Surgical PA Reimbursement Update

PAs in Orthopaedic Surgery Conference

September 8, 2021

Nashville, TN

Michael L. Powe, Vice President

Reimbursement & Professional Advocacy

American Academy of PAs

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Although every reasonable effort has been made to assure the accuracy of the information herein, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of the service and those submitting claims.

- **Medicare payment policy changes frequently. Be sure to keep current by accessing the information posted by your local Medicare Administrative Contractor and by CMS on www.cms.gov.**
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PA Title Change

- May 2021 AAPA House of Delegates voted to adopt "Physician Associate" as the official title of the profession.
- The change will more accurately describe the PA profession, better position PAs in the minds of patients and other stakeholders and increase their ability to improve care access in the ever-changing healthcare marketplace.
- AAPA's legal counsel recommends that PAs refrain from representing themselves as "physician associates" until state and federal laws and regulations recognize the new title.

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PA Title Change

- AAPA Board of Directors is discussing next steps relating to implementation of title change.
- Implementing the title change policy will be complex, challenging, and take years to complete. Specific changes will need to occur on both a state and federal level.
- AAPA will create a branding/awareness campaign to educate all stakeholders about the PA professional generally, and a new title specifically.

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Reaction from Some Physician Medical Associations

Pushback expressed include concerns over patient confusion about who provides their care and an advancement toward PA independent practice.

- AAPA responded indicating that the title "physician associate" more distinctly articulates the role and responsibilities of PAs.
- AAPA's reply noted, "We respect our relationship with your organization and the healthcare team members you represent."
- AAPA president stated that while our title is changing, our mission will not — to transform health through patient-centered, team-based medical practice.

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PA Title Change:
$Reimbursement Implications$

- AAPA will educate and engage with commercial third-party payers/insurers/HMOs.
- Medicare, Medicaid, Workers' Comp and other state and federal entities/agencies will need to officially recognize the new title.
- PA title change will likely not occur in each state at the same time.
- AAPA Title Change FAQ https://www.aapa.org/title-change-investigation/faqs/

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Direct Payment to PAs from Medicare

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Current Medicare Policy on PA Reimbursement

- Medical and surgical services delivered by PAs can be billed/have the claim submitted to Medicare under a PA's name.
- However, Medicare must make payment for those services to the PA's employer which could be a solo physician, physician group, hospital, nursing facility, ASC, professional corporation, or a professional/medical corporation substantially owned by a PA.
- There are limited examples of commercial payers paying directly to PAs/PA corporations.

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Why Is This an Issue?

- The inability to be paid directly hinders PAs from fully participating in certain practice, employment and/or ownership arrangements.
- When PAs can't be paid directly, they are unable to reassign their payments in a manner similar to physicians and APRNs.
- Creates an unnecessary distinction between PAs and physicians/NPs.
- One of the pillars of Optimal Team Practice.

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The Benefits of Direct Payment Will Authorize PAs To:

- Practice as independent contractors.
- Want to work part-time or as needed without having to deal with additional administrative paperwork associated with a formal employment relationship.
- Choose to own their own practice/medical or professional corporation.
- Work in rural health clinics (RHCs) and want to ensure they receive reimbursement for “carved out” (now Part B) RHC services.
- Work with staffing companies or medical groups and want the flexibility of re-assigning reimbursement for their services.

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Direct Payment – Important Qualifiers

- The effective date of the provision is **January 1, 2022.**

- The change in policy applies to the **federal Medicare program** and does not necessarily change reimbursement policies of state Medicaid programs or commercial payers. AAPA will use Medicare's policy to advocate for direct payment with all other payers.

- Medicare regulations **defer to state law.** If state law or regulation prohibit a PA from receiving direct pay, those restrictions will have to be removed before Medicare will directly pay PAs.

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2022 Proposed Physician Fee Schedule

- Includes implementation language on PA direct pay.
- Extends <u>certain</u> PHE telehealth coverage policies until 2023.
- Reduced the Medicare payment conversion factor by approx. 3.75%
- Proposed changes to shared visit billing (relevant for hospital-employed PAs)
- Seeks comment on allowing direct supervision/collaboration to occur virtually.

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Medicare Office-based Evaluation & Management (E/M) Outpatient Documentation Changes

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Former Outpatient Office-based Documentation Guidelines

Health professionals were required to document (or use time with counseling/coordination of care):

- Past, Family, Social History
- History of Present Illness (HPI)
- Chief Complaint (CC)
- Exam (including review of systems - an inventory of body systems)
- Medical decision making

Result: counting too many bullets/organ systems, gathering irrelevant information

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Level of E/M service based on either:

The level of the MDM (Medical Decision Making)

Total time for E/M services performed on date of encounter

Effective
January 1, 2021

Applies only to
New & Established Outpatient
Office Visits

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Levels of Medical Decision Making (MDM)

The level of MDM is the same level of MDM as previous documentation guidelines.

The providers must still meet 2 of the three broad categories:

- The number/complexity of problems
- Data, collected ordered or reviewed
- Risk levels of medical decision making

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Problem List Reminder

- Multiple problems whether new or known that are addressed at the encounter will affect the level of medical decision making.
- A long problem list may not increase the level of MDM.
- Comorbidities or underlying diseases may increase complexity if they increase the amount or complexity of data to be reviewed.
- While not directly contributing to code selection, history and exam must be performed to meet appropriate clinical standards.

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Reduce The Risk of Fraud and Abuse Allegations

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Compliance Scenario #1

A hospital in the Midwest paid back $210,739 for allegedly violating the Civil Monetary Penalties Law.

The HHS Office of Inspector General alleged improper billing for services delivered by PAs but billed under the physician's name under Medicare's split/shared billing provision.

The OIG stated the documentation requirements for a split/shared visit were not properly met. The services should have been billed under the PAs.

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Compliance Scenario #2

- A family physician repaid $285,000 to settle False Claims Act violations.
- Services provided by a NP were billed as “incident to” under the physician’s name.
- Medicare’s “incident to” provisions were not met. The payment should have been at the 85% rate.

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Promise to the Federal Government

On the Medicare Enrollment Application

"I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization . . . "

"I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

CMS 855 application https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf

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Promise to the Federal Government

On the Medicare 1500 claim form

"This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents or concealment of any material fact may be prosecuted under applicable Federal or State law."

CMS 1500 form https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500.pdf

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List of Excluded Individuals/Entities

https://exclusions.oig.hhs.gov/

Search the Exclusions Data...

An official website of the United States government. Here's how you know >

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Who Is Responsible?

The “chain of responsibility” is multi-faceted.

- Health professionals are responsible for claims submitted for services they deliver.
- Federal programs will typically expect recoupment/repayment from the entity that received the reimbursement.
- The biller (private billing company, practice or hospital billing staff) may also share in the responsibility if a mistake was made on their part in the electronic filing of the claim.

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Compliance

- In reality, most health professionals never see the actual paper or electronic claim being submitted to Medicare, Medicaid or other payers.
- Suggests the need for communication between all parties to ensure a basic comfort level with payer rules/requirements.
- PAs should be proactive in supplying basic reimbursement information to billers based on payer mix and the practice sites where they deliver care.

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Following the Rules Depends on Your Practice Setting

Location, location, location

- Office/clinic
- Inpatient or outpatient hospital setting
- Ambulatory surgical center (ASC)
- Critical Access Hospital
- Federally Qualified Health Center/Community Health Center
- Certified Rural Health Clinic
- Skilled nursing facility,
- Inpatient rehabilitation facility or psych hospital

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Anti-Kickback Statute

- Federal law prohibiting individuals from directly or indirectly offering, providing or receiving kickbacks or bribes in exchange for goods or services covered by Medicare, Medicaid and other federally funded health care programs.
- These laws prohibit someone from knowingly or willfully offering, paying, seeking or receiving anything of value in return for referring an individual to a provider to receive services, or for recommending purchase of supplies or services that are reimbursable under a government health care program.
- Requires some level of proof of intent.

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Examples of Anti-Kickback Violations

- A health professional who routinely waives patient copayments and deductibles to induce Medicare and/or Medicaid beneficiaries to receive services from the professional
- Payments to a health professional by a supplier (e.g., DME) to induce the purchase of Part B products from that supplier.
- Allowing reimbursement or professional services by a hospital-employed PA or NP to be received by a private physician/physician group that is not also employed by that same hospital.

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Anti-Kickback Violation - Scenario

- Patients of a non-hospital employed physician are in the local hospital.
- A hospital-employed PA is asked to deliver evaluation and management services (e.g., subsequent hospital visits or post-op care) to the non-hospital employed physician's patient in the hospital.
- There is not necessarily a problem with the PA being able to provide clinical services to those patients (I would prefer some type document indicating a relationship between the PA and the private practice physician).
- The question in determining if there could be a Stark/Anti-Kickback violation is who receives a benefit – either reimbursement or the benefit of professional services – from the PA-provided care.

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PA Professional Services

- Physicians who are not employed by the same entity as the PA have no ability to bill/receive payment for professional work provided by PAs unless the physician provides market rate compensation (e.g., leasing arrangement) to the PA's employer.

- Any transfer of value, including PA work/productivity, even if not reimbursed, must not accrue to a physician that doesn't appropriately compensate the PA's employer.

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Leasing PAs from the Hospital to Avoid Stark and Anti-Kickback Concerns

- Leasing means a written agreement between a PA's employer (e.g., hospital) and private physician or group for the PA delivering specified services.
- The terms of a lease agreement should specify the type, extent and duration of services.
- Compensation for such services must be at a fair market value.
- The agreement must be signed and dated by the parties and must be updated on a regular basis to reflect changes in fair market value.

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Medicare Billing Rules

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Medicare Reimbursement Myths

- PAs cannot see new patients
- Physician must be on-site when PAs deliver care.
- Physician must, at some point, see every patient.
- A physician co-signature is required whenever PAs treat patients.
- 85% reimbursement for services provided by PAs means practices lose money when utilizing PAs.
- Without enrollment, commercial payers won't cover services delivered by PAs.

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Overarching Scope of Practice

- "If authorized under the scope of their State license, PAs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests . . ."
  Current Procedural Terminology 2021
- Individual commercial payers and state Medicaid programs can impose their own restrictions on coverage.
- Commercial payers often have limited PA coverage policy details in writing.

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Medicare Billing Policy

- Medicare statutes
- Conditions of Participation & Payment
- Medicare Administrative Manuals
- Medicare Interpretive Guidelines
- Medicare Administrative Contractors (MACs)

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COVID-19 Public Health Emergency

- Federal & state regulatory flexibilities and policies aimed at maximizing the utilization of all health professionals.
- Regulations and law changes to reduce administrative burdens and outdated requirements (e.g., physician co-signature requirements).
- Telehealth, PAs certifying home health and delivering care in nursing facilities, licensure reciprocity among the many changes.
- Some of the changes are temporary, as long as the PHE is in effect (12/31/21). AAPA advocating for flexibilities be made permanent.

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Billing in the Office Setting

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Office/Clinic Billing under Medicare

- PAs can always treat new Medicare patients and new medical conditions when billing under their name and NPI with reimbursement at 85% following state law guidelines.
- Medicare restrictions (physician treats on first visit, physician must be on site) exist only when attempting to bill Medicare “incident to” the physician with payment at 100% (as opposed to 85%).
- “Incident to” is generally a Medicare term and not always applicable with private commercial payers or Medicaid.

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"Incident to" Billing

- Allows a "private" **office or clinic**-provided service performed by the PA to be billed under the physician's name (payment at 100%) (*not used in hospitals or nursing homes unless there is a separate, private physician office – which is extremely rare*).

- Terminology may have a different meaning when used by private payers (second notice!).

www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

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“Incident to” Billing

Does the “incident to” provision apply to services provided in hospitals?

Medicare’s “shared visit” rules can apply in a hospital setting.

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“Incident to” Rules

- “Incident to” billing is an option, and not required to be used.
- The PA must be a W-2 employee (or have a 1099 Independent contractor) or have a leasing arrangement.
- Requires that the physician personally treat the patient on their first visit for a particular medical condition/illness, and provide the exam, diagnosis and treatment plan (plan of care).

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“Incident to” Billing

- The original treating physician (or another physician in the group) must be physically present in the same office suite.
- Physician must remain engaged to reflect the physician’s ongoing involvement in the care of that patient.
- How is that engagement established? Physician review of medical record, PA discusses patient with physician, or physician provides periodic patient visit/treatment.

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“Incident to” Billing

- Is there a requirement for the physician to co-sign the chart/medical record when a PA delivers an “incident to” service?
- Nothing in national CMS policy requiring a physician co-signature each time the PA treats a patient under “incident to.”
- However, always follow the specific requirements of your local Medicare Administrative Contractor (MAC). A suggestion by a MAC is not a requirement.

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“Incident to” – New Problem

- Halfway through the exam, the patient tells you they have a new medical problem/condition.
- How is that new medical problem handled? Disrupt the physician’s schedule to diagnose and treat the new problem?
- PA can handle the new problem at 85%.
- Now there could be one medical problem billable under “incident to” and the other problem billable under the PA at 85% creating confusion.

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“Incident to”

When must a Medicare claim have a PA’s name and NPI ?

- New patients
- Established patients with new problems
- Physician is not physically present in the office suite
- In the hospital setting (except for “shared visits”)

www.cms.hhs.gov/MLNMattersArticles/downloads/SE0441.pdf
www.hgsa.com/newsroom/news09162002.shtml

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Split/Shared Billing in Hospitals

Hospital billing provision that allows services performed by a PA (or NP) and a physician to be billed under the physician name/NPI at 100% reimbursement

Must meet certain criteria and documentation

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Split/Shared Billing Rules

- Services provided must be **E/M services.**
  (does not apply to critical care services or procedures)

- PA and physician must **work for the same entity.**

- Physician must provide a "**substantive portion**" and have **face-to-face** encounter with patient.

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Split/Shared Billing Rules

- Professional service(s) provided by the physician must be **clearly documented** with clear distinction between the physician's and the PA's services.

- Both the PA and physician must treat the patient on the **same calendar day.**

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Split/Shared Billing

What Is a Substantive Portion?

"All or some portion of the history, exam, or medical decision-making key components of an E/M service" – CMS

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

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Split/Shared Documentation

- Document at least one element of the history, exam and/or medical decision making (ex. CGS, NGS, Novitas)
- Physician need only document attestation of face-to-face contact with patient and that a substantive portion of service was performed (ex. Palmetto GBA, WPS)

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Split/Shared Billing

Documentation Guidance – Generally Unacceptable

- Agree with above," signed by physician.
- "Patient seen and agree with above/plan," signed by physician.
- "Seen and examined," signed by physician.

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Split/Shared Billing

Documentation Guidance - Acceptable

- “I have personally seen and examined the patient, reviewed the PA’s hx, exam, and medical decision making and agree with assessment and plan,” signed by physician.
- “Seen and examined and agree with above/plan,” signed by physician.
- “Seen and agree”

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Split/Shared Billing

- No physician face-to-face encounter
- Physician failed to see patient on same calendar day
- Improper documentation of physician involvement
- Any other criterion not met

Bill under the PA for 85% reimbursement

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Procedures (Office or Hospital)

- PAs are covered by Medicare for personally performing procedures and minor surgical procedures.
- Can't be shared; must be billed under the name of the professional who personally performed the procedure.
- Physical presence of the physician is not required for billing.

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What about that 15%

Without split/shared or incident-to billing, Medicare payment is at 85% of the physician rate

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Office/Outpatient Visit: Established Patient

CPT Code	Work RVU	Non-facility Price* Physician	Non-facility Price* PA/NP
99213	0.97	$83.00	$70.55

15%=$12.45

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Discounted Reimbursement

Contribution Margin

a) What was the cost of providing the service?

b) What was the reimbursement/revenue?

c) What is the margin?

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PA-Physician Office "Contribution" Comparison Model

Assumptions:

- 8-hour days (7 clinical hours worked per day)
- 15-minute appointment slots = 4 visits per hour = 28 visits per day
- Physician salary $250,000 ($120/hr.); PA salary $110,000 ($53/hr.)
- 2,080 hours worked per year

Example does not include overhead expenses (office rent, equipment, ancillary staff, etc.)

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PA Contribution Model at 85% Reimbursement

A Typical Day in the Office	Physician	PA
Revenue with physician and PA providing the same 99213 service	$2,324 ($83 X 28 visits)	$1,975 ($70.55 X 28 visits) [85% of $83 = $70.55]
Wages per day	$960 ($120/hour X 8 hours)	$424 ($53/hour X 8 hours)
“Contribution margin” (revenue minus wages)	$1,364	$1,551

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Cost Effectiveness Takeaway Points

- The point of the illustration is not that PAs will always produce a greater office-based contribution margin than physicians.
- That may or may not happen (more likely in primary care/internal medicine vs. surgery or specialty medicine).
- However, PAs generate a substantial contribution margin for the practice even when reimbursed at 85% of the physician fee schedule.
- An appropriate assessment of “value” includes revenue generation, non- revenue generating professional activities and the cost to employ health professionals.

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Cost to Employ

• Salary	PA <physician
• Benefits (PTO, CME allotment, etc.)	PA ≤ physician
• Recruitment/Onboarding	PA ≤ physician
• Malpractice Premiums	PA < physician
• Overhead (building, staff, supplies)	PA = physician

Cost to employ PA is substantially lower

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Added Value

- PAs increase access to the practice. No reason for patients to wait 2 weeks to get an appointment when they can see the PA in 2 days. Extended waits for appointments will cause some patients to seek out other practices.

- PAs can provide surgical post-op global visits, freeing physicians to see new patients and consults, and perform other procedures which generate additional revenue.

- PAs often facilitate communications with patients, the patient's family, hospital personnel, complete forms and order medications - activities which don't show up as revenue, but are essential to an effective, patient-centered practice.

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Global Surgical Package

- Bundled payment for all usual and necessary pre-, intra-, and post-operative care for a procedure or surgery
- 0-day, 10-day, and 90-day post-operative period
- PA contribution is sometimes "hidden"

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/globallsurgery-icn907166.pdf

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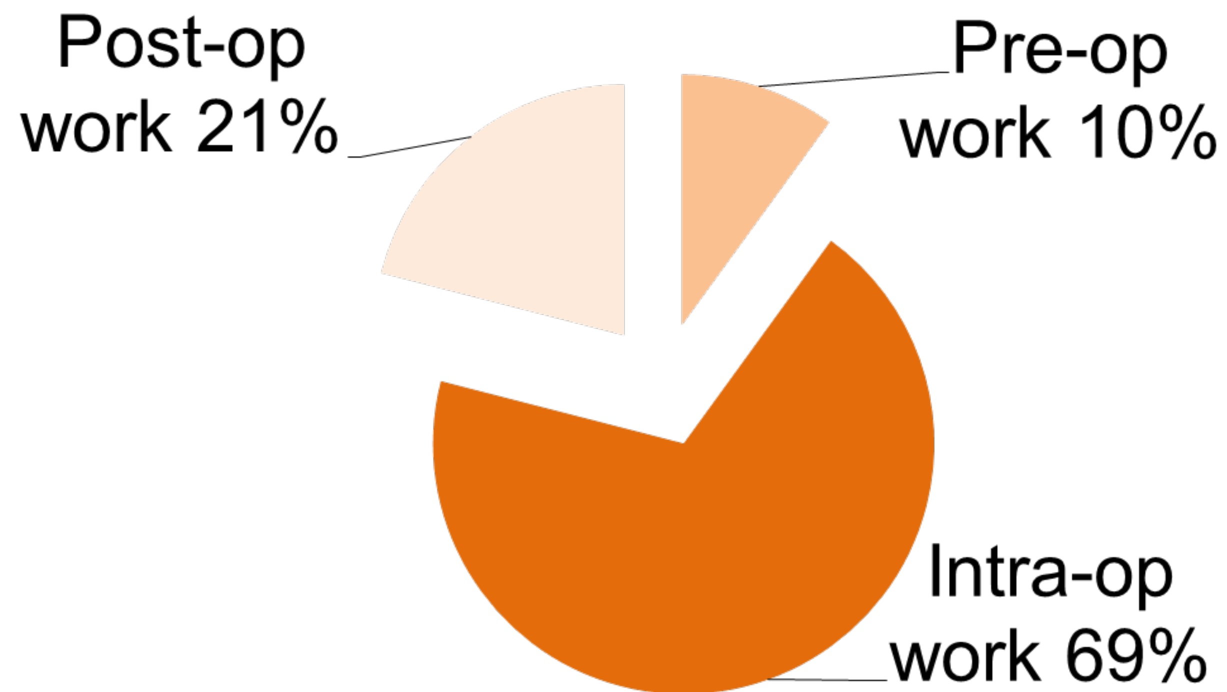
Global Surgical Package



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Global Work Contribution

- **31%** of the global payment is for work outside the OR.
- If the PA is doing the pre-op H&P, the post-op rounds, and the post-op office visits, then **31%** of the global payment could, theoretically, be applied to the PA.
- Additionally, 31% of the Work RVU attributed to the procedure could be applied to the PA.

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Global Work Contribution

Example:

27130 Total Hip (payable at $1,401*)

Pre-op work (10%): **$ 140.10** → **PA**
Intra-op work (69%): $ 966.69 (surgeon)
Post-op work (21%): $ **294.21** → **PA**

*Final figure impacted by geographic index

Source: CMS Physician Fee Schedule

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Global Work Contribution

- If a PA does pre-op exam and post-op rounding and office visits, **$434.31** could be "credited/allocated" to PA.
- An additional separate payment of **$190.54** can be officially credited to PA for the first assist (13.6% of surgeon's fee).
- However, billing records would show $1401 being attributed to the surgeon.

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PA Value/Contribution

True measure of global "value" might be:

First assist payment of **$190.54**

plus

E&M share of global payment **$434.31**

Total = $624.85 per THR

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CPT Code 99024

- *Postoperative follow-up visit, normally included in the surgical package*
- No separate reimbursement, no RVUs
- Captures services normally included in the surgical package

Captures post-op work provided in Global Surgical Package

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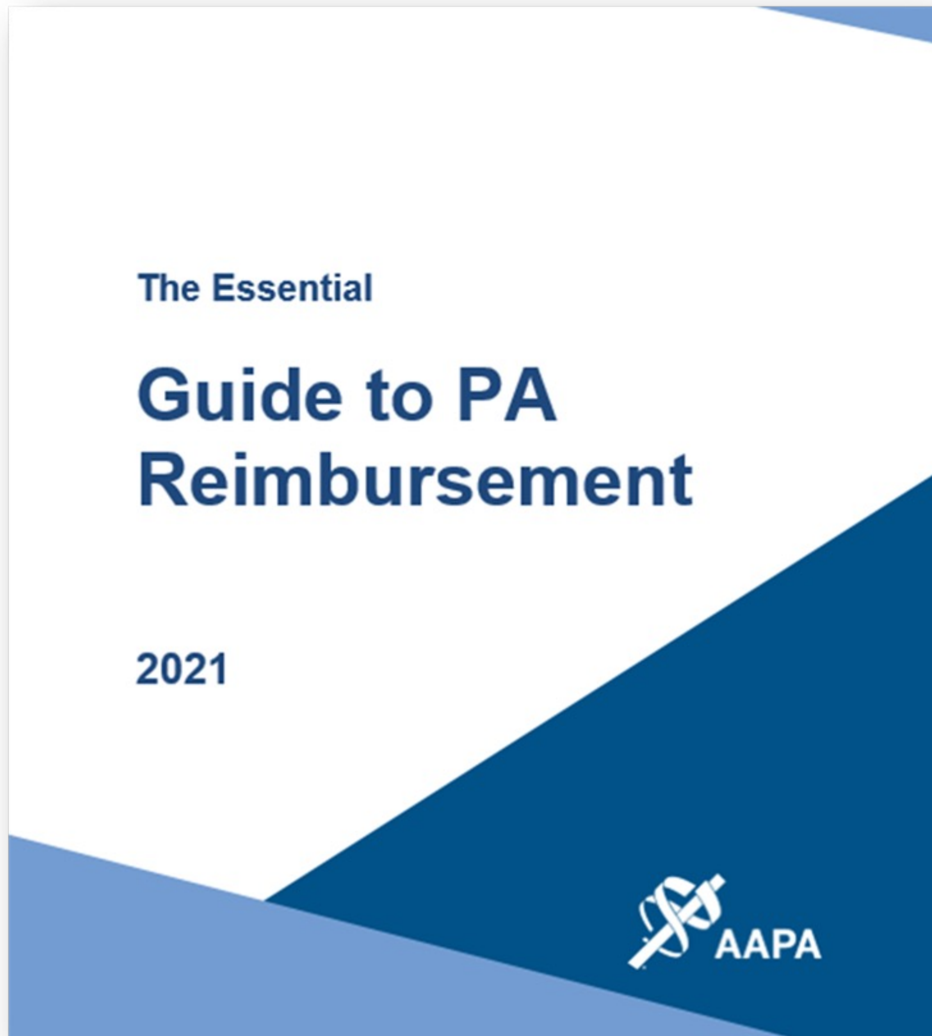
What makes it "essential"?



- Nearly 100-pages of description, analysis, and implications of reimbursement policy affecting PAs in all settings
- More than 300-pages of appendices compiled into a tool for reference and research
- A comprehensive glossary of reimbursement terms

Member Price - $25

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Questions

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