Updates in PA Practice and Reimbursement from AAPA

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American Academy of PAs

Doctor of Health Science
Concentrations: Leadership & Organizational Behavior; Fundamentals of Education

Graduate Certificate
Science of Healthcare Delivery

20+ Years
Licensed & Certified PA

10+ Years
Regulatory and professional advocacy

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I have no relevant relationships with ineligible companies to disclose within the past 24 months.

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Disclaimers

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

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

- Describe key billing concepts
- Summarize coding, documentation, and billing guidelines
- Recognize requirements to practice and bill for medical and surgical services

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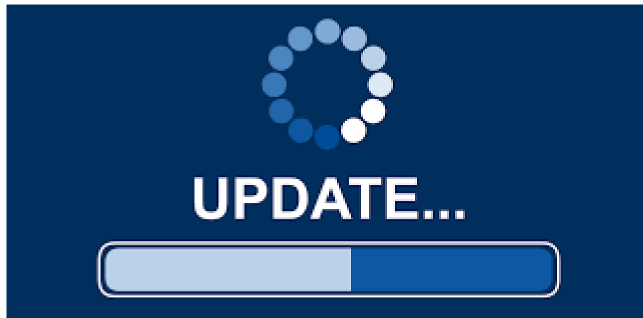

Will alert you to new policies
(< a few years old)

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Do I need to be concerned about billing and reimbursement?

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Benefits of Billing & Reimbursement Knowledge

Appropriate Payment for Services

Demonstrate PA Value

Improve PA Practice

Avoid Pitfalls

Serve as an Expert Resource

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Billing, Coding, & Documentation

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Medicare, Medicaid, Tricare, and nearly all commercial payers cover medical and surgical services provided by PAs

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

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Reimbursement Rates

Medicare (covers ~ 60 million Americans)

- Services provided by PAs covered at 85% of the Physician Fee Schedule
- *Optional* billing mechanisms may provide 100% reimbursement

Medicaid

- Rate may be same as or lower than that paid to physician

Commercial Payers

- Rate may be same as or lower than that paid to physician

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Medical Necessity and Documentation of Services

To bill for services

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

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"If it is not documented, it has not been done."

Centers for Medicare & Medicaid Services

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CPT® (Current Procedural Terminology) Codes

- Codes for reporting medical services and procedures
- Most codes are authorized for use by physicians and qualified health care professionals (e.g., PAs and NPs)
- Define services and the components and documentation needed to bill various services and levels of services

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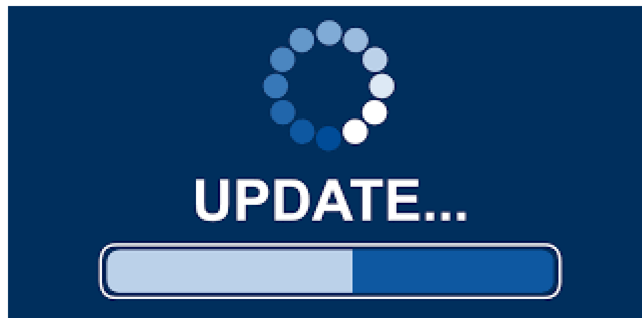
Services must follow current CPT Guidelines!



Level of E/M service based on . . .

Medical Decision Making (MDM) and/or Time

History and examination must be performed as is medically necessary but do not contribute to the level of service

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Level of Service Selection

Inpatient, Observation & Office Visits

MDM

or

Time

Emergency Department Services

MDM

Discharge Services & Critical Care Services

Time

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

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History and/or Examination

- Medically appropriate history and/or exam required – even though it does not contribute to the level of service billed
- Extent of history and/or exam determined by billing practitioner
  - Based on reasonable standards
  - For medicolegal practices

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History and/or Examination

- Billing practitioner must either gather or review history and exam information
  - Staff, patients, and students may contribute

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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

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

Example

Level of MDM	Elements of Medical Decision Making (2 of 3 needed)		
	Problems Addressed	**Data Analyzed**	**Risk of Patient Management**
Low	**Low** 2 or more self-limited or minor problems -or- 1 stable chronic illness -or - 1 acute, uncomplicated illness or injury -or- 1 stable acute illness	**Limited** Must meet at least 1 of 2 categories Category 1: Review of at least 2 of the following - external notes from each unique source, review and/or ordering tests (not separately reported) Category 2: Assessment requiring an independent historian	**Low Risk**

Example

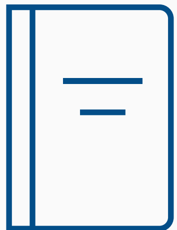
Level of MDM	Elements of Medical Decision Making (2 of 3 needed)		
	Problems Addressed	**Data Analyzed**	**Risk of Patient Management**
Moderate	**Moderate** 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment -or- 2 or more stable chronic Illnesses -or- 1 acute illness with systemic symptoms	**Moderate** Must meet at least 1 of 3 categories Category 1: Review of at least 3 of the following - external notes from each unique source, review and/or ordering of tests (not separately reported), and/or independent historians Category 2: Independent interpretation of a test (not separately reported) Category 3: Discussion of management with practitioner or appropriate source Example	**Moderate Risk** Examples: • Prescription drug management • Diagnosis or treatment significantly limited by SDOH

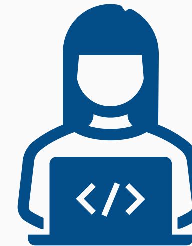
Level of MDM	Elements of Medical Decision Making (2 of 3 needed)		
	Problems Addressed	**Data Analyzed**	**Risk of Patient Management**
High	**High** 1 or more chronic illnesses with severe exacerbation or side effects of treatment -or- 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** Must meet at least 2 of 3 categories Category 1: Review of at least 3 of the following - external notes from each unique source, review and/or ordering of tests (not separately reported), and/or independent historians Category 2: Independent interpretation of a test (not separately reported) Category 3: Discussion of management with practitioner or appropriate source	**High Risk** Examples: • Drug therapy requiring intensive monitoring for toxicity, • Decision regarding emergency major surgery • Decision for DNR

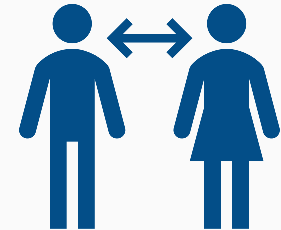
Example

Time-Based Billing

Qualifying Time – All patient-facing and non-patient facing time spent by the billing practitioner on the day of service







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

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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

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Medicare Policies

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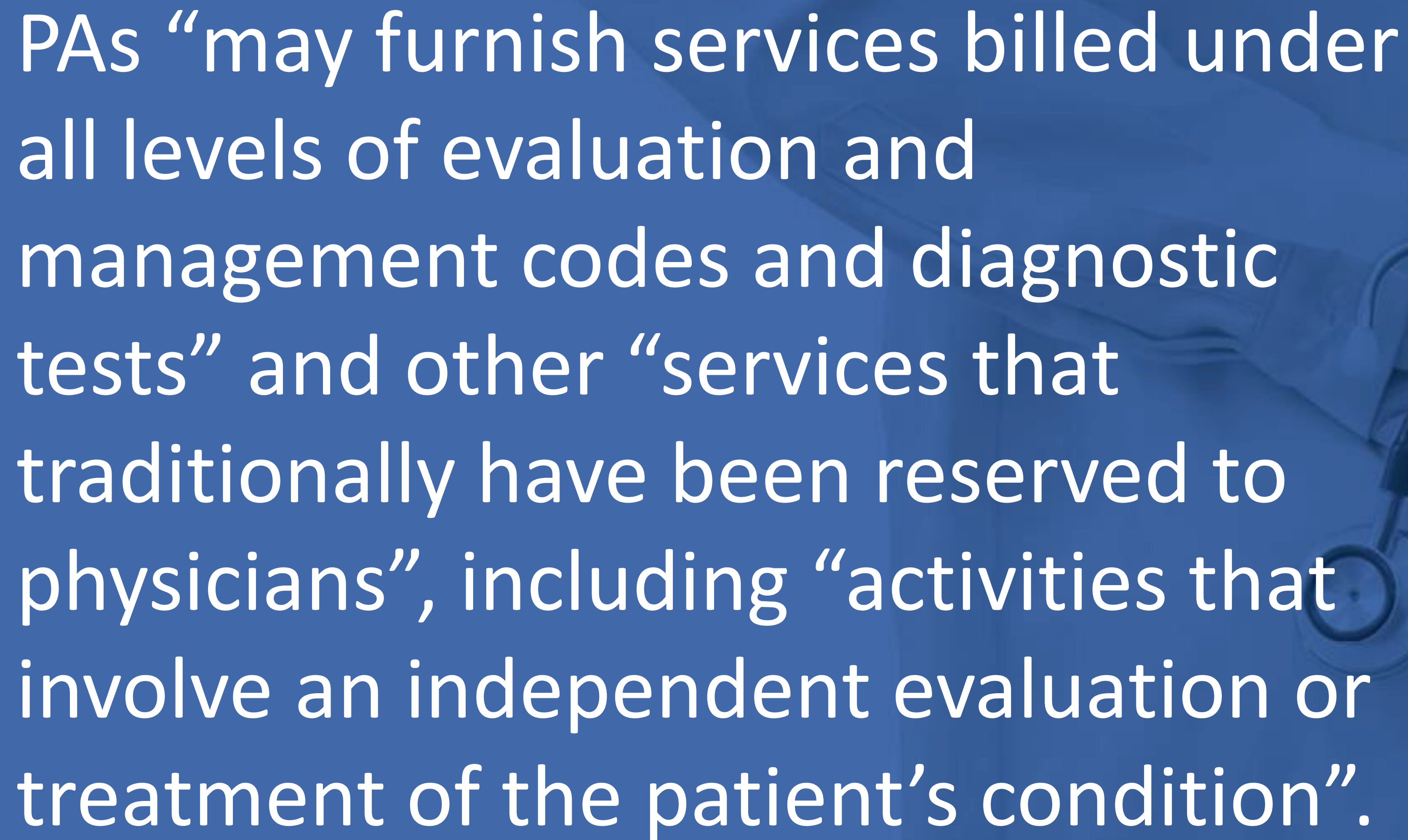

PAs "may furnish services billed under all levels of evaluation and management codes and diagnostic tests" and other "services that traditionally have been reserved to physicians", including "activities that involve an independent evaluation or treatment of the patient's condition".

Centers for Medicare and Medicaid Services

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

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Medicare Billing & Reimbursement

- Physicians, PAs, & NPs
  - Recognized in the Social Security Act
  - Paid under Part B Medicare
  - May receive "direct payment" or reassign payment

- Physicians paid 100% of Physician Fee Schedule
- PAs & NPs paid 85% of Physician Fee Schedule

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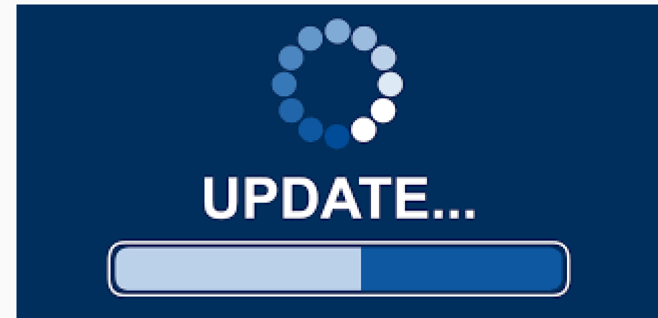
Medicare Direct Payment



- PAs *may* receive direct payment from Medicare as of 1/1/22
- Allows 100% state-recognized PA-owned corporations to be paid by Medicare
- Most PAs (like most physicians and APRNs) will continue to have payment go to their employer
- Does not change payment rate, services eligible for payment, scope of practice, etc.

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Optional Medicare Billing Mechanisms

- Optional billing mechanisms to receive 100% reimbursement from Medicare:
  - "Incident To" (office-based)
  - Split (or shared) billing (hospital- and facility-based)

- Sometimes referred to as "indirect billing"
- May lead to inefficiency and administrative burden

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“Incident To”

Services that are “an integral part of a patient’s course of treatment” and incidental to the “normal course of treatment” established by another practitioner

Optional Medicare Billing Mechanism

Only applies in non-facility-based office (Place of Service 11 or 50)

“Incident To” Billing Requirements

to bill PA services “incident to” a physician

A physician MUST

- **Personally perform an initial service**
- **Establish diagnosis** and **initiate treatment**
- Provide **ongoing, active participation** and management in patient’s care, including subsequent services
- Provide **“direct supervision”** – be **present** in **office suite** and **immediately available** during “incident to” service

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se0441.pdf

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“Incident To” Billing Requirements

to bill PA services “incident to” a physician

- Services must be **related to the treatment initiated by the physician**
- Physician and PA or NP must work for the **same entity**
- Only applies to services PAs or NPs are authorized to provide

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se0441.pdf

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“Incident to” Does NOT Apply

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

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“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

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“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

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

United States Attorney's Office

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

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

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

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Billing

Sharpen your billing after MACs warn practices to clean up incident to

A $900,000 settlement and a Medicare administrative contractor's (MAC) call to perform internal reviews are the latest reminders that incident-to billing remains a challenge. Failure to stay compliant can erase the additional revenue a practice might earn from billing a non-physician's service under a physician's name.

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

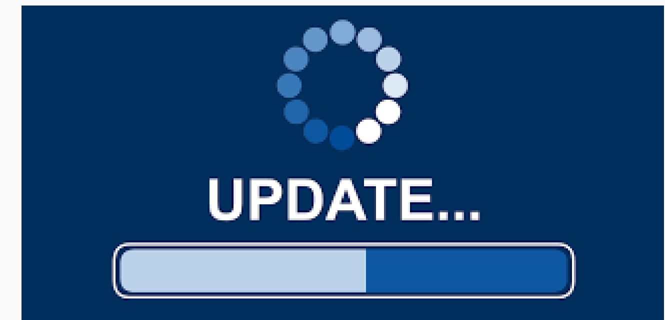
Split (or Shared) Billing

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 office (Place of Service 11 or 50)

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

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Split (or Shared) Billing Requirements

- 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

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All or some of the history, exam, or MDM

Before 2022

History, exam, or MDM in its entirety

-OR-

More than half of total time*

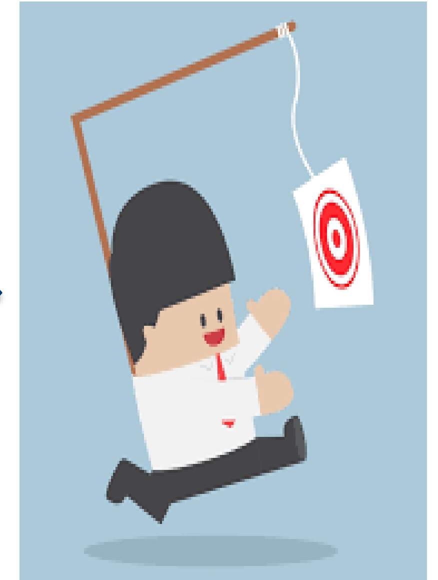
2022 & 2023

Substantive part of MDM

-OR-

More than half of total time*

through at least 2024



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Split (or Shared) Billing

"Substantive Portion"

2024 (and Indefinitely)

A substantive part of the medical decision-making

-OR-

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

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

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Time as “Substantive Portion”

- Only distinct, qualifying time can be counted
- When practitioners jointly meet with or discuss a patient, only the time of one of the practitioners can be counted toward total time
- “It may be helpful for each practitioner providing the split (or shared) visit to directly document and time their activities in the medical record.”

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

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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

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

Office of Inspector General

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

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

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Policies for Procedures & Services

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Admissions & Discharges

- PAs authorized by Medicare and most other payers to
  - Provide admission and discharge orders
  - Perform and be reimbursed for initial hospital encounters (AKA “admissions” & H&Ps) and discharge management services (AKA discharges)

The ordering practitioner and the practitioner performing the service do not have to be the same.

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Pre-Op H&Ps

Preoperative H&P must be performed and documented on all patients prior to surgery involving anesthesia services

- Performed no more than 30 days before or 24 hours after admission or registration
- If performed 24 hours or more before surgery, an updated exam and medical review is required

PAs may perform preoperative H&Ps and updated assessments

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter08-12.pdf

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Informed Consent

- Includes patient education about the risks, benefits, and alternatives of a proposed treatment
- Responsibility of the rendering practitioner to ensure the patient is competent, informed, and has given consent

PAs may obtain consent for procedures they perform and contribute to the process for physician-performed procedures

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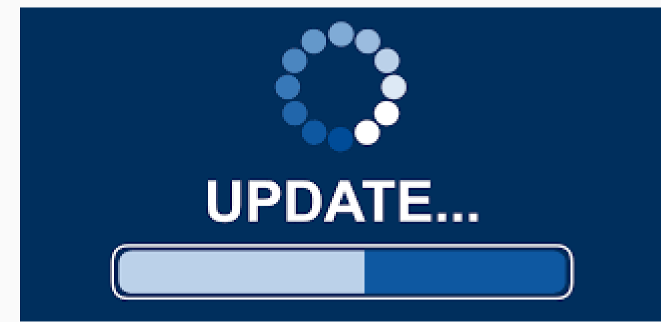
New Informed Consent Requirements



- Consent is required for all procedures
  - Written consent is required for procedures involving anesthesia
  - Verbal consent may be given for procedures not involving anesthesia but must still be reflected in the medical record

https://www.cms.gov/files/document/qso-24-10-hospitals.pdf

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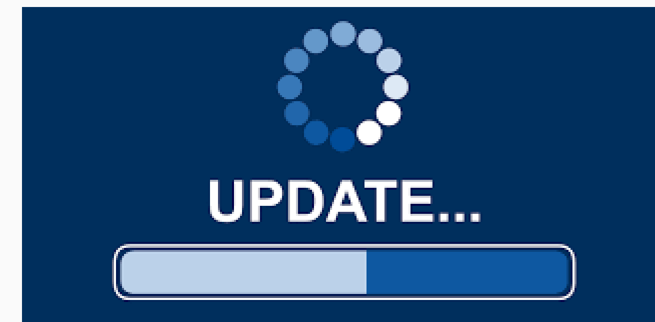
New Informed Consent Requirements



Must include information about:

- Practitioners other than the operating practitioner (including PAs) who will be performing components of the surgery
- Students (including PA students) who will performing
  - Tasks related to the surgery, and/or
  - Exams/invasive procedures for training purposes

https://www.cms.gov/files/document/qso-24-10-hospitals.pdf

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Surgical Site Marking

- Should be a standard part of the preoperative process
- Joint Commission requires surgical site marking be performed by:
  - The person performing/accountable for the procedure, or
  - A PA/NP
    - Working under a collaborative agreement or supervisory agreement
    - Familiar with the patient
    - Present when the procedure is performed

https://www.jointcommission.org/-/media/tjc/documents/standards/universal-protocol/up_poster1pdf.pdf

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Surgical Procedures and "First Assist"

- PAs may personally perform and bill for minor surgical procedures
- PAs covered by Medicare and most other payers for assistant-at-surgery services
  - -AS modifier for Medicare at 13.6% (85% of the 16% first-assist fee)
- Be aware of list of exclusion codes (procedures for which assistant at surgery is used < 5% of the time nationwide)

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Assisting at Surgery

- Scope of first-assist based on state law, facility policy, and what surgeon considers “critical or key components”
  - PAs generally considered able to perform critical/key components under direct guidance and supervision of physician
  - During non-critical/non-key components, physician does not need be present in surgical suite

Opening and closing of surgical site not generally considered “key or critical”

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

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Assisting at Surgery

Teaching Hospitals

- Based on the Social Security Act, Medicare does not generally reimburse for first assistant fees if there is a qualified resident available
- 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., multiple traumatic injuries)

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

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Duke University Health System, Inc. Agrees To Pay $1 Million For Alleged False Claims Submitted To Federal Health Care Programs

RALEIGH – United States Attorney for the Eastern District of North Carolina Thomas G. Walker and North Carolina Attorney General Roy Cooper announced jointly that Duke

Hospital). Duke University Health System allegedly made false claims to Medicare, Medicaid, and TRICARE by (1) billing the government for services provided by physician assistants (PA's) during coronary artery bypass surgeries when the PA's were acting as surgical assistants (along with graduate medical trainees), which is not allowed under government regulations and (2) increasing billing by unbundling claims when the unbundling was not appropriate, specifically in connection with cardiac and anesthesia

TRICARE by (1) billing the government for services provided by physician assistants (PA's) during coronary artery bypass surgeries when the PA's were acting as surgical assistants (along

https://www.justice.gov/usao-ednc/pr/duke-university-health-system-inc-agrees-pay-1-million-alleged-false-claims-submitted

Global Surgical Package

- Bundled payment for all usual and necessary pre-, intra-, and post-operative care for a procedure or surgery
- 0-day, 10-day, and 90-day post-operative period

Global Surgery Booklet

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

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Global Surgical Package

- Pre-operative visits (e.g., pre-operative H&P) after the decision is made to operate
- Local infiltration, digital blocks, or topical anesthesia
- Usual and necessary intraoperative services
- Immediate postoperative care and typical postoperative follow-up care (e.g., wound care, dressing changes, suture removal, post-surgical pain management, etc.)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

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Pre-Op H&P & Modifier 57

- No separate reimbursement for H&P ….. unless the decision for major surgery is made on the day of or day before the surgery (use modifier 57)
- H&P for minor surgical procedures and endoscopies is always included in the global surgery package
- “The hospital requires it” does not make it billable/reimbursable

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

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Post-Op Care & Modifier 79 & 24

- No separate reimbursement for usual and necessary post-operative care ….. unless unrelated to procedure
  - Use modifier 79 for an unrelated procedure by the same physician/group
  - Use modifier 24 for an unrelated E/M service by the same physician/group
- Must be accompanied by documentation that supports service is not related to post-operative care of the procedure

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

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FOR IMMEDIATE RELEASE

Tuesday, December 11, 2018

Coordinated Health and CEO Pay $12.5 Million to Resolve False Claims Act Liability for Fraudulent Billing

PHILADELPHIA, PA – United States Attorney William M. McSwain announced today that Coordinated

The government alleges that Coordinated Health and Dr. DiIorio engaged in a scheme to improperly unbundle claims for reimbursement for orthopedic surgeries in order to artificially inflate reimbursements from federal healthcare payers. Medicare and other public healthcare insurers reimburse physicians and hospitals a global fee for many types of orthopedic surgeries. The global fee is a single payment for all parts of a surgery. Although electronic safeguards automatically block separate reimbursements for parts of the same surgery when the global fee is paid, those safeguards can sometimes be circumvented when billing codes are misused. For example, a medical provider can circumvent the system by

hospitals a global fee for many types of orthopedic surgeries. The global fee is a single payment for all parts of a surgery. Although electronic safeguards automatically block separate reimbursements for parts of the same surgery when the global fee is paid, those safeguards can sometimes be circumvented when

https://www.justice.gov/usao-edpa/pr/coordinated-health-and-ceo-pay-125-million-resolve-false-claims-act-liability

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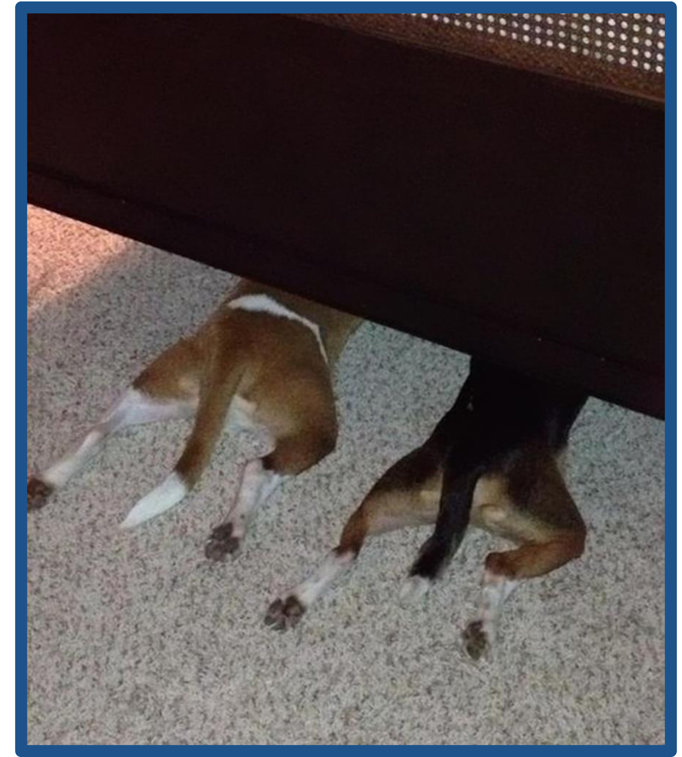
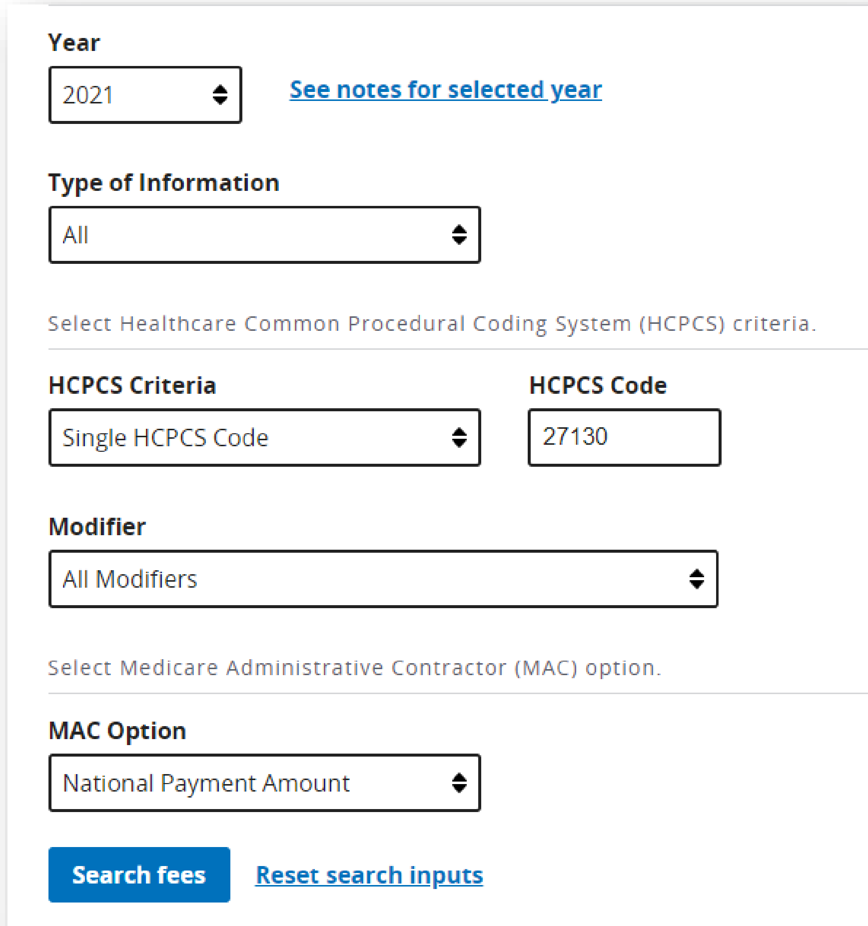
Global Surgical Package

The (not so) hidden value of PAs . . .



Physician Fee Schedule Search

https://www.cms.gov/medicare/physician-fee-schedule/search



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

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

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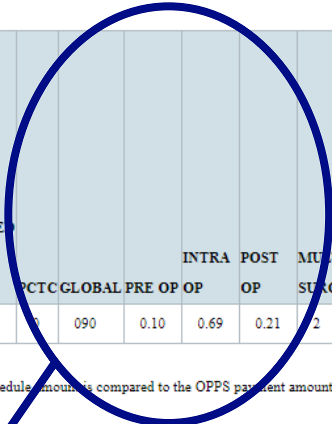
HCPCS CODE	MODIFIER	MAC LOCALITY	NON-FACILITY PRICE	FACILITY PRICE	NON-FACILITY LIMITING CHARGE	FACILITY LIMITING CHARGE	GPCI WORK	GPCI PE	GPCI MP	PROC STAT	WORK RVU	NA FLAG FOR TRANS NON-FAC PE RVU	TRANSITIONED NON-FAC PE RVU	NA FLG FOR FULLY IMP NON-FAC PE RVU	FULLY IMPLEMENTED NON-FAC PE RVU
27130		0000000	$1,409.74	$1,409.74	NA	$1,540.15	1.000	1.000	1.000	A	20.72	NA	14.44	NA	14.44

HCPCS CODE	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	BILT SURG	ASST SURG
27130		14.44		14.44	4.00	39.16	39.16	39.16	39.16	0	090	0.10	0.69	0.21	2	1	2



[1] Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment 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 schedule amount is compared to the OPPS payment amount and the lower amount is used for payment.

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

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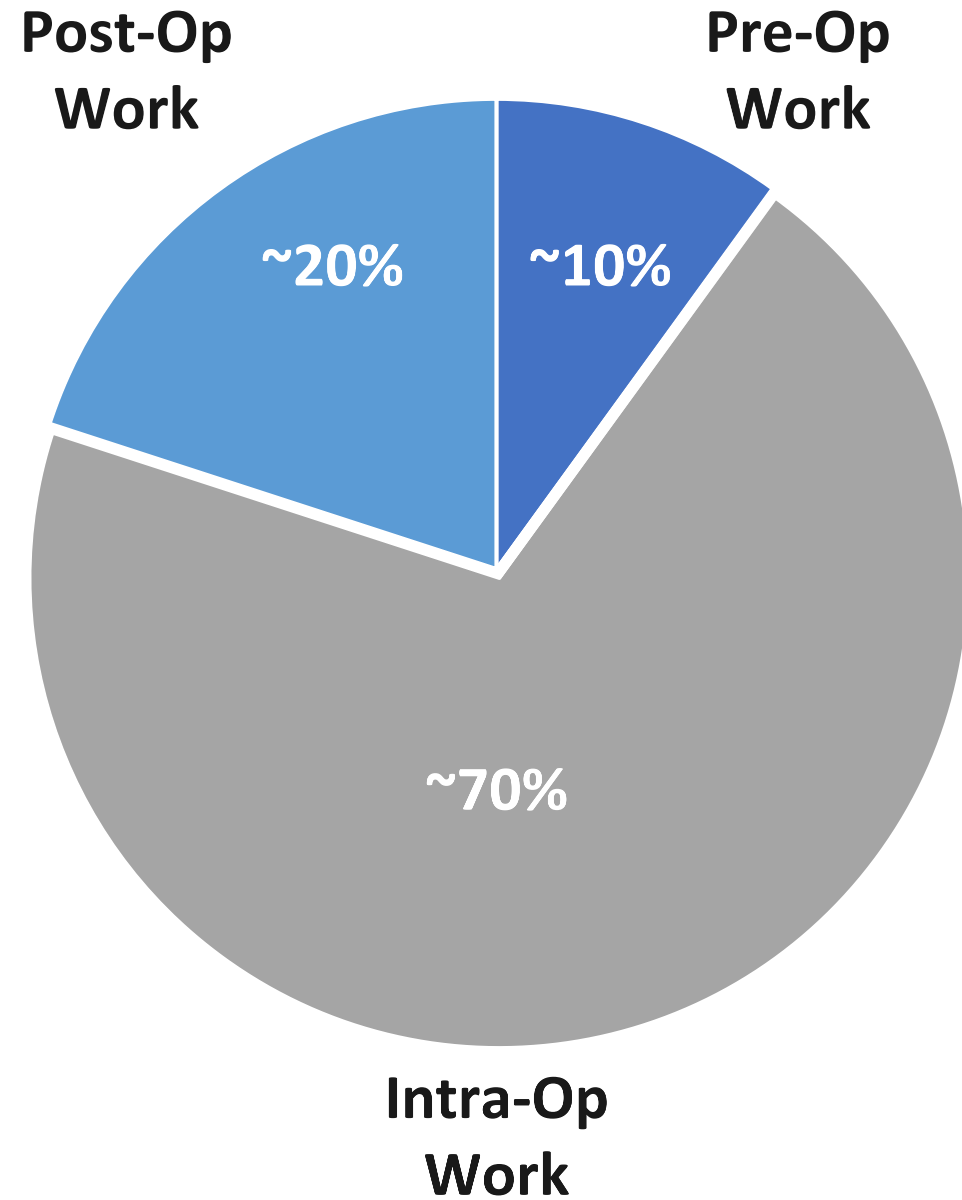

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Hypothetical Work Attribution for Total Hip Arthroplasty

27130	Global Surgical Package	Physician	PA
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 wRVU	**$972.72 14.30 wRVU**	**$437.02 6.42 wRVU**

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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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Radiographic Interpretation

Examples of the types of services that PAs & NPs may provide include "services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition."

Medicare Benefit Policy Manual, Chapter 15

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

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Radiographic Interpretation

Reimbursement for Radiographic Interpretation by PAs

- Requires a separate written report (also applies to physicians)
- Use Modifier 26 for Professional Component (Technical Component is billed by practice/facility)

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

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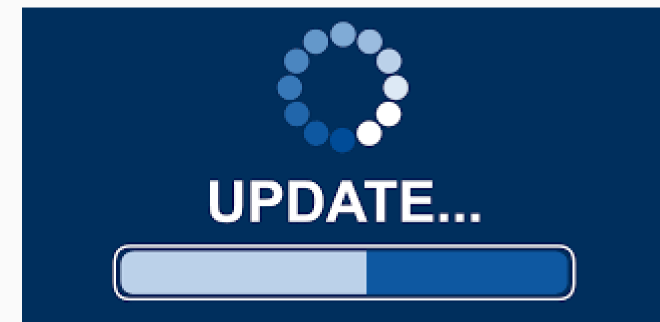
Diagnostic Tests



PAs are authorized to

- Order diagnostic tests
- Perform diagnostic tests
- Supervise ancillary staff performing diagnostic tests (as of 2020)
- Interpret most diagnostic tests

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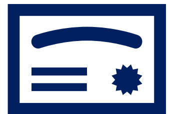
Telehealth

PAs are authorized to render and be paid for telehealth services



Must be licensed in the state where the patient is located

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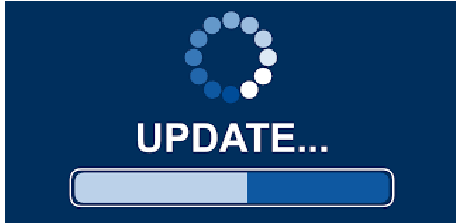
Interstate PA Licensure Compact



As of August 2024

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AAPA
American Academy of
Physician Associates

Other Updates

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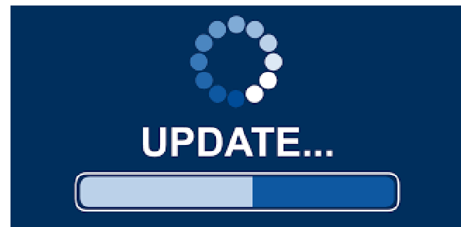
PA Practice Environment



- Optimal
- Advanced
- Moderate
- Reduced

As of August 2024

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Title Change

- 2021
  - AAPA House of Delegates passed a resolution affirming "physician associate" as the official title of the PA profession (vote of 198 to 68)
  - AAPA becomes the American Academy of Physician Associates
- 2022 – 2023
  - Several state and specialty PA organizations change association titles
- 2024
  - Oregon first state to recognize "physician associate"

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AAPA Speaks Out

Against the AMA's Harmful Attacks on PAs

On the "Scope Creep" Campaign:

"The AMA's campaign against 'scope creep' is a thinly veiled effort to maintain outdated practices rather than confronting the urgent issues we face. This unfounded campaign perpetuates division and undermines our collective ability to provide high-quality care."

2024

The Essential

Guide to PA Reimbursement

AAPA

FREE to AAPA Members

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

2024

Guide to PA Regulations, Compliance, and Professional Practice

Essential Information for PAs, Employers, and Healthcare Regulators

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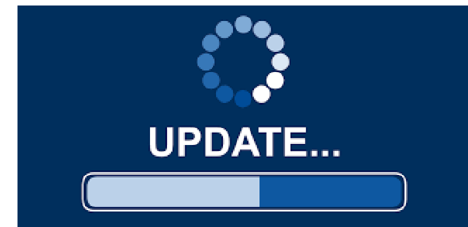
Resources for PAs in Administration



https://www.aapa.org/pa-administrators/

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AAPA Reimbursement & Professional Advocacy Resources

- Reimbursement webpage and resources https://www.aapa.org/advocacy-central/reimbursement/
- Subject Matter Experts – Email us at ReimbursementTeam@aapa.org!

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Thank you

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