Hospital and Surgical Reimbursement: Rules, Reality, and Risks

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Doctor of Health Science
Leadership & Organizational Behavior -and- Fundamentals of Education

Graduate Certificate
Science of Healthcare Delivery

20+ Years
Licensed & Certified PA

10+ Years
Regulatory and professional advocacy

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- This presentation does not represent payment or legal advice
- Payer guidelines differ and regulations can rapidly change
- It is your responsibility to understand and apply reimbursement and payment rules relative to your particular state, practice setting, and payer
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Educational Objectives

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

- Describe key billing concept (e.g., direct payment, split/shared billing, etc.)
- Summarize coding, documentation, and billing guidelines
- Recognize implications of fraud and abuse

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Billing & Reimbursement Overview

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NPI (National Provider Identifier)

- 10-digit unique practitioner identifier used by insurers, mandated by HIPAA

Medicare

- All practitioners must enroll in PECOS

Medicaid

- Nearly all state programs credential/enroll PAs as rendering and billing providers

Commercial Payers

- Most credential/enroll PAs

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Medicare Billing & Reimbursement

- Physicians, PAs, & NPs
  - Recognized in the Social Security Act
  - Paid under Part B Medicare
  - May receive "direct payment" or reassign payment

- Physicians paid 100% of Physician Fee Schedule
- PAs & NPs paid 85% of Physician Fee Schedule

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Eligible Services Under Medicare for PAs

"Services that traditionally have been reserved to physicians" including "activities that involve an independent evaluation or treatment of the patient's condition"

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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Eligible Services Under Medicare for PAs

If authorized under State law and not otherwise excluded from coverage, “may furnish services billed under all levels of evaluation and management codes and diagnostic tests”

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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“Most” claims for services provided by PAs are billed in the following manner:

A. PA as the “rendering” and “billing” provider
B. Employer as the “rendering” and “billing” provider
C. PA as the “rendering” provider and employer as the “billing” provider
D. Physician as the “rendering” provider and employer as the “billing” provider

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AAPA

A. PA as the “rendering” and “billing” provider
B. Employer as the “rendering” and “billing” provider
C. PA as the “rendering” provider and employer as the “billing” provider
D. Physician as the “rendering” and physician/employer as the “billing” provider

Direct Payment (arrow pointing to A)

“Incident to” & Split (or Shared) Billing (arrow pointing to D)

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Direct Payment

- PAs authorized by Medicare for direct payment 1/1/2022
- Payment *may* be made directly to PA – but most PAs (like most physicians and APRNs) will continue to have payment go to their employer
- Allows 100% state recognized PA-owned corporations to be paid by Medicare
- Does not change payment rate, services eligible for payment, scope of practice, etc.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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Optional Medicare Billing Mechanisms

Optional billing mechanisms to receive 100% reimbursement from Medicare:

- **Split/Shared billing** (hospital- and facility-based)
- **“Incident To”** (office-based)

Warning: may lead to inefficiency, risk for fraud and abuse, lack of transparency, and other unintended consequences

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“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)

Which type of encounter is eligible for "incident to" billing?

A. New patient with new problem
B. New patient with established problem
C. Established patient with new problem
D. Established patient with established problem

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Which type of encounter is eligible for “incident to” billing?

A. New patient with new problem
B. New patient with established problem
C. Established patient with new problem
D. Established patient with established problem

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“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 **office suite** and **immediately available** during “incident to” service

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se0441.pdf

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"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

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se0441.pdf

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“Incident to” Does NOT Apply

- New Patients (CPT Codes 99202-99205)
- New Problems
- New Treatments

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"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 19 & 22) and ineligible for "incident to" billing

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"Incident To"

- New patient or new problem
- Physician not in office
- Alteration in established plan of care
- Any other criteria not met

Bill Medicare under PA

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Split (or Shared) Billing

Services performed in combination by a physician and a PA or NP in a hospital or facility setting

Optional Medicare Billing Mechanism

Does NOT apply in non-facility-based medical office (Place of Service 11)

Split (or Shared) Billing

Services Eligible for Split (or Shared) Billing

Evaluation and management services, including
- Hospital inpatient and outpatient services
- Emergency department services
- Critical care services (as of 1/1/2022)
- Certain SNF/NF services (as of 1/1/2022)

Does **NOT** apply to procedures

https://www.cms.gov/files/document/r11288CP.pdf#page=9

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Which statement about split (or shared) billing is correct?

A. Physician and PA must both have face-to-face encounter with patient
B. Physician and PA must provide their services on the same calendar day
C. Physician must perform some of the history, exam, and medical decision making
D. Physician must perform most of the history, exam, and medical decision making

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D. Physician must perform most of the history, exam, and medical decision making

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Split (or Shared) Billing Requirements

- Physician and PA must work for **same group**
- Physician and PA must treat patient on **same calendar day**
- Either physician or PA must have **face-to-face encounter** with patient
- Physician must provide a **“substantive portion”** of encounter
- -FS modifier must be included on claim to identify service as split (or shared)

https://www.cms.gov/files/document/r11288CP.pdf#page=9

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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"

Substantive Portion

For 2022 & 2023

One key component
(history, exam, or medical decision-making)
"in its entirety"

-OR-

More than half of the total time spent by the PA/NP and physician (required for critical care and discharge management services)

Substantive Portion

2024 & Beyond

CMS proposes to make definition only ‘more than half the total time’

Time as "Substantive Portion"

- Only distinct, qualifying time can be counted
- 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 practitioner providing the split (or shared) visit to directly document and time their activities in the medical record."

https://www.cms.gov/files/document/r11288CP.pdf#page=9

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Split (or Shared) Case Scenario #1

- PA performs a history, exam, and medical decision-making on a hospital encounter
- Physician reviews results of diagnostic tests and response to medications, sees patient, and documents . . .
- "I saw the patient who reports decreased dyspnea since initiation of treatment by the PA. I reviewed and agree with the PA's assessment and plan."

Can this be billed split (or shared)?

Yes/No

Split (or Shared) Case Scenario #1

No

The physician has not completed the history, exam, or medical decision making in its entirety.

Split (or Shared) Case Scenario #2

- PA performs a history, exam, and medical decision-making on an initial hospital encounter
- Physician reperforms the exam
- Physician documents their exam findings

Can this be billed split (or shared)?

Yes/No

Split (or Shared) Case Scenario #2

Yes

- Nothing precludes both practitioners performing a component or a physician reperforming a component, as long as it is done “in its entirety”

Split (or Shared) Billing

- Physician did not perform a “substantive portion”
- Physician did not provide service same calendar day
- Improper documentation
- Any other criteria not met

Bill Medicare under PA/NP

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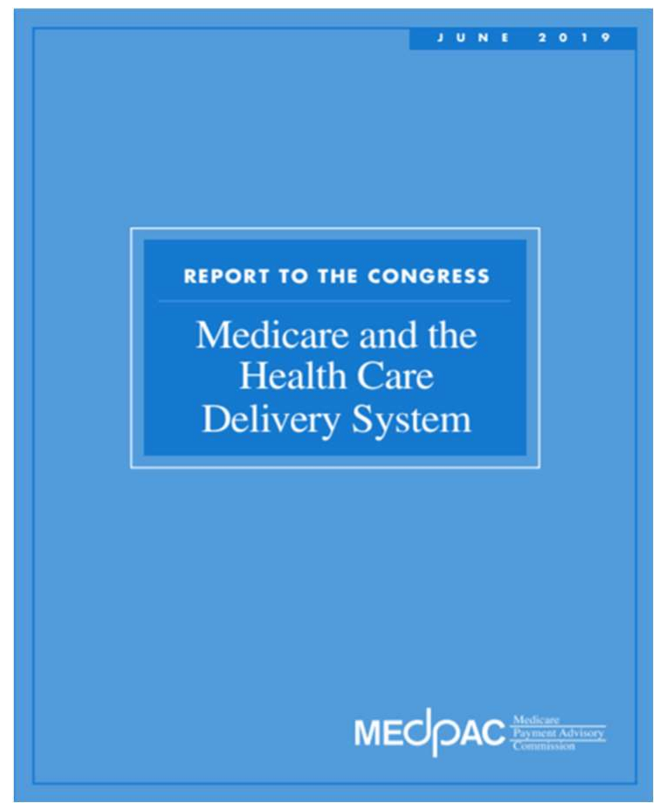
More than made up for by increased efficiency, decreased burden, and overall contribution margin.



"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

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Reimbursement & Profit

PA Reimbursement = 85% of Physician Fee Schedule

PA Salary = 30-50% of Physician Salary

Contribution margin for a PA is no less than (and sometimes greater than) that of a physician

Contribution Margin

revenue after costs

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Personnel Costs

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

Overall cost to employ PA ↓↓↓ physician

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Cost Effectiveness of PAs

A hypothetical day In the hospital	Physician	PA
Revenue with physician and PA providing the same 99232 service	$1080 ($72 X 15 visits)	$915 ($61 X 15 visits) [85% of $72 = $61]
Wages per day	$960 ($120/hour x 8 hours)	$440 ($55/hour x 8 hours)
"Contribution margin" (revenue minus wages)	**$120**	**$475**

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Cost Effectiveness Take-Aways

- Point is not that PAs produce greater revenue than physicians (they may or may not)
- Point is that PAs generate a substantial contribution margin for a practice/employer even when reimbursed at 85%
- An appropriate assessment of monetary “value” includes revenue, expenses, and non-revenue-generating services

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“Value” is More than Revenue

Definition of “Value”

- The worth of something
- Relative importance, usefulness, or desirability of something or someone

“Nowadays people know the price of everything and the value of nothing.”

Oscar Wilde

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The Value of PAs

- 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

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Coding & Documentation

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Medical Necessity and Documentation of Services

To bill for services

- Services must be reasonable and medically necessary
- Must be supported by appropriate documentation
  - Complete and legible
  - Signed and dated
  - Timely

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“If it is not documented,
it has not been done.”

Centers for Medicare & Medicaid Services

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CPT® (Current Procedural Terminology) Codes

- Codes for reporting medical services and procedures
- Most codes are authorized for use by physicians and qualified health care professionals (e.g., PAs and NPs)
- Define services and the components and documentation needed to bill various services and levels of services

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Which statement is correct about current coding and documentation guidelines?

Level of service can be based on . . .

A. Medical decision making
B. A combination of history, exam, and medical decision making
C. Time spent by practitioner and staff on day of service
D. Time spent by practitioner on day of and day before/after the service

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C. Time spent by practitioner and staff on day of service

D. Time spent by practitioner on day of and day before/after the service

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Services must follow current CPT Guidelines!

- 2023 – Changes made to inpatient, observation, emergency department, nursing facility, and home or residence services
- 2021 – Changes made to office and other outpatient services

- History and examination must be performed as is medically necessary but do not contribute to the level of service
- Level of service based on

  Medical Decision Making (MDM) and/or Time

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Level of Service Selection

Inpatient/Observation Care Services

The level of the MDM (Medical Decision Making)

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

Emergency Department Services

The level of the MDM (Medical Decision Making)

Discharge Services Critical Care Services (no change)

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

Effective 1/1/2023

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Level of Medical Decision Making (MDM)

Based on 2 of 3 Elements

Number & Complexity of Problems Addressed	Amount or Complexity of Data Reviewed and Analyzed	Risk of Complications, Morbidity, or Mortality of Patient Management

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<table>
<tr><th>Level of MDM</th><th colspan="3">Elements of Medical Decision Making (2 of 3 needed)</th></tr>
<tr><td></td><td>Problems Addressed</td><td>Data Analyzed</td><td>Risk of Patient Management</td></tr>
<tr><td>Low</td><td>Low

2 or more self-limited or minor problems
-or-
1 stable chronic illness
-or -
1 acute, uncomplicated illness or injury
-or-
1 stable acute illness</td><td>Limited
Must meet at least 1 of 2 categories

Category 1: Review of at least 2 of the following - external notes from each unique source, review and/or ordering tests (not separately reported)

Category 2: Assessment requiring an independent historian</td><td>Low</td></tr>
</table>

Level of MDM	Elements of Medical Decision Making (2 of 3 needed)		
	Problems Addressed	**Data Analyzed**	**Risk of Patient Management**
Moderate	**Moderate** 2 or more self-limited or minor problems -or- 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Moderate** *Must meet at least 1 of 3 categories* Category 1: Review of at least 3 of the following - external notes from each unique source, review and/or ordering of tests (not separately reported), and/or independent historians Category 2: Independent interpretation of a test (not separately reported) Category 3: Discussion of management with practitioner or appropriate source	**Moderate** Examples: • Prescription drug management • Diagnosis or treatment significantly limited by SDOH

<table>
<tr><th>Level of MDM</th><th colspan="3">Elements of Medical Decision Making (2 of 3 needed)</th></tr>
<tr><td></td><td>Problems Addressed</td><td>Data Analyzed</td><td>Risk of Patient Management</td></tr>
<tr><td>High</td><td>High

1 or more chronic illnesses with severe exacerbation or side effects of treatment
-or-
1 acute or chronic illness or injury that poses a threat to life or bodily function</td><td>Extensive
Must meet at least 2 of 3 categories

Category 1: Review of at least 3 of the following - external notes from each unique source, review and/or ordering of tests (not separately reported), and/or independent historians

Category 2: Independent interpretation of a test (not separately reported)

Category 3: Discussion of management with practitioner or appropriate source</td><td>High

Examples:
• Drug therapy requiring intensive monitoring for toxicity,
• Decision regarding emergency major surgery
• Decision for DNR</td></tr>
</table>

Time-Based Billing

Qualifying Time – All patient-facing and non-patient facing time spent by the billing practitioner on the day of service

- 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

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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
- Time spent by staff
- Time spent by practitioner before or after the day of service

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

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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

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Surgical & Other Services

Admissions & Discharges

- PAs authorized by Medicare and most other payers to
  - Provide admission and discharge orders
  - Perform and be reimbursed for initial hospital encounters (AKA “admissions” & H&Ps) and discharge management services (AKA discharges)

The ordering practitioner and the practitioner performing the service do not have to be the same.

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Pre-Op H&Ps

Preoperative H&P must be performed and documented on all patients prior to surgery involving anesthesia services

- Performed no more than 30 days before or 24 hours after admission or registration
- If performed 24 hours or more before surgery, an updated exam and medical review is required

PAs may perform preoperative H&Ps and updated assessments

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter08-12.pdf

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Surgical Procedures and “First Assist”

- PAs may personally perform and bill for minor surgical procedures
- PAs covered by Medicare and most other payers for assistant-at-surgery services
  - -AS modifier for Medicare
- Be aware of list of exclusion codes (procedures for which assistant at surgery is used < 5% of the time nationwide)

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Assisting at Surgery

- Scope of first-assist based on state law, facility policy, and what surgeon considers "critical or key components"
  - PAs generally considered able to perform critical/key components under direct guidance and supervision of physician
  - During non-critical/non-key components, physician does not need be present in surgical suite

Opening and closing of surgical site not generally considered "key or critical"

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

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Assisting at Surgery

Teaching Hospitals

- Based on the Social Security Act, Medicare does not generally reimburse for first assistant fees if there is a qualified resident available
- Teaching Hospital Exception allowed:
  - No qualified resident available (in required training/clinic-hours or resident-hour restrictions)
  - Physician NEVER uses a resident in pre-, intra-, and post-op care
  - Exceptional medical circumstances (e.g., multiple traumatic injuries)

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

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Global Surgical Package

Global Surgery Booklet

- 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

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

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Global Surgical Package

Includes:

- Pre-operative visits (e.g., pre-operative H&P) after the decision is made to operate
- Local infiltration, metacarpal/metatarsal/digital blocks, or topical anesthesia
- Usual and necessary intraoperative services
- Immediate postoperative care and typical postoperative follow-up care (e.g., wound care, dressing changes, suture removal, post-surgical pain management, etc.)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

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Critical Care

- Patient must be critically ill (high probability of imminent or life- threatening deterioration) and practitioner must provide “high complexity decision making”.

- PAs may autonomously perform and bill for critical care services
- As of 1/1/21, critical care may be billed to Medicare as a split (or shared) service, if all billing criteria are met

https://www.cms.gov/files/document/r11288CP.pdf#page=9

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Fraud & Abuse

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"When you submit a claim for services performed for a Medicare or Medicaid beneficiary, you are filing a bill with the Federal Government and certifying that you have earned the payment requested and complied with the billing requirements"

Centers for Medicare & Medicaid Services

MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS

"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."

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

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False Claims Act

Imposes civil liability on "any person who **knowingly** presents, or **causes** to be presented a false or fraudulent claim for payment."

Knowingly means a person has "actual knowledge of the information", acts in "**deliberate ignorance**", or "**reckless disregard**" of the truth or falsity.

"No proof of specific intent to defraud is required to violate the civil FCA."

https://www.govinfo.gov/content/pkg/USCODE-2010-title31/pdf/USCODE-2010-title31-subtitleIII-chap37-subchapIII-sec3729.pdf

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False Claims Act Penalties

In addition to refunding payments and cost to Federal government for civil action:

- Treble damages (up to 3x amount received)
- Civil monetary damages (up to more than $23,000 per claim)
- Criminal penalties (e.g., imprisonment and criminal fines)
- Exclusion from Medicare, Medicaid, and other Federal healthcare programs
- Loss of medical license

https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/#:~:text=False%20Claims%20Act%20%5B31%20U.S.C.&text=It%20is%20illegal%20to%20submit,plus%20%2411%2C000%20per%20claim%20filed.

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Anti-Kickback Statute

Prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals for services payable by Federal healthcare program business

Penalties

- False Claims Act liability and penalties
- Fines up to $100,000 per violation
- Up to 10 years imprisonment per violation

https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/#:~:text=The%20fact%20that%20a%20claim,intent%20to%20defraud%20is%20required.

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Physician Self-Referral Law (AKA Stark Law)

- Prohibits a physician from referring Medicare patients for health services to an entity with which a physician (or immediate family member) has a financial relationship
- Prohibits the health services entity with which a physician (or immediate family member) has a financial relationship from submitting claims to Medicare for services resulting from a prohibited referral

Penalties

- False Claims Act liability and penalties
- Additional fines

https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/#:~:text=The%20fact%20that%20a%20claim,intent%20to%20defraud%20is%20required.

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Federal Laws & Employment Arrangements

- Physicians who are not employed by the same entity as a PA (or NP) have no ability to bill (or receive payment) for work provided by PAs (or NPs)
- OIG determined it is improper for physicians to enter into arrangements that relieve them of a financial burden they would otherwise have to incur

Particularly problematic with a hospital-employed PA/NP and non-hospital employed physician

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Work being performed by a hospital-employed PA for a physician not employed by the same entity is subject to:

Anti-Kickback

Inurement for referrals to hospital

Stark Law

Remuneration (indirect compensation) by the hospital

False Claims Act Liability

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U.S. attorney investigating DMC over possible federal anti-kickback violations

by Jay Greene   Crain's Detroit Business

. . . **termination of the employment of 14 nurse practitioners and physician assistants** was **due, in part**, to the company's concerns that their **prior employment did not comply with the Anti-kickback Statute, the Stark law and False Claims Act**.

. . . **blatant violations** would be a hospital paying fees for admissions or services, but **could** also **include** offering doctors office leases at below market value, or free or discounted services like **advanced-practice providers' coverage of private doctors' patients**.

https://www.crainsdetroit.com/article/20180228/news/654046/us-attorney-investigating-dmc-over-possible-federal-anti-kickback

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Chicago Hospital Scam Had "Kickback on Steroids", Jury Told

by Lance Duroni Law 360

. . . Assistant U.S. Attorney Ryan Hedges walked the jury through . . . how the **hospital cloaked illegal payments** to doctors.

. . . the defendants took the conspiracy to a "whole new level" when they began **loaning out** mid-level medical professionals, including **physician assistants and nurse practitioners**, to doctors **free-of-charge** in return for patients, calling the maneuver **"kickbacks on steroids"**.

https://www.law360.com/articles/630708/chicago-hospital-scam-had-kickbacks-on-steroids-jury-told
https://www.justice.gov/usao-ndil/pr/sacred-heart-hospital-owner-executive-and-four-doctors-arrested-alleged-medicare

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Fraud & Abuse: By the Numbers

Fiscal Year 2021

Return on Investment $4.00 to $1.00

https://oig.hhs.gov/publications/docs/hcfac/FY2021-hcfac.pdf

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Take Home Points

PAs are valuable members of healthcare teams

It is important to know about billing and reimbursement

Failure to follow billing rules can result in fines and penalties

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