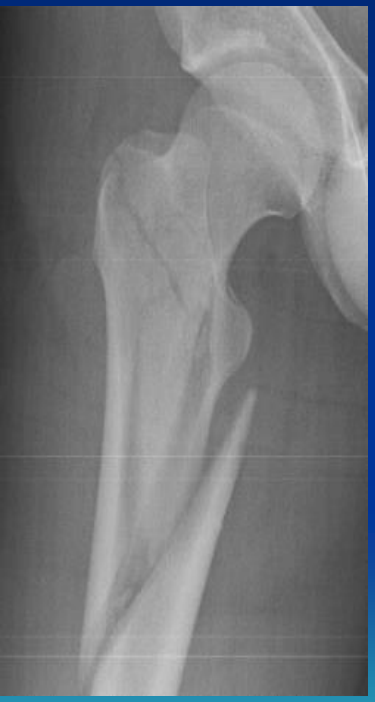
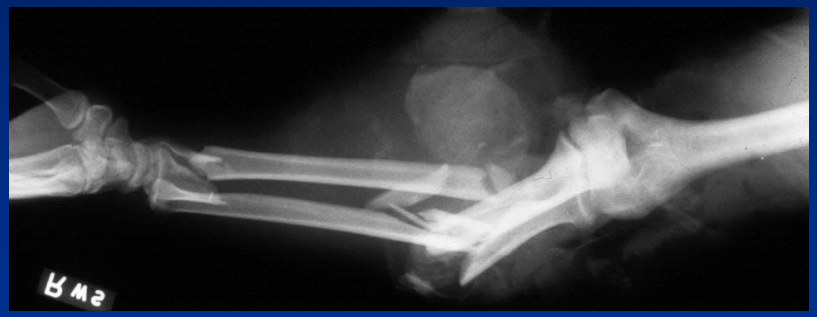
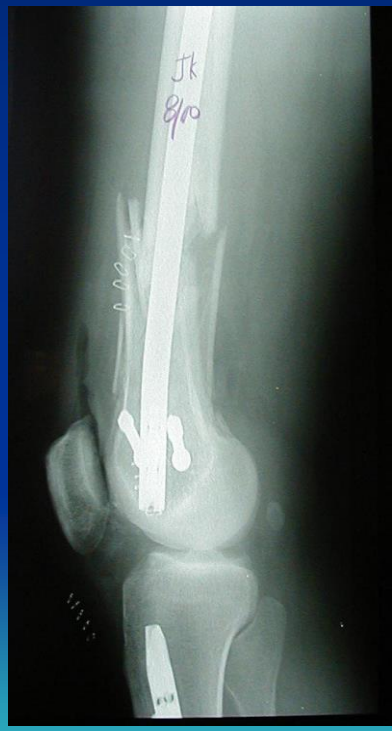
PHYSICIAN ASSISTANT UTILIZATION







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Purpose

- Review Common Employment Relationships, Models, and Utilization for Physicians and CMS “Non-Physician Practitioners” (NPP)
  - CMS NPP= PA/NPs
    - Physician Assistants (PA)
    - Nurse Practitioners (NP)

Acknowledgements

- The lecture contents are a conglomeration
  - Lectures and Employer Resources from American Academy of Physician Assistants
  - Cited Research on the utilization of NPs/PAs
  - Tricia Marriott, formerly of AAPA

I wish to acknowledge all of the work that helped with this topic presentation.

Disclaimer

- This presentation was current at the time it was submitted. It does not represent payment or legal advice.
- Medicare policy changes frequently, so be sure to keep current by going to www.cms.gov.

- The ultimate responsibility for the correct submission of claims and response to any remittance advice lies with **the provider** of services.
- The American Medical Association has copyright and trademark protection of CPT ©.

Why do (should) we care?

Insurers and Employers increasing and shifting payment to Surgeons/PAs and Hospitals for “Fee for Value” over past “Fee for Service”

As payer mix of hospital patients continue to change with insurance evolution and other economic drivers there is a continual push to improve efficiency (cost of episode of care) AND outcomes of surgical patients

Beckers Hospital Review Article

"Want higher HCAHPS scores? Physician assistants may be key"

http://www.beckershospitalreview.com/quality/want-higher-hcahps-scores-physician-assistants-may-be-key.html

New MGMA Data Shows Medical Practices Utilizing More Non-Physician Providers are More Profitable, Productive

"American medical practices continue to rely more and more on non-physician providers to treat their patients," said Dr. Halee Fischer-Wright, President and CEO of MGMA. "Today's findings not only further demonstrate this trend, but show **that by utilizing more non-physician providers in their practice, administrators can actually boost their practices' revenue and productivity by allowing physicians to focus on the most acute cases."**

https://www.mgma.com/news-insights/press/new-mgma-data-shows-medical-practices-utilizing-mo

PA JOB MARKET

Summary

Quick Facts: Physician Assistants	
2020 Median Pay	$115,390 per year $55.48 per hour
Typical Entry-Level Education	Master's degree
Work Experience in a Related Occupation	None
On-the-job Training	None
Number of Jobs, 2020	129,400
Job Outlook, 2020-30	31% (Much faster than average)
Employment Change, 2020-30	40,100

US BUREAU OF LABOR STATISTICS

PA and NP Roles and Responsibilities Maximizing Utilization PAs and NPs

Recognized as providers by Medicare

Services as defined by Medicare are “the type that are considered physician's services…”

Not clinical support staff

Not scribes

What are the best ways to use a PA in your practice?

- *PAs provide a broad range of medical services **that otherwise would be provided by physicians**.* (Source: AAPA)

- "*PAs may furnish services billed under **all levels** of CPT evaluation and management codes, and diagnostic tests if furnished under the general supervision of a physician.*"

  http://www.cms.gov/manuals/Downloads/bp102c15.pdf

- NOT ALL payers enroll, but virtually all payers cover services provided by PAs. PAs can provide reimbursable services in your office or clinic, the emergency room, the operating room, and inpatient floor care. Insurers will reimburse differently but pay up to 100% of physician fees for PA services.

Utilization of NP/PAs in Academic and Private Hospital

- Impact of Hospital-Employed Physician Assistants on a Level II Community-Based Orthopaedic Trauma System Journal of Orthopaedic Trauma. April 2013;27(4):e87-e91.

Althausen, Peter L.; Shannon, Steven; Owens, Brianne; Coll, Daniel; Cvitash, Michael; Lu, Minggen; O'Mara, Timothy J.; Bray, Timothy

Journal of Orthopaedic Trauma April 2013: Study Results

- PA collections from patient care covered 50% of their costs for salary and benefits.
- PA involvement:
  - Trauma patients with orthopedic injuries were seen 205 minutes faster (P = 0.006)
  - Total Emergency Room (ER) time decreased 175 minutes (P = 0.0001)
  - Time to surgery improved 360 minutes (P=0.03).

JOT Results Continued

Continued:

- DVT prophylaxis increased by a mean of 6.73% (P = 0.0084),
- Postoperative antibiotic administration increased by 2.88% (P = 0.0302)
- 4.67% decrease in postoperative complications (P = 0.0034).
- Average length of stay decreased by 0.61 days (P = 0.27).

JOT 2013 Conclusions

- Although the PA's collections did not cover their costs through charges, the indirect economic and patient care impacts are clear
  - Diminished times for patients in the emergency room by 3+ hours
  - Shortened time to the operating room by 6 hours
  - Diminished lengths of stays by ½ day
  - Improved core measures compliance

Impact of Hospital-Employed Physician Assistants on a Level II Community-Based Orthopaedic Trauma System:Althausen, Peter L.; Shannon, Steven; Owens, Brianne; Coll, Daniel; Cvitash, Michael; Lu, Minggen; O'Mara, T; Bray, T. J.:Journal of Orthopaedic Trauma. 27(4):e87-e91, April 2013.

Pilot Study: Utilization of Physician Assistants at Academic Teaching Hospitals

Travis L. Randolph, PA-C, ATC

E. Barry McDonough, MD

Eric D. Olson, PhD

Journal of the American Academy of Physician Assistants: October 2016 - Volume 29 - Issue 10 - p 1-2 doi: 10.1097/01.JAA.0000490116.12185.59

Introduction of Pilot Study

- A 6 month pilot study was conducted in Orthopaedics to compare the difference between using PAs in shared clinics vs split clinics at academic teaching institutions
- Shared Clinic Model: PA functions similar to a resident and each patient is staffed with Supervising Physician; PAs in this model function very similar to a scribe and billing is captured by the physician; very common in academic institutions
- Split Clinic Model: PA functions autonomously in clinic as a healthcare provider while Supervising Physician is in clinic or in the operating room; more common in private practice setting

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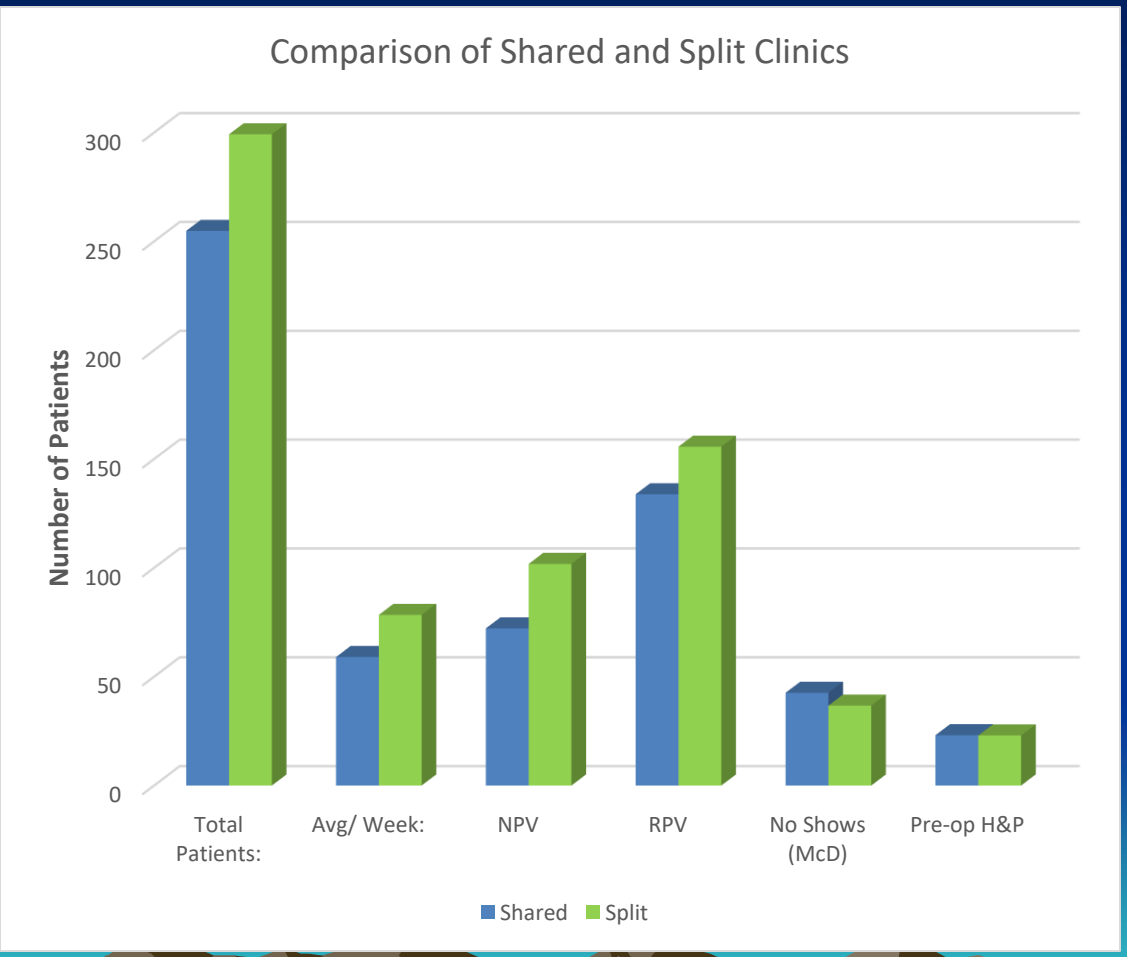
6 Month Results of Pilot Study



- Results averaged per month
- 17% ↑ in total patient volume
- 41% ↑ in New Patients
- 16 % ↑ in Return Patients
- 14 % ↓ in patient No Shows for Supervising Physician's clinic
- Clinic wait time for patients ↓ from 3 weeks to less than 1 week within 3 months
- 95% percent of patients rated the PA as a good or excellent clinician in survey

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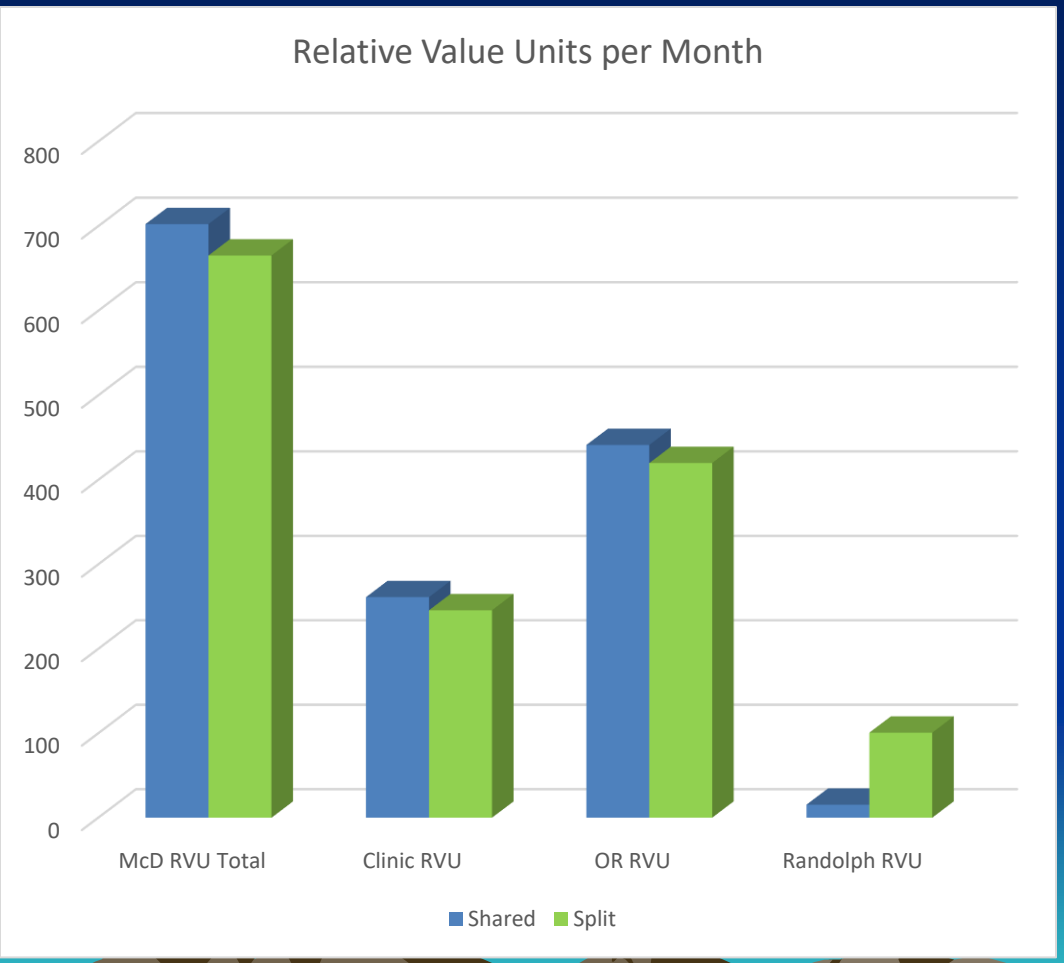
6 Month Results of Pilot Study



- PA's total patient volume ↑ by over 700%, payments ↑ over 600% while RVUs ↑ by more than 500%
- Supervising Physician experienced a 5% ↓ in total payments and RVUs during this 6 month study
- YTD numbers in 2016 show a 20 % ↑ in RVUs/ Charges and a 16 % ↑ in net payments for the Supervising Physician when compared to 2015

Slides used with permission from primary author

Conclusion of Pilot Study

- Utilizing a split clinic model allows PAs to function at the highest scope of their practice and provide quality patient care at academic teaching institutions
- This study illustrates that utilizing PAs appropriately can significantly increase patient access to care and generate increased revenue for the department
- It was determined that additional nursing support was needed to reduce administrative duties (forms, patient calls, etc.) for PAs in order to increase clinic availability
- Resident physicians reported an improved educational experience while utilizing the split clinic model

2020 Follow-up To Study

- The number of PAs and NPs in our practice grew from 8 in 2010 to 22 in 2019 (20 PAs and 2 NPs).
- 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,.

Journal of the American Academy of Physician Assistants. 33(12):1, Dec. 2020

Academic Settings

- PAs can be integrated into resident teams.

  https://www.acgme.org/acgmeweb/Portals/0/PDFs/DH_Definitions.pdf

- Teaching/Resident billing rules DO NOT apply to PAs.
- PAs must NOT be assigned as “resident” in the EMR. There are compliance and billing implications
- No PA billing restrictions Outside OR- Clinic, ER, Floor, Procedures etc.

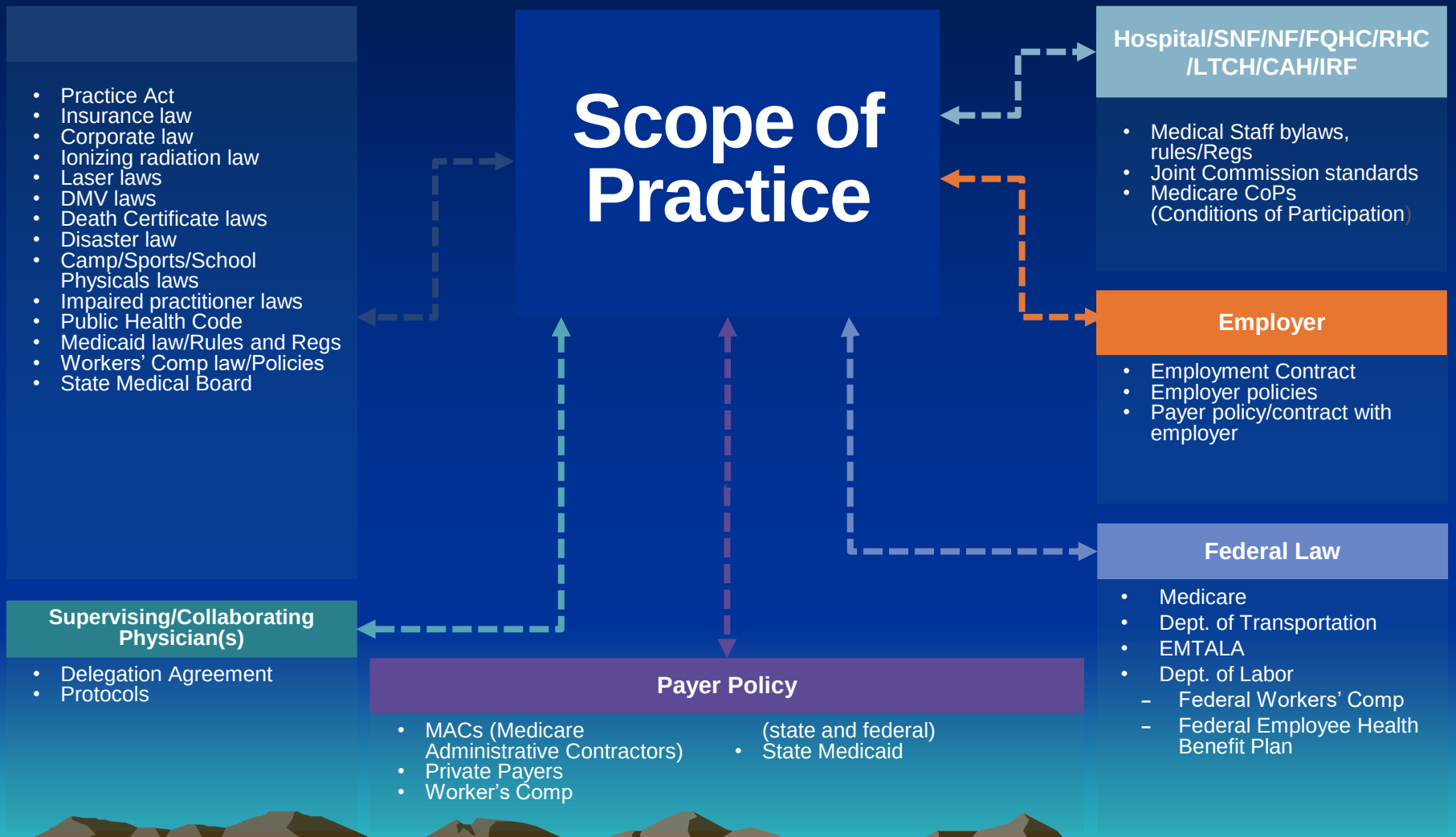
<u>PAs are allowed to First Assist in the operating room and bill if:</u>

- No qualified resident available: this can be because they are in required training sessions (Grand Rounds) or off-duty for sleep or required to be in clinic
- Physician NEVER uses the residents
- Trauma

Harvard Business School: Potential Cost Per Employee Category

	Surgeon	PAs	RN	X-Ray Tech	Scribe	Office Assistant
Total Clinical Costs	$546,400	$120,000	$100,000	$64,000	$51,000	$61,000
Personnel Capacity (minutes)	91,086	89,086	89,086	89,086	89,086	89,086
Personnel Capacity Cost Rate $/min	**$6.00**	**$1.35**	**$1.12**	**$0.72**	**$0.57**	**$0.68**

Interrelated Elements Determine Scope of Practice



What Employment Model?

Employment Relationships for Physicians and NP/PAs which is important for Billing:

Practice Bills for NP/PA Services:

- Private Practice/Physician employing NP/PA
- Private Practice where Hospital Contributes/Supports cost of NP/PA but does not employ
- Practice/Physician leasing Hospital NP/PA at FMV

NP/PA Employer Bills for NP/PA Services:

- Private Practice Physician working with Hospital Employed NP/PA
- Contracted Physician with Hospital Employed NP/PA
- Employed Physician working with Employed NP/PA

2022 Omnibus/CMS Changes

- The PA Direct Payment Act (S.596/H.R. 1052) was included in the omnibus, effective January 1, 2022.
- Authorizing PAs to be paid directly by Medicare similar to physicians and APRNs. (Locums, 1099)
- PAs who own their own practice in accordance with state law will be able to receive direct pay from the Medicare.
- PAs in RHCs and Federally Qualified Health Centers (FQHCs) to furnish and bill for hospice “attending physician” services for terminally ill .

Office or Clinic Practice PAs

- Run orthopedic urgent care/fresh fracture clinics
- Provider for Fragility Fracture Program
- Most efficient- PA has own clinic schedule, space, and staff.
  - Inefficient for the doctor to see every patient of the PA
  - PAs who meet patients throughout their care are better integrated as part of the patient's care team and have high patient satisfaction scores with lower liability*.

**Employing Physician Assistants and Nurse Practitioners May Decrease Liability"; Journal of Medical Licensure and Discipline; Vol 95, Number 2, 2009*

ER Evaluation and Triage

- Initiate Patient Contact and Evaluation for Orthopedic Consult
- Reviewing studies, ordering appropriate additional studies, properly immobilizing,
- “Triage” filter patients who need acute care, versus patients who can have delayed or urgent outpatient care, or just routine outpatient follow-up.

Operating Room Utilization

- Physician Assistant retrieves and posts preoperative studies, reviews the operating room setup including appropriate imaging equipment and its position for the procedure.

- Physician assistant then assists with patient transfer, positioning for procedure, assist with prep, draping, intraoperative first assisting, wound closure, dressing, splinting, and removal of patient from operating room table while protecting surgical repair.

Inpatient Care

- The inpatient abilities of the physician assistant are directly related to the hospital bylaws and privileges
- PA will COMMUNICATE with the hospital staff, consultants, care team, and patient.
- PAs also can play a large role of patient education, set recovery expectations, and increase satisfaction
- Postop follows Inpatients until discharge

Inpatient and/or Outpatient Post-Operative/Follow-up Care

- PA sees postop patients and provides education
- Physician assistant can order/apply postoperative equipment, medication, therapy, work/school communications, etc.
- Physician can make patient contact to satisfy patient but Surgeon can see new patients

Take Home Points for PA Productivity Quantification

Calculating PA Productivity requires in-depth knowledge of billing and reimbursement policy and claims methodology for the various payers. Many resources available.

Many claims are submitted under the physician's identification number (NPI), rendering the PA's work invisible in the claims data from practice and payers.

Unless a PA's work (production) and financial contribution can be fully attributed to the PA, a production based compensation formula is not calculable and should not be negotiated/used.

Conclusion/Discussion

To maximize the impact and satisfaction and retention of a PA/NP, they should be providing services that would otherwise be done by a Physician.

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