American Academy of PAs

Reimbursement Update for PAs in Orthopaedic Surgery

PAs in Orthopaedic Surgery
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Michael L. Powe, Vice President
Reimbursement & Professional Advocacy
American Academy of PAs

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Although every reasonable effort has been made to assure the accuracy of the information herein, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of the service and those submitting claims.

- **Medicare and commercial payer policies are subject to change. Be sure to stay current by accessing information posted by your local Medicare Administrative Contractor, CMS and commercial payers.**
- I am employed by the American Academy of PAs.
- The American Medical Association has copyright and trademark protection of CPT ©.

PAs, NPs and Medicare Payment Policies

- Detailed information about NP reimbursement can be obtained from the American Association of NPs (AANP) https://www.aanp.org/
- Nearly all of Medicare's reimbursement & coverage policies are the same for both professions.
- AAPA works closely with AANP on reimbursement, legislative and regulatory issues of mutual interest.

Not an Expert, But . . .

American Board of Surgical Assistants (ABSA)

- Headquartered in Milwaukee, WI, offering testing and credentialing services.
- Advertised as a “national credentialing organization for surgical assistants.”
- ABSA “acknowledged that certification as a surgical assistant through the ABSA (SA-C) does not allow for any independent performance of any medical or surgical procedures, within the United States of America or its territories.”

American Board of Surgical Assistants (ABSA)

- A limited number of hospitals appear to be requiring the ABSA certification for PAs (and others) who first assist at surgery.
- No indication that ABSA testing or certification process provides additional surgical skills or competencies for PAs.
- Notify AAPA's Reimbursement Team if hospitals/facilities where you work begin discussing/implementing this program.

CMS Interest in Post-operative Visits

- Reimbursement for surgical procedures has a set number of post-op visits “built into” the global payment rate based on whether the procedure has a 10- or 90-day post-op period.

- Over several years, the Centers for Medicare and Medicaid Services (CMS) has undertaken data collection activities to determine if the number of post-op visits is decreasing.

- CMS data suggests that there are fewer post-op visits now as compared to when the global rate was established.

CMS Interest in Post-operative Visits

- Potential for CMS to re-value reimbursement paid for the global surgical package.
- Previously, CMS suggested carving out all post-op visits from the global package and allowing health professionals to bill each post-op visit as an E/M visit.
- Surgeons are against any change in how the global is reimbursed.

CMS Interest in Post-operative Visits

Implication for PAs

- Under the current system, PA-provided post-op visits are not "identified" since no separate payment is made.

- Billing separately for post-op E/M visits could better identify PA productivity/professional work.

- **Concern**: the first assist payment is based on a percentage of the global payment. Would first assist reimbursement be lowered if payment for the global package is reduced?

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 seem 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 an August 30 completion date.

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 elimination of payer practice restrictions or denials when PAs deliver care.

Lack of clarity whether the provision will impact the concept of reimbursement parity (same payment for same services).

Documentation Requirements

Previous Documentation Elements

Type of History	CC	HPI	ROS (exam)	PFSH
Problem Focused	Required	Brief	N/A	N/A
Expanded Problem Focused	Required	Brief	Problem Pertinent	N/A
Detailed	Required	Extended	Extended	Pertinent
Comprehensive	Required	Extended	Complete	Complete

Changes to Coding and Documentation

2021 – Changes made to office and other outpatient services

2023 – Changes made to inpatient, observation, emergency department, nursing facility, and home or residence 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) or Time

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**

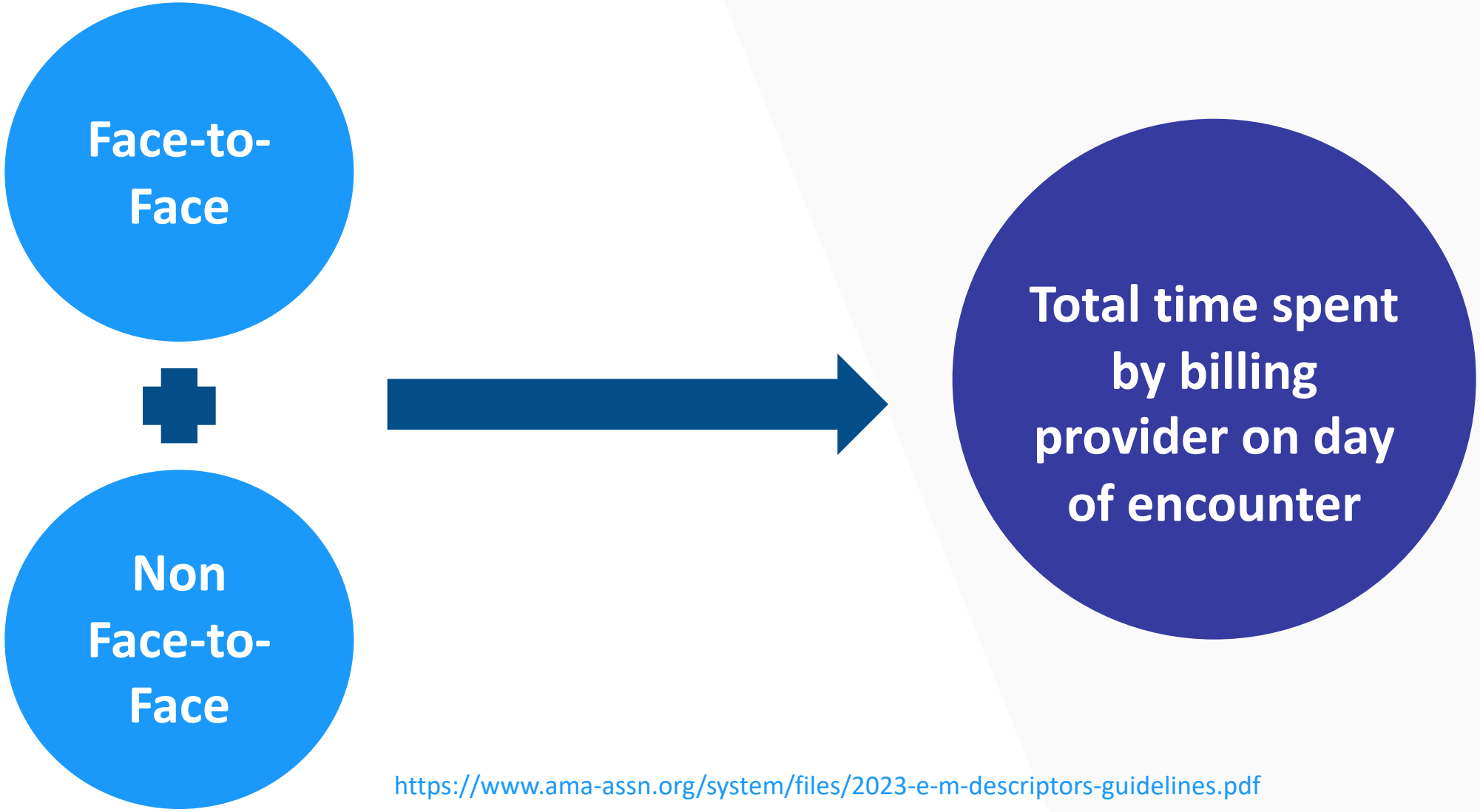
MDM Element	Examples of Element
Problems	One versus multiple, severity, acute versus chronic, stable or exacerbation
Data	Review of external note(s), number of tests ordered or reviewed, independent interpretation of tests
Risks	Number & type of management options, risk to patient, socioeconomic limitations, level of needed care (outpatient versus inpatient)

Level of Medical Decision Making (MDM)

Revisions effective January 1, 2023 are noted in red text

	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
	N/A	N/A	N/A	N/A
	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
	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; or • acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**
	Moderate	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
	High	**High** • **1** or more chronic illnesses with severe exacerbation, progression, 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 the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level of care

Time-Based Billing



https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

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

Reducing Fraud and Abuse Concerns

Error	Abuse	Fraud
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.

Compliance Scenario #1

- A physician repaid $285,000 to settle False Claims Act violations.
- Services provided by a NP were billed as “incident to” under the physician’s name.
- Medicare’s “incident to” provisions were not met. The payment should have been at the 85% rate.

Compliance Scenario #2

- A hospital in the Midwest paid back $210,739 for allegedly violating the Civil Monetary Penalties Law.
- The HHS Office of Inspector General alleged improper billing for services delivered by PAs but billed under the physician's name under Medicare's split/shared billing provision.
- The OIG stated the documentation requirements for a split/shared visit were not properly met. The services should have been billed under the PAs.

Promise to the Federal Government

On the Medicare Enrollment Application

"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."

CMS 855 application https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf

Who Is Responsible?

The “chain of responsibility” is multifaceted.

- Health professionals are responsible for claims submitted for services they deliver.
- Federal programs will typically expect recoupment/repayment from the entity that received the reimbursement.
- The biller (private billing company, practice or hospital billing staff) may also share in the responsibility if a mistake was made on their part in the electronic filing of the claim.

Compliance

- In reality, most health professionals never see the actual paper or electronic claim being submitted to Medicare, Medicaid or other payers.
- Suggests the need for communication between all parties to ensure a basic comfort level with payer rules/requirements.
- PAs should be proactive in supplying basic reimbursement information to billers based on payer mix and the practice site of service where care is delivered.

Who is Entitled to Reimbursement for a PA's Professional Work?

Who should receive reimbursement for the PA's professional services?

Only the PA's employer.

Who should receive a benefit (work product) from the PA's professional services?

Only the PA's employer.

Appropriate leasing arrangements can be an option when the physician/surgeon with whom the PA is providing care is not the PA's employer but wants to receive reimbursement for the PA's work or take credit for the PAs productivity.

Payment to the Employer

- Physicians who are not employed by the same entity as the PA(NP) have no ability to bill/receive payment for work provided by PAs/NPs unless the physician provides market rate compensation (e.g., salary, leasing arrangement) for the PA's/NP's time.

  - Potential False Claims, Stark &Anti Kickback Violations

Particularly problematic with a hospital-employed PA/NP working with a non-hospital employed physician.

PA Professional Services

- Physicians who are not employed by the same entity as the PA have no ability to bill/receive payment for professional work provided by PAs unless the physician provides market rate compensation (e.g., leasing arrangement) to the PA's employer.

- Any transfer of value, including PA work/productivity, even if not reimbursed, must not accrue to a physician that doesn't appropriately compensate the PA's employer.

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

Anti-Kickback Violation – July 2023

- 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

- 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.

Speaking of Fraud –
There Once Was a Hospital in Chicago

Chicago Hospital Scam Had “Kickback on Steroids”, Jury Told

by Lance 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 (sic) medical professionals, including physician assistants and nurse practitioners, to doctors free-of-charge in return for patients, Hedges said, calling the maneuver **“kickbacks on steroids”**.

https://www.law360.com/articles/630708/chicago-hospital-scam-had-kickbacks-on-steroids-jury-told

The End Result – Conviction & Sentencing

CEO – 4.5 yrs. in jail; $10.4m forfeiture; $770,000 fine

COO – 21 months in jail

CFO – 13 months in jail.

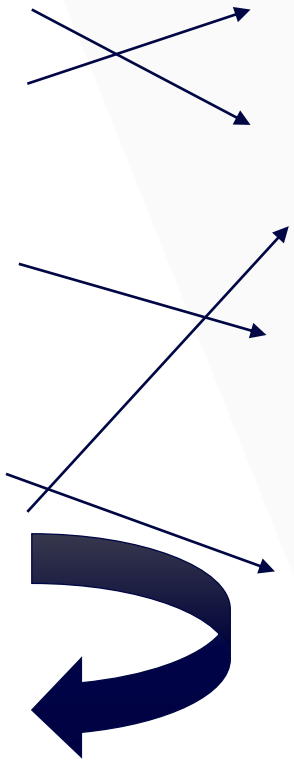
Physician – 2 yrs. in jail; $786,000 in forfeited funds and fines.

Hospital – permanently closed

A Look at Payer Policies

Understanding Payer Policies: Payers Often Have Multiple Plans/Policies

- Medicare
- Medicaid
- Commercial
- Workers' Compensation

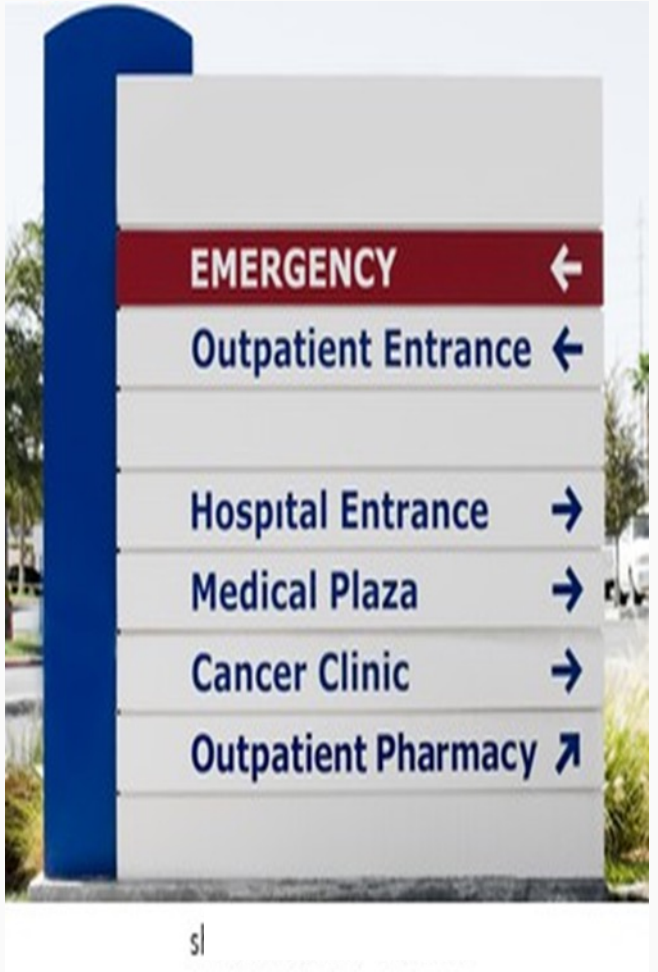


- Medicare Fee-for-service
- Medicare Advantage
- Medicaid managed care options
- State, federal and employer (self-funded) health plans administered by commercial payers

Following the Rules Depends on Your Practice Setting

Location, location, location

- Office/clinic
- Outpatient clinic owned by a hospital
- Certified Rural Health Clinic
- Ambulatory surgical center (ASC)
- Critical Access Hospital
- Federally Qualified Health Center/Community Health Center
- Skilled nursing facility,
- Inpatient rehabilitation facility or psychiatric hospital



The following must be met to submit a claim for Federal reimbursement:

- Federal Statutes & Regulation
- State Statutes & Regulations
- Accreditation Standards
- Hospital Policies & Bylaws
- Scope of Practice & Privileges

Medicare Reimbursement Myths

- PAs can’t treat new patients
- Physician must be on-site when PAs deliver care.
- Physician must see every patient a PA treats in the office/clinic.
- A physician co-signature is required whenever PAs treat patients.
- State, facility and commercial payer policies may be different/more restrictive than Medicare.

Overarching Scope of Practice

- State law ultimately determines scope.
- Individual commercial payers and state Medicaid programs can impose their own scope of practice rules (but can't supersede state law).
- Commercial payers often have limited scope of practice policy details in writing as compared to Medicare.
- "These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service."

  Current Procedural Terminology Guidelines 2023

Collaboration, Supervision and Beyond

- Medicare traditionally used the term “supervision” to describe how PAs practice with physicians.
- As of January 1, 2020, CMS modified its regulations and defers to PA state law in terms of the professional working relationship, if any, PAs have with physicians.
- The Medicare program will allow collaboration or other terms used by individual states to meet Medicare’s supervision requirement.
- NP Medicare policy uses the term collaboration and also defers to state law.

Medicare Billing Rules

Billing in the Office Setting

“Incident to” Billing

- **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.**

- 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” is generally a Medicare term and not always applicable with private commercial payers or Medicaid.

“Incident to” Billing

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

Optional billing method

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

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

“Incident to” Billing

- “Incident to” billing is an option, and not required to be used.
- The PA must be a W-2 employee (or have a 1099 Independent contractor) or have a leasing arrangement.
- 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” 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 discusses patient with physician, or physician provides periodic patient visit/treatment.

“Incident to” Does NOT Apply

- New Patients
- New Medical Problems
- Physician Not On-site

“Incident to” Does NOT Apply

Inpatient & Observation Services

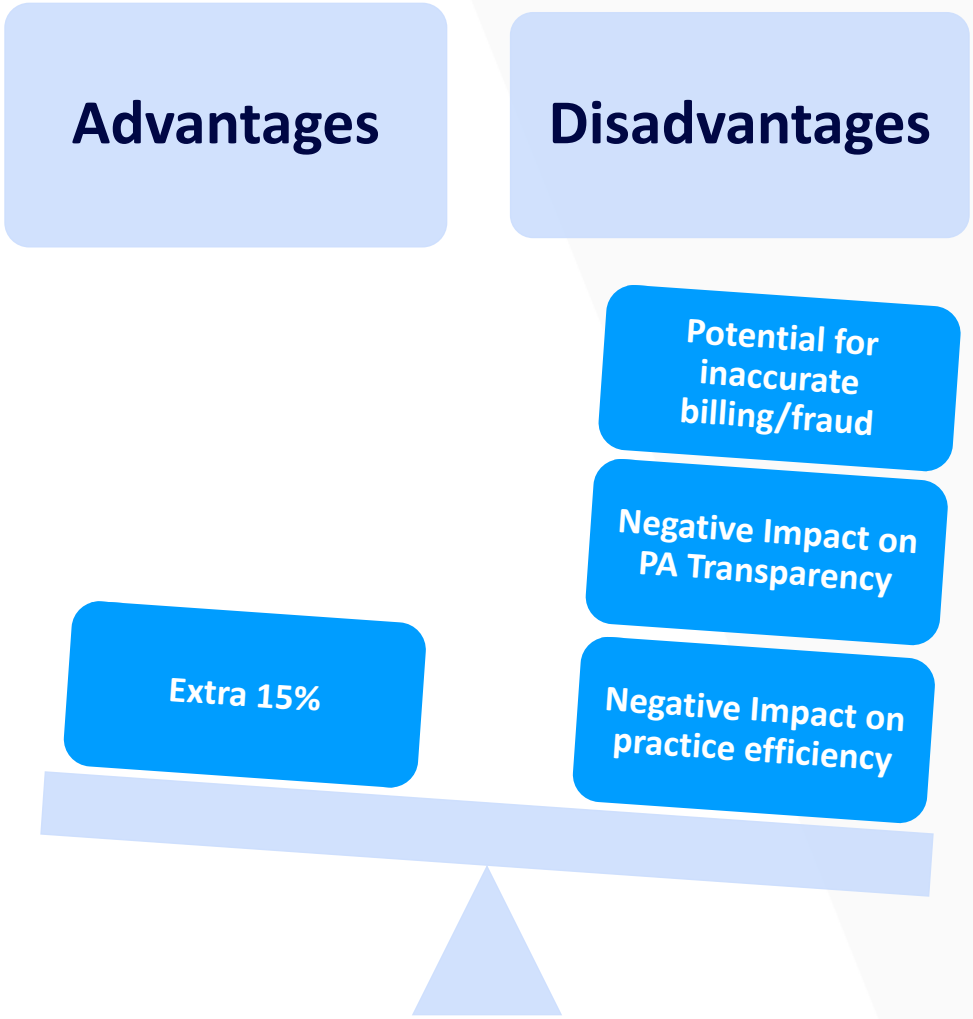
Hospital Outpatient Services

- **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

Is Billing “Incident to” Worth it?



Billing in the Hospital

CMS' Evolving Split/Shared Hospital Billing Policy

Split (or Shared) Billing

Medicare hospital billing provision that allows services performed by a PA/NP and a physician to be billed under the physician's name/NPI at 100% reimbursement.

PAs/NPs can treat new or established patients when billing under their own name and NPI.

Must meet specific criteria and documentation requirements

Split/Shared Visit Billing

Services eligible for split (or shared) billing

- Evaluation and management services (e.g., hospital inpatient and observation services, emergency department services, etc..)
- Critical care services (effective 1/1/22)
- Certain SNF/NF services (effective 1/1/22)

<u>Option for split/shared billing does NOT apply to procedures</u>

PA and physician must work for the same group

PA and physician must be involved the patient on the same calendar day

Physician must provide a “substantive portion” of the encounter

Either PA or physician must have face-to-face encounter with patient

Documentation must identify the practitioners who contributed to the service and the billing physician must sign & date the medical record

-FS Modifier must be included on claim to identify service as split/shared visit

Split (or Shared) Billing

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"

Split (or Shared) Billing

Substantive Portion

For 2022 & 2023 for Physician to Bill

Physician must perform one of the key components (history, exam, or medical decision-making) <u>“in its entirety”</u>

-OR-

Spend more than half of the total visit time with the patient (already required for critical care and discharge management)

https://public-inspection.federalregister.gov/2021-23972.pdf

Split (or Shared) Billing

Substantive Portion

Proposed CMS Policy Starting 2024

Policy Delayed Again!!

~~If billing under the physician, physician must account for more than half of the total visit time~~.

(AAPA is opposed to this policy.)

https://public-inspection.federalregister.gov/2021-23972.pdf

Split (or Shared) Billing

Substantive Portion

Proposed CMS Policy Starting 1/1/2024

No policy change from 2022 and 2023

Physician must perform one of the key components (history, exam, or medical decision-making) "in its entirety"

-OR-

Spend more than half of the total visit time with the patient (already required for critical care and discharge management)

https://public-inspection.federalregister.gov/2021-23972.pdf

First Assisting at Surgery

- PAs covered by Medicare for first assist
- Reimbursed by Medicare at 85% of the physician's first assisting fee
  - Physician who first assists gets 16% of primary surgeon's fee – PAs get 85% or 13.6% of primary surgeon's fee
- -AS modifier for Medicare
- Special rules for PAs/NPs/physicians when residents/fellows are available in the hospital.

Assisting at Surgery

Teaching Hospitals

- Medicare does not generally reimburse for first assistant fees if there is a qualified resident available.
- Applies when hospitals have an approved, accredited program in the particular surgical specialty.

Teaching Hospital Exception allowed:

- No qualified resident available (in required training/clinic-hours or resident-hour restrictions)
- Physician NEVER uses a resident in pre-, intra-, and post-op care
- Exceptional medical circumstances (e.g. traumatic injuries)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Assisting at Surgery

Teaching Hospitals

When no qualified resident available

- Physician must certify
  - I understand that § 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the A/B MAC (B).
- Must use second modifier -82 (teaching hospital) (in addition to –AS)

“A large body of research, including both randomized clinical trials and retrospective studies using claims and surveys, suggests that care provided by NPs and PAs produces health outcomes that are equivalent to physician-provided care.”

MedPAC

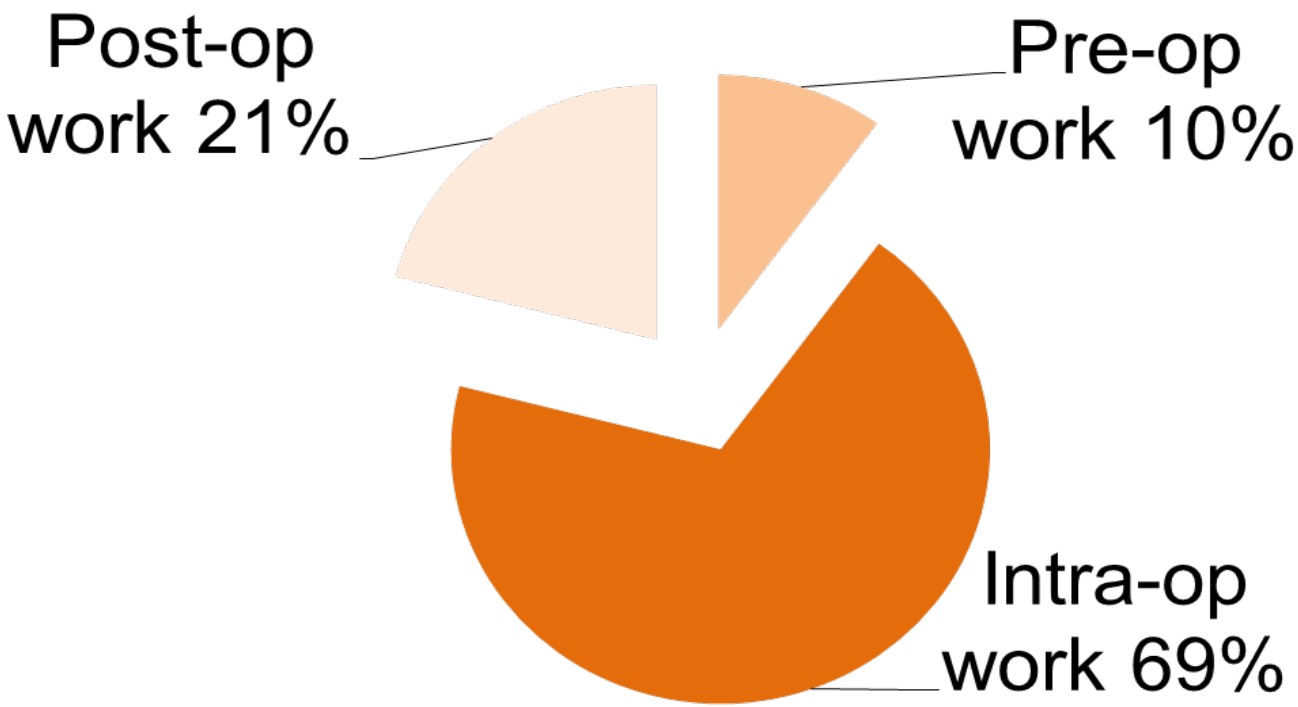
http://medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0

“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 (e.g., 15 percent discount in Medicare).”

MedPAC

http://medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0

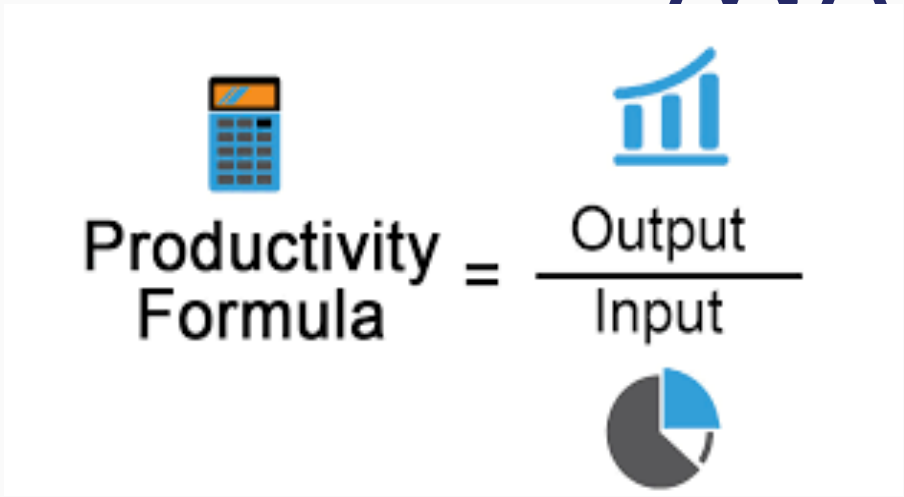
Global Surgical Package



Surgical Global Work Breakdown

- **31%** of the global payment is for work outside the OR.
- If the PA is doing the pre-op H&P, the post-op rounds, and the post-op office visits, then up to **31%** of the global payment could, theoretically, be attributed to the that professional.
- Additionally, **31%** of the Work RVU attributed to the procedure could be "credited" to the PA. Important not to set up a productivity system of direct competition with physicians for RVUs.

Global Work Breakdown



Example

27130 Total Hip (payable at $1,322*)

Pre-op work (10%):	**$ 132.20**	**PA/NP**
Intra-op work (69%):	$ 912.18	Surgeon
Post-op work (21%):	$ **277.62**	**PA/NP**

*Final figure impacted by geographic index

Global Work Contribution

- If a PA does pre-op exam and post-op rounding/ office visits, **$409.82** could be “credited/allocated” to PA.
- However, billing records would show $1,322 being attributed to the surgeon.
- In additional, a separate payment of **$179.79** can be officially credited to PA for the first assist (13.6% of surgeon’s fee) which does not reduce the surgeon’s fees.

Potential PA Value or Contribution

True measure of global "value" might be:

First assist payment of	$179.79
plus	
E&M share of global payment	$409.82

Total = $589.61 per THR

CPT Code 99024

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

Captures post-op work provided in Global Surgical Package

Tracking Clinical Work in the Global Surgical Period

- While not separately payable, track “global” visits by using the 99024 code in the EMR.
- The global visits performed by the PA would otherwise have to be performed by the physician. **Note:** post-op visits are not separately reimbursed so split/shared billing does not apply.
- If the PA provided 200 post-op global visits, for example, theoretically 200 appointment slots were then made available for the physician to see other “revenue generating” new visits.

What about that 15%

Without utilizing split/ shared or “incident to” billing, Medicare payment for PAs is at 85% of the physician rate

The Cost of Delivering Care – Contribution Margin

a) What is the cost of providing the service?

b) What is the reimbursement/revenue?

c) What is the margin (difference)?

Office/Outpatient Visit: Established Patient

CPT Code	Work RVU	Non-facility Price Physician (national average)	Non-facility Price PA
99213	1.3	$98.00	$83.30

15% = $14.70

PA-Physician “Contribution” Comparison Model

Assumptions:

- 8-hour days (7 clinical hours worked per day)
- 20-minute appointment slots = 3 visits per hour = 21 visits per day
- Physician salary $250,000 ($120/hr.); PA salary $110,000 ($53/hr.)
- 2,080 hours worked per year

Example does not include overhead expenses (office rent, equipment, ancillary staff, etc.) which don’t change based on the health professional delivering care

Contribution Model at 85% Reimbursement

A Typical Day in the Office	Physician	PA
Revenue with physician and PA providing the same 99213 service	$2,058 ($98 X 21 visits)	$1,749 ($83.30 X 21 visits) [85% of $98 = $83.30]
Wages per day	$960 ($120/hour X 8 hours)	$424 ($53/hour X 8 hours)
"Contribution margin" (revenue minus wages)	$1,098	$1,325

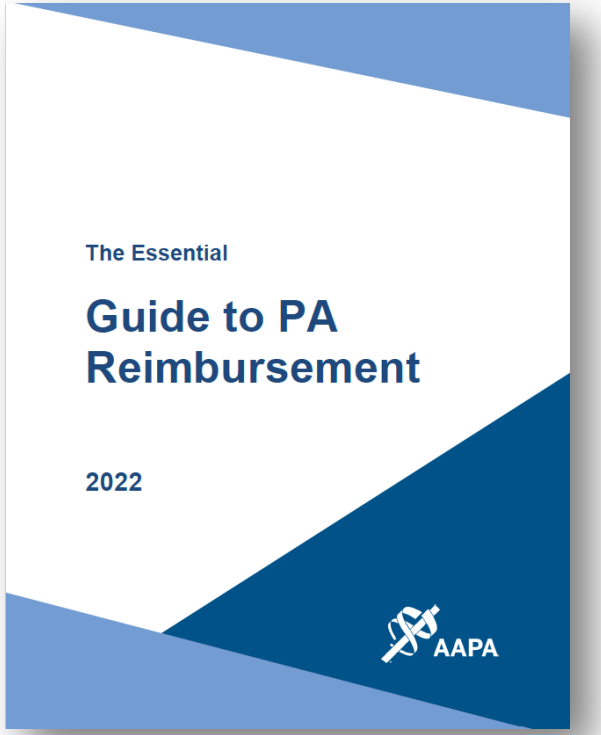
Contribution Model Takeaway Points

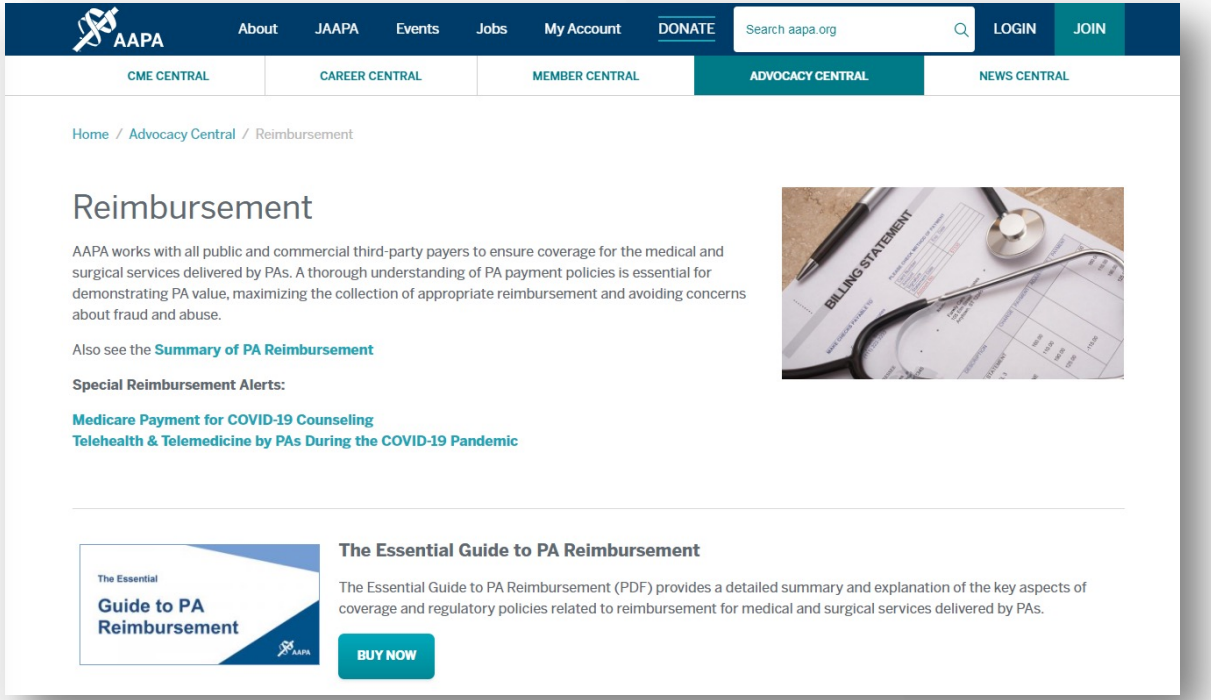
- The point of the illustration is not that PAs will produce a greater office-based contribution margin than physicians.
- That may or may not happen (more likely in primary care/internal medicine vs. surgery or specialty practices).
- PAs generate a contribution margin for the practice even when reimbursed at 85% of the physician fee schedule.
- An appropriate assessment of “value” includes revenue generation, delivery of non- revenue generating professional services (e.g., post op care) and the cost to employ health professionals.

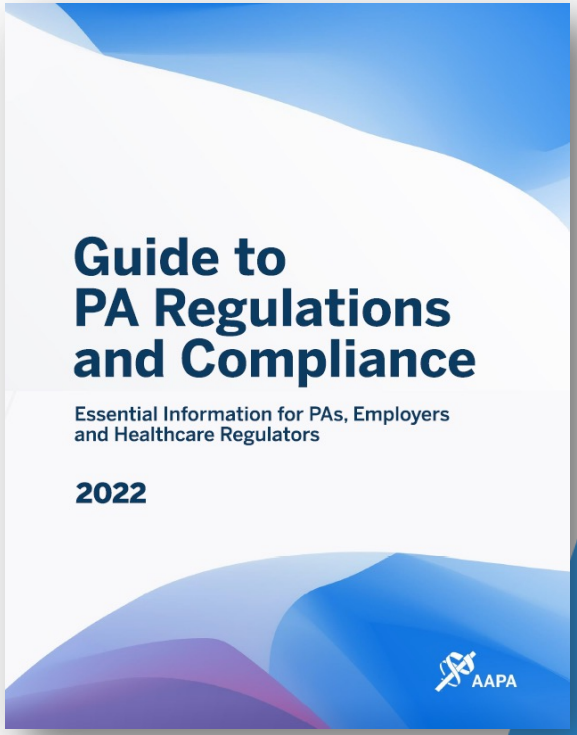
PA Value

- 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

AAPA Resources







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

Contact Information

- michael@aapa.org
- reimbursementteam@aapa.org
- **AAPA Reimbursement Website**

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