists, with no similar courtesy extended to our colleagues who participate in similar physics courses. These inequities have to be rectified if we want to be equal partners.

## 3. Preliminary work, reciprocity

Although we may not have always properly recognized radiation oncologists for their accomplishments, many of us have provided help when help was needed. Of special significance is the participation of medical physicists in the letter campaign to Congress that prevented radiologists and radiation oncologists to lose their direct billing privileges. I have still letters from our Alabama legislators in my files that show my participation in that campaign. I hope that AAPM has done the same, and has similar letters in its files as proof of its commitment to our common goals.

I was also able to obtain a letter of support from the Alabama Society of Radiation Oncology, which was approved by unanimous vote during the annual meeting. Although it does not mention direct billing explicitly, words like “key players” and “professional standing” leave the door wide open for this privilege. I also obtained a letter of support from Dr. John Watson, one of the founding fathers of radiation oncology, that puts us into a similarly favorable light.

I am certain that many other medical physicists have done even more significant work on behalf of radiation oncology. AAPM needs to send a request to all its members for copies of any letters of support or other indicators that could be used to convince potential opposition within the radiation oncology community that we are indeed full members of the team.

It is also very significant that Dr. Timothy Williams, who participated in one of the professional sessions of this year’s annual ACMP meeting, expressed his opinion that ASTRO would be willing to cooperate with AAPM on the issue of direct billing.

## **Administrators, Hospital Organizations**

Similar to radiation oncologists, we also need to demonstrate to this group that we do not want any professional fees to come from existing technical codes. All professional fees for medical physicists must come from newly created professional codes, so that we do not drain the already stretched technical fees and can continue our employment as before. A larger selection of high quality medical physicists and fewer malpractice suits would be a significant gain for hospital administrators at no cost to them.

I stated this position in an invited feature article in *Advance*, a magazine with 22,000 copies sold to a target audience of hospital administrators (Ivan Brezovich, PhD, *The Once and Future Physicist*, Vol 15, No 7, July 2005, pp. 18). I expressed the same opinion in an interview for another article in the same magazine, *Empty Nest Syndrome - Where Have All the Physicists Gone* (*Advance*, Vol 14, June 2004, pp. 41). I was also invited to give a talk by the Association of Community Cancer Centers (ACCC), where I made similar suggestions. The fact that I continue to be invited and quoted by hospital administrators indicates that they are not necessarily opposed to my suggestions.

In any communication with administrators we have to emphasize that we are not overpaid technicians, but grossly underpaid medical specialists who need to have their own professional codes to alleviate draining resources intended for technical services.

## **US Congress**

Our consulting law firm suggested specific parts of the Social Security Act that would have to be changed to allow direct billing. They considered adding physicists to the group as non-physician providers, like certified nurse anesthetists and clinical social workers. From their analysis, one can see that the law firm is under the widely held impression that medical physicists are merely extensions of the radiation oncologist, like nurse anesthetists who have to refer difficult cases to the anesthesiologist. Not surprisingly, the firm felt that Congress may be reluctant to add yet another group of technical staff to the existing list of 50 groups of providers. I believe that it would be more promising to ask Congress to classify medical physicists as providers by virtue of our status as medical specialists. We are providing our services at the request of the radiation oncologist, similar to an anesthesiologist who puts a patient to sleep when needed by the surgeon. We are not working under anybody's supervision when we verify IMRT plans or commission an accelerator.

Although Congress could add us to the group of providers based purely on merit, it is unlikely to happen without the customary lobbying. Since we did not ask or get from the law firm an estimate for the cost of this endeavor, I will try to make an educated guess based on expenditures by other medical societies.

Table 1 shows the amounts of money that were spent during the 2004 election cycle by medical PACs (political action committees) on congressional lobbying. Based on the many positive comments I have received from clinical medical physicists, I believe that we would be able to raise a sum in line with that of the other providers. Note that even the most generous ones spend less than \$50 per member during each (2-year) election cycle (\$25 per member per year). It is also interesting that nurse anesthetists (about 32,000 members) spend a relatively large amount of

money, although even that amounts to no more than about \$ 20 per member per year. The relatively high sum is a reflection of their competing against anesthesiologists for the same patients and the same services. It is also noteworthy that hospital-employed nurse anesthetists have an income in the range of \$125,000 to \$150,000 per year, about twice that of other hospital employees with comparable qualifications. In private practice, their income is in the \$300,000 range. The ensuing desirability of the profession provides a wide selection of applicants, allows standards to be raised, and ultimately benefits the patient.

Table 1. Money spent by Medical PACs for lobbying during the last election cycle

Cardiology	\$ 267,300
Emergency Physicians	\$ 882,992
Nurse Midwives	\$ 172,085
Nurse Practitioners	\$ 24,425
Internal Medicine	\$ 79,452 (1998)
	\$ 000 (2004)
Nurse Anesthetists	\$ 1, 290,540
ASTRO	\$16,685 (90,456 collected)
ACR	\$1,008,849 (\$ 1,067,781 collected)

As physicists, our services are distinctly different from any other profession, and that greatly reduces lobbying costs. Nurse midwives, e.g., spend much less on lobbying than nurse anesthetists. Their services are limited to uncomplicated vaginal deliveries, and therefore are only marginally competing with obstetricians who are the only ones allowed to carry out the much better reimbursed caesarian sections. Furthermore, the therapeutic medical physics community is small, having only about 2,500 members. Any increase in health care expenditures caused by such a small group would be well below the radar screen of the healthcare administration and could be attached to virtually any Congressional bill, further lowering the cost of lobbying. One can also argue that more accurate dose delivery will lead to fewer complications, higher cure rates and may even reduce long-term health care expenditures. It is also to our advantage that the request for provider status is very reasonable and logical. We are not asking for anything unusual or special, all we want is escape the current special lack of recognition.

To get a better estimate of how much money for lobbying could be raised, I propose that AAPM sends out a questionnaire or, even better, a request for pledges for contributions to a PAC devoted to attaining direct billing privileges. I know countless physicists who would be willing to make substantial contribution to this vital effort. I was even approached by a recruiting company offering \$2,000 per year for a medical physicists PAC; I had to take a rain check.

It is also in our favor that current campaign financing laws prohibit contributions from the general operating funds of organizations; all contributions to a PAC (political action committee)

must come voluntarily from individual members. This preempts any potential disagreement about the use of AAPM funds.

Another so far untapped resource are the many personal connections of physicists with members of the US Congress. Contrary to popular belief, physicists are excellent politicians - when they put their minds to it. US Representatives Rush Holt, PhD (D), New Jersey and Vernon Ehlers, PhD (R), Michigan, both physicists by training, are just two of the most noticeable examples.

A group of physicists used their own financial resources and personal connections to get a Chairman's letter from the late Sen. Moynihan (Chairman, US Senate Finance Committee), co-signed by Reps. Rostankowski (Chairman of the Ways and Means Committee), and Dingell (Chairman, Committee on Energy and Commerce), asking HCFA to investigate the method by which medical physicists are paid. These were among of the most powerful politicians in Washington, and it may have taken only little support by our professional organizations to make direct billing a reality. I talked to the staff of Sen. Richard Shelby and made substantial progress, but was eventually told that they cannot proceed until AAPM supports the concept. So the current challenge is to get AAPM to continue following the wishes of their membership.

#### Licensure NOT required for direct billing

The law firm also pointed out precedents of provider status in the absence of licensure. The Social Security Act § 1861(hh); *Medicare Benefit Policy Manual*, Pub. 100-02, Ch. 15, § 170 defines a Clinical Social Worker (CSW) as an individual who possesses a master's or doctor's degree in social work, ..... in a state that does not provide for licensure or certification, has completed at least two years or 3,000 hours of supervised clinical social work practice under the supervision..." Any qualified medical physicist meets such requirements. The absence of correlation between direct billing and licensure reconfirms what Dr. Hendee had published in an AAPM Newsletter in the year 1997.

#### Medical Physicists

Some of the most vocal opposition to direct billing comes from physicists in the diagnostic subspecialty. Such opposition is hard to understand, considering that elevation of any one subspecialty would enhance the standing of all others, and the cost would be borne by individual volunteers. Disagreement about priorities within ACR led to the establishment of ASTRO and later ACRO, now the leading organizations for therapeutic radiologists. A dialogue to pinpoint the reasons for the objections and some flexibility seem preferable to the establishment of a separate therapeutic physicists group. Nevertheless, formation of such a society parallel to AAPM has to remain an option. It is a viable one, considering that the number of therapeutic physicists exceeds the number of radiation oncologists that was present when ASTRO was formed.

Opposition by therapeutic physicists typically comes from established academicians and some owners of physics service groups. I believe all parties would benefit from direct billing. It is understood and accepted in any radiology department that the group leader cannot handle as large a patient load as other members, yet his/her compensation is the highest nevertheless. So it is unlikely that any chief physicist in a large department would lose. Teachers in physics residency programs could openly discuss the professional aspects of their subspecialty, a subject that is

currently taboo. Attracting more and better students would be an added benefit. (One of our current radiation oncology residents has a PhD from a first-class university in medical physics, but switched specialties when he realized the true nature of his original choice.)

Also, I cannot imagine how owners of physics service companies could lose. In order to maintain employment, the physicists would have to sign over their billing rights to the company, as it is done in physicians groups. It would still be up to the owner of the company to set the salary. Of course, the physicist could leave the group instead of signing over his billing rights, but this is not much different from the current situation. Any employee can leave the employer and start his own company, and compete on the basis of price and quality. With direct billing, competition on the basis of low price would be eliminated since the hospital would have no incentive to get a potentially unqualified low bidder if the savings did not go to the hospital.

## **CONCLUSIONS**

Substantial progress toward direct billing privileges by therapeutic medical physicists has been made. The need for licensure in all 50 states, a frequently quoted stumbling block, has been shown as non-existent. Radiation oncologists seem to accept the idea, and even hospital administrators have not openly shown opposition. Extrapolating from other providers suggests that lobbying expenditures are within our means. It is now up to the AAPM and its leaders to follow through on this groundbreaking work and elevate our profession to the status that we imply when recruiting dedicated, young physicists to join our profession.