Reimbursement Strategies for PA Leaders

AAPA's Reimbursement Team

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Split (or Shared) Billing

Sondra M. DePalma, DHSc, PA-C, DFAAPA
Senior Director, Regulatory & Professional Practice
American Academy of Physician Associates

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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

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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

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Split (or Shared) Billing Requirements

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

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Substantive Portion

Prior to 2022

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

Substantive Portion

As of Jan 1, 2022

One key component
(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)

Split (or Shared) Billing

- CMS has indicated intent to make definition of a “substantive portion” only time-based
- Has continually postponed implementation of new definition

2022 **2023** **2024** **“through at least Dec 31, 2024”**

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Disruption
in workflows

Confusion
about current definition of a "substantive portion"

Uncertainty
of role of PAs

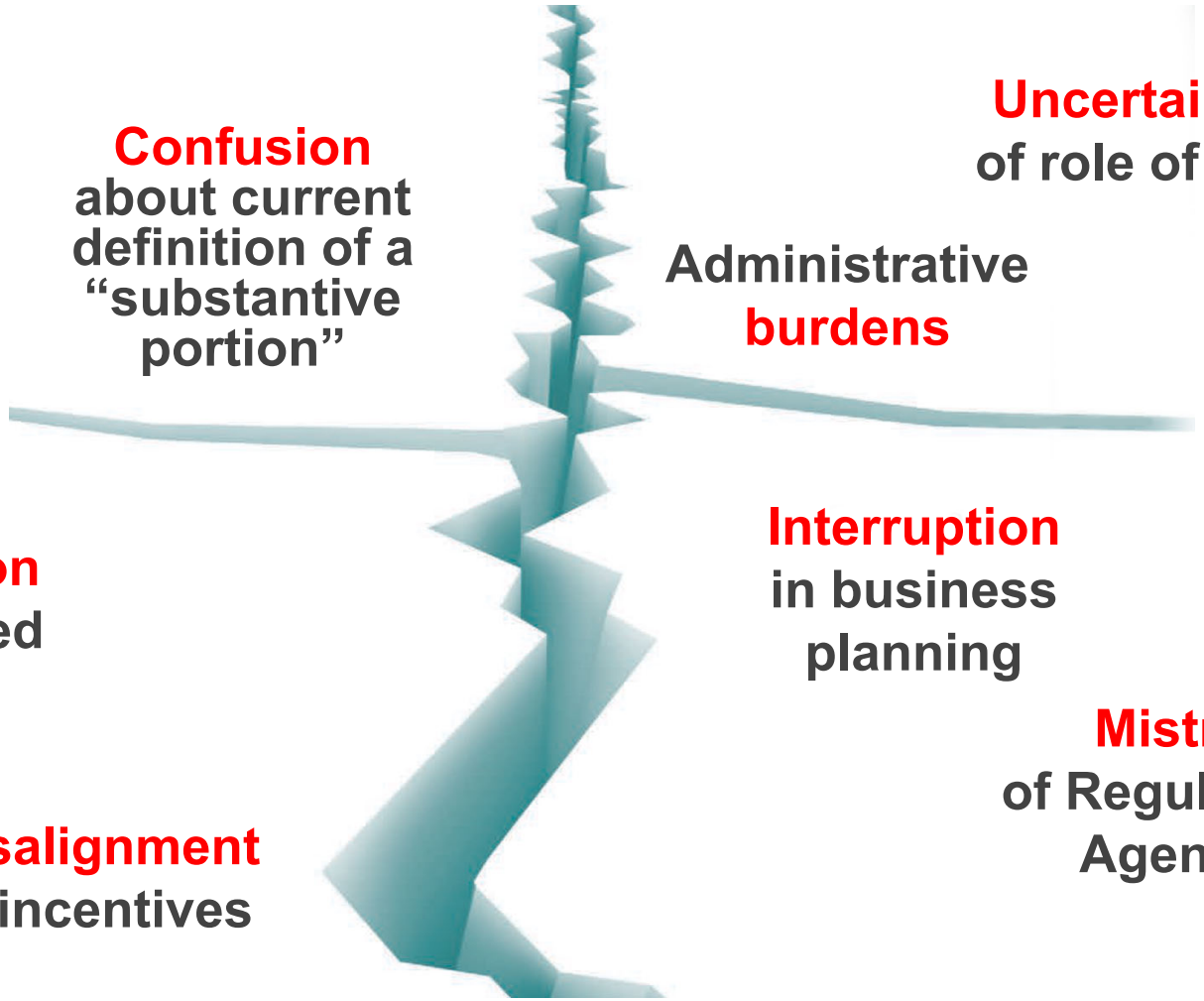
Administrative **burdens**

Fragmentation
of Team-Based Care

Interruption
in business planning

Mistrust
of Regulators & Agencies

Misalignment
of incentives



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What is the next move?

AAPA Shaping the Future

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- Advocate for maintenance of current definition of a "substantive portion"
- Listening sessions with PAs and administrators
- Outreach with professional organizations (e.g., Society of Hospital Medicine)
- Develop models of optimized workflows
- Demonstrate "value proposition" of PAs (AKA debunk myth of "lost 15%" with PA billing)

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COMING SOON!

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- PA Administrator Competencies
- PA Administrator Web Page
- Learning Modules and Skills Development
- Additional Resources

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“Incident to”

Trevor Simon, MPP
Director, Regulatory Policy

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A Quick Refresher

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What is “incident to?”

- “Incident to” is a Medicare billing provision that allows services provided by PAs in an office or clinic to be reimbursed at 100 percent of the physician fee schedule (as opposed to the typical 85 percent).
- Attributes services provided by PAs to the physicians with whom they work on claims
- “Incident to” billing only applies in the office or privately-owned clinic
- It does not apply in the hospital inpatient or outpatient setting

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“Incident to” Criteria

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- The service must be performed in a medical office (Places of Service 11 or 50)
- The service must be within the PA’s scope of practice and in accordance with state law
- The physician must personally furnish a professional service and initiate treatment for new patients or established patients with new problems
- The service the PA provides must be incidental to the course of treatment initiated by the physician
- The physician (or another physician within the practice) must be in the office suite when the PA renders the service
- The physician is responsible for the overall care of the patient and must perform services at a frequency that reflects his or her active and ongoing participation in the management of the patient’s course of treatment
- The PA must represent a direct financial expense to the physician billing (W-2, leased employee or independent contractor) or have the same employer (same tax ID)

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What is NOT “incident to?”

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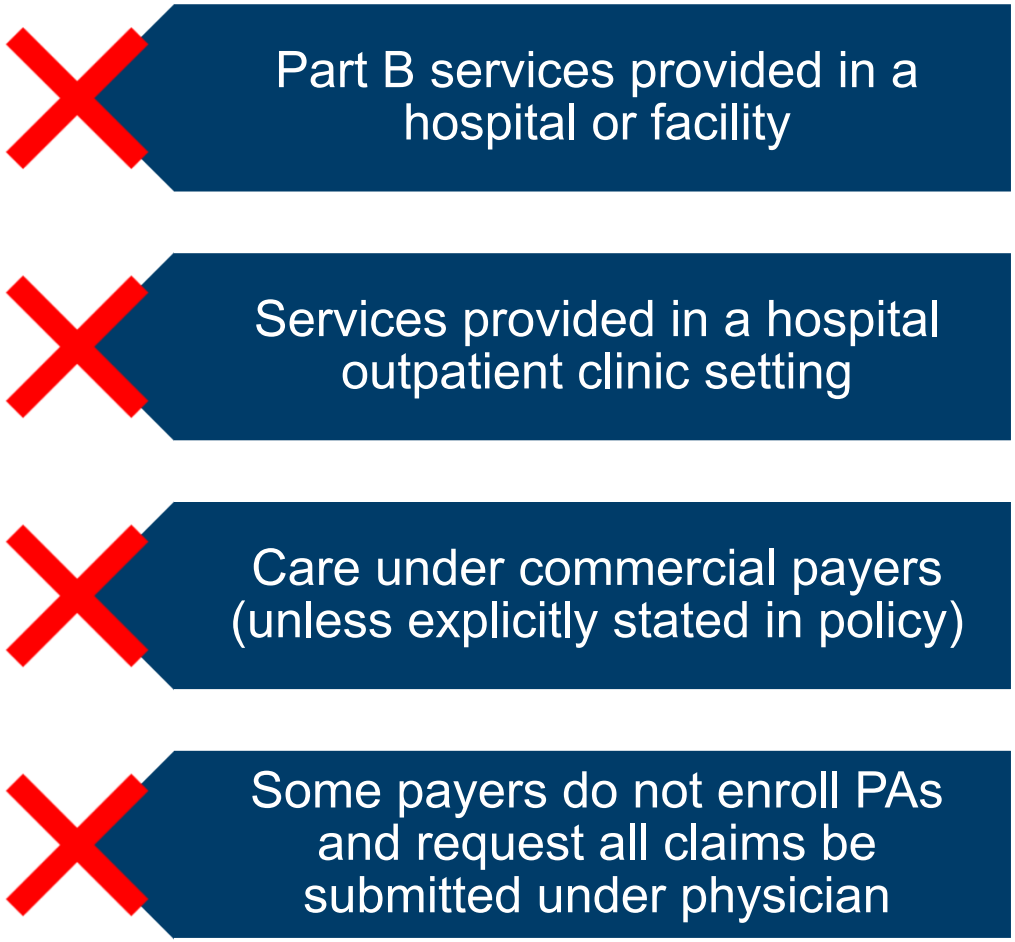

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You and Your Employer Have a Choice!

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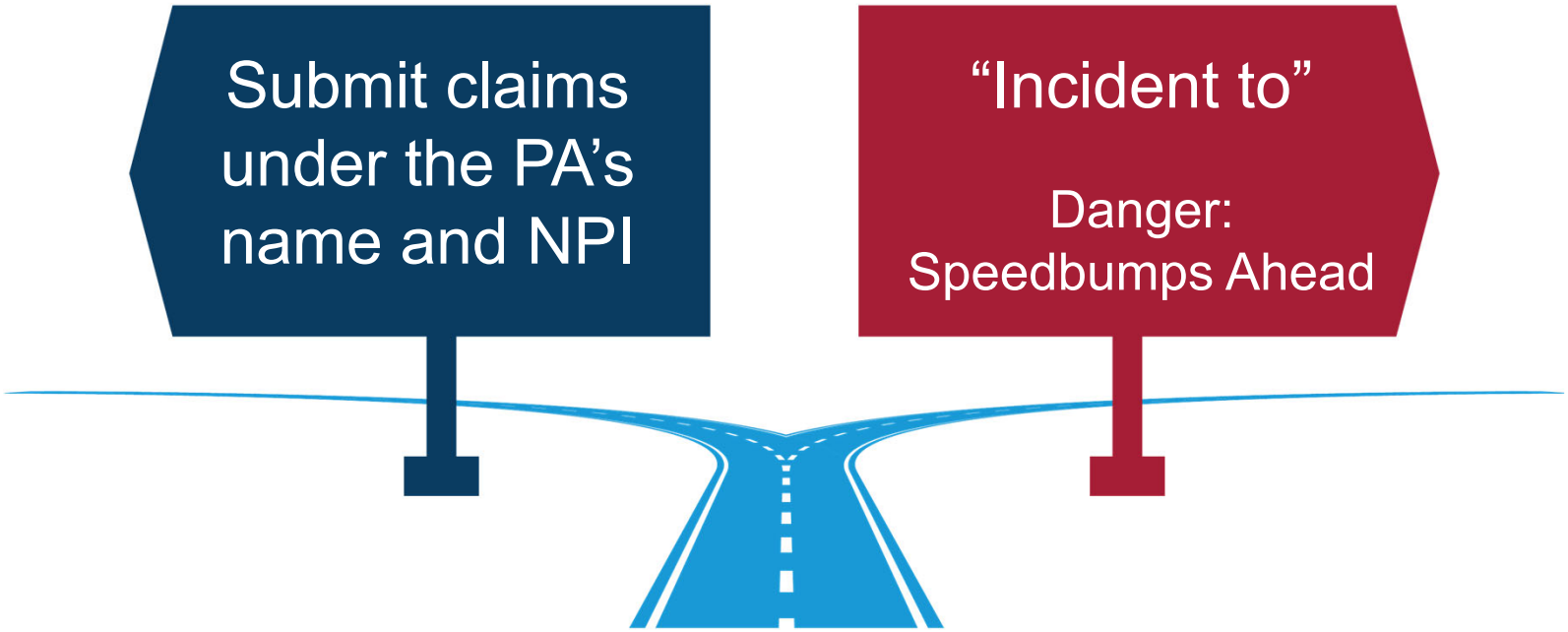

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Some Problems with “incident to”

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Efficiency

- When not doing “incident to,” PAs may see new patients and established patients with new problems
- When not doing “incident to,” the physician is not required to see the patient or be on-site; must be consistent with state law and scope of practice

Transparency

- A substantial percentage of medical services delivered to Medicare beneficiaries by PAs and NPs are attributed to the physicians with whom they work
- That means… it’s nearly impossible to accurately identify the type, volume or quality of services delivered by PAs and NPs
- Negatively affects many health stakeholders

Patients	Researchers	The Medicare Program	PAs and NPs

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Examples from the 2024 PFS Proposed Rule

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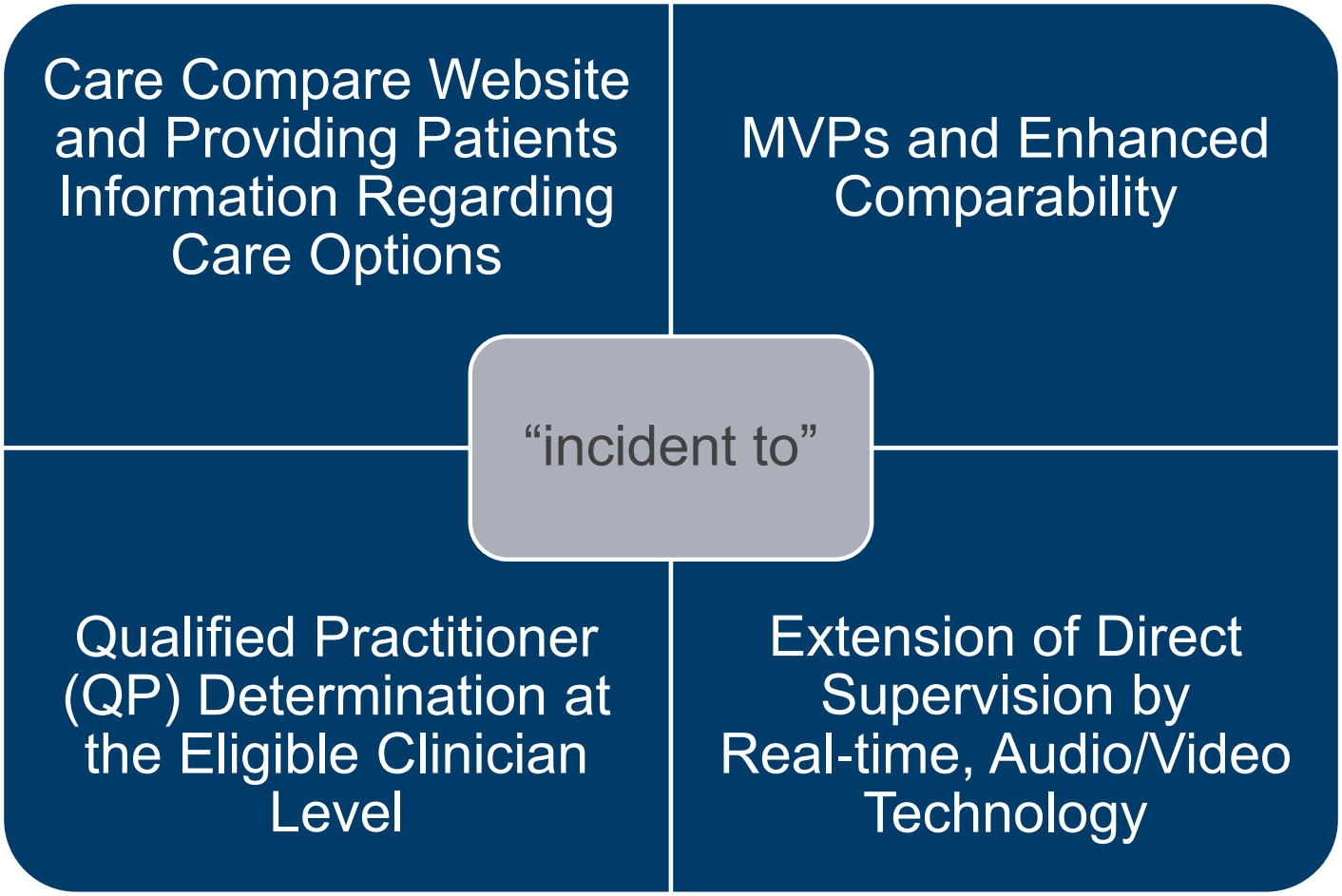

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2023 Comments… so far

Trevor Simon, MPP
Director, Regulatory Policy

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2023 Comments Snapshot

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Interoperability and Prior Authorization Proposed Rule (CMS)	DOJ Certification Forms Proposed Rule	Federal Air Marshal Certification Forms Proposed Rule	FTC Non-Compete Clause Proposed Rule
Letter to CMS on Split (or Shared) Visit Billing	Letter to CMS on the End of the Public Health Emergency	Hospice Wage Index Proposed Rule (CMS)	Skilled Nursing Facilities PPS Proposed Rule (CMS)
Medicaid Access Proposed Rules (CMS)	2024 Home Health PPS Proposed Rule	FDA Draft Guidance	2024 Physician Fee Schedule (CMS)
	2024 Hospital Outpatient Prospective Payment System (CMS)	Mental Health Parity	

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Spotlight: 2024 PFS Comments Topics

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- Authorization to supervise CR/ICR/PR
- ACO assignment and new Step 3
- Split (or shared) visit billing
- Direct supervision by electronic means
- Expansion of telehealth services
- Extension of telehealth coverage
- Payment at facility vs. non-facility rate
- Listing a provider's home address for telehealth
- Hospice restrictions
- Behavioral/Mental Health
- The Conversion Factor
- HCPCS add-on code G2211
- Caregiver training
- Social determinants of health risk assessment
- Community health integration
- Principal illness navigation
- Inpatient Rehabilitation Facilities
- Colonoscopies
- EKGs
- Payer policy alignment
- Ambulance services
- Skilled nursing facilities
- Under the care of a physician
- MIPS thresholds for participation
- Medicare's Care Compare website
- Qualifications for APM participation
- MIPS Value Pathways
- Advanced APM incentive bonus

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Fraud and Abuse

Carson S. Walker
Director, Policy & Professional Advocacy
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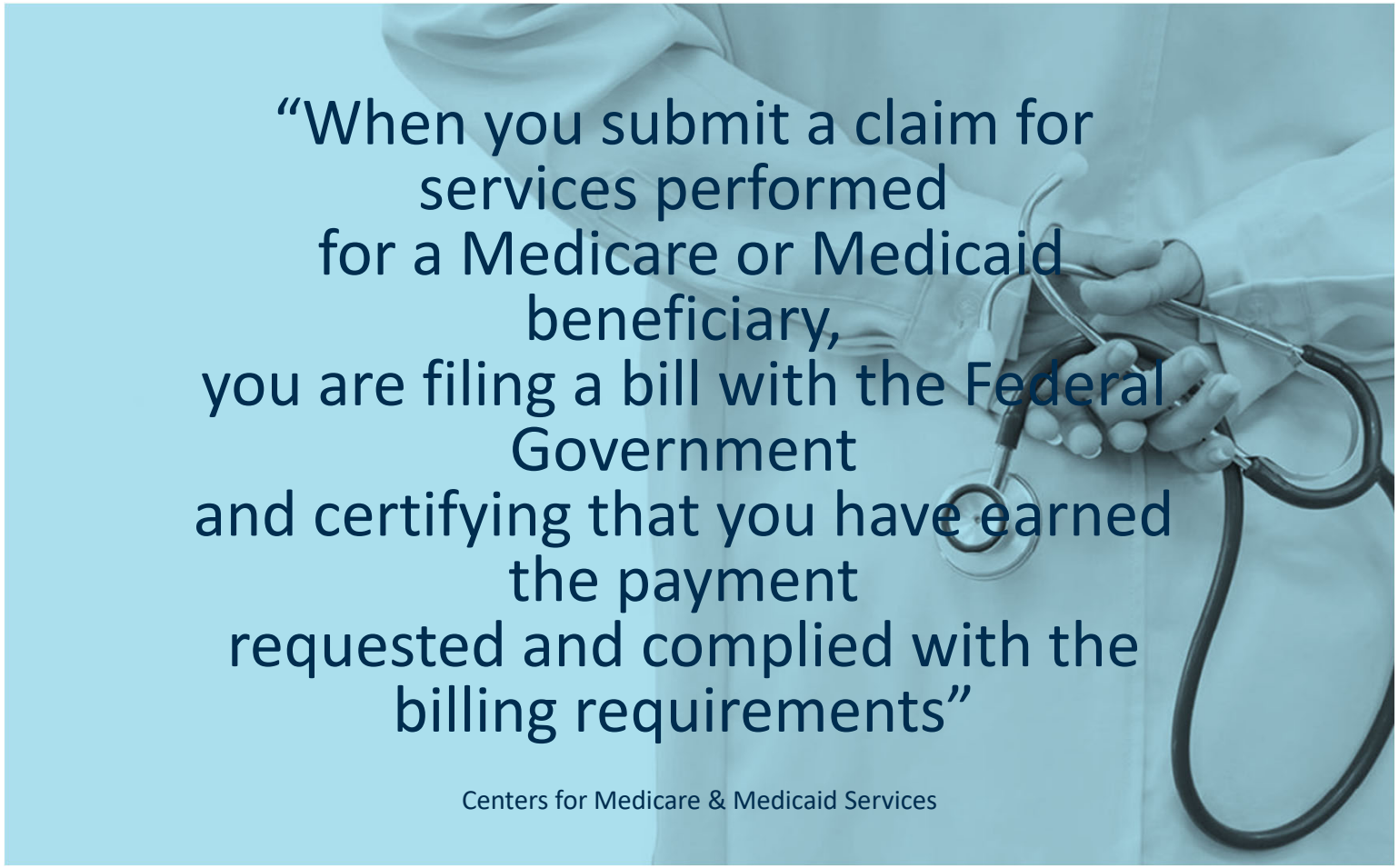

"When you submit a claim for services performed for a Medicare or Medicaid beneficiary, you are filing a bill with the Federal Government and certifying that you have earned the payment requested and complied with the billing requirements"

Centers for Medicare & Medicaid Services

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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

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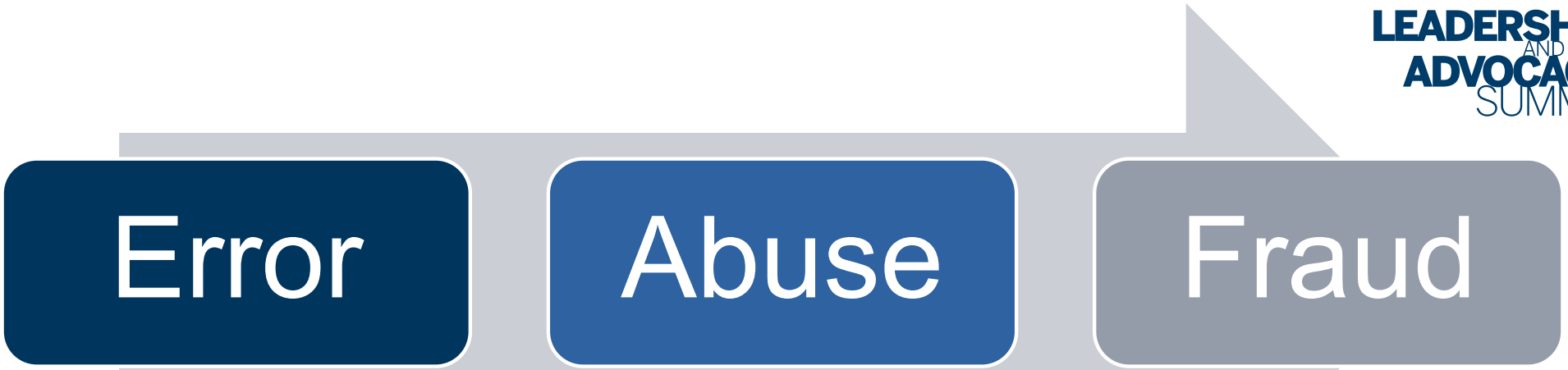

Mistakes
Errors in coding & documentation

Improper or Inappropriate Actions
Upcoding/Downcoding, waving deductibles, billing for non-medically necessary services

Intentional Deception
Falsifying records, billing for services not provided

Costs U.S. healthcare system tens of billions of dollars annually.

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Fraud & Abuse: By the Numbers

Fiscal Year 2021

$4.1 billion	504	669	1,689
recovered	criminal actions	civil actions	excluded

Return on Investment $12.00 to $1.00

https://oig.hhs.gov/publications/docs/hcfac/FY2021-hcfac.pdf

False Claims Act

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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

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False Claims Act Penalties

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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.

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Whistleblowers: By the Numbers

600+
whistleblower cases each year

$712M of $1.08
billion in FCA settlements from whistleblowers in 2021

30%
of recovered funds eligible to whistleblowers

https://oig.hhs.gov/publications/docs/hcfac/FY2021-hcfac.pdf

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False Claims Act and SCOTUS

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Anti-Kickback Statute

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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.

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Physician Self-Referral Law (AKA Stark Law)

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- 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.

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Federal Laws & Employment Arrangements

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- 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

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Controlled Substances

May only be prescribed:

- With a DEA license and according to DEA regulations
- For medically necessary purposes
- After an in-person evaluation
- In compliance with any state-required Prescription Drug Monitoring Programs (PDMP)

DEA and Telehealth

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Ryan Haight Online Pharmacy Consumer Protection Act

Federal law enacted in 2008

Created to regulate internet prescriptions

Prohibits providers from prescribing controlled substances to patients they have not examined in person

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Recent Examples Involving PAs

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U.S. Department of Health and Human Services
Office of Inspector General

Ascension Macomb Oakland Hospital Agreed to Pay $100,000 for Allegedly Violating the Civil Monetary Penalties Law by Paying Remuneration in the Form of Free Staff

After it self-disclosed conduct to OIG, Ascension Macomb Oakland Hospital (AMOH), Michigan, agreed to pay $100,000 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that AMOH paid remuneration to physicians who referred patients to AMOH for surgical procedures. The remuneration was in the form of clinical staff, specifically, advanced practice providers who performed pre-surgical histories and physicals for the physicians without cost to the physicians.

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Examples Cont'd

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Department of Justice

U.S. Attorney's Office

Northern District of Oklahoma

FOR IMMEDIATE RELEASE

Wednesday, April 1, 2020

Physician Assistant Agrees to Pay $620, 500 for Allegedly Engaging in Illegal Kickback Scheme

A Louisiana physician assistant entered into settlement agreement this week with the U.S. Attorney's Office for allegedly accepting illegal payments from OK Compounding, LLC, in return for recommending and prescribing compounded drugs produced by the pharmacy, announced U.S. Attorney Trent Shores.

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Examples Cont'd

LEADERSHIP AND ADVOCACY SUMMIT

Department of Justice

U.S. Attorney's Office

District of Massachusetts

FOR IMMEDIATE RELEASE

Friday, March 29, 2019

CareWell Urgent Care Center Agrees to Pay $2 Million to Resolve Allegations of False Billing of Government Health Care Programs

BOSTON – The United States Attorney's Office announced today that CareWell Urgent Care Centers of MA, P.C., CareWell Urgent Care of Rhode Island, P.C., and Urgent Care Centers of New England Inc. (CareWell), the owners and operators of urgent care centers located throughout Massachusetts and Rhode Island, have agreed to pay $2 million to resolve allegations that they violated the False Claims Act by submitting inflated and upcoded claims to Medicare, Massachusetts Medicaid (MassHealth), the Massachusetts Group Insurance Commission (GIC), and Rhode Island Medicaid.

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Clarifying Payer Policies

Eric Walczyk
Health Policy Coordinator

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Payer Policy vs State Laws and Regulations

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Bridging the Gap

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The PA profession has made incredible strides in recent years with both legislative and regulatory wins including:

- PA Modernization and Optimal Team Practice legislation
- Creation of PA specific regulatory boards or the inclusion of PAs on existing state regulatory boards
- Direct Pay from Medicare, bringing PAs up to par with physicians and NPs
- Rendering provider status with Medicaid programs in all 50 states and the District of Columbia

While these achievements are helping transform the PA profession to be more in-line with our peers and better suited to the modern healthcare landscape, we are finding that many commercial payers continue to maintain outdated and unfavorable positions regarding PA practice in their medical policies.

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Overcoming Barriers of Commercial Payers

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- While commercial payers tend to follow Federal policy and regulation, and in some instances are ahead of the curve, we hear from PAs on a weekly basis that they are having issues with reimbursement, credentialing, and scope of practice limitations imposed by a myriad of commercial payers.
- Some of these issues may be attributed to “the process” as there can be significant gaps in time between when a law is passed, when the rules and regulations are drafted, and when those rules and regulations are implemented.

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The Unique Challenges with Commercial Payers

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Setting aside the issue of the pace that state legislatures and regulatory agencies move at, the number one challenge to identifying and addressing the barriers to PA practice with commercial payers is…

The sheer number of commercial payers that exist, many of which have separate medical and reimbursement policies for the various plans they offer.

- Group policies, self-funded policies, individual policies, Medicare Advantage plans, Medicaid plans, etc.

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The AAPA Payer Database

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Development of a payer database to quickly sort through and identify policies related to PA practice.

Some of these database entries come from reviewing the medical and reimbursement policies published by various payers to develop a broader understanding of the practice environment for a given area or specialty.

Other entries come from payer surveys that AAPA develops and sends out various payers. Most recently these include our Medicaid survey and our behavioral health survey.

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The AAPA Payer Database

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The creation of this database serves two primary goals:

- Aid and guide AAPA internally by achieving a more robust understanding the commercial payer landscape, allowing us to be better advocates for you.
- To be a tool for our state chapters, constituent organizations, and PA leaders.
  - To identify problem payers and policies at a more localized level, allowing for more purposeful and targeted advocacy efforts.
  - To quickly be able to provide medical policy citations when PAs are presented with challenges or issues from a payer that are contradicted by that payer's own policies.

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But we'll need your help..

If you or your practice are encountering these issues, we want to hear from you!

ReimbursementTeam@aapa.org

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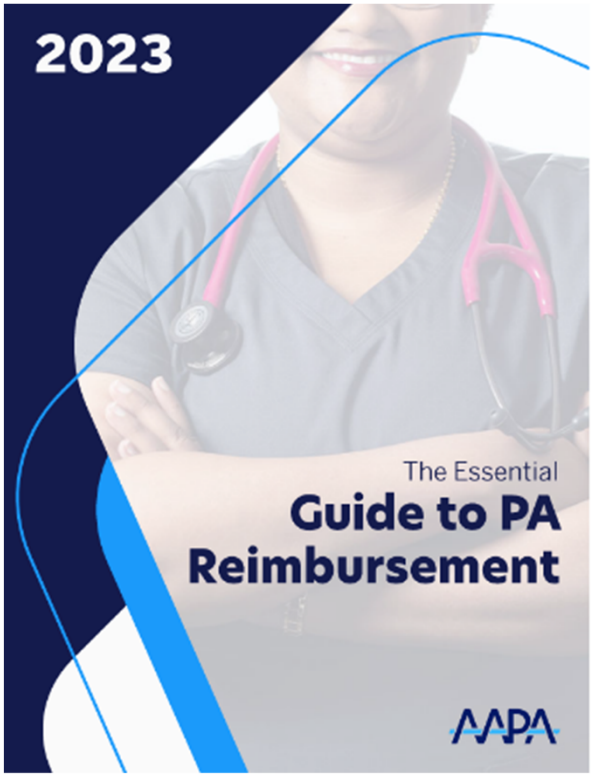

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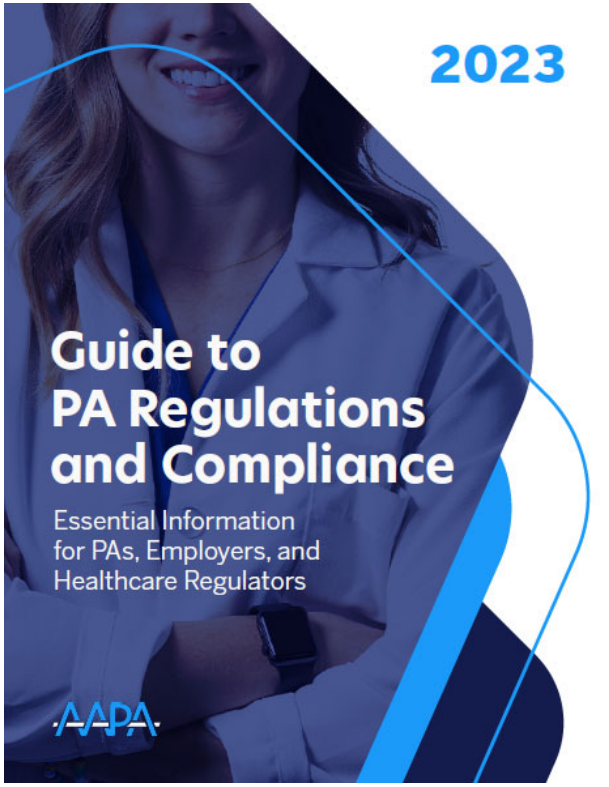

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Advocacy Central – Reimbursement

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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:

aapa.org/advocacy-central/reimbursement

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AAPA Payer Summit

Michael L. Powe
Vice President, Reimbursement & Professional Advocacy

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AAPA Payer Summit

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Opportunity for AAPA Reimbursement Team to interact with and educate payer representatives.

AAPA to provide information about PA scope of practice, quality of care, patient satisfaction, how PAs enhance value-based care delivery care models.

Payer representatives will have an opportunity to tell us about any concerns/challenges with PA practice.

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AAPA Payer Summit

October 24

Goal is to establish a long-term relationship with commercial payers to have input in current and future coverage policy decisions.

Medicare and Medicaid programs provide opportunities to review regulations and provide comments.

Commercial payers do not provide that level of engagement or interaction.

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A Conversation on PA Specialty Identification

Michael L. Powe
Vice President, Reimbursement & Professional Advocacy

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Discussion Issue – Identifying PAs by Specialty

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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

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Discussion Issue – Identifying PAs by Specialty

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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)

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PA Identification by Specialty - Unintended Consequences/Potential Downside

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How would identification within a specialty occur?

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

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PA Identification by Specialty

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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 removal of the physician tether.
- 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 with a designation in a particular specialty

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The Push Toward Value-based Care

Michael L. Powe
Vice President, Reimbursement & Professional Advocacy

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CMS and Commercial Payers Are Aligned

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- Most payers want to see a shift to value-based reimbursement.
- Payers believe cost controls (and attention to quality, continuity) can best be achieved through value-based/bundle care models.
- CMS' goal is that all fee-for-service Medicare enrollees will be under accountable care organizations or other valued-based care arrangements by 2030 (ACOs, specialty care models).

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Shift to Value-based Care Models

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- The COVID-19 pandemic put a hold on the movement to value-based care.
- Participation in Medicare Shard Savings ACOs has decreased.
- The agency wants to modify quality reporting and financial benchmarking requirements and phase in a new risk-adjustment model to increase participation.

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Shift to Value-based Care Models – Enhanced PA Authorizations

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- ACO Realizing Equity, Access, and Community Health, or ACO REACH program.

- Making Care Primary model will allow practices to enter at one of 3 levels (beginner, moderate or advanced).

- **PA impact on practice**: new care models often expand regulations authorizing PAs to provide care beyond FFS Medicare (e.g., order diabetic shoes, certify hospice)

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Shift to Value-based Care Models

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Potential Pitfalls:

- Reporting process and the technology standards that may be burdensome to some practices.

- ACOs currently report quality metrics for a sample group of Medicare enrollees. By 2025, required to report for all ACO members.

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