American Academy of PAs

Reimbursement for Family Medicine

We Are Family (Medicine) Conference
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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 and commercial payer policies are subject to change. Be sure to stay current by accessing information posted by your local Medicare Administrative Contractor, CMS and commercial payers.**
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Educational Objectives

At the conclusion of this session, participants should be able to:

- Review billing rules and payment policies affecting PAs
- Describe documentation and coding for healthcare services
- Discuss implications of fraud and abuse

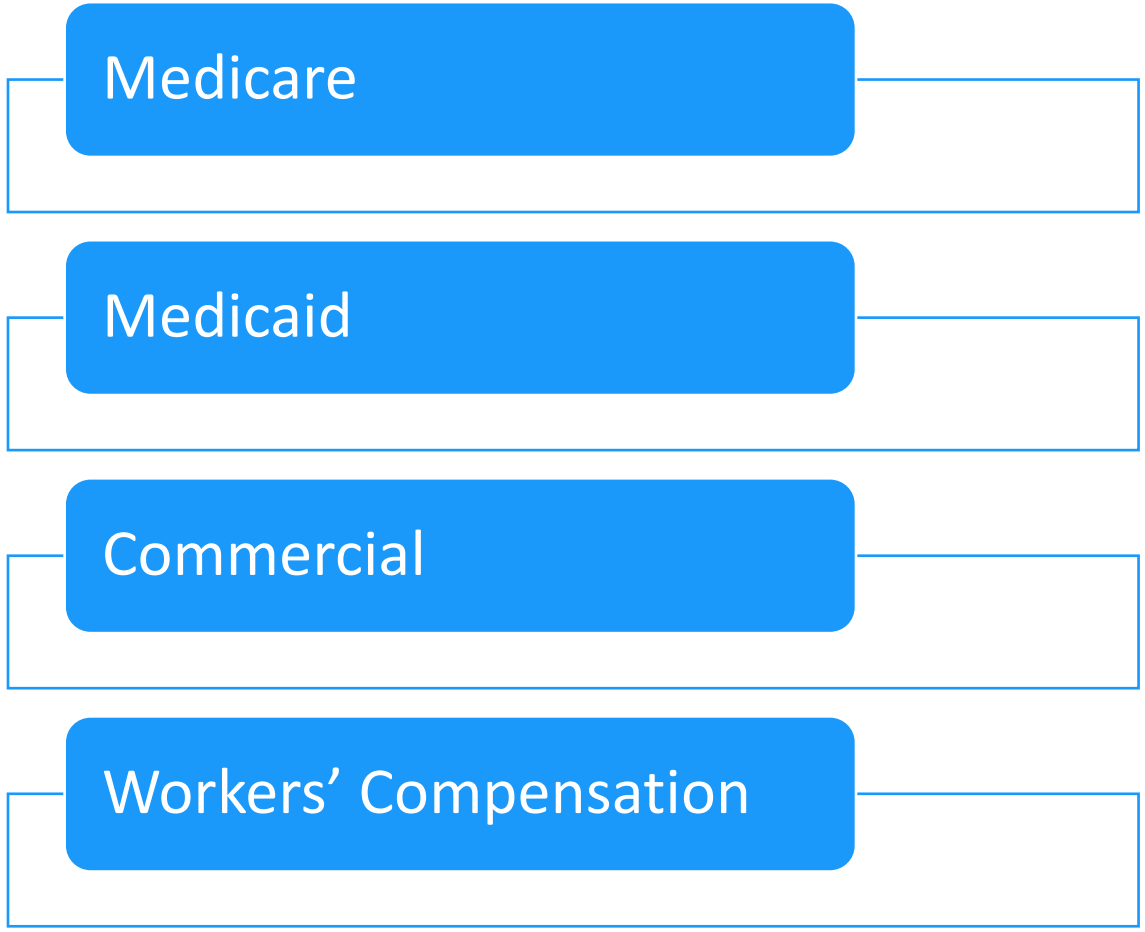
PAs, NPs and Medicare Payment Policies

- Detailed information about NP reimbursement can be obtained from the American Association of NPs (AANP) https://www.aanp.org/

- Nearly all of Medicare's reimbursement & coverage policies are the same for both professions.

- Similarities exist between the utilization and practice of PAs and NPs. AAPA works closely with AANP on reimbursement, legislative and regulatory issues of mutual interest.

Payers Often Have Multiple Plans/Policies



- Medicare Fee-for-service
- Medicare Advantage
- Medicaid managed care options
- State, federal and employer (self-funded) health plans administered by commercial payers

Direct Payment to PAs from Medicare

Previous Medicare Policy on PA Reimbursement

- Medical and surgical services delivered by PAs have been covered and billable to Medicare under a PA's name.
- Medicare was required (by law) to make the payment for PA-provided services only to the PA's employer (physician, physician group, hospital, nursing facility, ASC, professional corporation, or a professional/medical corporation up to 99% owned by a PA).
- As of 1/1/21, PAs became eligible to receive direct payment, and PAs can own 100% of a state-approved corporation that receives payment directly from Medicare.
- Need to re-enroll with the Medicare program to receive direct payment.

The Benefits of Direct Payment Will Be Especially Important to PAs Who:

- Practice as independent contractors (1099 relationship).
- Want to work part-time without having to deal with additional administrative paperwork associated with a formal employment relationship.
- Choose to own a practice/medical or professional corporation.
- Work in rural health clinics (RHCs) and want to ensure they receive reimbursement for “carved out” (Part B) services.

PA Direct Payment

- Just as with NPs, direct payment does not change scope of practice.
- Medicare's rate of reimbursement (85%) for PAs/NPs does not change.
- Similar to physicians and NPs, the majority of PAs will likely maintain their traditional W-2 employment arrangement with employers and not pursue direct payment.
- Direct payment is an option (not required).

Office-based Documentation

- A “medically appropriate” history and/or examination must be performed
- Neither the history nor exam contribute to the level of service

Level of Medical Decision Making (MDM)

Based on 3 Elements

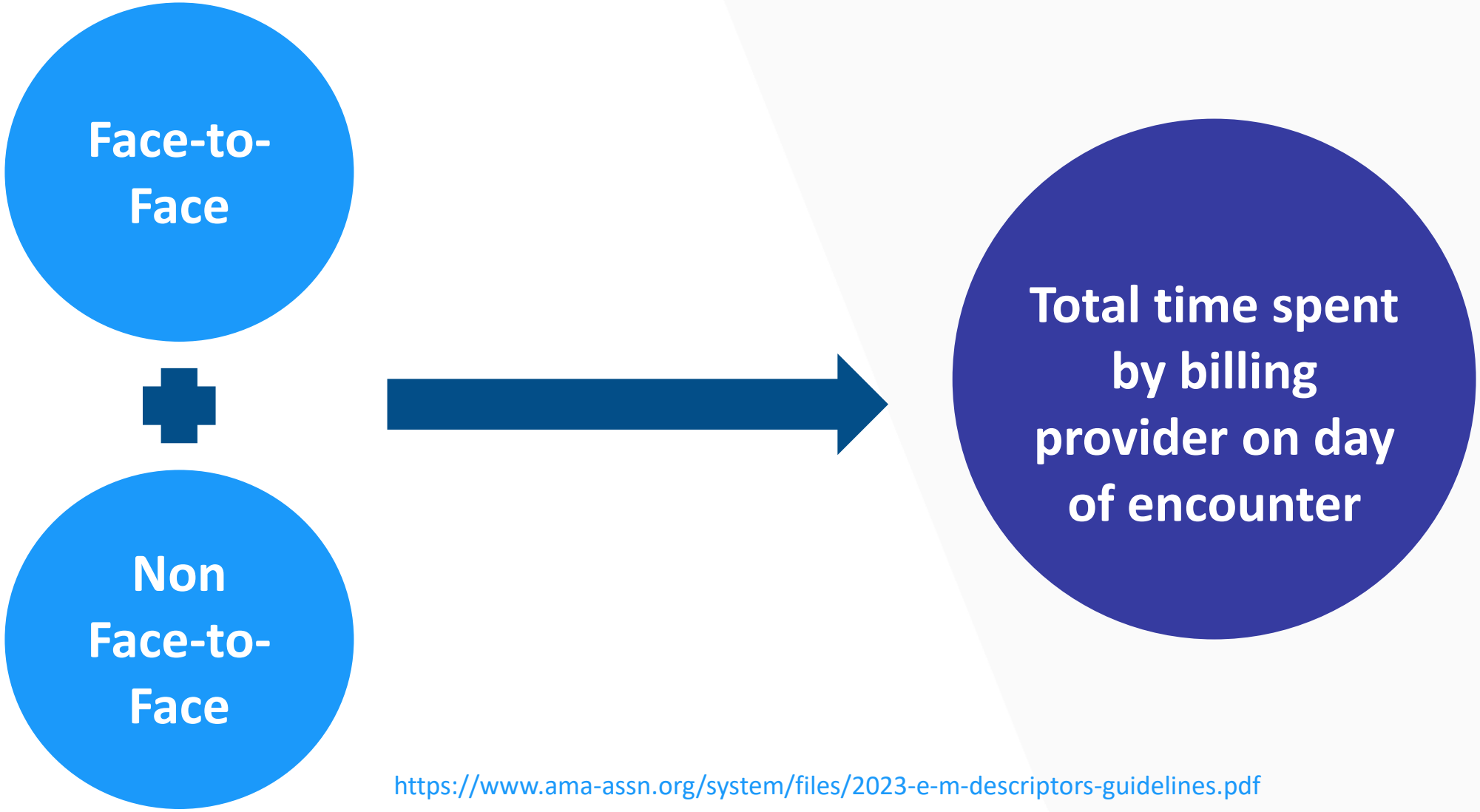
NUMBER & COMPLEXITY OF PROBLEMS

AMOUNT & COMPLEXITY OF DATA REVIEWED

RISK OF COMPLICATIONS, MORBIDITY & MORTALITY

MDM Element	Examples of Element
Problems	One versus multiple, severity, acute versus chronic, stable or exacerbation
Data	Review of external note(s), number of tests ordered or reviewed, independent interpretation of tests
Risks	Number & type of management options, risk to patient, socioeconomic limitations, level of needed care (outpatient versus inpatient)

Time-Based Billing



https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Time-Based Billing

Qualifying Time

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Documenting clinical information in the electronic or other health record
- Referring and communicating with other healthcare professionals
- Care coordination

https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Time-Based Billing

The following do NOT count toward Qualifying Time

- Travel
- Performance of other services that are separately reportable/payable
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

Additional Resources

https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

CMS Open Payments Program

CMS Open Payments Program

- National disclosure database aimed at improving transparency by identifying financial relationships between the pharmaceutical and medical device manufacturing industries, and health care professionals.

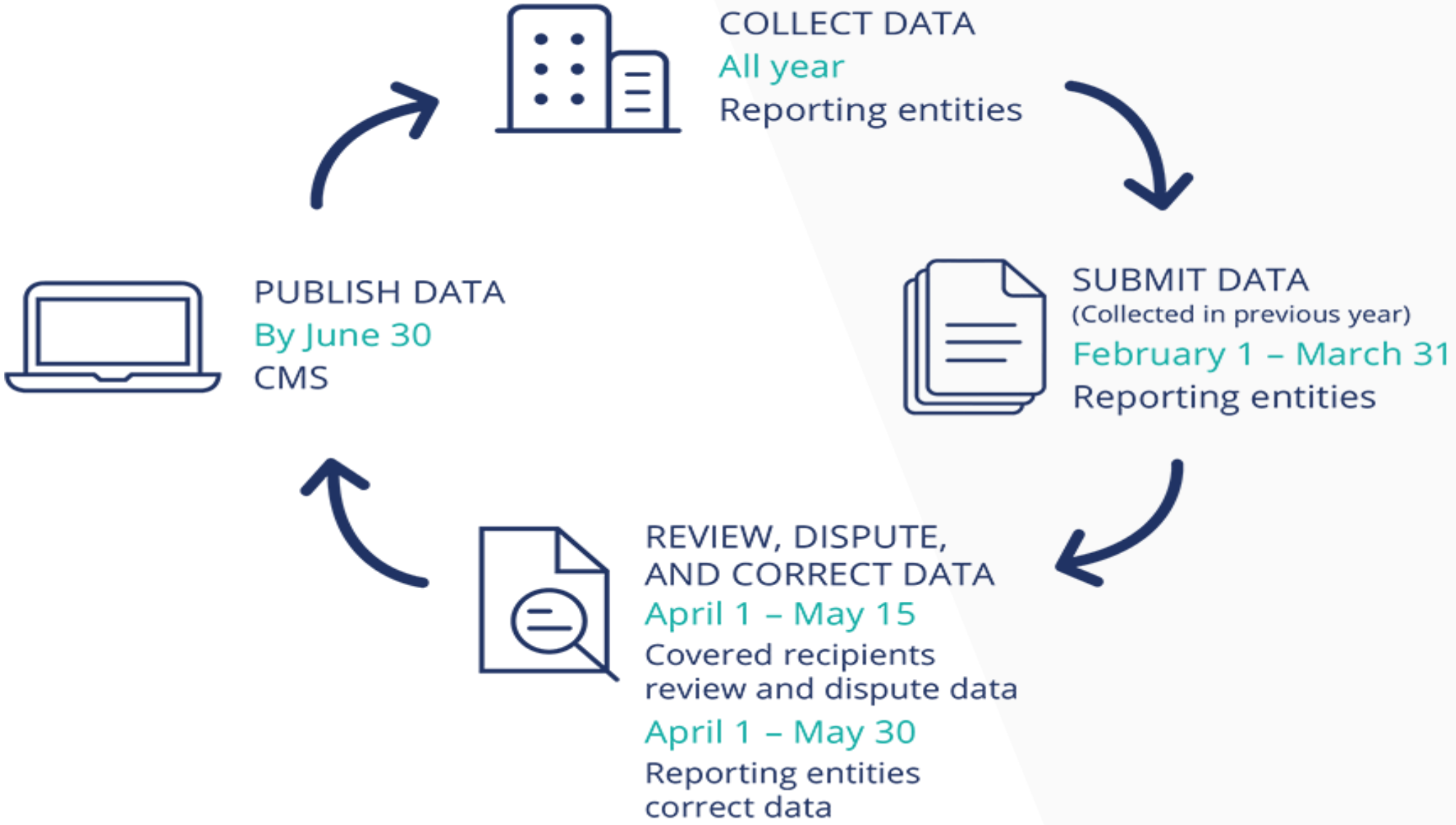
- CMS does not offer an official opinion regarding whether financial relationships are appropriate, or cause conflicts of interest.

- Legitimate reasons for payments or transfers of value to health professionals captured on the Open Payments site may including honorarium for delivering CME, participating in research, consulting activities, etc.

CMS Open Payments Program

- CMS will not reach out to health professionals when information is placed in the Open Payments data base under their name.
- To view collected data register through the CMS.gov Enterprise Portal.
- For more information, please view CMS' Open Payment explanatory video

OPEN PAYMENTS CALENDAR



Attribution to CMS

COVID Public Health Emergency

- **<u>The PHE will end on May 11, 2023.</u>**
- Be cautious of changing coverage and payment policies for Medicare, Medicaid, commercial policies and state laws/regs.
- Continuing to utilize PHE policies/flexibilities could lead to allegations of fraud.

COVID Public Health Emergency

Examples of PHE changes:

PAs/NPs authorized to perform all physician services in skilled nursing facilities under Medicare – ended May 2023.

Patients can be under the care of a PA/NP (instead of only a physician) – will end on May 11, 2023.

Exception – many telehealth flexibilities will remain in place until the end of 2024.

Reducing Fraud and Abuse Concerns

Error	Abuse	Fraud
Mistakes Errors in coding & documentation	**Improper or Inappropriate Actions** Upcoding/Downcoding, waving deductibles, billing for non-medically necessary services	**Intentional Deception** Falsifying records, billing for services not provided

Costs U.S. healthcare system tens of billions of dollars annually.

Compliance Scenario #1

- A 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.

Compliance Scenario #2

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.

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

Who Is Responsible?

The “chain of responsibility” is multifaceted.

- 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.

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.

Following the Rules Depends on Your Practice Setting

Location, location, location

- Office/clinic
- Outpatient clinic owned by a hospital
- Certified Rural Health Clinic
- Ambulatory surgical center (ASC)
- Critical Access Hospital
- Federally Qualified Health Center/Community Health Center
- Skilled nursing facility,
- Inpatient rehabilitation facility or psychiatric hospital

Medicare Reimbursement Myths

- PAs can’t treat new patients
- Physician must be on-site when PAs deliver care.
- Physician must see every patient a PA treats in the office/clinic.
- A physician co-signature is required whenever PAs treat patients.
- State, facility and commercial payer policies may be different/more restrictive than Medicare.

Overarching Scope of Practice

- State law ultimately determines scope.
- Individual commercial payers and state Medicaid programs can impose their own scope of practice rules (but can't supersede state law).
- Commercial payers often have limited scope of practice policy details in writing as compared to Medicare.
- "These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service."

  Current Procedural Terminology Guidelines 2023

Collaboration, Supervision and Beyond

- Medicare traditionally used the term “supervision” to describe how PAs practice with physicians.
- As of January 1, 2020, CMS modified its regulations and defers to PA state law in terms of the professional working relationship, if any, PAs have with physicians.
- The Medicare program will allow collaboration or other terms used by individual states to meet Medicare’s supervision requirement.
- NP Medicare policy uses the term collaboration and also defers to state law.

Medicare Billing Rules

Billing in the Office/Clinic

“Incident to” Billing

- **PAs/NPs can always treat new Medicare patients and and patients with 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.

“Incident To”

Services that are “an integral part of a patient’s course of treatment” and incidental to the “normal course of treatment” established by another practitioner

Optional Medicare Billing Mechanism

Only applies in non-facility-based medical office (Place of Service 11)

“Incident To” Billing Requirements

to bill PA & NP services “incident to” a physician

A physician MUST

- **Personally perform an initial service**
- **Establish diagnosis** and **initiate treatment**
- Provide **ongoing, active participation** and management in patient’s care, including subsequent services
- Provide **“direct supervision”** – be **present** in the **office suite** and **immediately available** during the “incident to” service

“Incident To” Billing Requirements

to bill PA & NP services “incident to” a physician

- Services must be **related to the treatment initiated by the physician**
- Physician and PA or NP must work for the **same entity**
- Only applies to services PAs or NPs are authorized to provide

“Incident to” Does NOT Apply

New Patients

New Problems

New Treatments Plans for Est. Patients

“Incident to” Does NOT Apply

Inpatient & Observation Services

Hospital Outpatient Services

- **Outpatient Clinic**
- Emergency Department
- Same Day Surgery Center

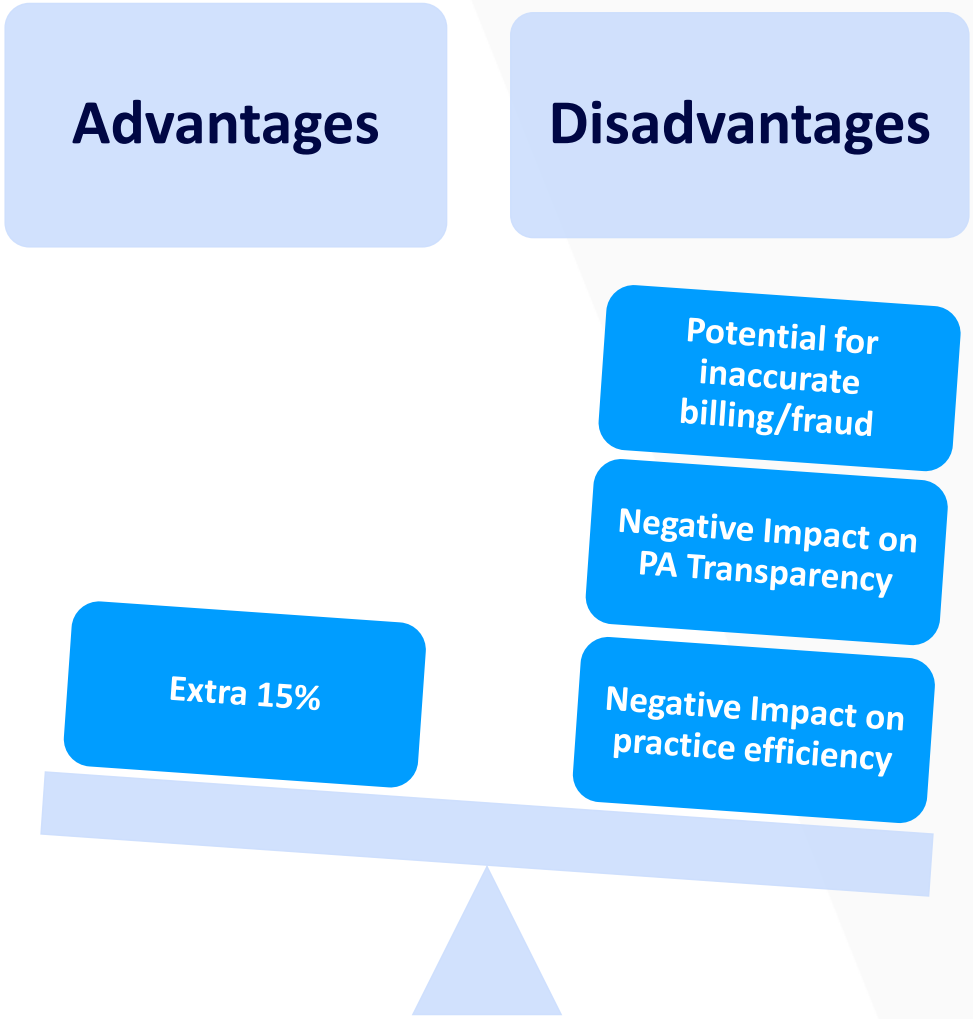
Inpatient Nursing & Rehabilitation Facilities

Some hospital-owned practices are considered ‘hospital outpatient clinics’ (Place of Services &), and ineligible for “incident to” billing

“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.

Is Billing “Incident to” Worth it?



CMS’ Evolving Split/Shared Hospital Billing Policy

Split (or Shared) Billing

Medicare hospital billing provision that allows services performed by a PA and a physician to be billed under the physician's name/NPI at 100% reimbursement. PAs can treat new or established patients when billing under their own name and NPI.

Must meet specific criteria and documentation requirements

Split/Shared Visit Billing

Services eligible for split (or shared) billing

- Evaluation and management services (e.g., hospital inpatient and observation services, emergency department services, etc..)
- Critical care services (effective 1/1/22)
- Certain SNF/NF services (effective 1/1/22)

Option for split/shared billing does NOT apply to procedures

PA and physician must **work for the same group**

PA and physician must be involved the patient on the **same calendar day**

Physician must provide a "**substantive portion**" of the encounter

Either PA or physician must have face-to-face encounter with patient

Documentation must identify the practitioners who contributed to the service and the billing physician must sign & date the medical record

-FS Modifier must be included on claim to identify service as split (or shared)

Split (or Shared) Billing

Substantive Portion

Prior to 1/1/22

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

Split (or Shared) Billing

Substantive Portion

For 2022 for Physician to Bill

Physician must perform one of the key components (history, exam, or medical decision-making) "in its entirety"

-OR-

Spend more than half of the total visit time with the patient (already required for critical care and discharge management)

https://public-inspection.federalregister.gov/2021-23972.pdf

Key Component as “Substantive Portion”

- The “substantive portion” performed by the physician is what determines the level of service.

- A PA and a physician can both contribute to the history, exam, and medical decision making – but only the portion or service provided by the physician can be used to determine the level of service

https://www.cm .gov/files/document/r11181CP.pdf#page=6

Split/Shared Visit Quiz

- PA performs and documents the history, examination, and medical decision making and orders medication and a diagnostic test.

- Physician comes in after the PA and reviews results of diagnostic tests and response to medications, sees the patient, and documents “I saw and examined the patient who reports decreased dyspnea since initiation of treatment by PA. I reviewed and agree with the PA’s assessment and plan.”

- **Can this be billed as a split (or shared) service under the physician’s name/NPI?**

Split/Shared Visit Billing

The answer is No. The physician did not personally complete either the history, exam or medical decision making in its entirety. Also, in this example the physician did not spend more than half the total visit time involved with the patient.

Using Time as “Substantive Portion”

- Only use time of PA/NP/physician (not RN/LPN nurses, medical assistants)
- When practitioners jointly meet with or discuss a patient, only the time of one of the practitioners can be counted toward total time.
- It may be helpful for each health professional providing the split/shared visit to directly document and time their activities in the medical record.

https://www.cms.gov/files/document/r11181CP.pdf#page=6

Using Time as “Substantive Portion”

- ✓Preparing to see the patient (e.g., review of tests, medical records)
- ✓Counseling and educating the patient/family/caregiver*
- ✓Ordering medications or tests*
- ✓Documenting clinical information in the electronic or other health record*
- ✓Care coordination
- ✓Referring and communicating with other healthcare professionals*

*even after the patient has left the appointment

Split (or Shared) Billing

Substantive Portion

CMS Policy Starting ~~2023~~ 2024*

If billing under the physician, physician must account for more than half of the total visit time.

*proposed

https://public-inspection.federalregister.gov/2021-23972.pdf

What about that 15%

Without utilizing split/ shared or “incident to” billing, Medicare payment for PAs is at 85% of the physician rate

The Cost of Delivering Care – Contribution Margin

a) What is the cost of providing the service?

b) What is the reimbursement/revenue?

c) What is the margin (difference)?

Office/Outpatient Visit: Established Patient

CPT Code	Work RVU	Non-facility Price Physician (national average)	Non-facility Price PA
99213	1.3	$98.00	$83.30

15% = $14.70

PA-Physician “Contribution” Comparison Model

Assumptions:

- 8-hour days (7 clinical hours worked per day)
- 20-minute appointment slots = 3 visits per hour = 21 visits per day
- Physician salary $250,000 ($120/hr.); PA salary $110,000 ($53/hr.)
- 2,080 hours worked per year

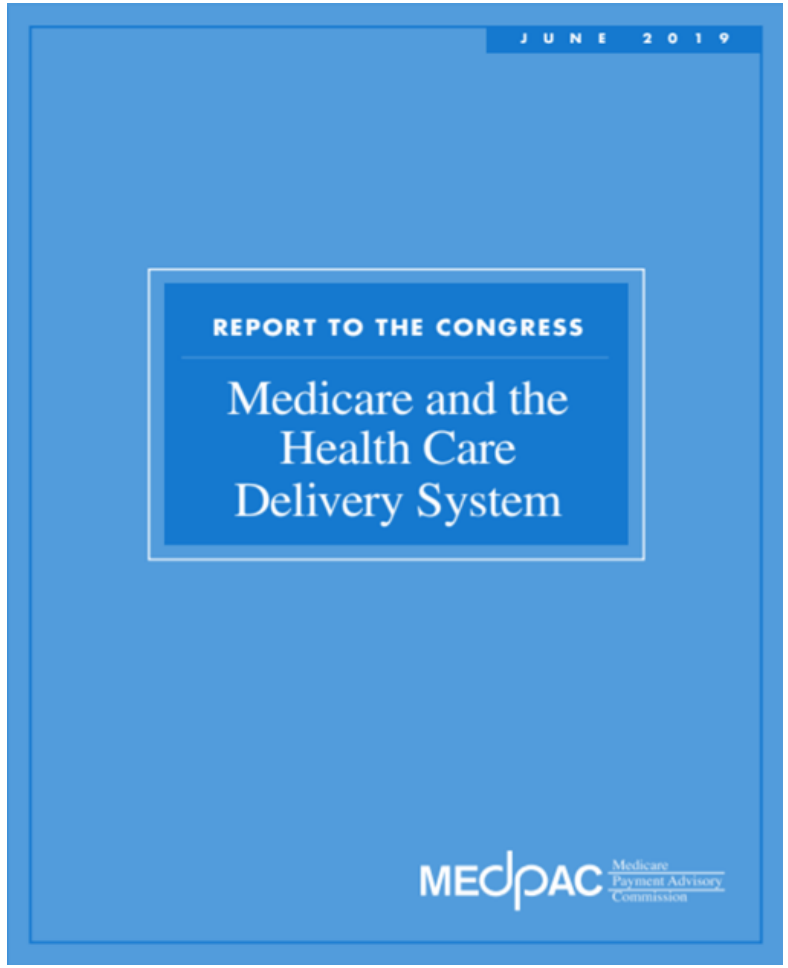
Example does not include overhead expenses (office rent, equipment, ancillary staff, etc.) which don’t change based on the health professional delivering care

Contribution Model at 85% Reimbursement

A Typical Day in the Office	Physician	PA
Revenue with physician and PA providing the same 99213 service	$2,058 ($98 X 21 visits)	$1,749 ($83.30 X 21 visits) [85% of $98 = $83.30]
Wages per day	$960 ($120/hour X 8 hours)	$424 ($53/hour X 8 hours)
"Contribution margin" (revenue minus wages)	$1,098	$1,325

Contribution Model Takeaway Points

- The point of the illustration is not that PAs will 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 practices).
- PAs generate a contribution margin for the practice even when reimbursed at 85% of the physician fee schedule.
- An appropriate assessment of “value” includes revenue generation, delivery of non- revenue generating professional services (e.g., post op care) and the cost to employ health professionals.



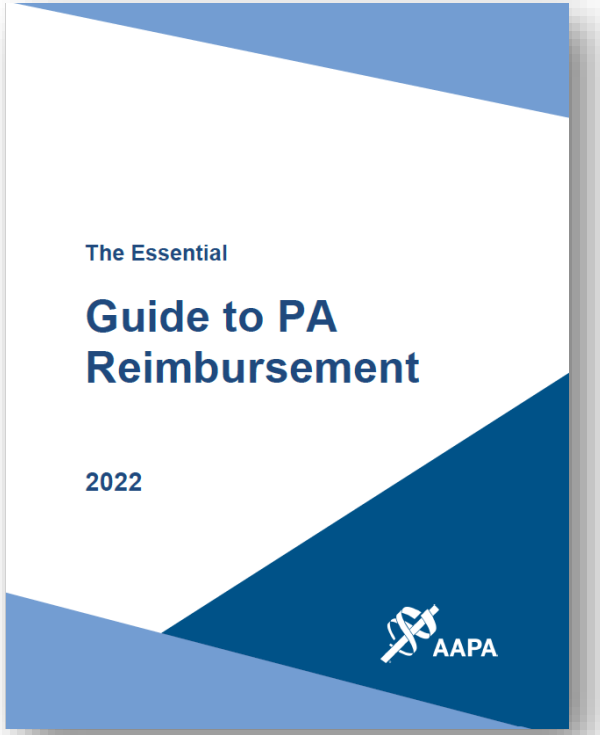
"PAs nearly always lower costs and increase profits for their employers because their salaries are less than half of physician salaries, on average, but their services can be billed at the full physician rate or at a modest discount ."

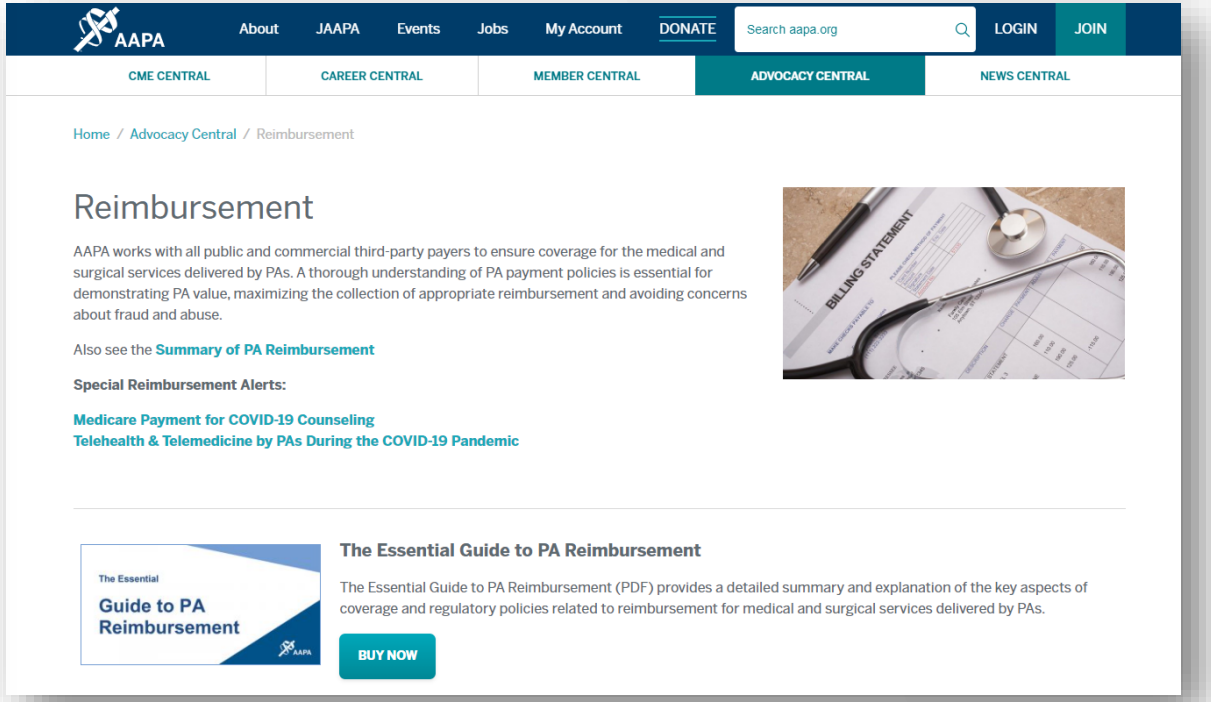
http://medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0

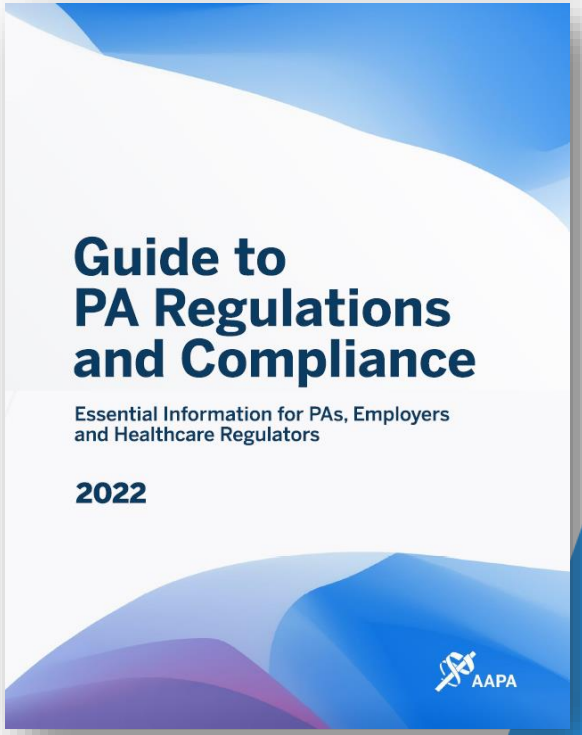
The Value of PAs/NPs

- Increase reimbursement and revenue
- Improve access to care and patient throughput
- Provide expanded hours and services
- Facilitate care coordination and communications
- Contribute to process/quality improvement and outcomes
- Improve patient and staff satisfaction

AAPA Resources







https://www.aapa.org/advocacy-central/reimbursement/

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  https://www.aapa.org/advocacy-central/reimbursement/