American Academy of Physician Associates

Medicare Billing Policies That Affect PA and NP Practice

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Disclaimer

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

We 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.

Learning Objectives

- Review Medicare billing policies that affect PA and NP practice
- Recognize the value and benefits of “independent billing” for PAs and NPs
- Optimize PA and NP practice and demonstrate value and productivity
- Debunk some of the billing and practice myths that hinder efficient PA and NP practice

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Medicare Billing:
Overview & Updates

PAs and NPs “may furnish services billed under all levels of evaluation and management codes and diagnostic tests” and other “services that traditionally have been reserved to physicians”, including “activities that involve an independent evaluation or treatment of the patient’s condition”

Centers for Medicare and Medicaid Services

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

Medicare Policy:

From “Supervision” to “Collaboration
. . . and Beyond!

NPs and “Collaboration”

In the absence of state laws requiring collaboration, there must be documentation at the practice level of the NPs

- Scope of practice
- Relationships 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”

Any mention of “collaboration” or working relationships between PAs and physicians in state law meets statutory “supervision” requirement

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 & NP Billing

Direct . . . Indirect . . . Hidden

Previous Medicare Policy on PA Reimbursement

- Previously, payment for PA-provided services went to the PA's employer (physician, physician group, hospital, nursing facility, ASC, professional corporation, or a professional/medical corporation up to 99% owned by a PA).

- PAs/NPs are eligible to receive direct payment and are authorized to own 100% of a state-approved corporation that can receive payment directly from Medicare.

- Need to "re-enroll" with the Medicare program to receive direct payment (payment directed to SS # or corporation tax ID#).

The Benefits of Direct Payment Will Be Especially Important to PAs/NPs Who:

- Practice as independent contractors (1099 relationship).
- Want to work part-time without having to deal with additional administrative paperwork associated with a formal employment relationship.
- Choose to own a practice/medical or professional corporation.

Direct Payment

- Direct payment does not change scope of practice.
- Medicare's rate of reimbursement (85%) for PAs/NPs does not change.
- Similar to physicians, the majority of NPs/PAs will likely maintain their traditional W-2 (salaried) employment arrangement with employers and not elect direct payment.
- Direct payment is an option (not required).

“Incident to” Billing

“Incident to” Billing Option

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

- **Potential for “incident to” billing occurs on a patient visit after the physician initiates care for a particular medical problem and develops a diagnosis/plan of care.**

- 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” Billing

Allows a “private” **office or clinic**-provided service performed by a PA/NP 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*).

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

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

“Incident to” Billing

- The NP/PA and physician must be employed by same group (W-2 employee, 1099 Independent contractor or a leasing arrangement is acceptable).
- 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” is generally a Medicare term and not always applicable with private commercial payers or Medicaid.

“Incident to” Billing

- The original treating physician (or another physician in the group) must be physically present in the same office suite.
- 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.

“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

“Incident to” Does NOT Apply

Inpatient & Observation Services

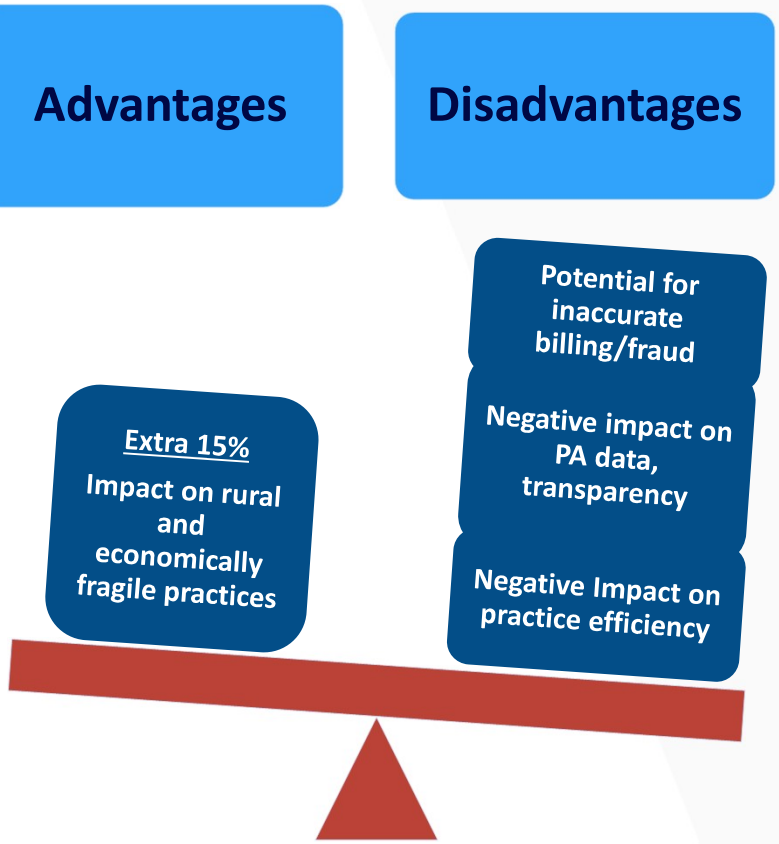
Hospital Outpatient Services

- **Outpatient Clinic**
- Emergency Department
- Same Day Surgery Center

Inpatient Nursing & Rehabilitation Facilities

Some hospital-owned practices are considered ‘hospital outpatient clinics’ (Place of Services 19 & 22) and ineligible for “incident to” billing

Is Billing “Incident to” Worth it?



Split (or Shared) Billing

Split (or Shared) Billing

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

Optional Medicare Billing Mechanism

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

Split (or Shared) Billing

Services Eligible for Split (or Shared) Billing

Evaluation and management services, including

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

Does **NOT** apply to procedures

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

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

Substantive Portion

Prior to 1/1/22

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

Substantive Portion

For 2022 & 2023

One 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/NP and physician (required for critical care and discharge management services)

Substantive Portion

2024 & Beyond

CMS <u>proposes</u> to make definition only ‘more than half the total time’

Split (or Shared) Billing

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

Bill Medicare under PA/NP


Potential Effects Split (or Shared) Billing
Patient Dissatisfaction
Clinician Burnout
Fraud & Abuse
Delays in Care
Administrative Burden
Decreased Care Continuity
Decreased Efficiency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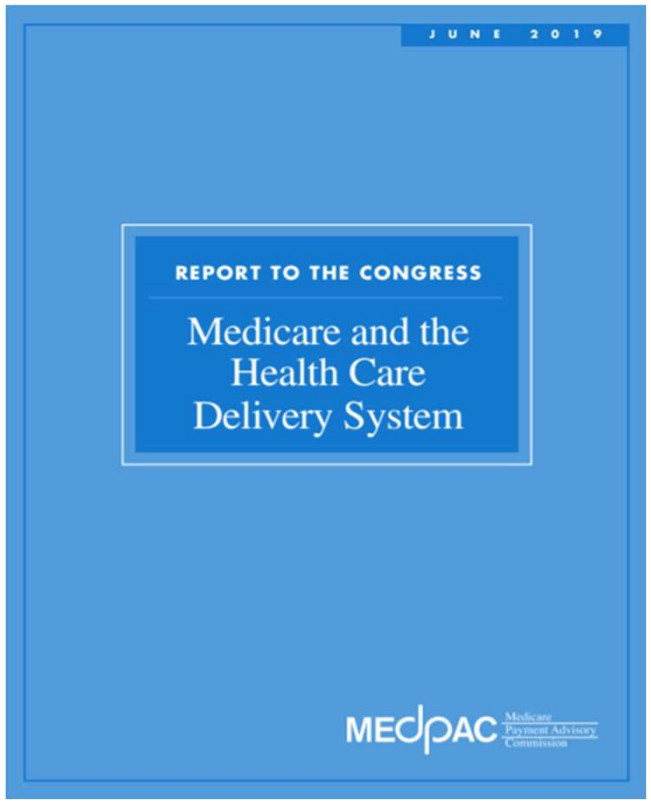
Value & Productivity


What about the extra 15%?
More than made up for by increased efficiency, decreased burden, and overall contribution margin.



"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

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

Cost Effectiveness Take-Aways

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

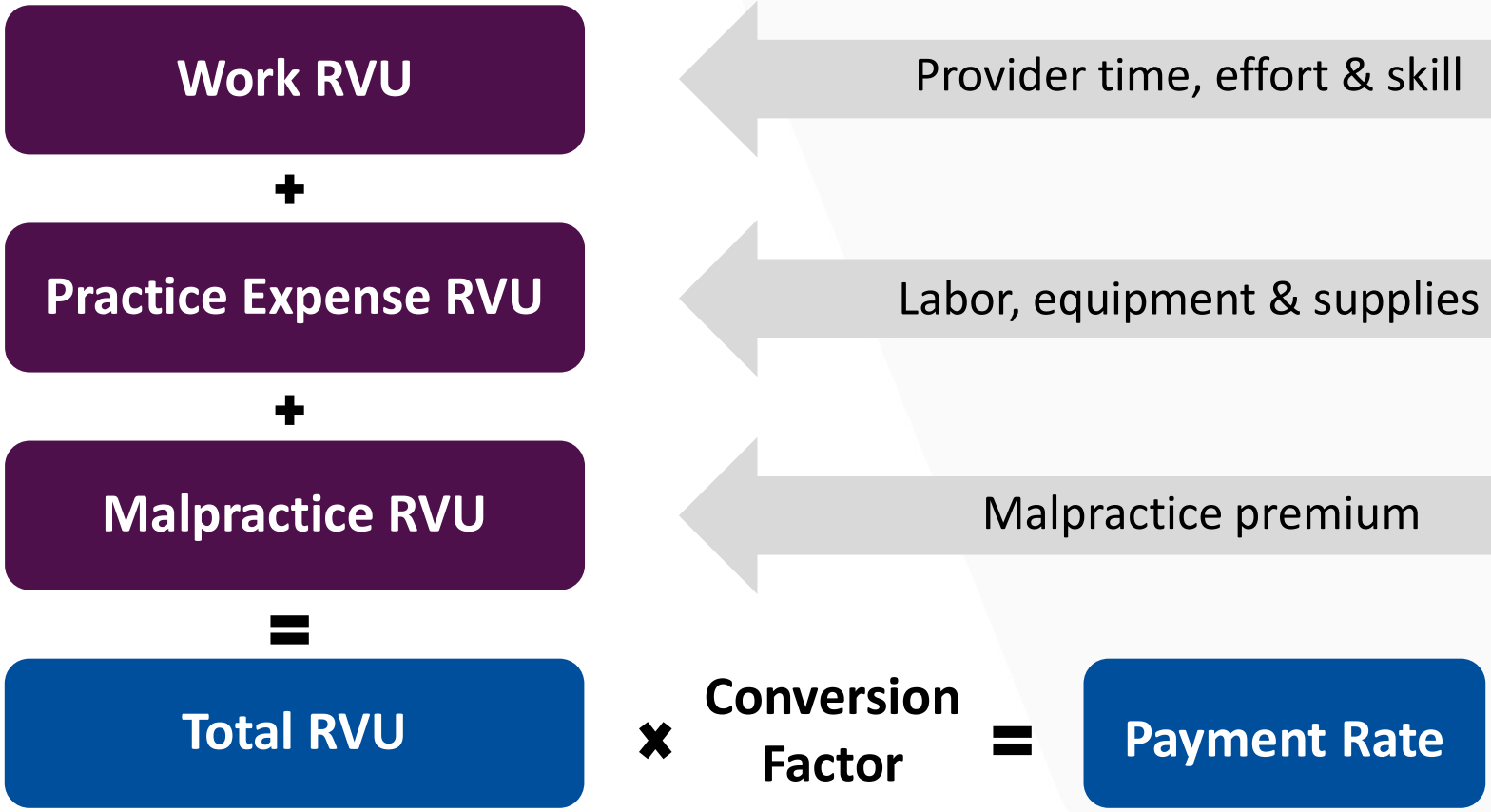
Relative Value Units (RVUs)

RVUs

- RVU data can track professional work, productivity, reimbursement, gross charges, net collections, etc.
- If used properly, can be used to objectively compare health professional contributions.
- An RVU is a number (e.g., 2.31 or 12.5) not a dollar or reimbursement amount.

RVU

Standardized measure used by Medicare to determine payment for services



wRVUs

- Is there a PA/NP RVU scale? **NO**
- Is there a standard PA/NP RVU conversion factor? **NO**
- The purpose of wRVUs is to compare medical and surgical professional work and should not be based on a particular health professional type if performing the same service.

"A service is a service is a service"

Potential Limitations for PAs/NPs

Methods of measuring productivity may be inaccurate, particularly depending on:

- Variations in practice culture, workflow
- Billing mechanisms and policies (e.g., “incident to”)
- Unrecognized contribution to global surgical billing and bundled payments (non-billable, but professional work requiring physician, PA, or NP)

Potential Pitfalls in Measuring Productivity

In addition to the risk of inaccuracy, measuring value by productivity may:

- Cause colleagues to compete for patients
- Lead to unnecessary tests or procedures
- Decrease professional satisfaction and perceived clinical contribution
- Devalue other, non-revenue-generating contributions

Productivity & Value
What Is It?

“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

Value Equation

$$\text{Value} = \frac{\text{Benefits}}{\text{Costs}}$$

(financial & otherwise)

- Quality & Outcomes
- Access to Care
- Efficiency & Care Coordination
- Patient Satisfaction
- Provider & Staff Satisfaction
- Productivity
- Revenue

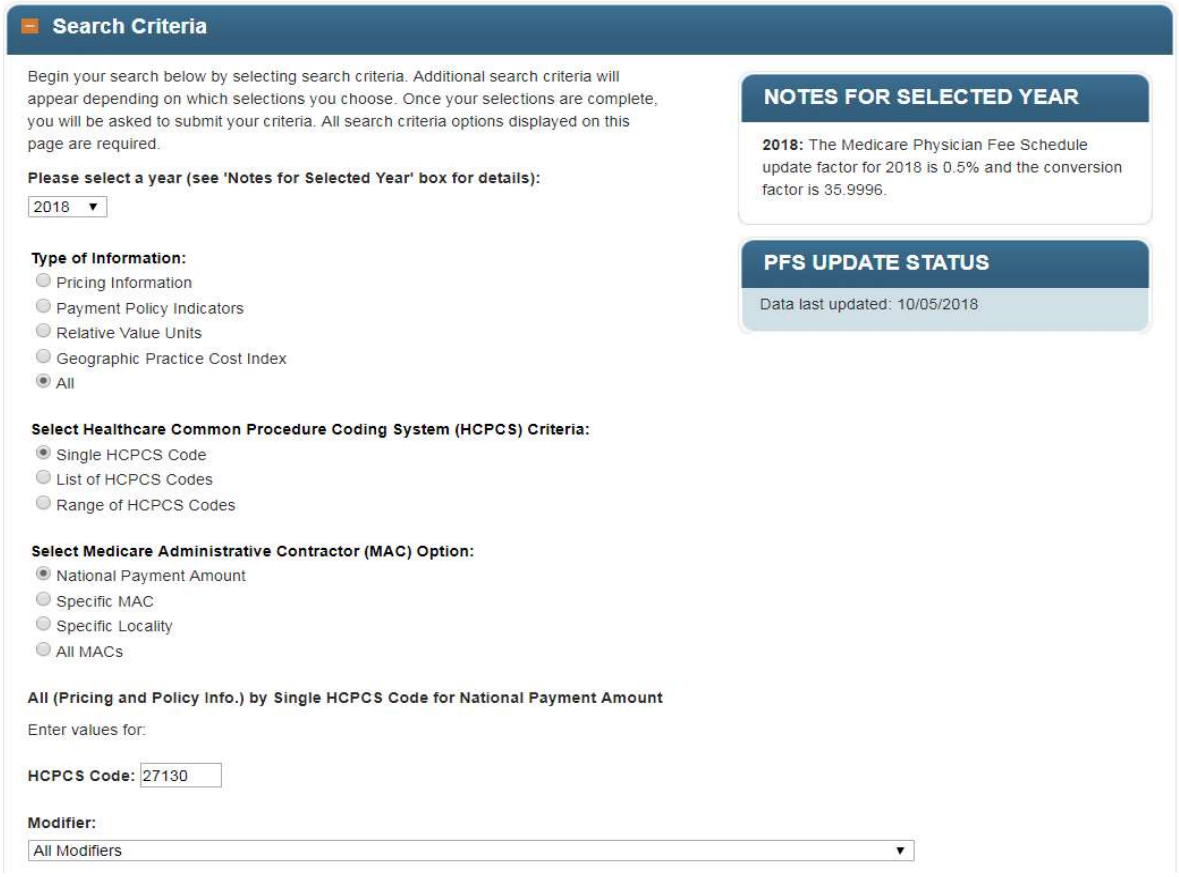
The Value of PAs & NPs

- 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

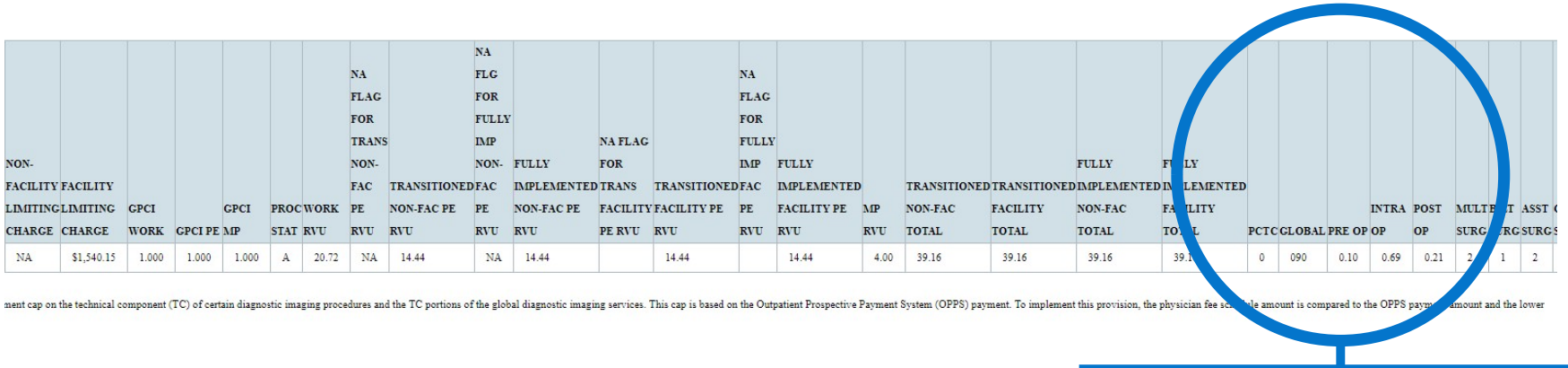
Contribution to Global Surgical Package

Physician Fee Schedule Search

https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx



- ✓ Type of information: All
- ✓ Single HCPCS Code
- ✓ Select MAC/Locality option
- ✓ Modifier: All Modifiers



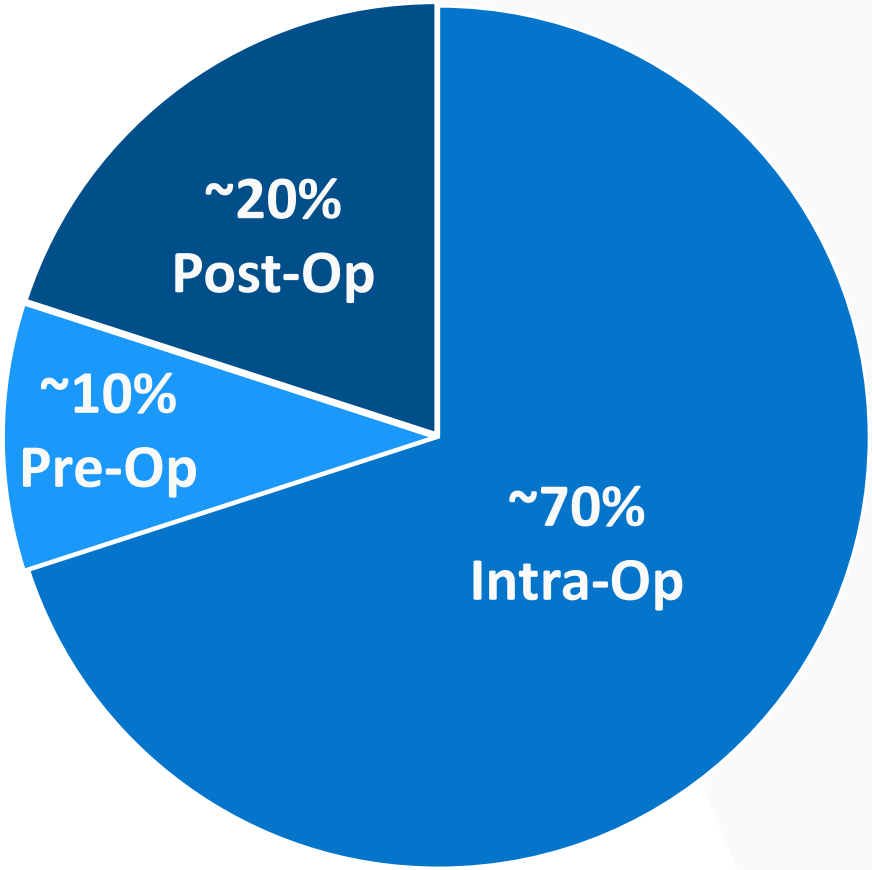
NON-FACILITY LIMITING CHARGE	FACILITY LIMITING CHARGE	GPCI WORK	GPCI PE	GPCI MP	PROC STAT	WORK RVU	NA FLAG FOR TRANS NON-FAC PE RVU	TRANSITIONED NON-FAC PE RVU	NA FLG FOR FULLY IMP NON-FAC PE RVU	FULLY IMPLEMENTED NON-FAC PE RVU	NA FLAG FOR TRANS FACILITY PE RVU	TRANSITIONED FACILITY PE RVU	NA FLAG FOR FULLY IMP FAC PE RVU	FULLY IMPLEMENTED FACILITY PE RVU	MP RVU	TRANSITIONED NON-FAC TOTAL	TRANSITIONED FACILITY TOTAL	FULLY IMPLEMENTED NON-FAC TOTAL	FULLY IMPLEMENTED FACILITY TOTAL	PCTC	GLOBAL	PRE OP	INTRA OP	POST OP	MULT SURG	T SURG	ASST SURG
NA	$1,540.15	1.000	1.000	1.000	A	20.72	NA	14.44	NA	14.44		14.44		14.44	4.00	39.16	39.16	39.16	39.1	0	090	0.10	0.69	0.21	2	1	2

ment cap on the technical component (TC) of certain diagnostic imaging procedures and the TC portions of the global diagnostic imaging services. This cap is based on the Outpatient Prospective Payment System (OPPS) payment. To implement this provision, the physician fee sc le amount is compared to the OPPS paym amount and the lower

HCPCS CODE	SHORT DESCRIPTION	GLOBAL	FACILITY PRICE	WORK RVU	**PRE OP**	**INTRA OP**	**POST OP**
27130	Total hip arthroplasty	90	$1,409.74	20.72	**0.1**	**0.69**	**0.21**

https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

Global Surgical Package



Hypothetical Work Attribution for Total Hip Arthroplasty

27130	Global Surgical Surgical Package	Physician	PA/NP
Pre-operative (0.1)	$140.97 2.07 wRVU		**$140.97** **2.07 wRVU**
Intra-operative (0.69)	$972.72 14.30 wRVU	$972.72 14.30 wRVU	
Post-operative (0.21)	$296.05 4.35 wRVU		**$296.05** **4.35 wRVU**
Total	**$1,409.74** **20.72 wRVUs**	**$972.72** **14.30 wRVU**	**$437.02** **6.42 wRVU**

CPT Code 99024

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

Captures post-op work provided in Global Surgical Package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Optimized PA & NP Practice

What is Optimized Practice?

- PAs/NPs working
  - To the full extent of their education, licensure/certification, and competency
  - effectively within healthcare teams/systems to meet the needs of patients
- Non duplicative work
- The right person performing the right role
  - Including PAs/NPs NOT acting as scribes
- Clinical and administrative support
- Educational/skill development

Examples of Optimized Practice

- Autonomous patient panels
- PA/NP-run observation units, pre-operative optimization clinics, disease-specific clinics, etc.
- PA/NP-directed transitions of care
- Appropriate billing for services rendered

AAPA MAY 14–18 2016 SAN ANTONIO, TX

AAPA POSTER SESSION ABSTRACT

Using physician assistants at academic teaching hospitals

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

https://www.chlm.org/wp-content/uploads/2017/12/Using_physician_assistants_at_academic_teaching.pdf

6-Month Pilot Study

PA Results	700% ↑ in PA's total patient volume
	600% ↑ in PA's payments
	500% ↑ in PA's RVUs

https://www.chlm.org/wp-content/uploads/2017/12/Using_physician_assistants_at_academic_teaching.pdf

6-Month Pilot Study

Physician Results	5% ↓ in total payments and RVUs for physician during 6-month pilot
	33% ↑ in physician's operating projections for first month following pilot study

https://www.chlm.org/wp-content/uploads/2017/12/Using_physician_assistants_at_academic_teaching.pdf

6-Month Pilot Study

Practice Results

- 17% ↑ in total patient volume
- 41% ↑ in New Patients
- 16% ↑ in Return Patients
- 66% ↓ in patient wait times
- 14% ↓ in patient no-shows for physician
- 95% of patients rated PA as good or excellent
- Medical residents reported improved learning experience

https://www.chlm.org/wp-content/uploads/2017/12/Using_physician_assistants_at_academic_teaching.pdf

AAPA 2020 POSTER SESSION ABSTRACTS

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

Travis L. Randolph, PA-C, ATC

4 years follow-up compared to 6 years prior to pilot

- 175% ↑ # of PAs/NPs
- 100% ↑ collections per PA/NP
- 125% ↑ wRVUs per PA/NP

https://pubmed.ncbi.nlm.nih.gov/33496501/

Internal Medicine after adjustment for increase in PAs/NPs

ORIGINAL RESEARCH

Demonstrating advanced practice provider value

Implementing a new advanced practice provider billing algorithm

Brooks, Paula B. DNP, FNP-BC, MBA, RNFA; Fulton, Megan E. MSPAS, PA-C

Author Information

Journal of the American Academy of Physician Assistants 32(2):p 1-10, February 2019. | **DOI:** 10.1097/01.JAA.0000550293.01522.01

PA/NP Results	Physician Results	Practice Results
608% ↑ wRVUs	3% ↑ wRVUs	24% ↑ wRVUs
769% ↑ collections	5% ↑ collections	29% ↑ collections

https://journals.lww.com/jaapa/Fulltext/2019/02000/Demonstrating_advanced_practice_provider_value_.17.aspx

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Trending Issues

Specialty Identification

Discussion Issue – Identifying PAs by Specialty

Value of not identifying PAs by specialty

- Maintain existing flexibility for PAs to move between specialties, professional satisfaction
- PAs meeting changing work force needs by shifting to specialty areas of need
- Limited risk of additional specialty "certification" or verification

Value of specialty identification

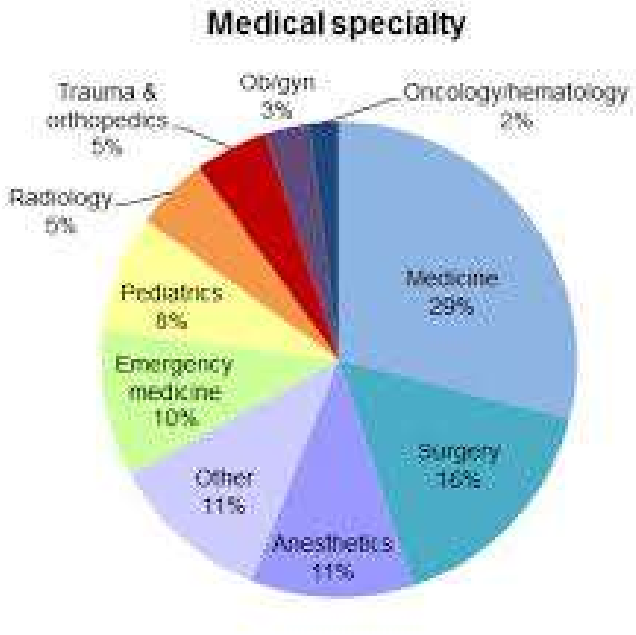
- PAs listed in provider directories by specialty (as opposed to a "PA category")
- Primary Care Provider status with more payers
- Assist in achieving PA coverage in traditionally challenging specialties (e.g., psychiatry/ behavioral health)

PA Identification by Specialty

Law of Unintended Consequences/Potential Downside

How would identification within a specialty occur?

- Self-attestation? (probably not acceptable)
- Certifying exam/additional educational requirements?
- Additional specialty-specific CME, residency requirement?
- Some other “proof of competency” required by payers?



PA Identification by Specialty

Who might advocate for PA identification?

- ❑Congress/Medicare program ⟹ to align PAs with other health professions
- ❑Commercial payers ⟹ as is done for physicians, especially with OTP
- ❑Policy makers/researchers ⟹ interested in workforce/primary care data

NPs are in a similar position to PAs, even though they may graduate from educational programs in a particular specialty

“Incident to” Billing

Is It Going Away???

Discussion Issue – Incident to Billing
Keep or Eliminate?

AAPA is on record stating that “incident to” should be eliminated. “Incident to” billing hides PA contribution, productivity, impact on care delivery.

- Trade-offs should occur with some of the financial savings from eliminating “incident to” being used to offset the cost of other PA Medicare legislative changes (certifying hospice, ordering diabetic shoes, medical nutritional therapy, etc.).

- Consideration of raising the Medicare PA/NP reimbursement rate should be in the mix.

Discussion Issue – Incident to Billing
Keep or Eliminate?

Who might advocate for eliminating "incident to"?

- ❑ Congress/Medicare program/commercial payers → to save money.
- ❑ Policy makers/researchers → interested in accurate data (knowing who actually provided the care).

Who will likely fight eliminating "incident to"?

- ❑ Physicians, group practices, equity investors in health care.

Discussion Issue – "Incident to" Billing
Keep or Eliminate?

Additional considerations:

- NPs have similar issues/concerns as PAs
- AAPA and AANP talk about strategy/approach/timing
- Need sensitivity about disrupting payment policy during and following COVID-19
- Need to consider this issue in light of other PA/NP healthcare legislative priorities

Provider Non-Discrimination

Section 2706(a) of the Affordable Care Act

Provider Nondiscrimination Provision

- Legislative provision expanding support for to health professionals.
- Added by the Affordable Care Act and effective January 1, 2014.
- Unique in that multiple federal agencies have responsibility for promulgating the rule (Depts. of Labor, Health & Human Services, and Treasury).
- Previously, agencies indicated they would not issue implementing regulations.

Provider Nondiscrimination Provision

- The nondiscrimination language states that insurers "offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan for any health care provider who is acting within the scope of their license or certification under state law."

- If a service is covered the nondiscrimination provision would appear to prevent a health plan or insurer from denying coverage to a class or specific type of health professional, if state law allows the professional to perform that service.

- Agencies are in the process of promulgating regulations/clarifications, suggesting a May issuance of a proposed rule.

Provider Nondiscrimination Provision

Will not add coverage for services not already covered/included in the patient's benefit package and is not an any willing provider requirement.

Could lead to increased utilization of health professionals and the allowance of PAs to be designated as primary care providers or mental health providers, if a plan doesn't currently authorize coverage.

Likely that the proposed regulations will not be as assertive as we would prefer.

Provider Nondiscrimination Provision

Payers/physician groups argue that the provision should not increase the ability of non-MD/DO professionals to:

- Fully practice in accordance with state law
- Obtain reimbursement parity with physicians (payments at 100%)

AAPA is lobbying for a more expansive interpretation of the provision.

Hierarchical Condition Category (HCC) Coding Accuracy vs. Risk-based Payment

HCC Coding

- Implemented by CMS to help estimate the health care costs of Medicare enrollees in the coming year.

- Represents a category of chronic medical conditions that share similar cost patterns.

- Medicare Advantage plans, the Medicare Shared Savings Program, Medicaid, and certain commercial health plans use the CMS-HCC risk adjustment model to determine the health mix of their member enrollment and the reimbursements they receive from CMS.

HCC Coding

- Uses an ICD-10 code to “map” to a chronic medical condition.
- HCC code is assigned a certain weight/score.
- When combined with the patient’s age and gender, the HCC code is used to determine a patient’s risk adjustment factor (RAF), also known as a risk score.

HCC “UpCoding”

- Sen. Warren specifically referenced tactics that Medicare Advantage plans have used to increase the number of diagnosis codes to inflate risk scores and receive over payments.

- Specific problematic diagnosis included asthma, CKD, overstating cardiac issues when patient has mild lvh).

End of PHE and Flexibilities

What Ends, What Doesn’t, and When?

Examples of Flexibilities and When They End

End of PHE (5/11/23)	End of CY 2023	End of CY 2024	Extended Indefinitely
Hospital inpatients may be under the care of a PA/NP	"Direct supervision" for billing purposes can be met by audiovisual availability	No geographic restrictions for telehealth originating site locations and beneficiaries may receive telehealth from their home	FQHCs and RHCs can serve as a distant site provider for behavioral/mental telehealth service
Exception to in-person visit requirement for RX of controlled substances via telehealth		Some non-behavioral/mental telehealth services can be delivered using audio-only communication platforms.	Practitioners can bill Medicare outside their state of enrollment and without a license in the state they are practicing **IF** allowed by state laws/regulations
Practitioner may provide telehealth from their home without reporting the home address on Medicare enrollment		FQHCs and RHCs can serve as a distant site provider for non-behavioral/mental telehealth services.	

- https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/policy-changes-after-the-covid-19-public-health-emergency/#temporary-medicare-changes-through-december-31-2024
- https://public-inspection.federalregister.gov/2022-23873.pdf
- https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf

Surgical Assistant Certification

"Medicare makes payment for an assistant at surgery when the procedure is authorized for an assistant and the person performing the service is a physician, physician assistant (PA), nurse practitioner (NP) or a clinical nurse specialist (CNS)."

https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r1620cp.pdf

AORN Position Statement on APRNs in the Perioperative Environment

- It is the position of the AORN that as of 2016, an APRN practicing as a first assistant complete "a program that covers the content of the AORN Standards for RN First Assistant Education Programs"
- Program may be:
  - Standalone program (e.g., RNFA program)
  - Portion of an APRN graduate program
  - Postgraduate program

https://www.aorn.org/guidelines-resources/clinical-resources/position-statements

PAs in the Perioperative Environment

- No position that PAs have additional education, training or certification beyond completion of ARC-PA accredited PA program & NCCPA initial certification (PANCE)
  - All PA graduates meet minimum requirements in medical and surgical training, including completion of a general surgery rotation
  - Up to 20% of content of PANCE related to general surgical topics

https://www.aapa.org/download/92815/?tmstv=1675780923

Surgical Assistant Certification

Some hospitals requiring for PAs & NPs

- No known benefit
- Problematic for PAs/NPs, employers & patients
- AAPA advocating against it – supported by Society of Thoracic Surgeons

Employment Arrangements

Work being performed by a hospital-employed PA/NP 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

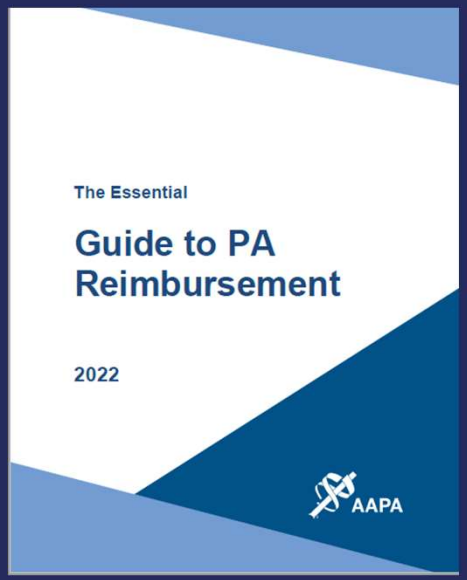
. . . **termination of the employment of 14 nurse practitioners and physician assistants** was **due, in part**, to the company's concerns that their **prior employment did not comply with the Anti-kickback Statute, the Stark law, and False Claims Act**.

. . . **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

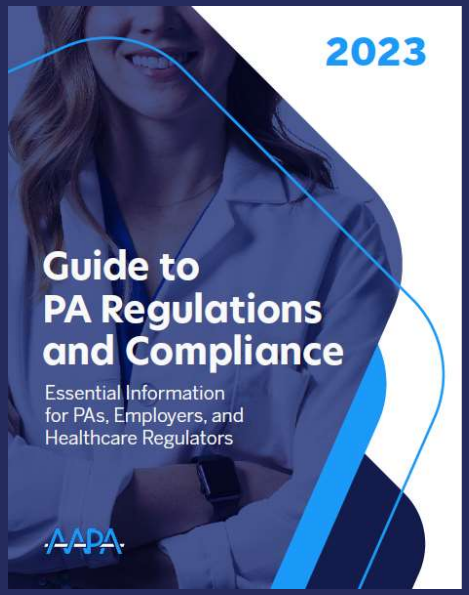
American Academy of
Physician Associates

AAPA Resources



FREE to AAPA Members

https://www.aapa.org/advocacy-central/reimbursement



Advocacy Central - Reimbursement
aapa.org/advocacy-central/reimbursement

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Reimbursement

AAPA works with all public and commercial third-party payers to ensure coverage for the medical and surgical services delivered by PAs. A thorough understanding of PA payment policies is essential for demonstrating PA value, maximizing the collection of appropriate reimbursement and avoiding concerns about fraud and abuse.

Also see the **Summary of PA Reimbursement** and a **Primer on PA Reimbursement**.

Special Reimbursement Alerts:

COMING SOON

PA Administrator Resources

- PA Administrator Skills & Competencies
- Learning Modules
- Webpage
- Additional Resources

Take Home Points

- PAs, NPs and billing personnel should maintain an awareness of current reimbursement rules and requirements
- As PA/NP practice expands, hospital/facility work flow and PA/NP utilization should also evolve
- PAs and NPs should be prepared to explain the concept of their monetary and non-monetary value

Thank you

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