American Academy of Physician Associates

Decoding Coding, Documentation, and Reimbursement

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Senior Director, Regulatory & Professional Practice
American Academy of Physician Associates

Doctor of Health Science
Leadership & Organizational Behavior

Graduate Certificate
Science of Healthcare Delivery

20+ Years
Licensed & Certified PA

10+ Years
Regulatory and professional advocacy

Disclosures

I have no relevant relationships with ineligible companies to disclose within 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.

Disclaimers

- 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
- The American Medical Association has copyright and trademark protection of CPT®

Educational Objectives

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

- Summarize documentation, coding, and billing policies relevant to PAs and NPs
- Recognize common documentation, coding, and billing misperceptions and errors
- Describe possible implications of improper documentation, coding, and billing

MYTH

Billing and reimbursement is significantly different for physicians than PAs and NPs

REALITY

Billing and reimbursement is similar for physicians, PAs, and NPs

NPI (National Provider Identifier)

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

Medicare

- All practitioners must enroll in PECOS (Provider Enrollment, Chain, and Ownership System)

Medicaid

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

Commercial Payers

- Most credential/enroll physicians, PAs, and NPs

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

Eligible Services Under Medicare for PAs & NPs

"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

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

Examples of PA & NP Services
New & Established Outpatient Visits
Initial & Subsequent Hospital, Discharge, and Observation Services
Critical Care & Emergency Department Services
Minor Surgical Procedures and Assistant-At-Surgery Services
Diagnostic Tests and Interpretations
Preventive Services and Chronic Care Management
Telehealth and Telemedicine Services

List is NOT all-inclusive

Medical Necessity and Documentation of Services

To bill for E/M services

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

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

Centers for Medicare & Medicaid Services

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

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

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

Initial Hospital Inpatient or Observation Encounter		**Subsequent Hospital** Inpatient or Observation Encounter		**Hospital Inpatient or Observation Care** When Patient Admitted and Discharged on Same Day	
99221	Straightforward or low MDM	99231	Straightforward or low MDM	99234*	Straightforward or low MDM
	≥ 40 minutes		≥ 25 minutes		≥ 45 minutes
99222	Moderate MDM	99232	Moderate MDM	99235*	Moderate MDM
	≥ 55 minutes		≥ 35 minutes		≥ 70 minutes
99223	High MDM	99233	High MDM	99236*	High MDM
	≥ 75 minutes		≥ 50 minutes		≥ 85 minutes

*Medicare requires a patient to be in observation status for at least 8 hours to bill same-day admission and discharge codes

Emergency Department Visit	
99281	Evaluation and management that does not require presence of healthcare practitioner
99282	Straightforward MDM
99283	Low-level MDM
99284	Moderate-level MDM
99285	High-level MDM

Level of service for emergency department visits is only based on medical decision making (there is no option for time-based determination)

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**

Level of MDM	Elements of Medical Decision Making (2 of 3 needed)		
	Problems Addressed	**Data Analyzed**	**Risk of Patient Management**
Straightforward	**Minimal** 1 self-limited or minor problem	**Minimal or none**	**Minimal**

Level of MDM	Elements of Medical Decision Making (2 of 3 needed)		
	Problems Addressed	**Data Analyzed**	**Risk of Patient Management**
Low	**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	**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	**Low**

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

Level of MDM	Elements of Medical Decision Making (2 of 3 needed)		
	Problems Addressed	**Data Analyzed**	**Risk of Patient Management**
High	**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	**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	**High** Examples: • Drug therapy requiring intensive monitoring for toxicity, • Decision regarding emergency major surgery • Decision for DNR

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

MYTH

A physician must directly supervise a PA or NP as a condition of Medicare payment

REALITY

Medicare defers to state law regarding physician supervision/ collaboration requirements (generally does not require the personal presence or involvement of a physician)

Social Security Act authorizes Medicare payment when services are performed by NPs/PAs with physician supervision/collaboration . . . .

Nurse Practitioners	Physician Assistants
Services are payable when performed by NPs "working in collaboration with a physician"	Services are payable when performed "under the supervision of a physician (as so defined)"

. . . however, Medicare largely defers to state law in defining "collaboration" and "supervision"

https://www.ssa.gov/OP_Home/ssact/title18/1861.htm

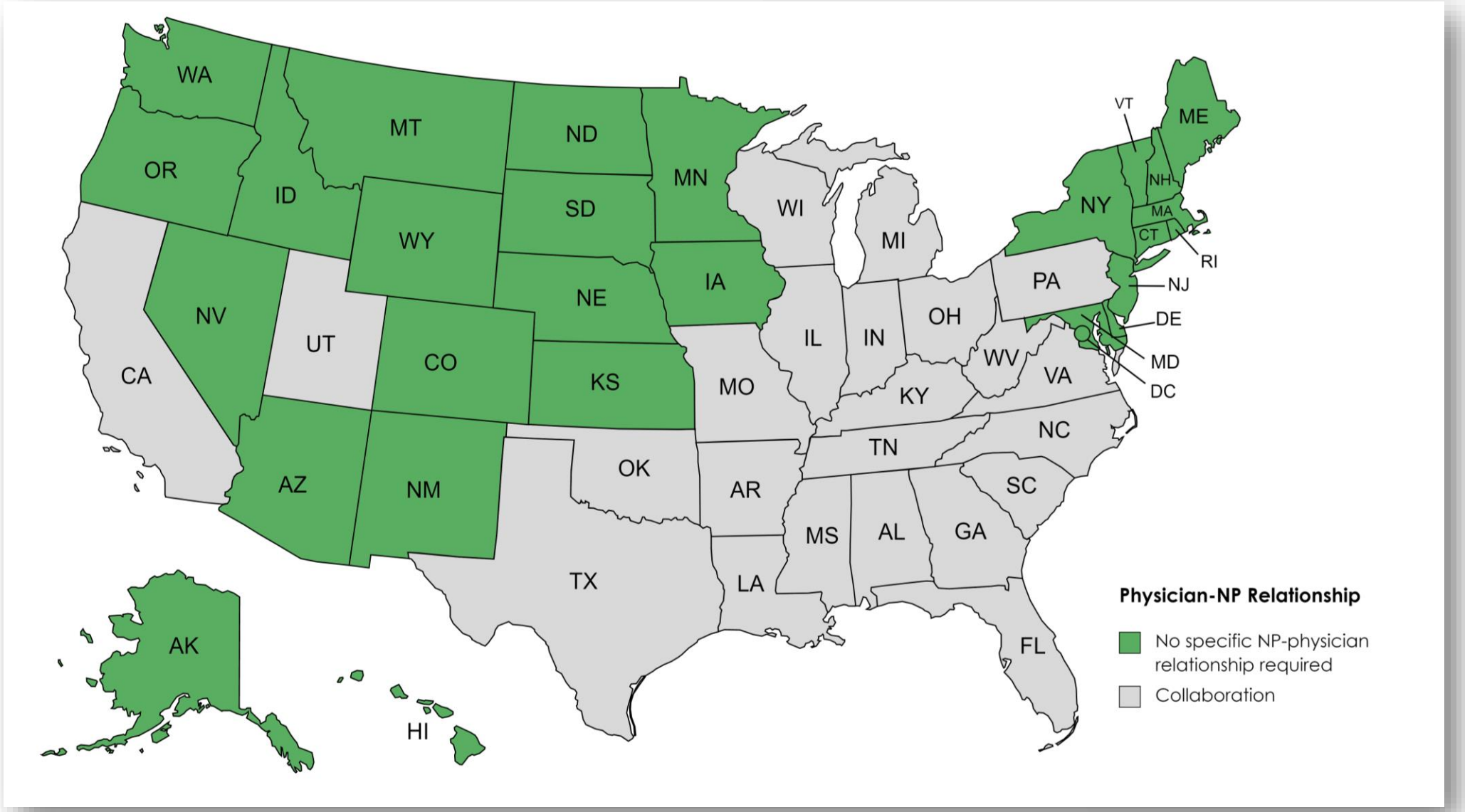
NPs and Collaboration

Medicare defines “collaboration” as a process in which a nurse practitioner

- Works with one or more physicians to deliver health care services within the scope of the practitioner's expertise
- With medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by the law of the State in which the services are performed

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

NP State Practice Environment



NPs and Collaboration

In the absence of state laws requiring it, collaboration must be evidenced by NPs

- Documenting their scope of practice
- Indicating the relationships they have with physicians to deal with issues outside their scope of practice

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

PAs and Supervision

- Medicare defines “supervision” as a process in which a PA has a working relationship with one or more physicians
- The “supervision” requirement is met if there is any required practice relationships between physicians and PAs in state law (including collaboration requirements)

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

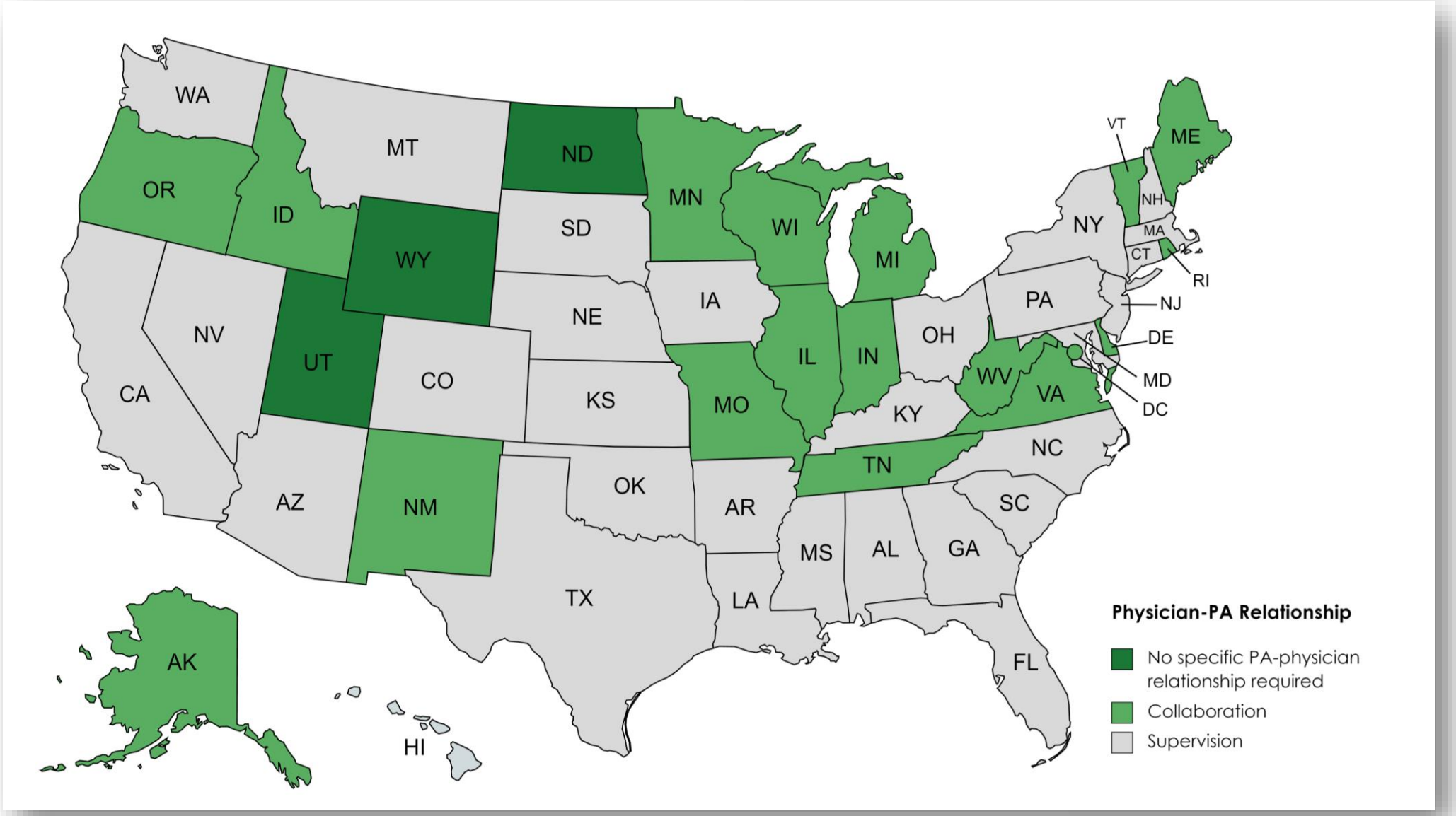
PAs Supervision

In the absence of state laws requiring any relationship between a physician and PA, there must be documentation at the practice level of a PA's

- Scope of practice
- Working relationships with physician(s)

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

PA State Practice Environment



MYTH

A physician may co-sign a PA's or NP's clinical encounter and bill Medicare for the service (under the physician)

REALITY

A physician must meet "incident to" or split (or shared) billing criteria to bill Medicare for the service (under the physician)

Optional Medicare billing mechanisms allowing services performed by PAs & NPs to be billed by physicians and paid at 100%

- **“Incident To”**
- **Split (or Shared) Billing**

- Require specific criteria to be met (more than co-signature)
- May not be recognized by Medicaid programs and/or commercial payers
- Risk for inefficiency, administrative burden, fraud and abuse

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

“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

Doctors and Medical Facilities in Lehigh Valley Pay $690,441 to Resolve Healthcare Fraud Allegations

United States Attorney's Office

. . . the defendants submitted claims to the federal government to receive reimbursement for **services performed by non-physicians as "incident to"** the services of supervising physicians when, in fact, supervising physicians were away from the office or otherwise incapable of supervising.

. . . defendants also agreed that, **for the next thirty months**, they **will not submit claims** to federal payors **for any services performed by non-physician providers** under the rate that applies for services **rendered "incident to"** the services of a physician, regardless of whether or not the claims could be billed properly in that manner.

https://www.justice.gov/usao-edpa/pr/doctors-and-medical-facilities-lehigh-valley-pay-690441-resolve-healthcare-fraud

“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/NP (not physician)

Split (or Shared) Services

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

Optional Medicare Billing Policy

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


FORGET EVERYTHING
YOU KNOW, YOU MUST
memegenerator.net

Split (or Shared) Billing

Services Eligible for Split (or Shared) Billing

Evaluation and management services (e.g., hospital inpatient and outpatient services, observation care, 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

Split (or Shared) Billing Requirements

- Physician and PA/NP must work for **same group**
- Physician and PA/NP must treat patient on **same calendar day**
- Either physician or PA/NP 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

Split (or Shared) Billing

"Substantive Portion"

Prior to 1/1/2022

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

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

Split (or Shared) Billing

"Substantive Portion"

For 2022

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

-OR-

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

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

Split (or Shared) Billing

"Substantive Portion"

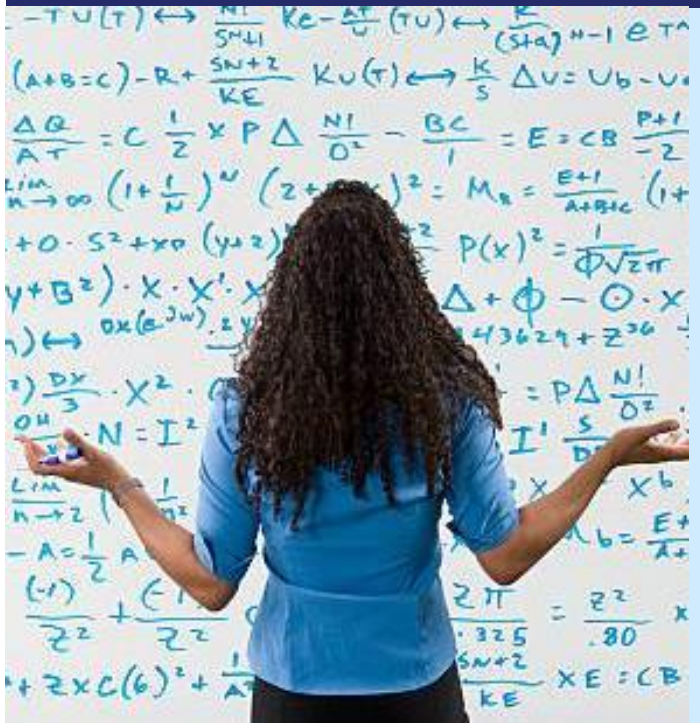
CMS intends to make the definition only time-based (i.e., more than half of the total time)

Planned for 2024

https://public-inspection.federalregister.gov/2022-14562.pdf

Split (or Shared) Billing

“Substantive Portion”



Proposed for 2023

- CMS proposes to keep 2022 definition
- But based on CPT guideline changes, history and exam would no longer contribute to the level of service
- Only decision-making or time would seem to be able to be used as the “substantive portion”

https://public-inspection.federalregister.gov/2022-14562.pdf

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

Mercy Medical Center Agreed to Pay $210,000 for Allegedly Violating the Civil Monetary Penalties Law by Submitting Claims that Misidentified Rendering Providers

Office of Inspector General

After it self-disclosed conduct to OIG, Mercy Medical Center (MMC), Ohio, agreed to pay $210,739.53 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that MMC billed for the professional services of physician assistants under the supervising physician's provider number as a shared/split, when the **documentation did not meet the requirements for a shared/split visit**.

https://oig.hhs.gov/fraud/enforcement/mercy-medical-center-agreed-to-pay-210000-for-allegedly-violating-the-civil-monetary-penalties-law-b
submitting-claims-that-misidentified-rendering-providers/

Split (or Shared) Billing

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

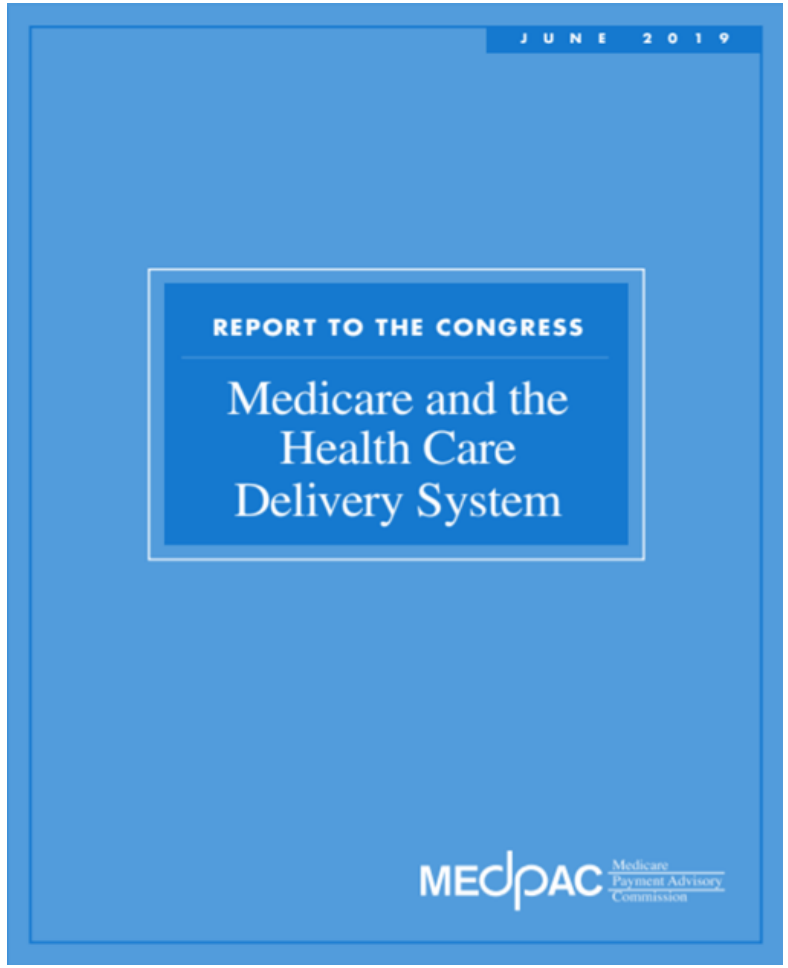
Bill Medicare under PA/NP (not physician)

MYTH

15% is “lost” in revenue when billing a service under a PA or NP instead of a physician

REALITY

There is a favorable contribution margin when PAs and NPs provide and bill for services



"NPs and 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

What about the extra 15%?

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

Reimbursement & Profit

PA & NP Reimbursement = 85% of Physician Fee Schedule

PA & NP Salary = 30-50% of Physician Salary

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

Contribution Margin

revenue after variable costs

Personnel Costs

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

Overall cost to employ PA/NP ↓↓↓ physician

Cost Effectiveness of PAs & NPs

A hypothetical day in an ED	Physician	PA/NP
Revenue with physician and PA/NP providing the same 99283 service	$1650 ($66 X 25 visits)	$1400 ($56 X 25 visits) [85% of $66 = $56]
Wages per day	$1440 ($120/hour x 12 hours)	$636 ($53/hour x 12 hours)
"Contribution margin" (revenue minus wages)	**$210**	**$764**

Cost Effectiveness Take-Aways

- Point is not that PAs & NPs produce greater contribution margin than physicians
- Point is that PAs & NPs 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

“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

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

MYTH

Practitioners do not need to be concerned about billing and reimbursement

REALITY

There are significant risks and potential penalties for not knowing and following billing policies

Knowledge of billing & reimbursement may

Increase Revenue	Improve Access & Efficiency	Avoid Pitfalls

"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

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

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.

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.

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.

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

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

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

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

Fraud & Abuse: By the Numbers

Fiscal Year 2020

$4.1 billion recovered	**578** criminal actions	**781** civil actions	**2,148** excluded

Return on Investment $12.40 to $1.00

https://oig.hhs.gov/publications/docs/hcfac/FY2020-hcfac.pdf


TATTLETALE!
I PREFER "WHISTLEBLOWER."
COOKIES
THE WHISTLEBLOWERS

Whistleblowers: By the Numbers

600+
whistleblower cases each year

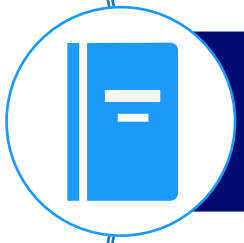
$1.2 of $1.3
billion in FCA settlements from whistleblowers in 2020

30%
of recovered funds eligible to whistleblowers

https://oig.hhs.gov/publications/docs/hcfac/FY2020-hcfac.pdf

Take Home Points

PAs and NPs 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

Thank you

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