Hospital Medicine and PAs: Rules, Reimbursement, and Productivity

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May 2020

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- This presentation was current at the time it was submitted.
- 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 services. The provider must ascertain payment policy and claims methodology for each payer with whom they contract.

Objectives

- Understand rules and regulations affecting PA scope of practice in a hospital setting
- Describe Medicare payment policies and requirements that effect the ability of PAs to deliver services in hospital and facility settings
- Review billing rules for inpatient and hospital care
- Discuss implications of fraud and abuse in healthcare

Do I need to be concerned about billing and reimbursement?

Benefits of Knowing About PA Billing & Reimbursement

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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

False Claims Act

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

False Claims Act

In addition to refunding payments and costs to the Federal government for civil action:

- Treble damages (up to 3X amount violator received)
- Civil monetary penalties (up to $20,504 per false claim)
- Additional fines and/or imprisonment
- Exclusion from Medicare, Medicaid, and all other Federal healthcare programs

https://www.federalregister.gov/documents/2019/11/05/2019-23955/annual-civil-monetary-penalties-inflation-adjustment

Fraud & Abuse: By the Numbers

5 billion
recovered
in FY 2019

809
criminal actions

695
civil actions

2,640
excluded from
participation

https://oig.hhs.gov/reports-and-publications/archives/semiannual/2019/2019-fall-sar.pdf

Whistleblowers: By the Numbers

600+
whistleblower cases each year

$2.1 of $3
billion in FCA settlements from whistleblowers in 2019

30%
of recovered funds eligible to whistleblowers

https://www.justice.gov/opa/pr/justice-department-recovers-over-3-billion-false-claims-act-cases-fiscal-year-2019

Medicare Payment & Employment Arrangements

- Physicians who are not employed by the same entity as the PA have no ability to bill for work provided by PAs
- OIG determined that it is improper for physicians to enter into arrangements that relieve them of a financial burden that they would otherwise have to incur

Particularly problematic with a hospital-employed PA and non-hospital employed physician

Work being performed by a hospital-employed PA for a physician not employed by the same entity is subject to:

Anti-Kickback

Inurement for referrals to hospital

Stark Law

Remuneration (indirect compensation) by the hospital

False Claims Act Liability

U.S. attorney investigating DMC over possible federal anti-kickback violations

by Jay Greene **Crain's Detroit Business**

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

. . . **services the NPs and PAs were delivering to private doctors** might run afoul of federal laws designed to prevent improper patient referrals to the hospital.

. . . **blatant violations** would be a hospital paying fees for admissions or services, but **could** also **include** offering doctors office leases at below market value, or free or discounted services like **advanced-practice providers' coverage of private doctors' patients.**

https://www.crainsdetroit.com/article/20180228/news/654046/us-attorney-investigating-dmc-over-possible-federal-anti-kickback

After it Self-Disclosed Conduct to the OIG, Inova Health Care Services Agreed to Pay $528, 158

Healthcare FMV Advisors

. . . agreed to pay $528,158 for allegedly **violating** the Civil Monetary Penalties Law **provisions applicable to kickbacks and physician self-referrals**.

The OIG alleged that Inova **paid remuneration** to Arrhythmia Associates (AA) **in the form of services provided by certain PAs within the office of AA**. Specifically, Inova provided PA service to AA without written contract in place and failed to bill and collect for those PA services.

http://www.healthcarefmvadvisors.com/NewsUpdates/tabid/63/EntryId/13/After-it-self-disclosed-conduct-to-the-OIG-Inova-Health-Care-Services-d-b-a-Inova-Fairfax-Hospital-Inova-Virginia-agreed-to-pay-528-158.aspx

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Chicago Hospital Scam Had "Kickback on Steroids", Jury Told

by Lance Duroni
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 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

Medicare, Medicaid, TRICARE, and nearly all commercial payers cover medical and surgical services delivered by PAs

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

Reimbursement Rates

Medicare

- 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

Balanced Budget Act of 1997

PAs (& NPs) became recognized in the Medicare program:

- As providing Part B services typically performed by physicians
- At 85% of the physician fee schedule
- In all settings

Effective January 1, 1998

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Medicare & 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"

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

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Medicare & PAs

Services of a PA may be covered, if all requirements are met:

- Performed by a person who meets all **PA qualifications**
- Type that are **considered physicians' services** if furnished by a doctor of medicine or osteopathy
- Are performed under the **general supervision** of an MD/DO
- Legally authorized in the state in which they are performed
- Not otherwise precluded from coverage because of a statutory exclusion

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

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Examples of PA Services

New & Established Outpatient Visits
Initial & Subsequent Hospital, Discharge and Observation Services
Critical Care & Emergency Department Services
Minor Surgical Procedures and Assistant-At-Surgery Services
Diagnostic Tests and Interpretations
Chronic Care Management
Telehealth Services

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PA Qualifications

- Graduated from a physician assistant educational program that is accredited by the ARC-PA (or its predecessor agencies)
- Passed the national certification examination that is administered by NCCPA
- Be licensed by the State to practice as a PA

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

General Supervision

"The physician supervisor (or physician designee) **need not be physically present** with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary, unless State law or regulations require otherwise."

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

When State law does not require “supervision”…

- > 10 states and the District of Columbia use terms other than supervision
  - Several states use “collaboration”
  - Michigan uses “participating physician”
- At least one state (North Dakota) has no defined relationship between a PA and physician
- Medicare has new policy that largely defers to state law on how PAs practice with physicians and other members of the health care team

When State law does not require "supervision"…

"In the absence of state law [requiring supervision], if there is documentation at the practice which demonstrates the working relationship that PAs have with physicians in furnishing their professional services, then this would be adequate to ensure that the statutory requirement for PA physician supervision is met."

https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf?utm_source=federalregister.gov&utm_medium=email&utm_campaign=pi+subscription+mailing+list

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PAs

- Provide services **under general supervision** of a physician
- May bill under own name/NPI
- Reimbursed at 85%
- PAs **may not receive direct payment** (PAs employer listed in payment field)

NPs

- Provide services **in collaboration** with a physician
- May bill under own name/NPI
- Reimbursed at 85%
- May receive direct payment
- **Most NPs reassign payment as a condition of employment**

Optional Medicare Billing Mechanisms

Optional billing mechanisms to receive 100% reimbursement from Medicare:

- "Incident To"
- Split/Shared billing

Warning: may lead to inefficiency, risk for fraud and abuse, lack of transparency, and other unintended consequences

Split/Shared Billing

Hospital billing provision that allows services performed by a PA (or NP) and a physician to be billed under the physician name/NPI at 100% reimbursement

Must meet certain criteria and documentation

Split/Shared Billing

- Services provided must be **E/M services**
  (does not apply to critical care services or procedures)
- Both PA and physician must **work for the same entity**
- Physician must provide a "**substantive portion**" and have **face-to-face** encounter with patient
- Professional service(s) provided by the physician must be **clearly documented** with clear distinction between the physician's and the PA's services
- Both the PA and physician must treat the patient on the **same calendar day**

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

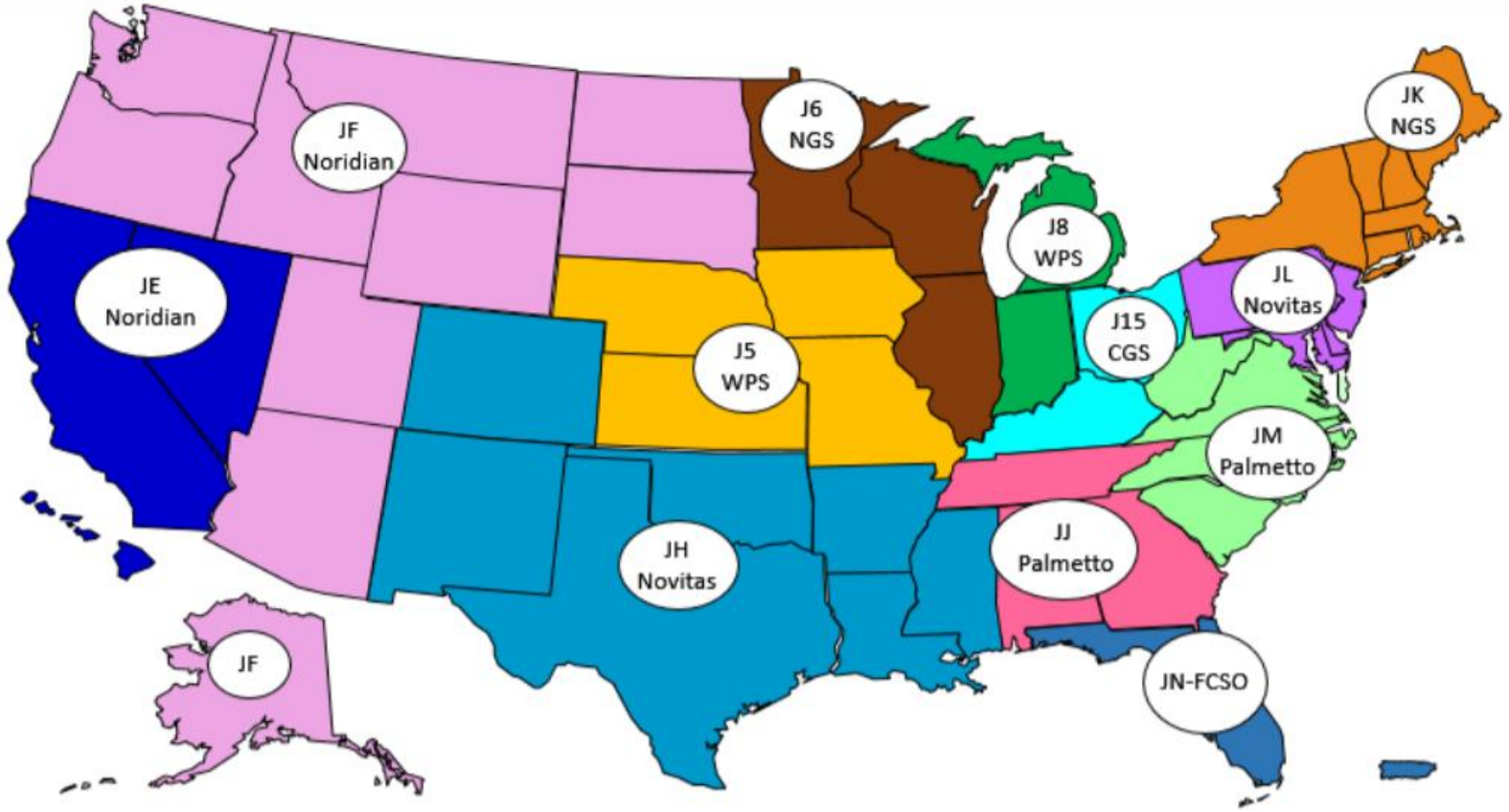
Split/Shared Billing

Substantive Portion

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

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

Medicare Administrative Contractors (MACs) & Jurisdictions



https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/AB-MAC-Jurisdiction-Map-Oct-2017.pdf

Split/Shared Documentation

Documentation requirements vary significantly by MAC (Medicare Administrative Contractor)

- Physician must document at least one element of the history, exam and/or medical decision making
- Physician need only document attestation of face-to-face contact with patient and that a substantive portion of service was performed

Split/Shared Billing

- No physician face-to-face encounter
- Physician failed to see patient on same calendar day
- Improper documentation
- Any other criterion not met

Bill under the PA for 85% reimbursement

Incident-To Billing

- Office billing provision that allows services performed by PAs/NPs to be billed under physician's name/NPI at 100% reimbursement
- ONLY applies to services furnished incident to physician professional services in a physician's office

NEVER applies in a hospital or facility setting

“Incident To” Billing

- The **physician must personally treat the patient** and establish the diagnosis for all new patients and new problems.
- The incident to services must **follow the course of treatment planned by the physician** at the initial service.
- The physician is responsible for the overall care of the patient and should 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 physician (or a physician in the group practice) must be **present in the office** suite when the incident to service is provided.
- Both the PA and physician must **work for the same entity**

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

“Incident To” Billing

- New patient or new problem
- Physician not in office
- Alteration in established plan of care
- Any other criteria not met

Bill under the PA for 85% reimbursement

Incident-To Billing Does NOT Apply

Inpatient & Observation Services

Hospital Outpatient Services

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

Inpatient Nursing & Rehabilitation Facilities

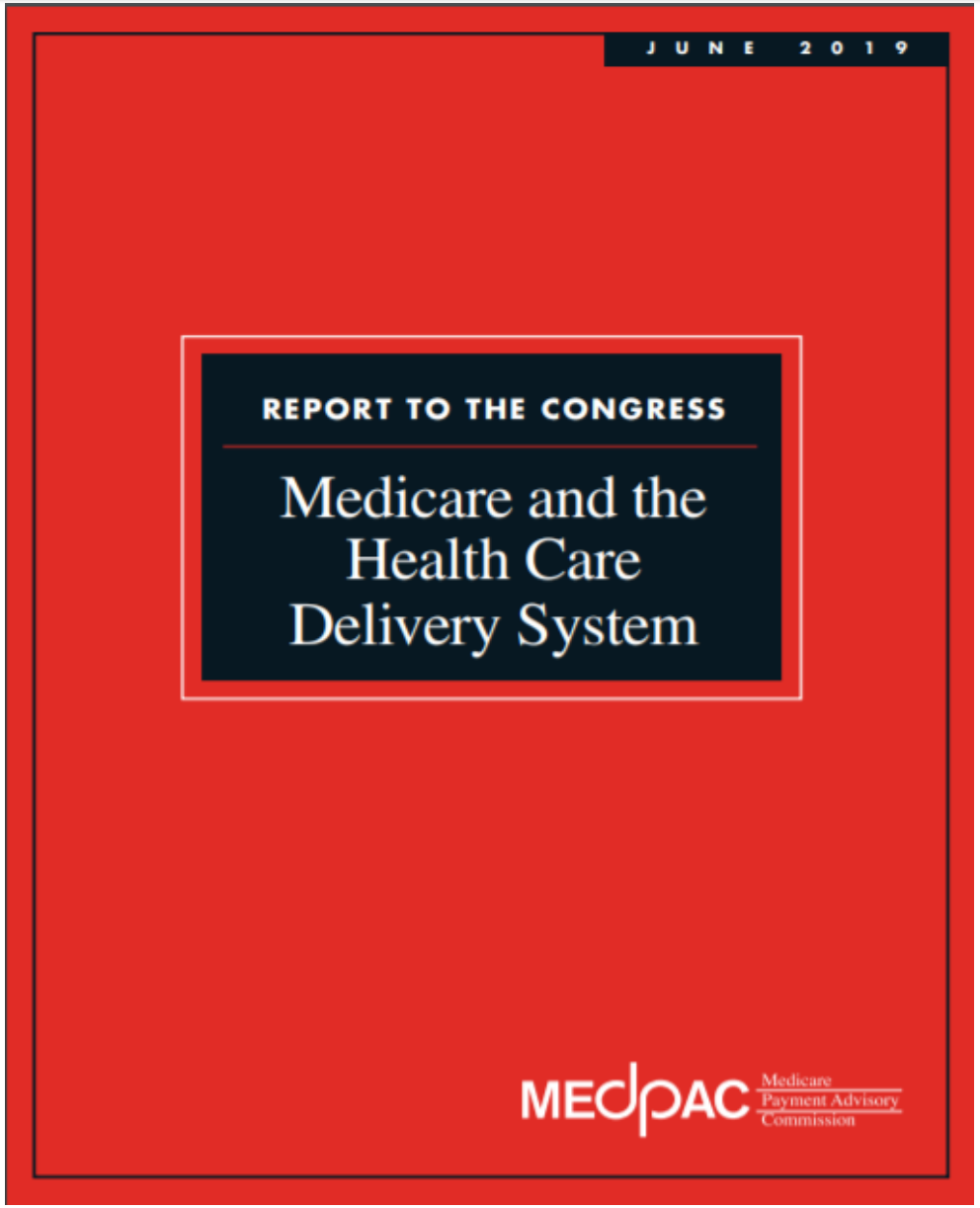
Some physician practices that have been purchased by a hospital are now considered hospital outpatient clinics, rendering them ineligible for incident-to billing

Billing "Best Practices"

- An increasing number of employers and healthcare systems are minimizing or eliminating "incident to" and split/shared billing (instead billing under the PA's name/NPI)
  - Increased efficiency
  - Improved workflows
  - Increased patient access
  - Decreased administrative and documentation burden
  - Increased transparency and accountability
  - Reduced risk of non-compliance

What about the extra 15%

More than made up for in increased efficiency, decreased burden, and actual contribution margin.



"PAs nearly always lower costs and increase profits for their employers because their salaries are less than half of physician salaries, on average, but their services can be billed at the full physician rate or at a modest discount ."

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

Reimbursement & Profit

- PA reimbursement at 85% of physician fee schedule
- PA salary is 30% - 50% that of physician salary*
- Contribution margin for a PA is no less than (and sometimes greater than) that of a physician

Contribution Margin

revenue after variable costs

*MGMA Data

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Costs of "Personnel"

▪Salary	PA < physician
▪Benefits (PTO, CME allotment, etc.)	PA ≤ physician
▪Recruitment/Onboarding	PA ≤ physician
▪Malpractice Premiums	PA < physician
▪Overhead (building, staff, supplies)	PA = physician

Overall cost to employ PA ↓↓↓ physician

Profit and Gross Profit: Initial Hospital Care

Provider Type	Median Annual Compen-sation	Hourly Salary	Initial Hospital Care (99221)		Initial Hospital Care (99222)		Initial Hospital Care (99223)	
			Reimburse-ment	Contribu--tion Margin	Reimburse-ment	Contribu--tion Margin	Reimburse-ment	Contribu--tion Margin
MD/DO	$250,000	$120	$103	**-$17**	$139	**+$19**	$205	**$85**
PA/NP	$110,000	$53	$88	**+$35**	$118	**+$65**	$174	**$121**
Difference			$15		$21		$31	

https://www.medpagetoday.com/practicemanagement/salary-survey/77085
https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

Contribution Margin
=
reimbursement
-
hourly salary

(assuming 60 minute time spent)

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Profit and Gross Profit: Subsequent Hospital Care

Provider Type	Median Annual Compen-sation	Hourly Salary	Subsequent Hospital Care (99231)		Subsequent Hospital Care (99232)		Subsequent Hospital Care (99233)	
			Reimburse-ment	Contribu--tion Margin	Reimburse-ment	Contribu--tion Margin	Reimburse-ment	Contribu--tion Margin
MD/DO	$250,000	$120	$40	**-$20**	$74	**$14**	$106	**$46**
PA/NP	$110,000	$53	$34	**-$7.5**	$63	**$36.5**	$90	**$63.5**
Difference			$6		$11		$16	

https://www.medpagetoday.com/practicemanagement/salary-survey/77085
https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

Contribution Margin
=
reimbursement
-
0.5 hourly salary

(assuming 30 minute time spent)

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Profit and Gross Profit: Hospital Discharge

Provider Type	Median Annual Compen-sation	Hourly Salary	Hospital Discharge (99238)		Hospital Discharge (99239)	
			Reimbursement	Contribution Margin	Reimbursement	Contribution Margin
MD/DO	$250,000	$120	$74	**$14**	$109	**$49**
PA/NP	$110,000	$53	$63	**$36.5**	$93	**$66.5**
Difference			$11		$16	

Contribution Margin
=
reimbursement
-
0.5 hourly salary

(assuming 30 minute time spent)

https://www.medpagetoday.com/practicemanagement/salary-survey/77085
https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

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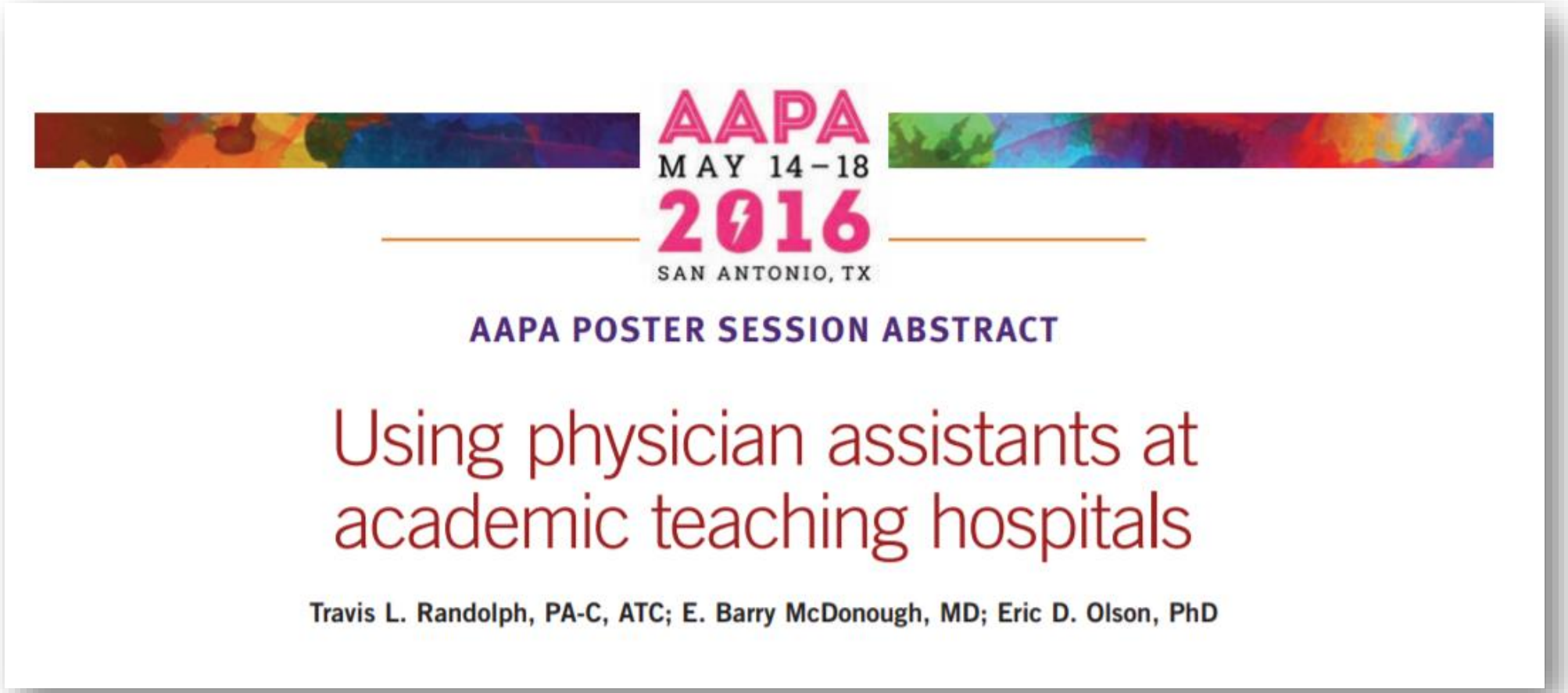
Cost-Effectiveness Take Away Points

- Point is not that PAs produce greater contribution margin than physicians
  - That may or may not happen
    (more likely in primary care versus surgical specialty)
- Point is that PAs generate a substantial contribution margin for a practice/employer even when reimbursed at 85%
- An appropriate assessment of monetary “value” includes revenue, expenses, and non revenue-generating services

Optimization of PA practice & billing …



AAPA
MAY 14–18
2016
SAN ANTONIO, TX

AAPA POSTER SESSION ABSTRACT

Using physician assistants at academic teaching hospitals

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

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

6-Month Pilot Study

Compared *shared clinic* to *split clinic* model

- Shared clinic model
  - PA functions like a medical resident or scribe
  - Services billed under the name/NPI of physician
  - Risk of fraud/abuse/compliance violations
- Split-clinic model
  - PA functions autonomously while physician is in clinic or operating room
  - Services billed under the name/NPI of the rendering provider

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

6-Month Pilot Study

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

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

6-Month Pilot Study

Physician Results

5% ↓ in total payments and RVUs

Projected 33% ↑ in surgical services* after 6 months

*in orthopaedics at an academic medical center

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

6-Month Pilot Study

Practice Results

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

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

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
- PA contribution is sometimes "hidden"

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

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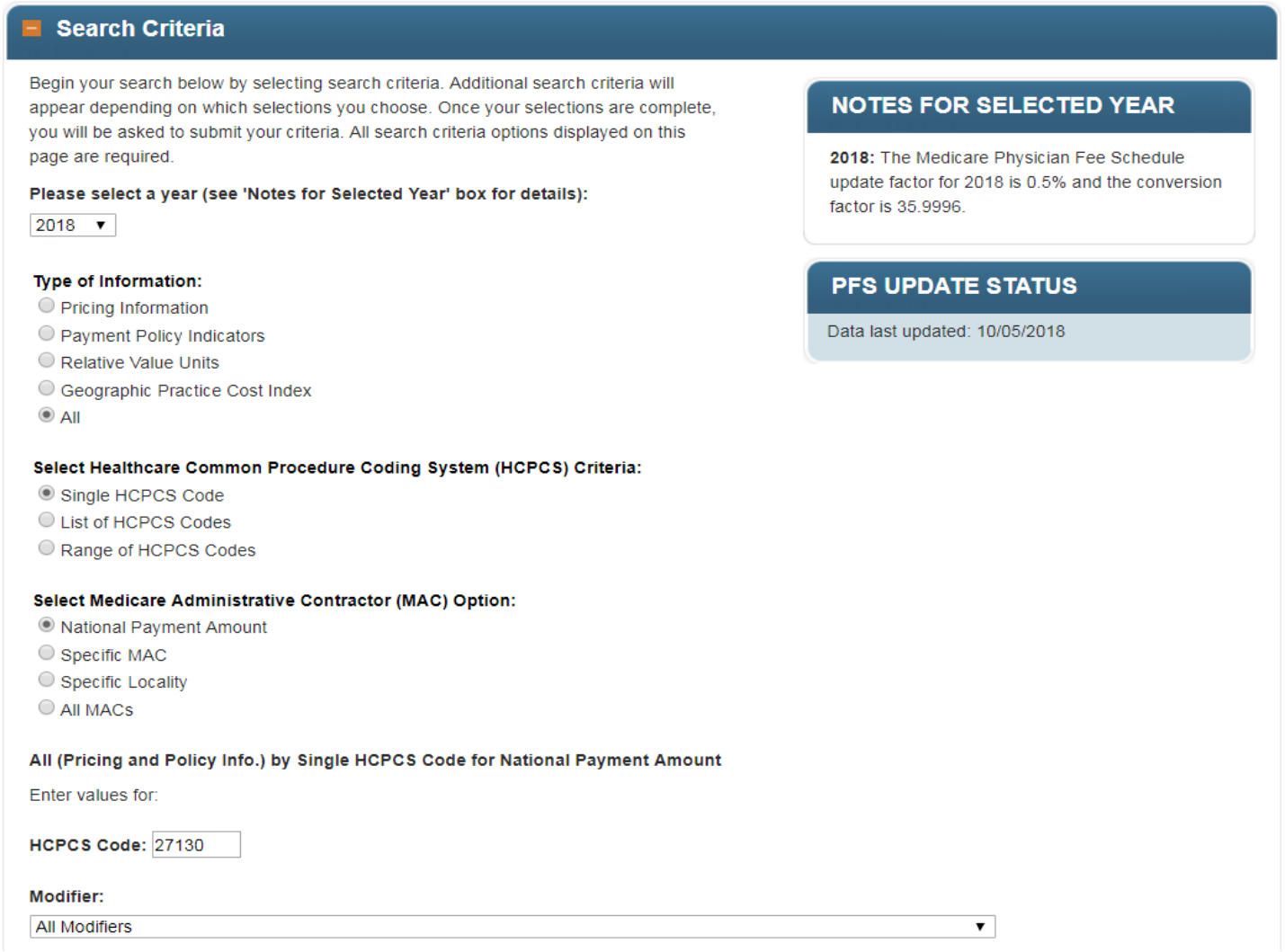
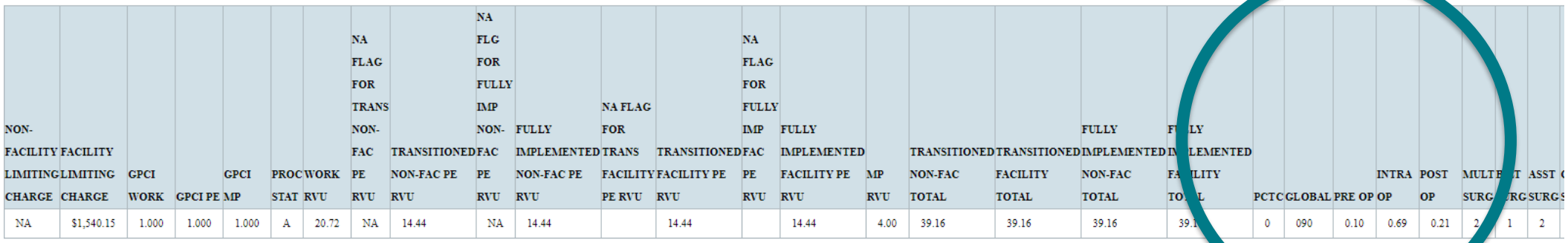
Physician Fee Schedule Search

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



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



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

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

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

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

Hypothetical Work Attribution for Total Hip Arthroplasty

27130	Global Surgical 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 wRVUs	$972.72 14.30 wRVU	$437.02 6.42 wRVU

CPT Code 99024

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

Captures post-op work provided in Global Surgical Package

PA Value = More than $

- Increase revenue and decrease health care costs
- Improve access to care and patient throughput
- Increase patient and staff satisfaction
- Contribute to process/quality improvement and outcomes
- Facilitate care coordination and communication

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Medicare Billing Policies

- Federal Law
- Hospital Conditions of Participation & Payment
- Medicare Administrative Manuals
- Medicare Interpretive Guidelines
- Medicare Administrative Contractors (MACs)

Admissions

- Based on “two-midnight” rule, it was mistakenly believed that CMS prohibited PAs from performing H&Ps or writing admission orders
- CMS issued clarification 1/30/14 acknowledging that PAs are authorized to write admission orders and perform H&Ps
- May be performed and billed under PA name/NPI (at 85%) or under physician name/NPI if split/shared rules met (100%)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R234BP.pdf

Admissions

- Every Medicare patient must be “under the care of a doctor”, which was demonstrated by signature or co-signature of the admission order
- Medicare guidance - physician co-sign admission order prior to patient discharge (1 day prior to submission of the claim if a CAH)

https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec482-12.pdf
https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf

Admissions

Effective 1/1/19, “no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment”

To cosign or not to cosign?

https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec482-12.pdf
https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf

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Discharges

- Time-based (< 30 min or ≥ 30 min)
- May be performed and billed under PA name/NPI (at 85%) or under physician name/NPI if split/shared rules met (100%)
- *Discharge Summary used to require cosignature by a physician within 30 days of discharge*

CMS clarified in correspondence to AAPA that a discharge summary does not need to be co-signed by a physician if the following criteria are met:

PA completing the d/c summary was part of the team responsible for the care of the patient while hospitalized

PA is acting within their scope of practice, state law, and hospital policy; and co-signature is not required by state law or hospital policy

PA authenticates the discharge summary with his or her signature (written or electronic) and the date/time

Although not required, surveyors may still look for co-signatures and cite hospitals for their absence until Medicare updates guidance documents.

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Consults

- Could be requested and performed by physicians and PAs/NPs but could not be billed as split/shared services
- Effective 1/1/10 Medicare eliminated consult codes
- No consult codes = no consult split/shared rules

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6740.pdf

Surgical Procedures

- PAs may personally perform and bill for minor surgical procedures

- Practitioner who does the majority of a procedure is the one under whom the procedure should be billed

Remember, procedures not eligible for split/shared billing

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2282CP.pdf

Assisting at Surgery

- PAs/NPs covered by Medicare for first assist
- At 85% of the physician's first assisting fee
  - Physician who first assists gets 16% of primary surgeon's fee – PAs/NPs get 13.6% of primary surgeon's fee
- -AS modifier for Medicare
- Be aware of list of exclusion codes (procedures for which assistant at surgery is used < 5% of the time nationwide)

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

Assisting at Surgery

- Physician must be physically present during all **critical or key portions** of the procedure and be immediately available during the entire procedure
- Critical portions of two surgeries performed by the same physician may not take place at the same time
- If physician not immediately available during non-critical portions, must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed

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

Whistle-blower files suit over alleged double-booked surgeries

Boston Globe

> Orthopedic surgeons at Massachusetts General Hospital repeatedly kept patients waiting under anesthesia longer — sometimes more than an hour longer — than was medically necessary or safe, as they juggled two or even three simultaneous operations, according to a federal lawsuit

that at least five surgeons endangered patients by regularly performing simultaneous surgeries. Wollman charges that the doctors also defrauded the government by submitting bills for surgeries in which they were not in the operating room for critical portions of procedures, leaving the work to unsupervised trainees.

https://www.bostonglobe.com/metro/2017/06/07/mgh-surgeons-left-patients-waiting-under-anesthesia-while-they-did-second-surgeries-whistle-blower-charges/QshFeHhRn92WOSwDEIi1LO/story.html

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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

Assisting at Surgery

Teaching Hospitals

When no qualified resident available

- Physician must certify

  I understand that § 1842(b)(7)(D) of the Act (follow the link and select the applicable title) 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 (in addition to –AS)

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

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

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Critical Care Services

3 criteria to bill critical care:

- Patient must be critically ill

  "acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition"

- Provider must treat the critical illness using "high complexity decision making"

  care must be provided at the bedside or on the floor/unit

- Time

  must spend at least 30 minutes

Critical Care Services

After first 30 minutes of critical care time

- Any additional care time is counted
- Time spent may be either continuous or intermittent and then aggregated
- Must document total time that critical care services were provided

The following two codes define critical care time:

- 99291 – 30-74 minutes of critical care on a given day
- 99292 - each additional 30 minutes of critical care

Critical Care Services

- PAs/NPs may provide services and receive payment
- More than one physician can provide critical care at another time and be paid if the service meets critical care, is medically necessary and is not duplicative care
- Critical care time provided by a physician and a PA/NP cannot be combined

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2282CP.pdf

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Critical Care Services

"Unlike other E/M services where a split/shared service is allowed the critical care service reported shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified non-physician practitioner and shall not be representative of a combined service between a physician and a qualified NPP [e.g. PA & NP]."

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

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Timothy Clark

On March 20, 2014, Chief United States District Court Judge Christopher Conner sentenced doctor Timothy Clark, age 47, to 15 months imprisonment for health care fraud and pension fraud.

Clark was ordered to pay restitution of $130,535.05 and forfeiture of $105,518.46.

On April 22, 2013, Clark pleaded guilty in federal court in Harrisburg.

Clark is a medical doctor and pulmonologist and the sole owner of Central Pennsylvania Pulmonary Associates(CPPA) and Sleep Disorder Centers of Central Pennsylvania. In June 2012 and again in July, Clark was indicted by a federal grand jury in Harrisburg in separate indictments.

In July 2012, Clark was indicted on charges that from December 2007 through September 26, 2008, Clark, who provided critical care services to patients of Holy Spirit Hospital, intentionally inflated the amount of time the healthcare providers he employed spent with each patient, thereby fraudulently inflating the health insurance claims Clark submitted to Medicare, Highmark, Inc., and Capital Blue Cross. The dollar amount of the fraudulent claims exceeded $500,000. In the

healthcare benefit programs in connection with the delivery and payment of healthcare benefits and money laundering.

The case involving the embezzlement from an employee benefit plan was investigated by the United States Department of Labor, Employee Benefits Security Administration, the United States Department of Labor, Office of Inspector General, the United States Department of Health and Human Service, Office of

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Restraint & Seclusion

Prior to December 2019
Medicare Conditions of Participation stated:

§ 482.13(e)(5) use of restraint or seclusion must be in accordance with the order of a physician or licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law

Licensed Independent Practitioner
An individual authorized to provide care and services without direction or supervision

Restraint & Seclusion

- CMS changed term "Licensed Independent Practitioner" to "Licensed Practitioner
- Effective November 29, 2019
- Resulted from ongoing AAPA advocacy

482.13(e)(5) use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law

NEW Joint Commission Elements of Performance Effective 3/15/20

PC.03.05.05

The hospital initiates restraint or seclusion based on an individual order.

Elements of Performance for PC.03.05.05

1. A physician~~, clinical psychologist,~~ or other authorized licensed ~~independent~~ practitioner ~~primarily~~ responsible for the patient's ~~ongoing~~ care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation.

Restraint & Seclusion

For PAs to order restraint and the following criteria must be met:

- Consistent with hospital bylaws and policies
- Included as part of a PA's scope of practice, practice agreement, and granted privileges
- Not prohibited by State laws or regulations

Student Documentation

Former CMS Policy

Only teaching physicians could use documentation in the medical record made by medical students

New CMS Policy

Physicians, PA and APRNs may review & verify, rather than redocument, information recorded by:

- Medical students, residents, and physicians
- PA and APRN students
- Other members of the medical team

Student Documentation

Caveats & Best Practices

- Must be allowed by hospital/facility policy
- Provider submitting claim for service should:
  - Personally examine & evaluate patient
  - Review & verify accuracy of student documentation
  - Sign & date note
    (with necessary, if any, updates to documentation)

May require changes to existing EHR software & programming

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Changes to Outpatient Documentation

- Based on 1995 and 1997 Guidelines
- Level of Service – determined largely by number of elements documented in history and examination

Outdated
Burdensome
Note Bloat

Changes to Outpatient Documentation

- 2019 Proposed Physician Fee Schedule
  - Sought to reduce documentation burden
  - Documentation would only need to be at a level 2 E/M visit, but . . .
  - 5 levels of E/M codes collapsed to 2
    (ex: proposed payment of $93 for established patient, whether being seen for f/u of pharyngitis or new onset atrial fibrillation)
- AMA and medical associations (including AAPA) proposed an alternative to CMS

Outpatient Level of Service Selection

Level of E/M service based on either:

The level of the MDM (Medical Decision Making)

Total time for E/M services performed on date of encounter

Effective
January 1, 2021

Applies only to
New & Established
Outpatient
Office Visits

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Components of Care	Outpatient Documentation Requirements
History	**As medically appropriate** (not used in code selection)
Examination	**As medically appropriate** (not used in code selection)
MDM*	**Amount and complexity of problems addressed and data reviewed**
Time	**Statement of specific time spent** (ex: total time spent on date of encounter is 22 minutes)

Only 1 required for billing purposes

***If billing based on time, still need to document as medically appropriate**

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Medical Decision Making for Office Visits

4 levels of MDM based on:

NUMBER & COMPLEXITY OF PROBLEMS

AMOUNT & COMPLEXITY OF DATA REVIEWED

RISK OF COMPLICATIONS, MORBIDITY & MORTALITY

Medical Decision Making for Office Visits

New & Established Patient E/M Codes	MDM
99201 & 99211	*n/a*
99202 & 99212	Straightforward
99203 & 99213	Low
99204 & 99214	Moderate
99205 & 99205	High

Medical Decision Making for Office Visits

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)

2 of 3 determine level of MDM

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Time Reporting for Office Visits

Total time spent on day of encounter

- Includes face-to-face time AND non face-to-face time of the clinician
- Will not have current requirement that ≥ 50% of encounter be counseling and/or coordination of care

Does not include

- Time spent by staff
- Time spent by the clinician for work before or after the day of encounter

Time Reporting for Office Visits

Examples of work that can contribute to time

- Evaluating and examining the patient
- Ordering medications, tests, or procedures
- Reviewing medial records and independently interpreting results (if not reported separately)
- Documenting in the health record
- Communicating with patients or family
- Communicating with other health care professionals
- Arranging care coordination

Time Reporting for Office Visits

New Patient E/M Code	Total Time (2021)
99201	*code deleted*
99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes

Established Patient E/M Code	Total Time (2021)
99211	*component n/a*
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

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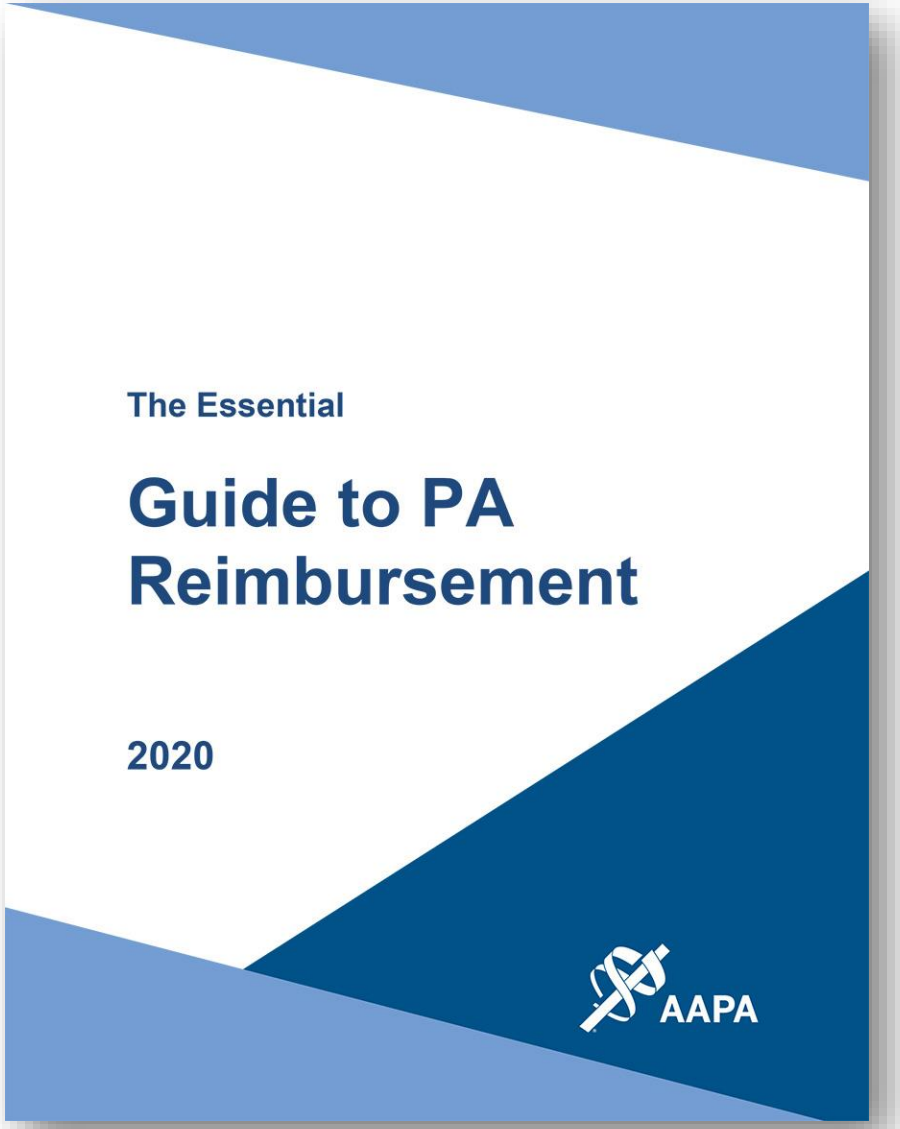
Learn more about office E/M documentation changes…

AAPA educational materials & resources at https://www.aapa.org/advocacy-central/reimbursement

Pending OIG Reports

- Assessment of inpatient hospital billing
- Billing for critical care services
- Post-op services in the global surgical period



$25 for members

https://www.aapa.org/shop/essential-guide-pa-reimbursement-2020/

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Additional References & Resources

- Medicare Claims Processing Manual
  - Chapter 12 – Physicians/Nonphysician Practitioners

    https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
  - Chapter 15 – Covered Medical and Other Health Services

    https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Code of Federal Regulations
  - Title 42 – Public Health

    https://www.ecfr.gov/cgi-bin/text-idx?SID=28cbafbbd980d94723375b715d900a73&mc=true&tpl=/ecfrbrowse/Title42/42tab_02.tpl

Key Takeaways

- PAs are valuable, cost-effective members of the healthcare team!
- Know Medicare laws and policies that affect your practice
- Understand implications of Medicare fraud and abuse, and how to avoid them
- Call on AAPA as a resource for guidance

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