AAPA 2024

Demonstrating PA Value: The Good, The Bad & the Ugly

TRICIA MARRIOTT, PA-C, MPAS, MJ (HEALTH LAW), CHC, DFAAPA

MAY 21, 2024 HOUSTON

Learning Objectives

At the conclusion of this session, participant will be able to:

- Access the Physician Fee Schedule to determine work RVUs and local reimbursement rates for services provided using CPT® codes for inpatient and outpatient services.
- Calculate the PA's contribution from work provided to surgical patients who fail under the global surgical package, even though no claim can be separately submitted.
- Recognize that demonstrating value can ositively impact the PA's compensation and/or bonus structure, but negatively impact the physician/PA working relationship.

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 This presentation was current at the time it was submitted.
- 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 services.
- **Non-Declaration Statement: I have no relevant relationship with ineligible companies to disclose in the past 24 months. (Note: Ineligible companies are defined as those whose primary business is producing, marketing, selling re-selling, or distributing healthcare products used by or on patients).**
- Medicare policy changes frequently, and is subject to local administrative contractor policy.
- Payment policy varies by payer and contract. Each practice must ascertain payment policy and claims instructions for each payer with whom they contract.
- The speaker has no conflicts or financial disclosures to report.
- The American Medical Association has copyright and trademark protection of CPT ©.

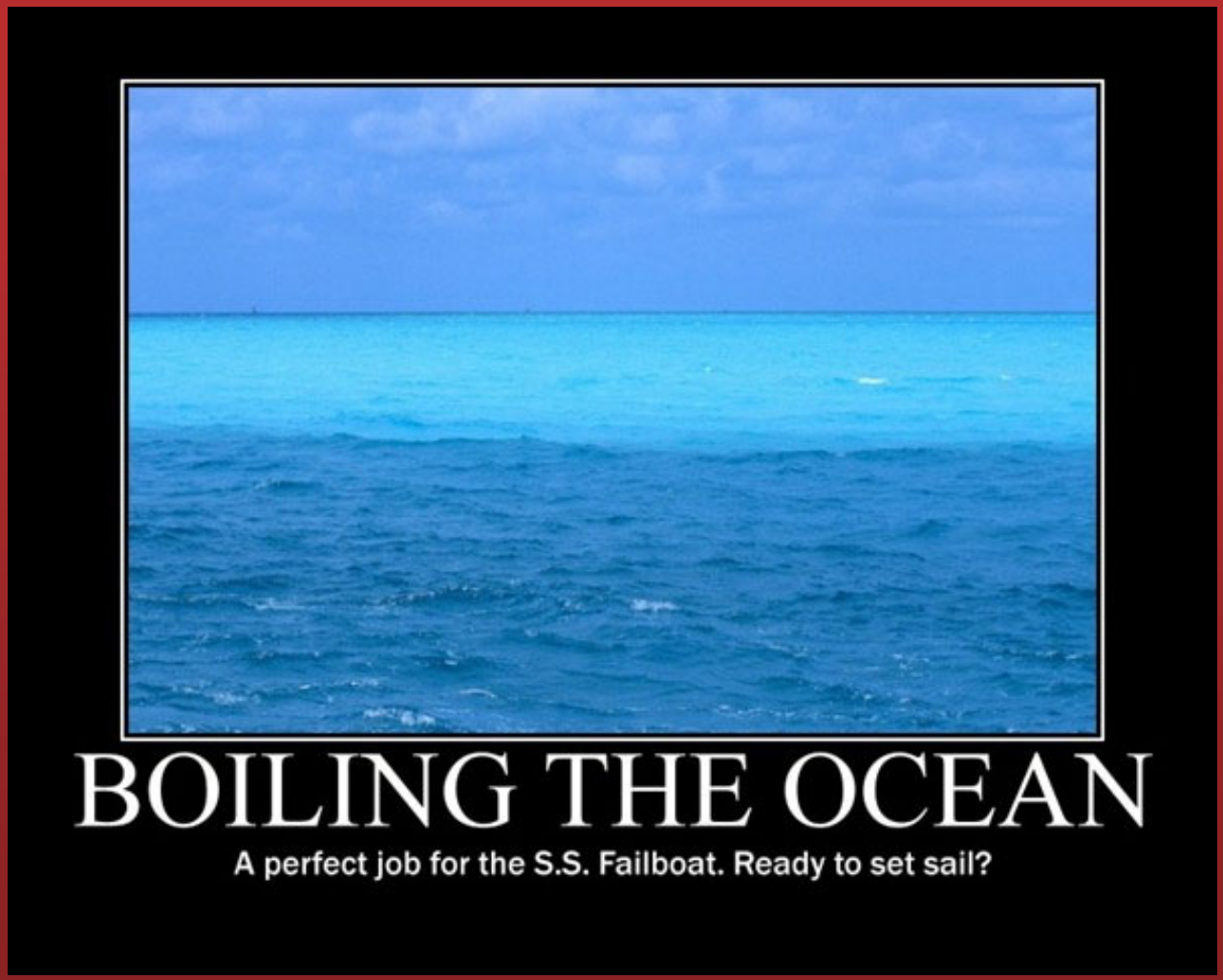
What is the Return on Investment?

LEADERSHIP/FINANCE TEAM

- "Where are the wRVUs?"
- "Accounts receivable and collections are negligible…"
- "PAs don't cover their salary…"
- "PAs cost $XXXXXXXX".

PEOPLE IN THE KNOW

- Claims reports do not tell the full story.
- Contribution to the Global package must be considered.
- Production and downstream revenue is often hidden under the physician.
- Tangible "intangibles: Patient Access, Quality measures, LOS, OR efficiencies.


BOILING THE OCEAN
A perfect job for the S.S. Failboat. Ready to set sail?

BACKGROUND BILLING CONCEPTS

Background MYTHS

- PAs/NPs cannot see new patients.
- Physician must be on-site.
- Physician must see every patient.
- A physician co-signature or “attestation” means the claim may be submitted under the physician’s NPI.
- Reimbursement for services provided by PAs/NPs “leaves 15% on the table”.
- Patients won’t be happy. What about the “brand”? (Insert academic medical center name or famous physician here.)

Medicare

Incident-to Billing

- Physician physically present
- Only applies to office setting-not hospital outpatient clinics
- Physician must have seen on initial visit to establish diagnosis
- PA/NP sees patient on follow-up of SAME issues and follows the physician's treatment plan
- Consequence: **Claim submitted under the physician's NPI.**

Shared Visit Billing

- PA/NP and physician SHARE the work.
- Claim often submitted
- under the physician's NPI

TABLE 26: Final Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2022 Definition of Substantive Portion	2023 Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/Nursing Facility	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

Acronyms: E/M (Evaluation and Management), MDM (medical decision-making).
*Office visits will not be billable as split (or shared) services.

Table Source:
MPFS final rule, split (or shared) visits: C: Definition of substantive portion. https://www.federalregister.gov/d/2021-23972/p-1243 2022;C, Definition of Substantive Portion

Medicaid

- Enrolled as billing provider
- Enrolled as ordering/ referring provider
- Claims methodology, particularly for MANAGED MEDICAID, still defaults to the physician

Commercial Payers

- More and more commercial payers are enrolling PAs (and NPs) as billing providers. The consequence often results in reimbursement at 85% of the physician fee schedule.
- Some payers continue to instruct practices to submit claims under the enrolled physicians, choosing not to enroll the PAs or NPs as individually recognized providers. The consequence results in 100% reimbursement. PAs and NPS are covered, but not listed in directories or on the claim.

CLAIMS DATA

The PA/NP is often invisible, or at best obscured, unless the bean counters take specific steps to identify the claims by provider.

Who Gets the RVUs?

What's an RVU?
Relative Value Units

Relative Value Units (RVU) are assigned to every Evaluation and Management CPT® code as well as Procedure codes

RVUs are published in the Medicare Physician Fee Schedule (MPFS)

The MPFS uses 3 separate RVUs to calculate a payment:

1. **The Work RVU** reflects the relative time and intensity associated with furnishing a Medicare PFS service
2. **The Practice Expense (PE) RVU** reflects the costs of maintaining a practice (such as renting office space, buying supplies and equipment, and staff costs)
3. **The Malpractice (MP) RVU** reflects the costs of malpractice insurance

- To demonstrate value/productivity, we measure the WORK.
- Every CPT® code has an assigned WORK RVU (wRVU)
- The number remains the SAME, regardless of who provided the service.
- DO NOT APPLY the 15% discount to wRVUs when services are provided by a PA!

THE PHYSICIAN FEE SCHEDULE

The Physician Fee Schedule Look-up Tool

Physician Fee Schedule Look-Up Tool

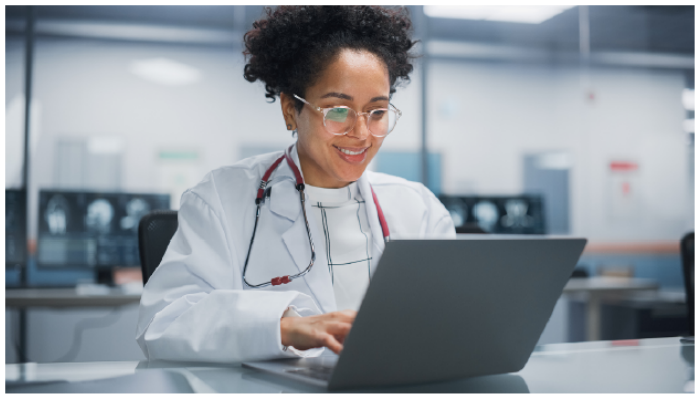
CMS.gov Centers for Medicare & Medicaid Services

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup

mln Booklet

KNOWLEDGE • RESOURCES • TRAINING

How to Use the PFS Look-Up Tool



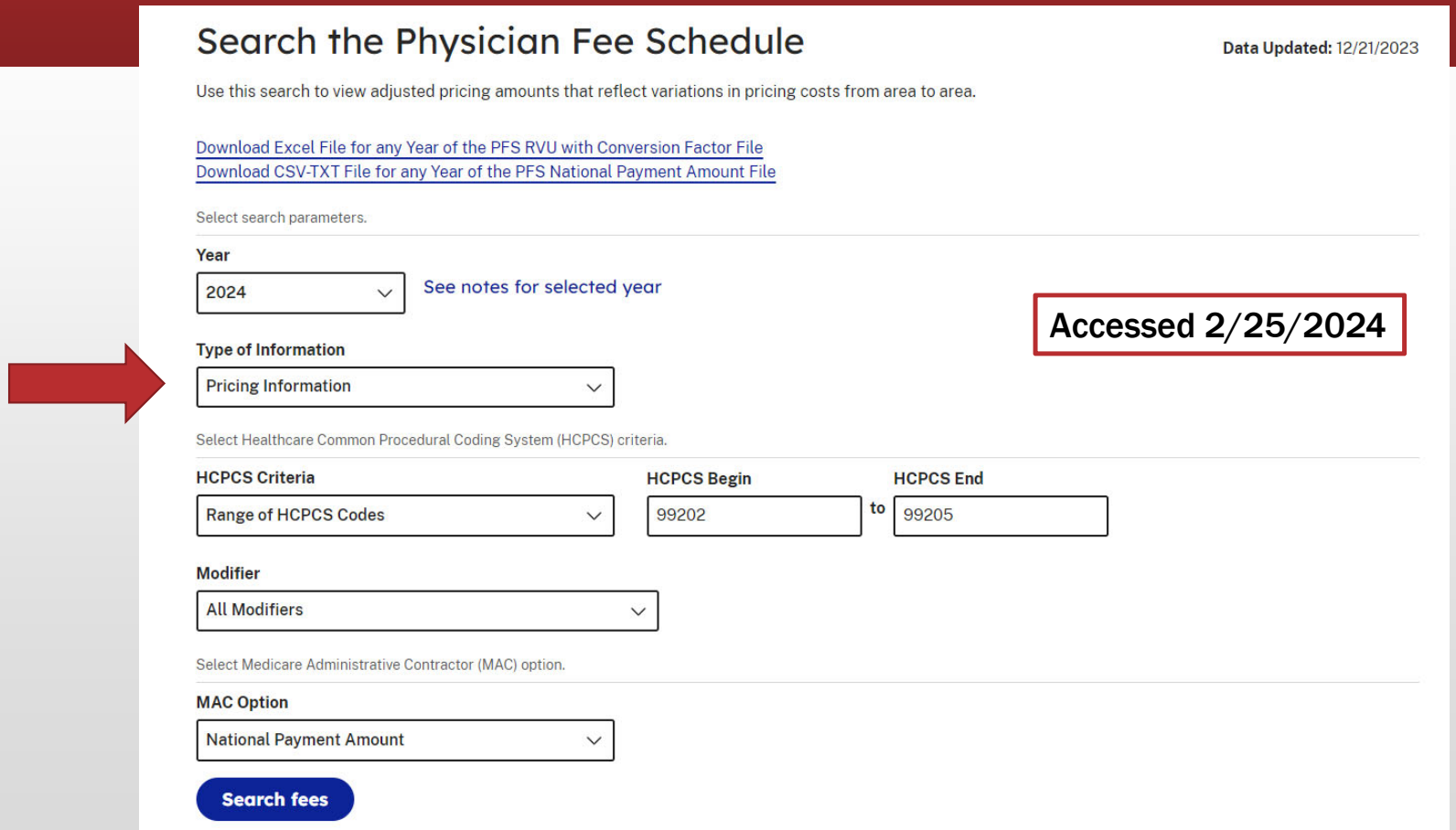
What is the MPFS Look-Up Tool?

The CMS MPFS Look-Up Tool provides Medicare payment information on more than 10,000 services, including:

- Pricing
- Associated RVUs
- Payment policies

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How_to_MPFS_Booklet_ICN901344.pdf

Search the Physician Fee Schedule: Pricing Information



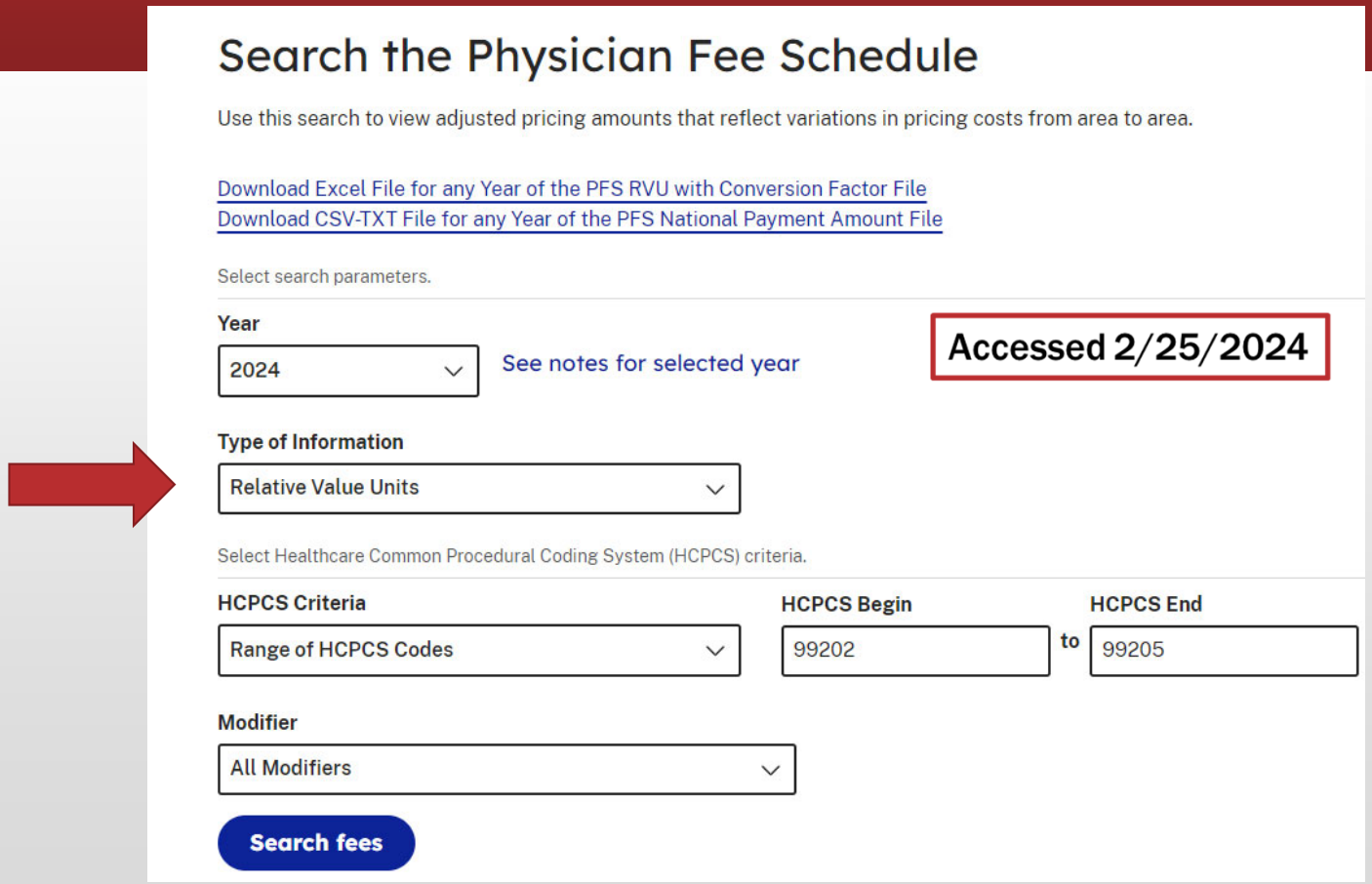
Pricing Information: New patient

HCPCS Code	Modifier	Short Description	Proc Stat	Mac Locality	Non-Facility Price	Facility Price	Non-Facility Limiting Charge	Facility Limiting Charge	Conv Fact
99202		Office o/p new sf 15 min	A	0000000	$71.06	$46.17	$77.63	$50.44	32.7442
99203		Office o/p new low 30 min	A	0000000	$109.69	$79.90	$119.84	$87.29	32.7442
99204		Office o/p new mod 45 min	A	0000000	$164.38	$129.99	$179.58	$142.02	32.7442
99205		Office o/p new hi 60 min	A	0000000	$216.77	$176.82	$236.82	$193.17	32.7442

Pricing Information: Established patient

HCPCS Code	Modifier	Short Description	Proc Stat	Mac Locality	Non-Facility Price	Facility Price	Non-Facility Limiting Charge	Facility Limiting Charge	Conv Fact
99211		Off/op est may x req phy/qhp	A	0000000	$22.92	$8.51	$25.04	$9.30	32.7442
99212		Office o/p est sf 10 min	A	0000000	$55.67	$34.38	$60.81	$37.56	32.7442
99213		Office o/p est low 20 min	A	0000000	$89.39	$64.18	$97.66	$70.11	32.7442
99214		Office o/p est mod 30 min	A	0000000	$126.07	$94.63	$137.73	$103.38	32.7442
99215		Office o/p est hi 40 min	A	0000000	$177.47	$140.47	$193.89	$153.47	32.7442

Search the Physician Fee Schedule: Work RVUs



Office Work RVUs: New patient

HCPCS Code	Modifier	Short Description	Proc Stat	PCTC	Not Used for Medicare	Work RVU
99202		Office o/p new sf 15 min	A	0		0.93
99203		Office o/p new low 30 min	A	0		1.60
99204		Office o/p new mod 45 min	A	0		2.60
99205		Office o/p new hi 60 min	A	0		3.50

Office Work RVUs: Established patient

HCPCS Code	Modifier	Short Description	Proc Stat	PCTC	Not Used for Medicare	Work RVU
99211		Off/op est may x req phy/qhp	A	0		0.18
99212		Office o/p est sf 10 min	A	0		0.70
99213		Office o/p est low 20 min	A	0		1.30
99214		Office o/p est mod 30 min	A	0		1.92
99215		Office o/p est hi 40 min	A	0		2.80

Post-op Global Visit?

No results

99024: The current Physician Fee Schedule does not price the requested HCPCS Code.

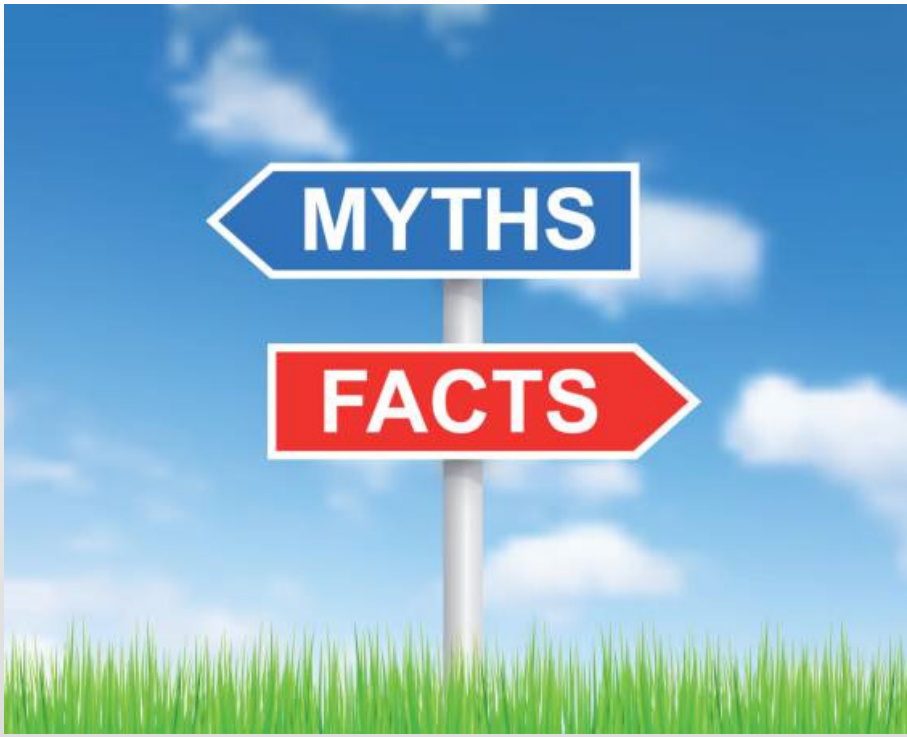
CPT code 99024 describes a **postoperative follow-up visit** for an E/M service usually included in the surgical package. 99024 can be used when a patient has recently had surgery and is returning to the doctor for a follow-up visit to evaluate their progress and address any issues related to the original procedure.

What is Bupkis?

https://www.bupkis.org/index.php/what-is-bupkis

Bupkis is a Yiddish word, which is literally translated as "beans" and is derived from a Slavic word for "goat droppings." Apparently goat droppings look like beans, although I've never actually seen any goat droppings.

THE GOOD: DISPELLING THE MYTH OF THE 15%



Heard across the land....

What about the

15%

Business Term: Contribution Margin

- Definition: Contribution Margin

Revenue Generated by a Service MINUS The Cost of Delivering the Service

Contribution margin = revenue – variable costs

Collections minus salary and overhead

Translation:

What did we get paid?

What did it cost us to provide the care?

Inpatient/ Hospital Medicine

Inpatient Medicine Examples:
99222-Initial Hospital Care (ADMISSION H&P)
99232-Subsequent Hospital Care

CPT Code	Work RVU	Price* Physician	Price* PA/NP	
99222	2.60	$127	$108	15%=$19
99232	1.59	$77	$65	15%=$12

Source: 2024 CMS Physician Fee Schedule
*National Payment Amount: Actual price will vary by geographic index

Inpatient Medicine Margins

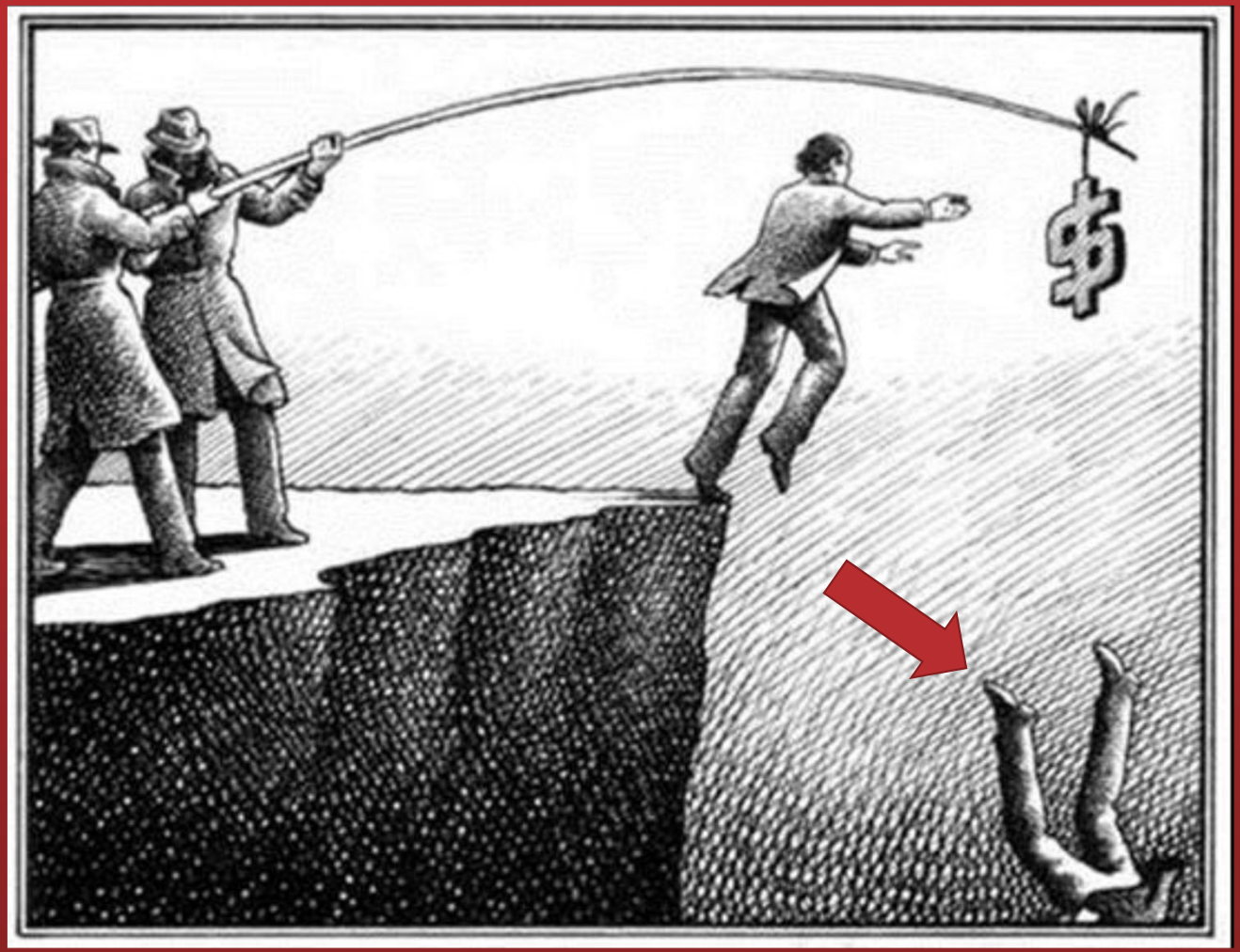
	Internist†	PA Hospital Medicine‡
Annual Compensation	$ 273,000 ($131/hr)	$120,615 ($58/hr)
Admission H&P (99222) is reimbursed*	100% for $127	85% for $108
Margin	-$4	+$50

† Medscape Internist (Average) Compensation Report 2023 Retrieved 2.26.2024
https://www.medscape.com/slideshow/2023-compensation-internist-6016363#2

‡ National Commission on Certification of PAs, Inc. (2023, August). 2022 Statistical Profile of Board Certified PAs by Specialty: An Annual Report of the National Commission on Certification of PAs, p23 (Mean) Retrieved 2.25.2024, www.nccpa.net/resources/nccpa-research/

*Source: 2024 CMS Physician Fee Schedule
National Payment Amount: Actual price will vary by geographic index

Do your hospitalist physicians Stop admitting patients before midnight so they can capture the "Shared visits"?



DATA!!!

Conclusion:

"An expanded PA hospitalist staffing model at a community hospital provided similar outcomes at a lower cost of care."

https://www.mdedge.com/jcomjournal/article/146081/practice-management/comparison-conventional-and-expanded-physician

Expanded Physician Assistant Hospitalist Staffing at a Community Hospital Yielded Noninferior Outcomes at Substantially Lower Cost

Timothy M. Capstack, MD[1], Cissy Segujja, MS[2], Lindsey M. Vollono, PA-C[1], Joseph D. Moser, MD[3], Barry R. Meisenberg, MD[3], Henry J. Michtalik, MD, MPH, MHS[4]
[1]Adfinitas Health, Hanover, Maryland; [2]Versant Statistical Solutions LLC, Raleigh, North Carolina; [3]Anne Arundel Medical Center, Annapolis, Maryland; [4]Johns Hopkins Hospital, Baltimore, Maryland

Adfinitas HEALTH

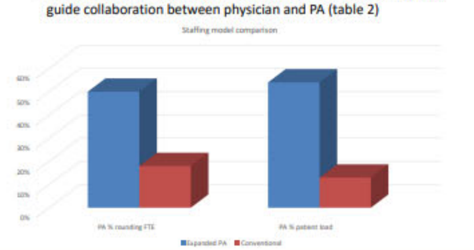
Can expanded use of hospitalist physician assistants impact patient outcomes or costs?

Research Objectives and Rationale

- Hospitalist physicians are widely utilized but are expensive – over 91% of programs' expenses were not covered by professional fees alone[2]
- Median program subsidy is well over $150,000 per physician FTE[2]
- We developed a staffing model which deploys highly trained physician assistants (PAs) to see our patients collaboratively with physicians, and with a substantially higher patient census per PA than has been reported.[2-5]
- Research questions: does expanded-PA hospitalist staffing yield similar outcomes for patients, and are the costs less?

Study Design

- Observational, retrospective study conducted at a single, 384-bed community hospital (Anne Arundel Medical Center, Annapolis, Maryland)
- Two hospitalist groups were compared: a hospital-employed group ("conventional" group) and a contracted hospitalist group ("expanded-PA" group, the Adfinitas Health team). Table 1 summarizes staffing and rounding arrangements for each group. **Conventional group PAs were expected to see 9 patients a day, versus 14 a day in the expanded-PA group.**
  - In the expanded-PA group, a formal written protocol was used to guide collaboration between physician and PA (table 2)



Study design, continued

- Adult medical patients discharged by either hospitalist group between 1 January 2012 and 30 June 2013 : 17,294 candidate hospitalizations
- After exclusions for referral bias, 6,612 hospitalizations in the expanded PA group and 10,352 in the conventional group were included.

Measurements

- Inpatient mortality
- 30-day all-cause intra-hospital readmissions
- Cost of care (patients charges)
- Consultant use
- Length of stay
- Encounter type: "physician-only," "physician co-visit," and "PA-only"

Charge capture data for both groups was used to determine the proportion of encounters rendered by each provider type or combination.

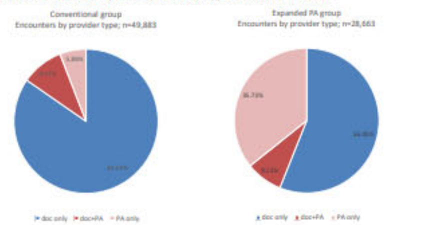


Table 1. Characteristics of Conventional and Expanded PA Groups

	Conventional	Expanded PA
Patient census		
Per physician rounder, goal	13	13
Per physician rounder, actual mean ± SD	12.8 ± 2.0	12.8 ± 2.1
Per PA rounder, goal	9	14
Per PA rounder, actual mean ± SD	8.9 ± 1.4	14.2 ± 2.1
Years as hospitalist clinician		
Physician, median (range)	2.4 (0–11)	4 (0–14)
PAs, median (range)	2.2 (1–4.6)	4 (0–20)
Staffing team per 24-hour cycle		
Physician day rounders	6	3
PA day rounders	2	3
Physician night staff	2	1
PA night staff	0	1
Admitter clinician type	Physician	PA
PA initial visit responsibility (admissions, consults)	Rare	Routine
PA discharge visit responsibility	Routine	Routine
PA-physician collaboration model	In person physician visit not less than every third hospital day	In person physician visit not less than every third hospital day. Protocol for mandatory physician contact (Table 2).

Table 2. Expanded PA Group Collaboration Protocol

PA Contacts Physician:
To discuss progress on currently hospitalized, uncomplicated patients not less than daily;
To address unanticipated significant changes in patient status at time of service; prior to requesting specialist consultation, particularly critical care;
For urgent patient care situations, including but not limited to starting assisted ventilation in those not chronically dependent, initiation of continuous medication infusions, situations in which an arterial blood gas is ordered, unstable EKG changes or cardiac arrhythmias;
Whenever PA has doubt as to the appropriate course of action;
Whenever PA or patient feels patient would benefit from direct physician involvement in furthering the plan of care.
Physician:
Discusses each PA patient with PA daily, specifically addressing areas of concern;
Sees PA patients no less frequently than every third hospital day, depending on acuity;
Sees PA admissions/consults within 24 hours of initial encounter;
Provides patient-centered education in real time;
Available at all times for consultation with PA.

Principal findings

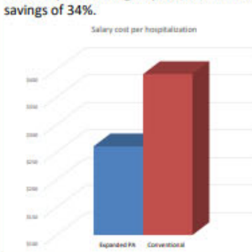
After multivariate statistical analysis, there were no significant differences between the groups for:

- Mortality
- Readmission
- Consulting service use
- Length of stay ($p = 0.34$)

Equivalent patient care outcomes, lower patient charges…

Multivariate analysis revealed significantly lower adjusted patient charges in the expanded PA group relative to the conventional group (3.52% lower in the expanded PA group [95% CI, 2.66%–4.39%, $P < 0.001$).

Using annual FTE median salary costs per daily rounding provider divided by number of hospitalizations, expected salary cost per hospitalization was $261 in the expanded PA group vs $392 in the conventional group – a dramatic savings of 34%.



…and 34% savings per hospitalization on provider salaries.

Conclusions and Relevance to Care Delivery

This is the first study to compare hospitalist PAs in a community, non-teaching practice, directly and contemporaneously to peer PAs and attending physicians and examine the impact on outcomes. Even though a much larger proportion of patient visits were conducted primarily by PAs without a same-day physician visit in the expanded PA group (35.73%, vs 5.89% in the conventional group), there was no statistically significant difference in inpatient mortality, length of stay or readmissions. Costs of care measured as hospital charges to patients were lower in the expanded PA group.

Of greater health workforce significance, deploying hospitalist PAs, whose median annual salary was $106,246 in 2016[2], rather than hospitalist physicians, whose median annual salary was $278,471 in 2016[2], to see similar numbers of patients each day, has a dramatic impact on salary costs for employers. With an estimated 3,800 hospitalist programs and 52,000 physician hospitalists providing services as of 2015[2], the potential for savings across multiple care environments is significant.

We are aware of no other published care model in which hospitalist PAs are this efficient – seeing a number of patients considered optimal even for a hospitalist physician[1] – and safe. At the same time, integral to the expanded-PA model was that patients and the rounding PAs had access to physicians at all times. The PAs in the expanded-PA group received six months of intensive classroom and bedside education to reach this level of proficiency – this high a level of functioning outside a similar education and support structure should not be expected.

Hospitalist rounding paradigm of the future?

Research Funder

The statistical analysis was conducted by a contractor hired by Adfinitas Health. Administrative data were supplied free of charge by Anne Arundel Medical Center and Adfinitas Health.

Conflict of interest statement: Dr. Capstack is part owner, and Ms. Vollono was an employee, of Adfinitas Heath

Contact

Timothy M. Capstack, MD, SFHM
Adfinitas Health, 7250 Parkway Drive, Suite 500, Hanover MD 21076
tcapstack@adfinitashealth.com
http://www.adfinitashealth.com
Office (443) 949-0814

Original Publication

Research originally published as "A Comparison of Conventional and Expanded Physician Assistant Hospitalist Staffing Models at a Community Hospital" in Journal of Clinical Outcomes Management, October, 2016. This poster was updated with the latest Society of Hospital Medicine salary and hospitalist demographic data, and the savings-per-hospitalization data were added.

References

Retrieved 2.26.2024 from:
https://academyhealth.confex.com/academyhealth/2018arm/meetingapp.cgi/Paper/22212

Outpatient Medicine (Office/Clinic)

Outpatient Medicine Examples:
99204-Office o/p new mod 45 min
99213-Office o/p est low 20 min

CPT Code	Work RVU	Non-facility Price* Physician	Price* PA/NP	
99204	2.60	$164	$139	15%=$25
99213	1.30	$89	$76	15%=$13

Source: 2024 CMS Physician Fee Schedule
*National Payment Amount: Actual price will vary by geographic index

Outpatient Medicine Margins

	Internist†	PA Internal Medicine‡
Annual Compensation	$ 273,000 ($131/hr)	$113,727 ($55/hr)
New patient 99204 is reimbursed*	100% for $164	85% for $139
Margin	+$33	+$84

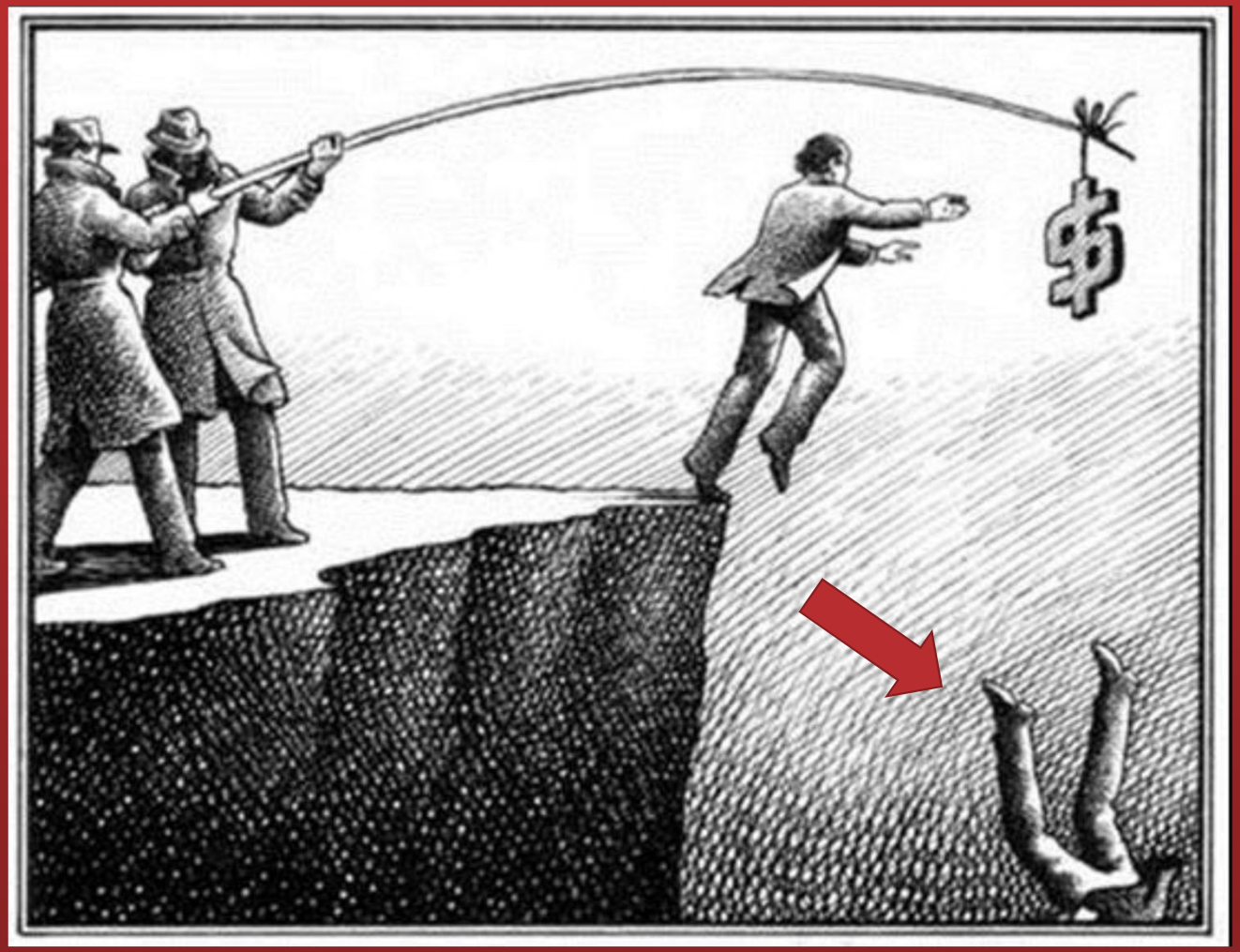
† Medscape Internist (Average) Compensation Report 2023 Retrieved 2.26.2024
https://www.medscape.com/slideshow/2023-compensation-internist-6016363#2

‡ National Commission on Certification of PAs, Inc. (2023, August). 2022 Statistical Profile of Board Certified PAs by Specialty: An Annual Report of the National Commission on Certification of PAs, p23 (Mean) Retrieved 2.25.2024, www.nccpa.net/resources/nccpa-research/

*Source: 2024 CMS Physician Fee Schedule
National Payment Amount: Actual price will vary by geographic index

Does your practice make new patients wait for an appointment with a physician?

Opportunity cost = the potential forgone profit from a missed opportunity—the result of choosing one alternative over another

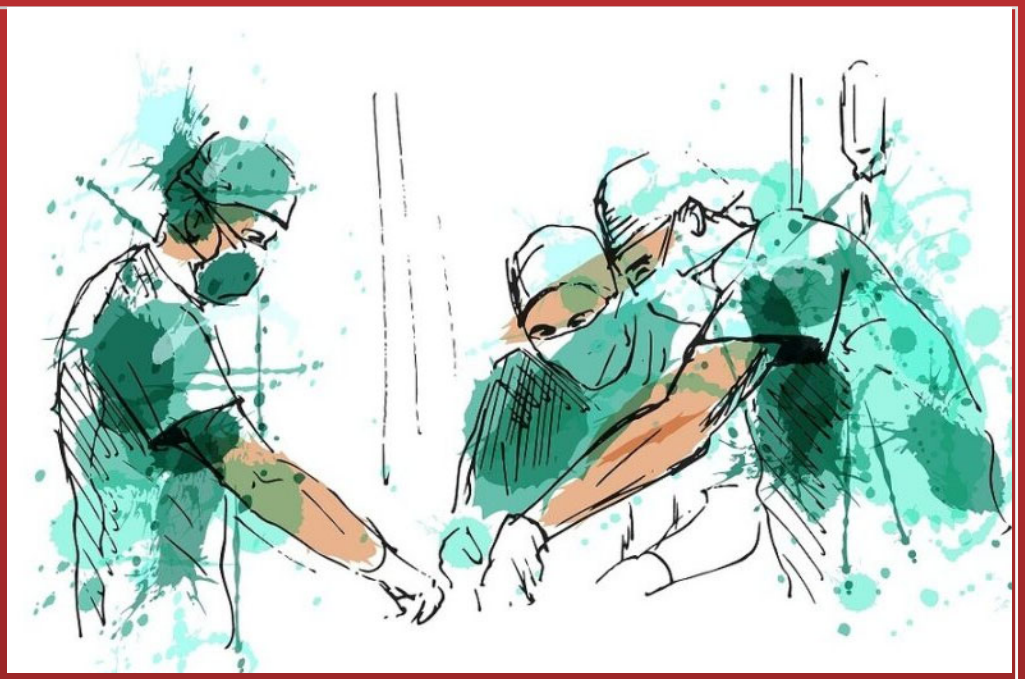


New Patients

"25% of New Patient visits

have downstream ancillary revenue attached."

Mike McCaslin, Principal, Somerset CPAs and Advisors.



Surgical Practices-Ortho

Office Visit-New Patient Ortho Surgical MARGINS

	Physician/Ortho†	PA Ortho‡
Annual Compensation	$573,000 ($275/hr)	$126,640 ($61/hr)
New patient 99204 is reimbursed*	100% for $164	85% for $139
Margin	-$111	+$78

15%=$25

† Medscape Orthopedist (Average) Compensation Report 2023 Retrieved 2.26.2024
https://www.medscape.com/slideshow/2023-compensation-orthopedist-6016369

‡ National Commission on Certification of PAs, Inc. (2023, August). 2022 Statistical Profile of Board Certified PAs by Specialty: An Annual Report of the National Commission on Certification of PAs, p23 (Mean) Retrieved 2.25.2024, www.nccpa.net/resources/nccpa-research/

*Source: 2024 CMS Physician Fee Schedule
National Payment Amount: Actual price will vary by geographic index

Case Studies-Ortho

2016 AAPA POSTER SESSION ABSTRACTS

Using physician assistants at academic teaching hospitals

Randolph, Travis L. PA-C, ATC; McDonough, E. Barry MD; Olson, Eric D. PhD

Author Information

Journal of the American Academy of Physician Assistants 29(10):p 1-2, October 2016. | **DOI:** 10.1097/01.JAA.0000490116.12185.59

https://journals.lww.com/jaapa/citation/2016/10000/using_physician_assistants_at_academic_teaching.47.aspx

2020 AAPA POSTER SESSION ABSTRACTS

Four-year follow-up study on the use of PAs at academic teaching hospitals

Randolph, Travis L. PA-C, ATC

Author Information

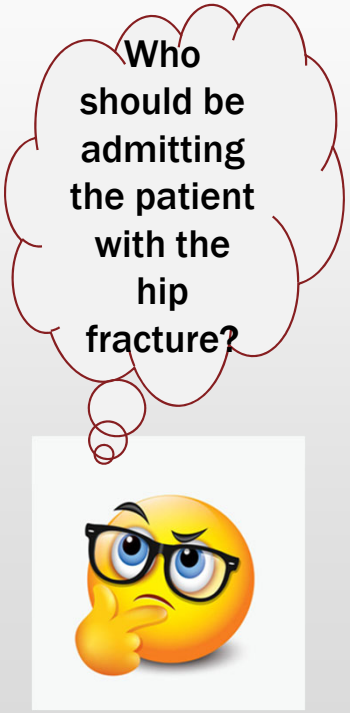
Journal of the American Academy of Physician Assistants 33(12):p 1, December 2020. | **DOI:** 10.1097/01.JAA.0000723172.44102.42

https://journals.lww.com/jaapa/Fulltext/2020/12000/Four_year_follow_up_study_on_the_use_of_PAs_at.25.aspx

In the 4 years after the pilot study, collections per clinician increased 100% and wRVUs increased 125% from the 6 years before the pilot study. Even with the increase in the number of PAs and NPs, the increase in collections and productivity since the 2015 pilot study remained significant.

Inpatient/Initial Hospital Visit-Surgery/Ortho

	Physician/Ortho†	PA Ortho‡
Annual Compensation	$573,000 ($275/hr)	$126,640 ($61/hr)
Admission H&P (99222) is reimbursed*	100% for $127	85% for $108
Margin	-$148	+$47



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*Source: 2024 CMS Physician Fee Schedule
National Payment Amount: Actual price will vary by geographic index

Global Surgical Package

AN ORTHO EXAMPLE

Global Surgical Package - Medicare

- Each procedure has a defined number of days of follow-up included in the global payment.
- The components of the package include the following services which generally are assigned the following weights:

INTRAOPERATIVE WORK=69%
POSTOPERATIVE WORK=21%
PRE-OP WORK=10%

Global Package Surgical Example

Price

Showing 1-1 of 1

HCPCS Code	Modifier	Short Description	Proc Stat	Mac Locality	Non-Facility Price	Facility Price
27130		Total hip arthroplasty	A	0000000	NA	$1,264.91

Work RVUs

Global	Pre Op	Intra Op	Post Op
090	0.10	0.69	0.21

Source: 2024 CMS Physician Fee Schedule
National Payment Amount: Actual price will vary by geographic index

Global Work Has Value!

While not separately payable, track “Global” visits:

- CPT ® 99024: “Postoperative follow-up visit included in global service.”
- Create a “dummy code” for the pre-op H+P if they are being provided as a separate encounter from the decision for surgery visit

- The global visits performed by the PA would otherwise have to be performed by the physician, tying up revenue generating physician slots.
- For example, if the PA provided 300 post-op global visits, 300 appointments were then made available for the physician to see revenue generating visits.

Global Work Contribution Calculation

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

Global Work Contribution Calculation

Example:

27130 Total Hip Arthroplasty (payable at $1,265*)

Pre-op work (10%): **$ 126.50**

Post-op work (21%): **$ 265.65**

Total: **$ 392.15** **(surgeon plus PA)**

Intra-op work (69%): $ 872.85(surgeon)

Source: 2024 CMS Physician Fee Schedule

National Payment Amount: Actual price will vary by geographic index

Global Work Contribution Calculation

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Global Work Contribution Calculation

- If PA does **80%** of the pre-op and post-op work, $313.72 *could* be "credited/allocated" to PA.
- An additional separate payment of $172.04 can be officially credited to PA for the first assist (13.6% of surgeon's fee).
- Billing records would show $1265 being attributed to the surgeon. Zero (BUPKIS) attributed to the PA.

PA Global Value Contribution

- First Assist payment of $172.04

PLUS

- E&M Share of the global payment $313.72

Total=$485.76 per THR

PA Global Value Contribution

If the practice performed 300 total hip replacements last year, revenue attributed to the PA might be…

$145,728

THE BAD:
DATA COLLECTION

Data Collection

- Claims data is inadequate and incomplete to adequately assess PA productivity
- The nuances of each billing, payer and payment policy can obfuscate the work provided by the PA.
- “Garbage in/Garbage out” applies.
- The E%!C/Name your EMR Reports Team needs to get involved. The billing team cannot just “run a report”.
- WARNING: Transparent data reporting and FULL attribution of work performed are required for any production-based compensation formula.

THE UGLY: CONFLICT

Crucial Conversations

- This can be a very dangerous topic to broach with the wrong people. Find the right audience. A physician champion can be an important ally.
- Who is at the table? Who are the stakeholders? It is different in every organization.
- Facts, Math and Logic are not powerful enough to overcome perceived (potential) loss of income:

Take Home

- Claims Data not sufficient information to adequately assess PA/NP productivity. Knowledge of billing and payment policy is required.
- PAs/NPs, physicians, and administrative staff must recognize that some billing rules render the PA/NP “invisible”, or that the work and revenue is mis-attributed.
- PAs/NPs must be able to articulate these points to illustrate their “value” to the practice.
- Do not negotiate any compensation based on production without transparent data reporting and full attribution of work performed.

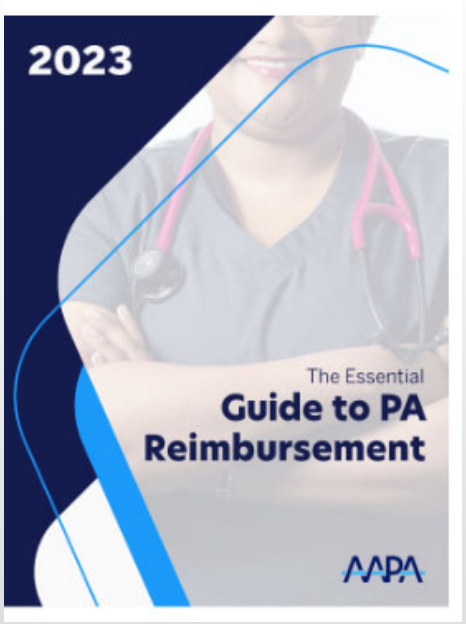
Recommended Resources

AAPA website Member Login required

https://www.aapa.org/no-access/download-id/5457/

https://www.aapa.org/download/69550/

https://www.aapa.org/download/69553/?tmstv=1675889387



https://www.aapa.org/shop/essential-guide-pa-reimbursement/

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