American Academy of PAs

Keeping Your Job: Understanding Reimbursement & Knowing Your Value

AAPA Musculoskeletal Galaxy

June 11, 2023

Michael L. Powe, Vice President
Reimbursement & Professional Advocacy
American Academy of PAs

Disclaimer/Disclosure

This presentation and any document(s) included or referenced therein are for informational purposes only, and nothing herein is intended to be, or shall be construed as, legal or medical advice, or as a substitute for legal or medical advice. All information is being provided AS IS, and any reliance on such information is expressly at your own risk.

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.**
- **I am employed by the American Academy of PAs.**
- **The American Medical Association has copyright and trademark protection of CPT ©.**

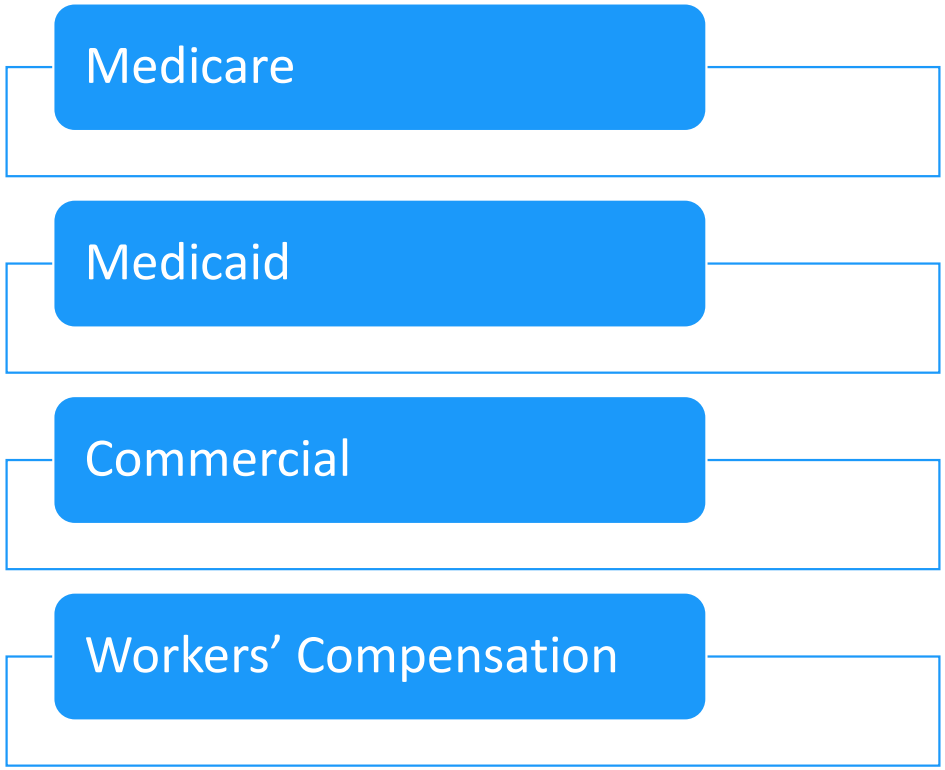
Learning Objectives

- Review changes in reimbursement policies and how PAs/NPs will be impacted.
- Discuss the current reimbursement landscape within both fee-for-service and value-based payment models.
- Identify strategies to improve recognition and tracking of the productivity and value NPs/PAs provide to their employers.

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

COVID-19 PHE Ends

The Department of Health and Human Services officially ended the Public Health Emergency on May 11, 2023.

COVID Public Health Emergency (PHE)

- Be cautious of changing coverage and payment policies for Medicare, Medicaid, commercial policies and state laws/regs. now that the PHE has ended.

- Continuing to utilize PHE-authorized policies/flexibilities could lead to allegations of fraud or abuse.

COVID Public Health Emergency – Certain Medicare Flexibilities Ended/Scheduled to End

- Hospitalized patients were able to be under the care of a PA/NP (instead of a physician) – ended on May 11, 2023.

- Certain HIPAA privacy requirements were relaxed for telemedicine visits. Skype, Apple face time and Facebook Messenger are not generally considered to be secure platforms.

- CMS allowed the on-site supervision requirement (e.g., for “incident to”) to be met remotely. That provision is scheduled to end on December 31, 2023

Medicare Telemedicine Flexibilities Continuing Through December 31, 2024

- Telemedicine allowed in any geographic area (not just in rural communities).
- Beneficiaries can receive telehealth services while in their home (instead of traveling to a health care facility).
- The use of audio-only platforms for certain evaluation and management (E/M) services are covered.

Permanent Medicare Telemedicine Changes

- Medicare patients can receive telehealth services for behavioral/mental health care in their home.
- There are no geographic restrictions for originating site for behavioral/mental telehealth services.
- Behavioral/mental telehealth services can be delivered using audio-only communication platforms.

Medical Record Documentation: Medical Decision Making or Time-based

- A “medically appropriate” history and/or examination must be performed.

- However, neither the history nor exam contribute to the level of service/CPT code billed.

Office-based Documentation

- This change has been in place since 2021.
- Overshadowed by COVID-19 pandemic and the PHE.
- EHR systems may not have been updated to recognize the new requirements.
- If you are part of an ACO or participate in risk-based hierarchical condition category (HCC) coding, your documentation requirements may be different.

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

Level of Medical Decision Making (MDM)

Based on 3 Elements

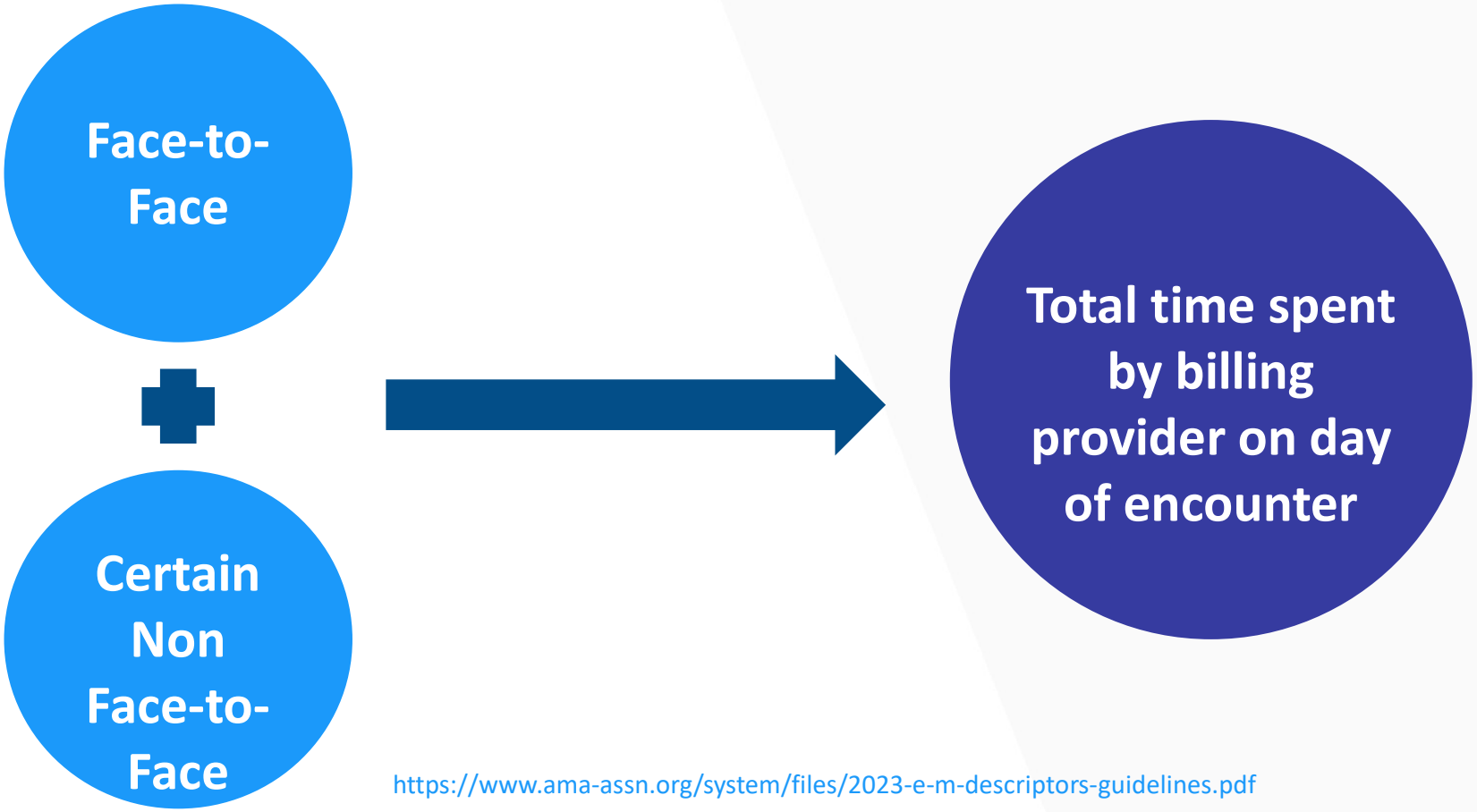
NUMBER & COMPLEXITY OF PROBLEMS

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, imaging)
- 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

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

Additional Resources

- AAPA E/M Guidelines presentation now available on Learning Central https://player.vimeo.com/video/466187979

- AMA CPT E/M Office or Other Outpatient and Prolonged Services Code & Guideline Changes

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

- AMA CPT E/M Office Revisions Level of MDM Table

  https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Reducing Fraud and Abuse Concerns

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

The difference between "fraud" and "abuse" depends on specific facts, circumstances, intent, and knowledge.

Fraud – Knowingly Engaging in Certain Activities

- Knowingly billing for services at a level of complexity higher than services actually provided or documented in the medical records.
- Knowingly ordering medically unnecessary items or services for patients

Abuse – Practices Resulting in Unnecessary Costs to Federal Programs

- Billing for unnecessary medical services.
- Charging excessively for services or supplies.
- Improper billing practices.

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

- 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/NPs should be proactive in supplying basic reimbursement information to billers based on payer mix and the practice sites where they deliver care.

Who is Entitled to Reimbursement for a PA's/NPs Professional Work?

Who should receive reimbursement for the PA's NP's professional services?

Only the PA's/NPs employer.

Who should receive a benefit (work product) from the PA's/ NP's professional services?

Only the PA's/NPs employer.

Appropriate leasing arrangements are an option when the physician with whom the PA/NP works is not the employer, and the physician wants to utilize the professional services of the PA.

Payment to the Employer

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

  - Potential False Claims, Stark &Anti Kickback Violations

Particularly problematic with a hospital-employed PA/NP working with a non-hospital employed, private physicians.

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/NPs can't treat new patients
- Physician must be on-site when PAs/ NPs deliver care.
- Physician must see every patient a PA/ NP treats in the office/clinic.
- A physician co-signature is required whenever PAs/NPs 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

Eligible Services Under Medicare for PAs/NPs

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

Collaboration, Supervision and Beyond

- Medicare traditionally used the term “supervision” to describe how PAs/NPs 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

Reimbursement in the Office/Clinic

- PAs/NPs can always treat new Medicare patients and established patients with new medical conditions when billing under their own name and NPI with reimbursement at 85% following state law guidelines.

- There is no requirement for a physician to be on-site or to interact with patients when PAs/NPs deliver care in the office/clinic when submitting claims under PA's/NP's name.

“Incident to” Billing

- “Incident to” is a Medicare billing convention.
- 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” 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 office – which is extremely rare*).

Optional billing method

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

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

“Incident to” Billing

- “Incident to” billing is an option, and not required to be used.
- “Incident to” can’t occur on the patient’s first visit; must be at a subsequent visit.
- 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).

“Incident to” Billing

- The original treating physician (or another physician in the group) must be physically present in the same office suite (direct supervision).
- 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/NP discusses patient with physician or physician provides periodic patient visit/treatment (type of engagement should be documented in medical record).

“Incident to” Does NOT Apply

- New Patients
- New Medical Problems
- Physician Not On-site

“Incident to” Billing Questions

Q. Can a physician meet the “incident to” on-site requirement if he/she is on a different floor but in the same medical office building as the PA/NP if the practice owns the office space on both floors?

“Incident to” Billing Questions

- **A.** Typically, Medicare requires that the physician be in the same suite of offices to meet “incident to” requirements. The PA/NP providing care on the first floor with the physician being on the third floor of the same building, for example, would likely not meet requirements.

“Incident to” Billing Questions

Q. The physician has been treating a patient for diabetes. The patient presents to the office with an upper respiratory infection and sees a PA/NP in the same group. Can this be billed as an “incident to” service because the patient is established to the practice?

“Incident to” Billing Questions

A. No, this is not an “incident to” situation and cannot be billed under the physician since the physician never examined the patient or created a care plan for the new problem (respiratory infection). The claim would be submitted under the PA’s/NP’s name and NPI.

“Incident to” Billing Questions

Q. The physician orders a particular drug at a certain dosage for a patient. The PA/NP sees the patient on a follow-up visit and determines that the drug is not working. The drug and dosage are changed but the diagnosis remains the same. Can the service be billed as an “incident to” service?

“Incident to” Billing Questions

A. No, because the PA/NP changed the plan of care for the patient. The service no longer meets the “incident to” requirements and the visit should be billed under the PA’s/ NP’s name and NPI number.

Services Not Subject to “Incident to” Billing

- Diagnostic tests
- Pneumococcal, influenza, and hepatitis B vaccines
- Flu shots, EKGs, laboratory tests and X-rays
- These services have their own statutory benefit categories and are subject to the rules applicable to their specific category. They are not “incident to” services and the “incident to” rules do not apply.

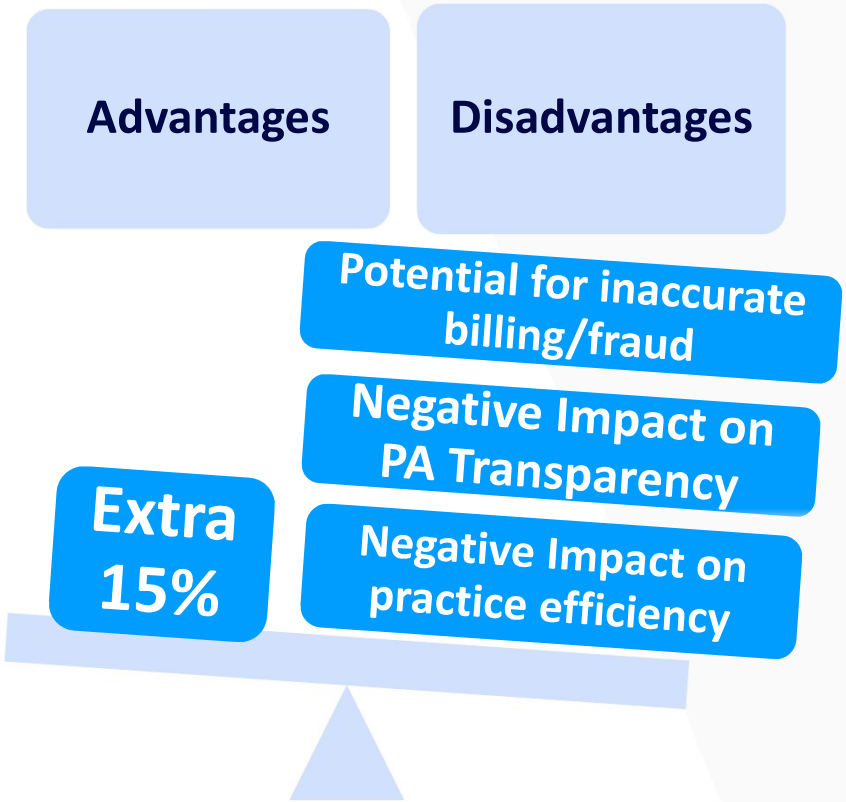
What About Private, Commercial Payers and “Incident to”?

- If a payer requires billing of a PA’s/NP’s service under the physician’s name, it doesn’t necessarily mean Medicare’s “incident to” provisions have to be followed.

- “Incident to” is a Medicare term, but some commercial payers utilize the concept. Check with your individual payers.

- Certain commercial payers ask for a modifier code (SA) when billing under the physician’s name.

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/NP and a physician to be billed under the physician's name/NPI at 100% reimbursement.

PAs/NPs can treat new or established patients when billing under their own name and NPI with 85% reimbursement.

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)

<u>Option for split/shared billing does NOT apply to procedures</u>

PA/NP and physician must work for the same group

Split/shared services must be delivered on the same calendar day

Physician must provide a substantive portion of care

-FS modifier must be included on claim to identify service as split/ 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 & 2023 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

Split (or Shared) Case Scenario #1

- PA performs a history, exam, and medical decision-making on an initial hospital encounter
- Physician reviews results of diagnostic tests and response to medications, sees 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 split (or shared)?

Split (or Shared) Case Scenario #1

No d a history, exam, or the
tirety.

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)?

Split (or Shared) Case Scenario #2

Yes

Split (or Shared) Billing

Substantive Portion

Proposed CMS Policy Starting 2024

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

(AAPA is opposed to this policy and has advocated for maintaining the current policy)

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

First Assisting at Surgery

- PAs/NPs covered by Medicare for first assist.
- Reimbursed by Medicare at 85% of the physician's first assisting fee
  - Physician who first assists gets 16% of primary surgeon's fee – PAs get 85% or 13.6% of primary surgeon's fee.
- -AS modifier for Medicare.
- Special rules for PAs/NPs/physicians when residents/fellows are available in the hospital.

Assisting at Surgery

Teaching Hospitals

- Medicare does not generally reimburse for first assistant fees if there is a qualified resident available.
- Applies when hospitals have an approved, accredited program in the particular surgical specialty.

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. traumatic injuries)

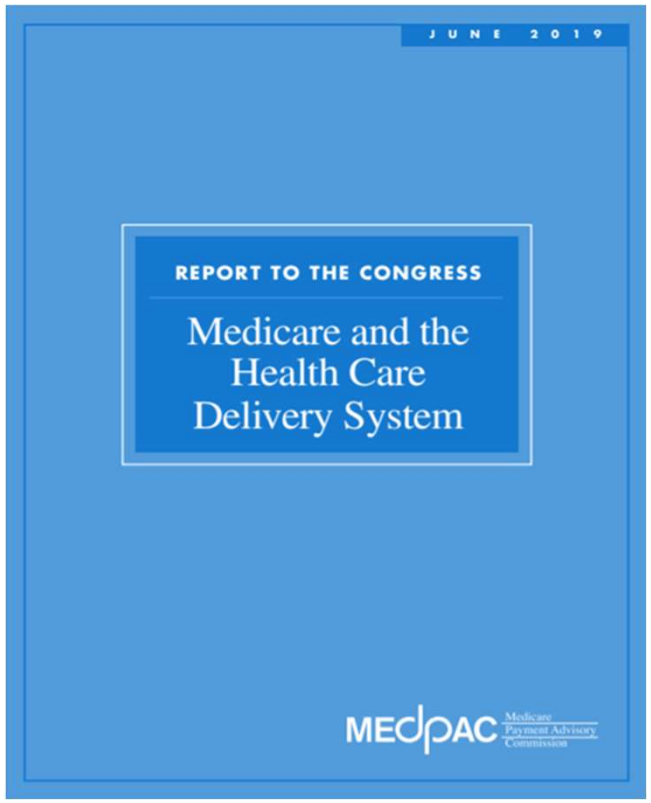
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Assisting at Surgery

Teaching Hospitals

When no qualified resident available

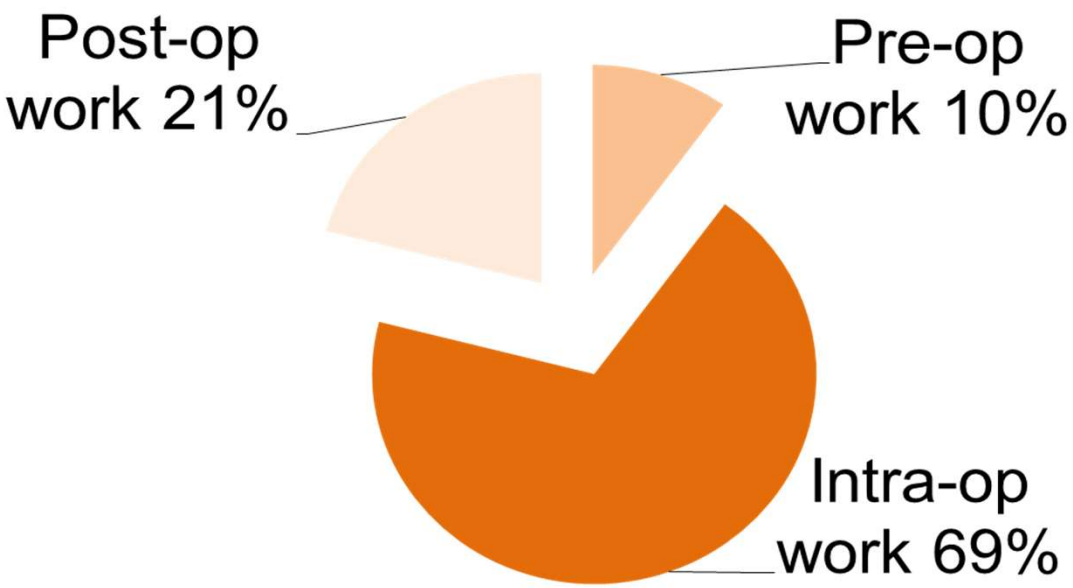
- Physician must certify
  - I understand that § 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the A/B MAC (B).
- Must use second modifier -82 (teaching hospital) (in addition to –AS)



"PAs/NPs 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

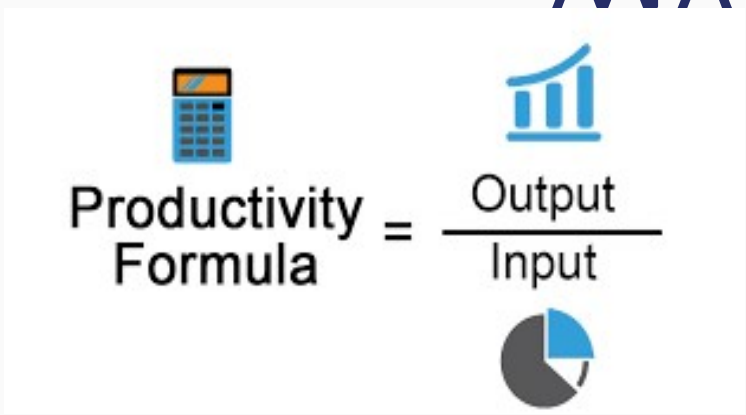
Global Surgical Package



Surgical Global Work Breakdown

- **31%** of the global payment is for work outside the OR.
- If the PA/NP is doing the pre-op H&P, the post-op rounds, and the post-op office visits, then up to **31%** of the global payment could, theoretically, be attributed to the that professional.
- Additionally, **31%** of the Work RVU attributed to the procedure could be "credited" to the PA/NP. Important not to set up a productivity system of direct competition with physicians for RVUs.

Global Work Breakdown



Example

27130 Total Hip (payable at $1,322*)

Pre-op work (10%):	**$ 132.20**	**PA/NP**
Intra-op work (69%):	$ 912.18	Surgeon
Post-op work (21%):	$ **277.62**	**PA/NP**

*Final figure impacted by geographic index

Global Work Contribution

- If a PA does pre-op exam and post-op rounding/ office visits, **$409.82** could be “credited/allocated” to PA/NP.
- However, billing records would show $1,322 being attributed to the surgeon.
- In additional, a separate payment of **$179.79** can be officially credited to PA/NP for the first assist (13.6% of surgeon’s fee) which does not reduce the surgeon’s fees.

Potential PA Value or Contribution

True measure of global "value" might be:

First assist payment of	$179.79
plus	
E&M share of global payment	$409.82

Total = $589.61 per THR

CPT Code 99024

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

Captures post-op work provided in Global Surgical Package

Tracking Clinical Work in the Global Surgical Period

- While not separately payable, track “global” visits by using the 99024 code in the EMR.
- The global visits performed by the PA/NP would otherwise have to be performed by the physician. **Note:** post-op visits are not separately reimbursed so split/shared billing does not apply.
- If the PA/NP provided 200 post-op global visits, for example, theoretically 200 appointment slots were then made available for the physician to see other “revenue generating” new visits.

What about that 15%

Without utilizing split/ shared or “incident to” billing, Medicare payment for PAs/ NPs 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/NP-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/NP 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/NP
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

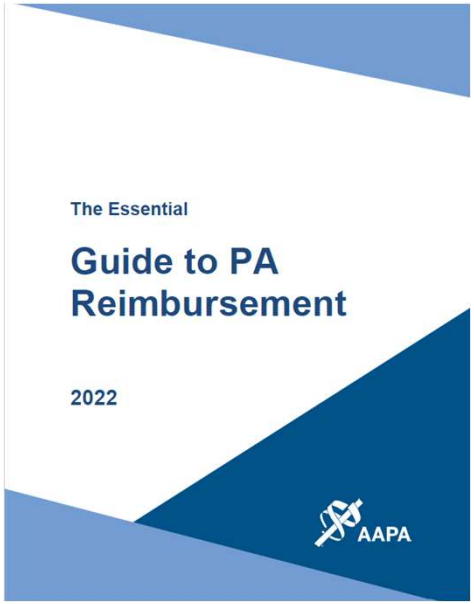
Contribution Model Takeaway Points

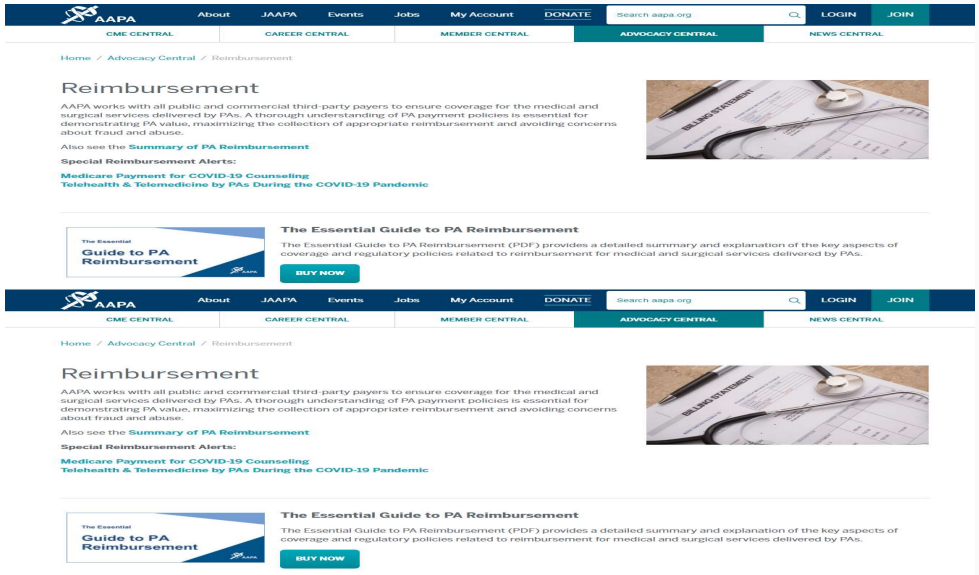
- The point of the illustration is not that PAs will produce a greater office-based contribution margin than physicians.
- That may or may not happen (more likely in primary care/internal medicine vs. surgery or specialty practices).
- PAs/NPs generate a contribution margin for the practice even when 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.

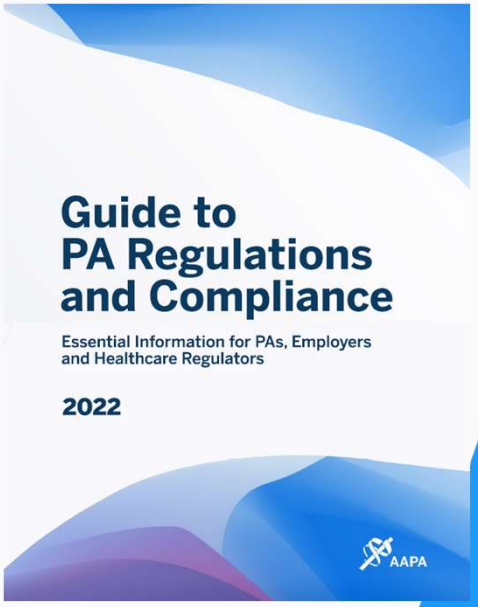
The Value of PAs/NPs

- 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/

Contact Information

- michael@aapa.org
- reimbursementteam@aapa.org
- **AAPA Reimbursement Website**
  https://www.aapa.org/advocacy-central/reimbursement/