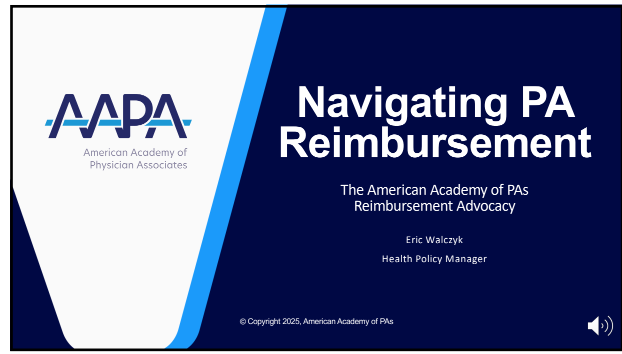

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Disclaimer

This presentation and any document(s) included or referenced therein are for informational purposes only, and nothing herein is intended to be, or shall be construed as, legal or medical advice, or as a substitute for legal or medical advice. All information is being provided AS IS, and any reliance on such information is expressly at your own risk.

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 policy changes frequently. Be sure to keep current by accessing the information posted by your local Medicare Administrative Contractor and by CMS on www.cms.gov.**
- We are employed by the American Academy of PAs.
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2

Learning Objectives

1. Explore health care reimbursement, evolving payment models, and value-based payment
2. Explain optional Medicare billing policies, including “incident to” and “shared visit” billing
3. Understand requirements, such as enrollment and credentialing with payers, for PA reimbursement

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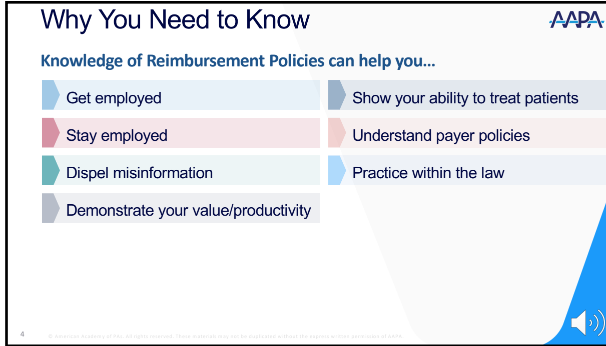

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Definitions

- **Enrollment**: The process of adding a provider's credentials to the system. AAPA's definition includes the practice of identifying PA services on a claim by indicating their NPI under the rendering provider section
- **Credentialing**: The process of assessing and confirming (verifying) the qualifications of a health care practitioner. It includes collecting and verifying information about a practitioner (such as licensing, certification, and education), assessing and interpreting the information, and making decisions about the practitioner

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Enrollment in Medicare and Medicaid

- Medicare enrolls PAs
  - The Provider Enrollment, Chain and Ownership System (PECOS) (https://pecos.cms.hhs.gov/)
- Medicaid enrolls PAs as rendering providers in all 50 states and DC
  - Arkansas passed legislation in 2024 allowing PAs to enroll as rendering providers, will not take effect until rules promulgated in 2025
  - Important note: PAs are covered in all 50 states and D.C. and are enrolled as "ordering and referring" providers

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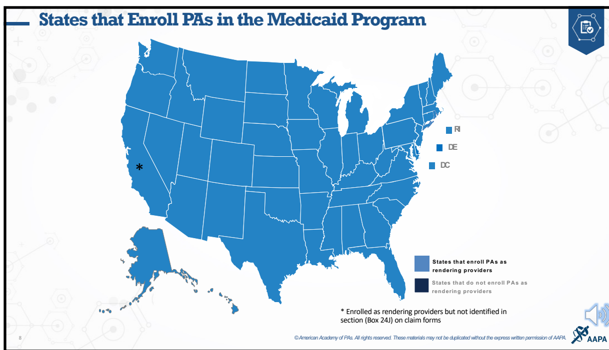
States that Enroll PAs in the Medicaid Program



* Enrolled as rendering providers but not identified in section (Box 24J) on claim forms

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Commercial Payers

- Private payers may promulgate their own rules
- Some choose not to enroll PAs and instruct the practice to bill all services provided by a PA under the physician's number
  - Reminder: This is NOT "incident to" billing! Even if they use the term
- Billing methodology must be clearly ascertained by every individual practice for every individual payer with whom they contract

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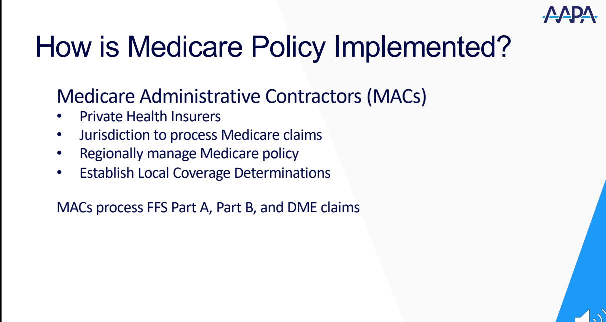

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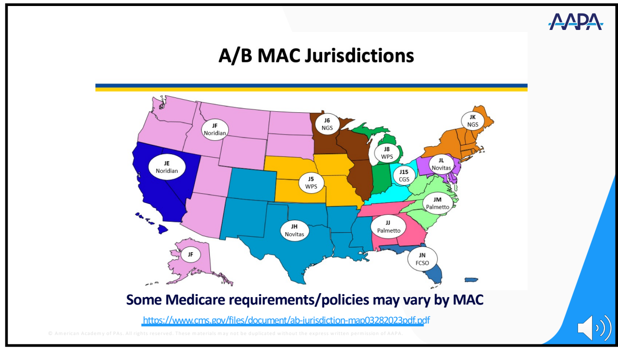

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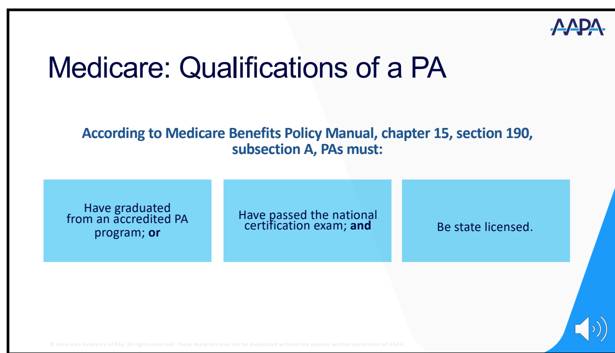

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Medicare: Requirements of PA Practice

- **Must** have a National Provider Identifier (NPI) (https://nppes.cms.hhs.gov/)
- **Must** be enrolled in Medicare (PECOS) if ordering, referring, and/or billing (https://pecos.cms.hhs.gov/)
  - A health professional's enrollment must reflect all current employers

Scope of Practice determined by:

- Medicare regulations/Conditions of Participation (CoPs)
- State law
- Hospital bylaws, policies, and granted privileges

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Medicare: Supervision/Collaboration

Medicare will defer to states with laws that do not require a specific collaborative relationship between a PA and a physician.

- Personal presence of the physician is generally not required
- Medicare policies largely defer to state law and facility policies, allowing for states with more progressive PA policy to maximize their use of PAs

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Medicare: Reimbursement

- Medicare has long authorized PAs to submit claims under their own NPI as the rendering provider on 1500 claim form (box 24J)
- As of January 2022, Medicare authorizes PAs to enroll to receive direct payment in certain circumstances and subject to state law; when not receiving direct payment, the billing provider remains the PA's employer
- Services provided by PAs and NPs are reimbursed at 85% of the physician fee schedule
- There are provisions for 100%, such as "incident to" in the office & split/shared visits in the hospital setting
  - Specific rules apply.

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Medicare: Direct Payment for PAs

Allows PAs to submit claims to Medicare and be reimbursed directly or reassign their payment to their employer. This is useful for PAs who:

- Practice as independent contractors.
- Want to work part time without having to deal with additional administrative paperwork associated with a formal employment relationship.
- Choose to own their own practice/medical or professional corporation.
- Work in rural health clinics (RHCs) and want to ensure they receive reimbursement for "carved out" (now Part B) RHC services.

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Direct Payment – Important Qualifiers

- The change in policy applies to the **federal Medicare program** and does not necessarily change reimbursement policies of state Medicaid programs or commercial payers. AAPA will use Medicare's policy to advocate for direct payment with all other payers.
- Medicare regulations **defer to state law**. If state law or regulation prohibits a PA from receiving direct pay, those restrictions will have to be removed before Medicare will directly pay PAs.

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Medicare and PAs

"If authorized under the scope of their State license, PAs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests if furnished under the general supervision of a physician."

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

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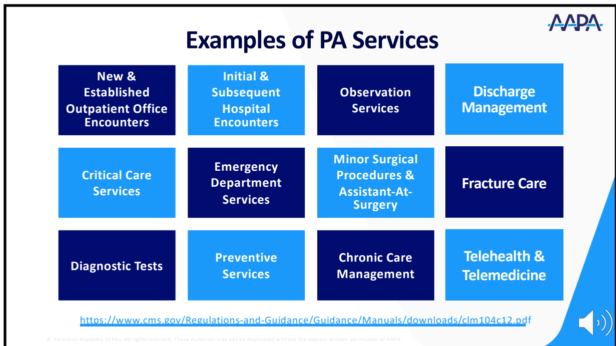

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PAs and Surgery

- Surgical procedures are bundled services
  - Global period which includes Pre-op H&P and follow-up care (Except >24 hrs before, medical necessity)
- PAs can first assist at surgery, which is separately billable
- PAs can also participate in various parts of the bundle (including follow-up care)

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Medicare: First Assisting at Surgery

- Bill the surgical code followed by the AS modifier
  - Some commercial payers ask for 80, 81, 82, AS
- Use PA's NPI as rendering provider
- Reimbursement is 13.6% of primary surgeon's allowable
- Restricted list for first assists – applies to all health professionals

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Medicare: First Assisting in a Teaching Hospital

- No reimbursement for first assisting when the teaching hospital has a specialty program related to the surgery in question
- Exceptions
  - Resident not available
  - Surgeons that have an across-the-board policy of never involving a resident
  - Under exceptional medical circumstances (emergency, life threatening situations such as multiple traumatic injuries).

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Medicare: Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)

- Patient must be seen every 30 days for first 90 days, then every 60 days
- Initial comprehensive visit must be done by a physician
- Required visits may be alternated w/ PA or NP
- Additional medically necessary visits may be done exclusively by PAs without disrupting the required visit schedule
- Differences between SNFs and NFs: who pays, who may perform 'physician only' services
- PAs not employed by the facility may order SNF and NF care as allowed by state law and regulation

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Current Procedural Terminology (CPT) Codes

- Coding system that provides a common language to describe and document services provided
- Virtually every service or procedure you provide can be characterized with a five-digit code – PAs have access to virtually all CPT codes
- Constantly being updated – over 8,000 codes currently available
  - PAs are involved in this process

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International Classification of Diseases (ICD) Codes

- International Classification of Diseases
  - Currently using ICD-10
- Describes patient’s symptom, condition, complaint or problem
- Justifies medical necessity
- 69,000 codes from which to choose

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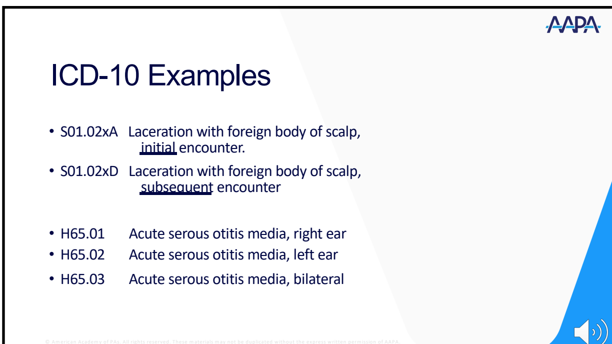

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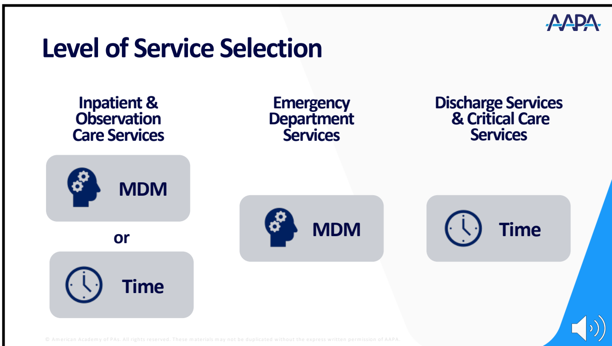

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Levels of Medical Decision Making (MDM)

Health professionals must use 2 of the 3 broad MDM categories to determine code level:

- **Number and Complexity of Problems Addressed at the Encounter**
- **Amount and/or Complexity of Data to Be Reviewed and Analyzed**
- **Risk of Complications and/or Morbidity or Mortality of Patient Management**

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Time-Based Billing

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

- 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

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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
- Time spent by staff
- Time spent by practitioner before or after the day of service

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

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Resources

- **CPT Table for Elements of Medical Decision Making** https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

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Optional Medicare Billing Mechanisms

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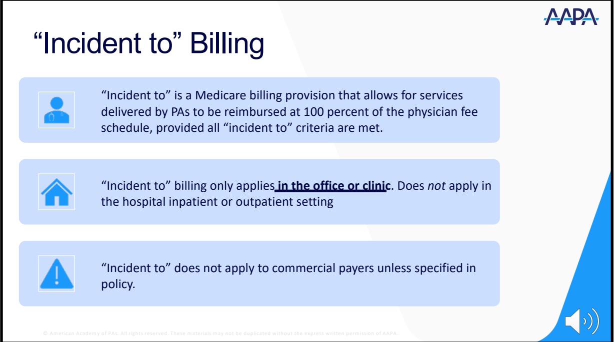

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"Incident to" Rules

- The service must be performed in a medical office that is not financially integrated with a hospital (Place of Service 11 or 50), excluding places of service that include an on- or off-campus outpatient hospital (places of service 19 and 22)
- 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 billing physician (W-2, leased employee or independent contractor) or have the same employer (same tax ID)

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What's NOT "incident to?"

- "Incident to" billing NEVER applies to Part B services provided in the hospital or facility (SNF/NF/LTAC/IRF) setting
- Some physician practices that have been purchased by hospitals are now considered hospital outpatient clinics, rendering them ineligible for "incident to" Part B billing
- "Incident to" does not apply to commercial payers unless specified in policy (Example: Aetna)
- Some payers do not enroll PAs and request that claims be submitted under the physician's name and NPI
  - This is NOT "incident to" billing: There are no on-site or first-visit rules attached

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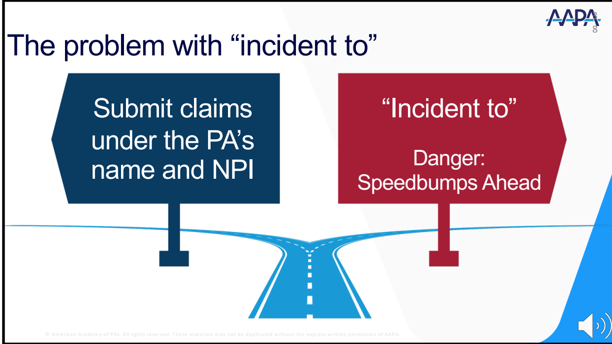
The problem with "incident to"



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The Transparency Problem(s) with "incident to"

- 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 is nearly impossible to accurately identify the type, volume or quality of services delivered by PAs and NPs
- Negatively affects many health stakeholders
  - Patients (transparency, EOB)
  - Health researchers
  - Medicare
  - PAs and NPs

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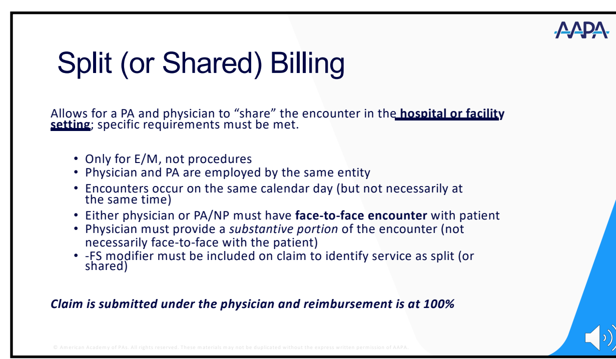

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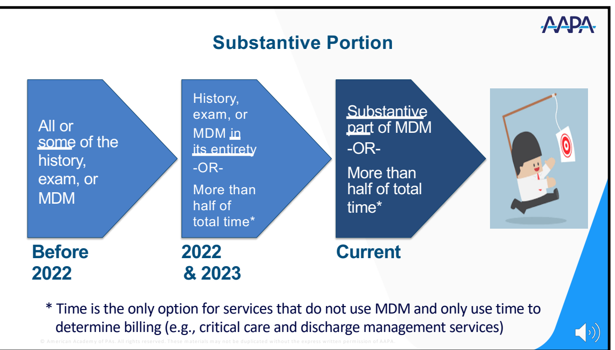

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Current Definition of "Substantive Portion"

- Finalized in the 2024 Physician Fee Schedule, CMS defines "substantive portion" of a split (or shared) visit as:

"More than half the total time spent by the physician or nonphysician practitioner performing the split (or shared) visit, or a substantive part of the medical decision making."

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Substantive Portion of MDM

2 of 3 Elements

- Number and Complexity of Problems Addressed at the Encounter
- Amount and/or Complexity of Data to Be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management

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

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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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The Changing Healthcare Environment

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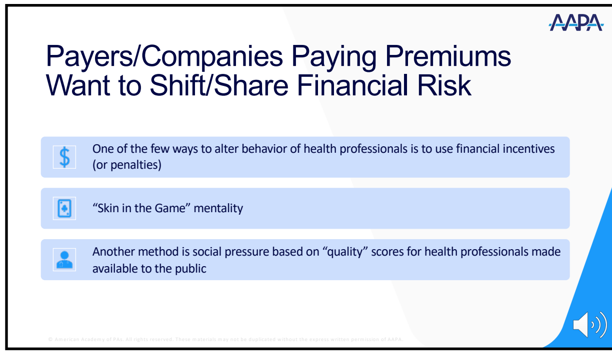

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Value-Based Care

Success (and reimbursement) will be based on:

- Patient outcomes
- Objective & measurable delivery of high-quality care
- Efficient use of resources (lack of duplication of tests, procedures, exams)
- Timely access to complete, accurate medical records
- Consumer/patient involvement
- Care coordination
- Recognition and financial rewards for team care

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Why Change from FFS to Value-Based Care?

Costs/expenditures are too high

Quality of care is uneven with too much variation

Medical treatments/interventions are not always evidenced-based

Medicine is not always outcome driven

Prevention is often not at the forefront

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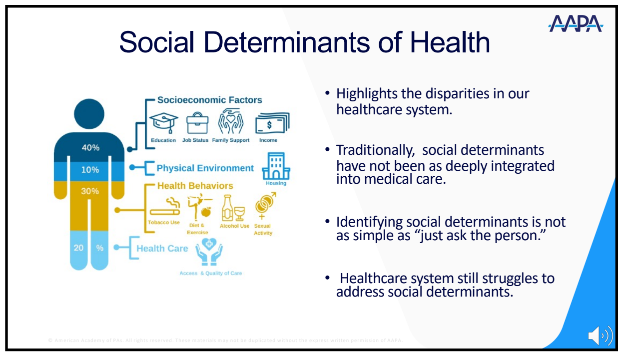

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Social Determinants of Health Examples

- Housing
- Transportation
- Food security
- Income & Employment
- Race, ethnicity, language
- Gender, sexual orientation
- Environment/neighborhood
- Educational attainment
- Childhood challenges/upbringing

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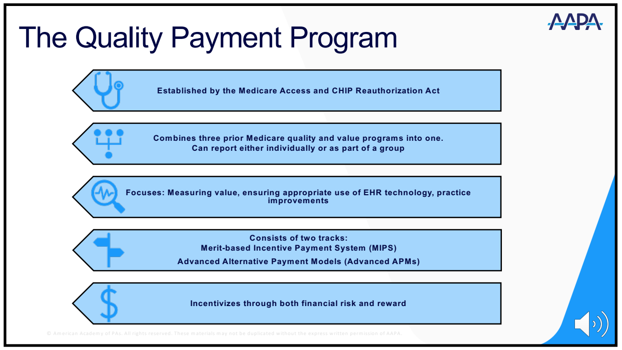

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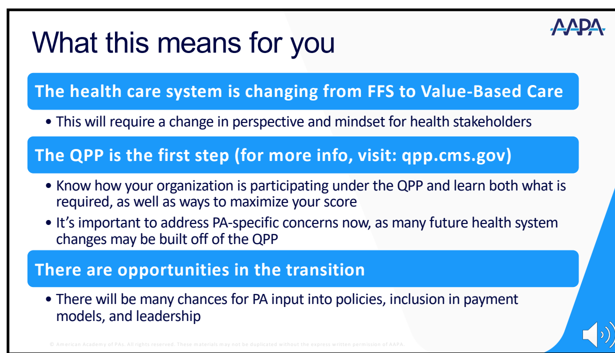

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Fraud and Abuse

- Examples of violations
  - Improper billing
  - Stark Act: patient referrals sent to entity in which the provider has a financial interest
  - Anti-kickback: solicitation/transfer of something of value to induce/reward behavior
- Potential Fraud and Abuse Remedies
  - Take back of reimbursement dollars paid
  - Civil monetary penalties (more than $22,000 per incident)
  - Exclusion from the Medicare, Medicaid, and other government-related health care programs
  - Imprisonment

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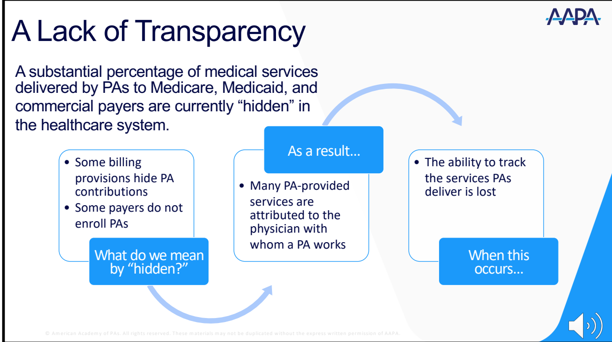

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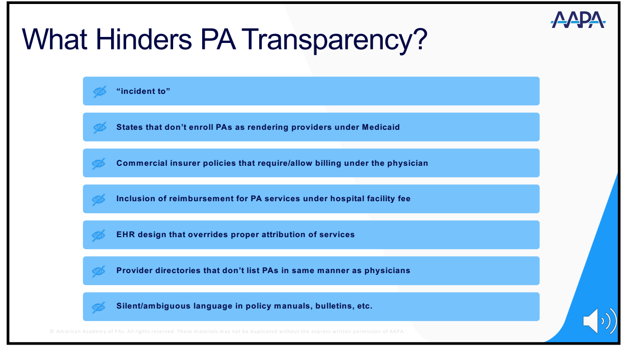

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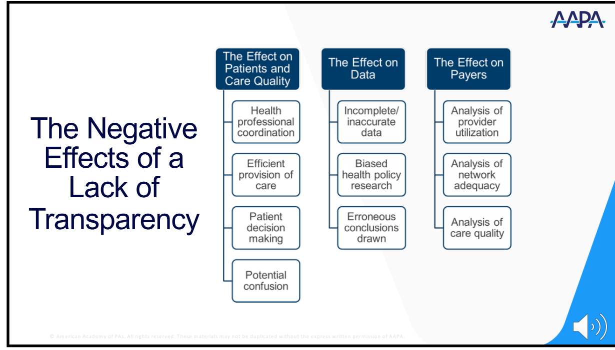

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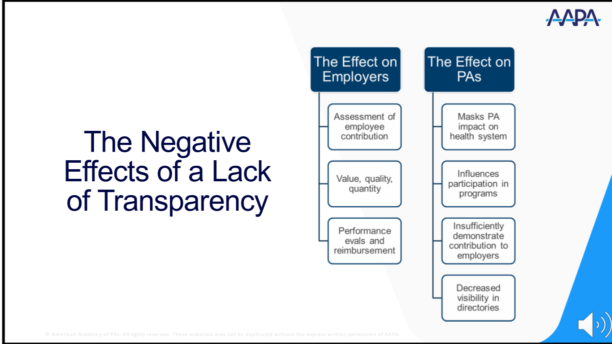

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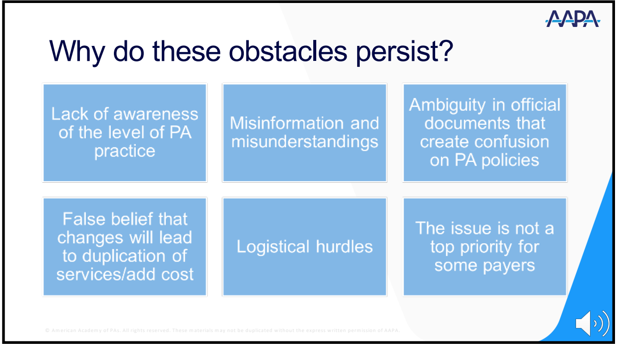

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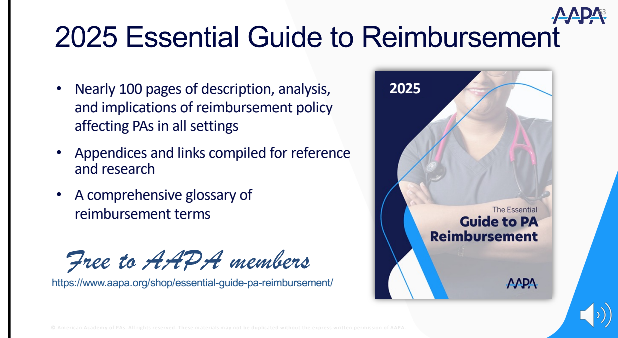

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Getting Involved

- AAPA's Grassroots Advocacy and Information Network (GAIN) is a nationwide network of PAs who are strengthening the future of the profession by:
  - Building relationships with members of Congress and their staff
  - Acting on advocacy alerts to let their legislators know how decisions made on Capitol Hill impact patients and communities back home

View AAPA's action center and sign up for GAIN at https://aapa.quorum.us/

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AAPA Membership Benefits

- Premier CME package
- Premier career package
- Clinical tools
- Subscriptions
- Access to AAPA Staff Experts
- Advocacy for PA professional achievement

https://connect.aapa.org/Login/Index?ReturnUrl=%2fmembership%2fpurchase

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