PA Reimbursement Update

PAs in Orthopaedic Surgery
20th Annual Conference

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Michael L. Powe, Vice President
Reimbursement & Professional Advocacy

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American Academy of Physician Assistants

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

- **Medicare 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.**
- I am employed by the American Academy of PAs.
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Potential Dramatic Changes to Medicare Policy

2020 Proposed Physician Fee Schedule

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PA-Physician Relationship

- Medicare proposes to change its PA supervision policy to be in alignment with state law (collaboration, participating, other).
- Consistency with state law brings continuity within PA practice.
- 12 states currently have language other than supervision to describe the PA-physician relationship.
- Medicare policy would not override state law.
- Parity with NP Medicare policy.

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PA Preceptors & PA Student Contribution

- PA students' work can be used in the medical record of PAs, NP and physicians) for Medicare billing purposes similar to medical students.
- PAs can be preceptors (not teaching physicians) similar to physicians and use the work of students in the medical record for billing purposes.
- Expanded ability to use the work of other health professionals in the medical record.

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Rand Report on Surgical Post-op Visits

- CMS is concerned that there are fewer post-op visits being provided.
- If true, then CMS believes it is overpaying for post-op care in the global surgical bundle.
- Rand was hired by CMS to research the issue. Preliminary reports (9 states with practices of 10 or more health professionals) suggest fewer post-op visits.
- 10-day global surgeries show post-op visits approx. 4% of the time.
- 90 –day global surgeries show post-op visits approx. 71% of the time.

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Rand Report on Surgical Post-op Visits

- Reasons for lower reporting percentages?
  - Lack of reporting awareness
  - Don’t understand importance since no separate payment for post-op visits
  - Limited number of states participating
  - Care being provided by providers who are not part of the surgeon’s team
  - Surgeries performed at Centers of Excellence with patients returning to local health professionals for follow-up care

***Impact on first assist payments?

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Office-based E/M Documentation

- Medicare's documentation guidelines have not changed in over 22 years.
- Meeting documentation requirements by counting the number of organ systems or body areas reviewed/examined is outdated.
- There is a movement toward elevating medical decision making as being more central to documentation and visit levels.

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New Patient Office Visits

CPT Code New Office Visits	CY 2018 Non-Facility Payment Rate	CY 2019 Proposed Non-Facility Payment Rate
99201	$45	$44
99202	$76	$135
99203	$110	
99204	$167	
99205	$211	

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AAPA Had Serious Concerns with the CMS Approach

- Removes intensity of the service and challenges of cognitive assessment as a driver of payment.
- Could reimburse for a mildly symptomatic 20-year old patient with a complaint consistent with an upper respiratory track infection the same as a 65-year old patient with rheumatoid arthritis, hypertension, hyperlipidemia who has increased pain and redness in several joints with a low-grade fever for the last three weeks.
- Potential for unintended consequences (cherry picking healthier patients, asking patients to return for a second visit to treat additional issues).
- 170 societies including AAPA signed a letter asking CMS not to move forward with their proposal.

AMA-Sponsored Initiative to Respond to CMS Proposal

- Created new clinical scenarios (vignettes) to utilize documentation based more on medical decision making. Removal of history and exam as key components for selection of the E/M service level (still have to document that history and exam were performed).
- Goal is to make the scenarios clinically relevant to all specialties.
- Ensure that payment is based on intensity, complexity and/or time.
- Codes 99202-05 and 99211-15 will remain intact and each code level will have a payment amount similar to the current reimbursement scale; proposal to be submitted to CMS.

  (Note the proposed elimination of 99201)

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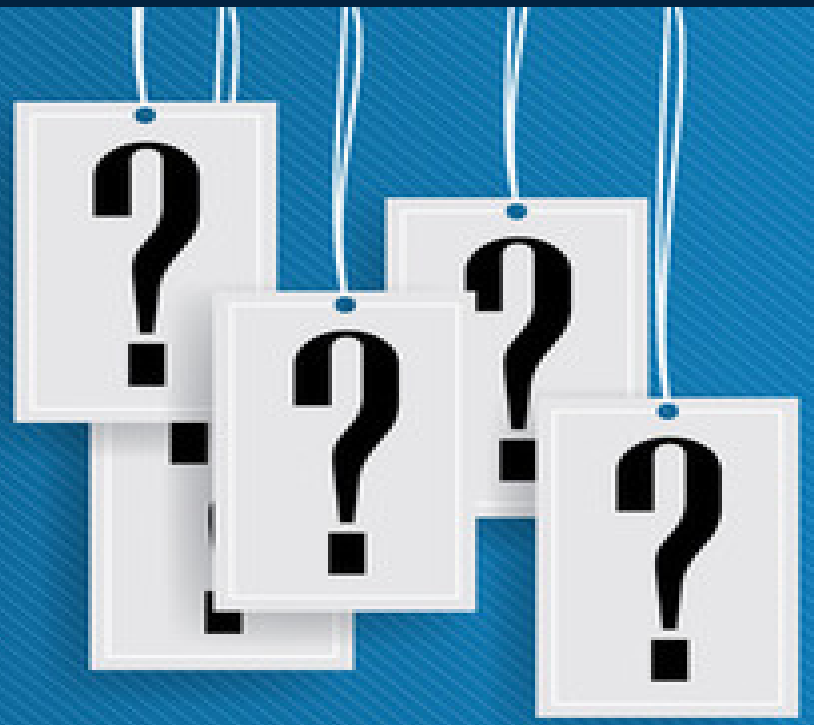
AAPA Concerns with Any Documentation Rule Changes

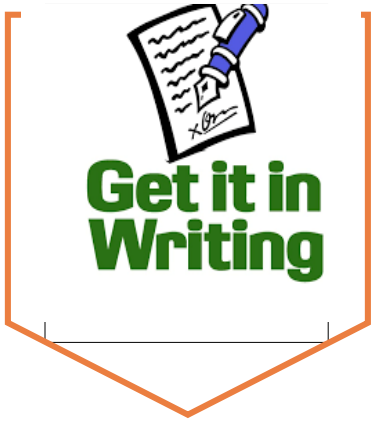
- What if Medicare changes its documentation requirements and commercial payers don't?
- Will the reduced amount of medical documentation regarding HPI and exam cause problems with medical liability/lawsuits?
- When/how will EHR systems be adjusted to reflect the new documentation standards?
- **Bottom line:** Documentation changes will go into effect until January 1, 2021.

How concerned do you need to be about billing and reimbursement?



Reduce Your Risk of Fraud and Abuse Allegations

Working with “Reimbursement Experts”



Get the facts. Ask for written policies, statutes, regulatory language and citations.

Don’t assume.

Realize that billing & reimbursement rules are subject to interpretation and can change frequently.

When in doubt, be conservative in your billing practices until the issue is clarified in writing with the payer.

Ultimately, those who **provide the care and submit claims for the service** are responsible for knowing and following the rules.

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Promise to the Federal Government

On the Medicare Enrollment Application

"I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization."

"I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity."

CMS 1500 form https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500.pdf

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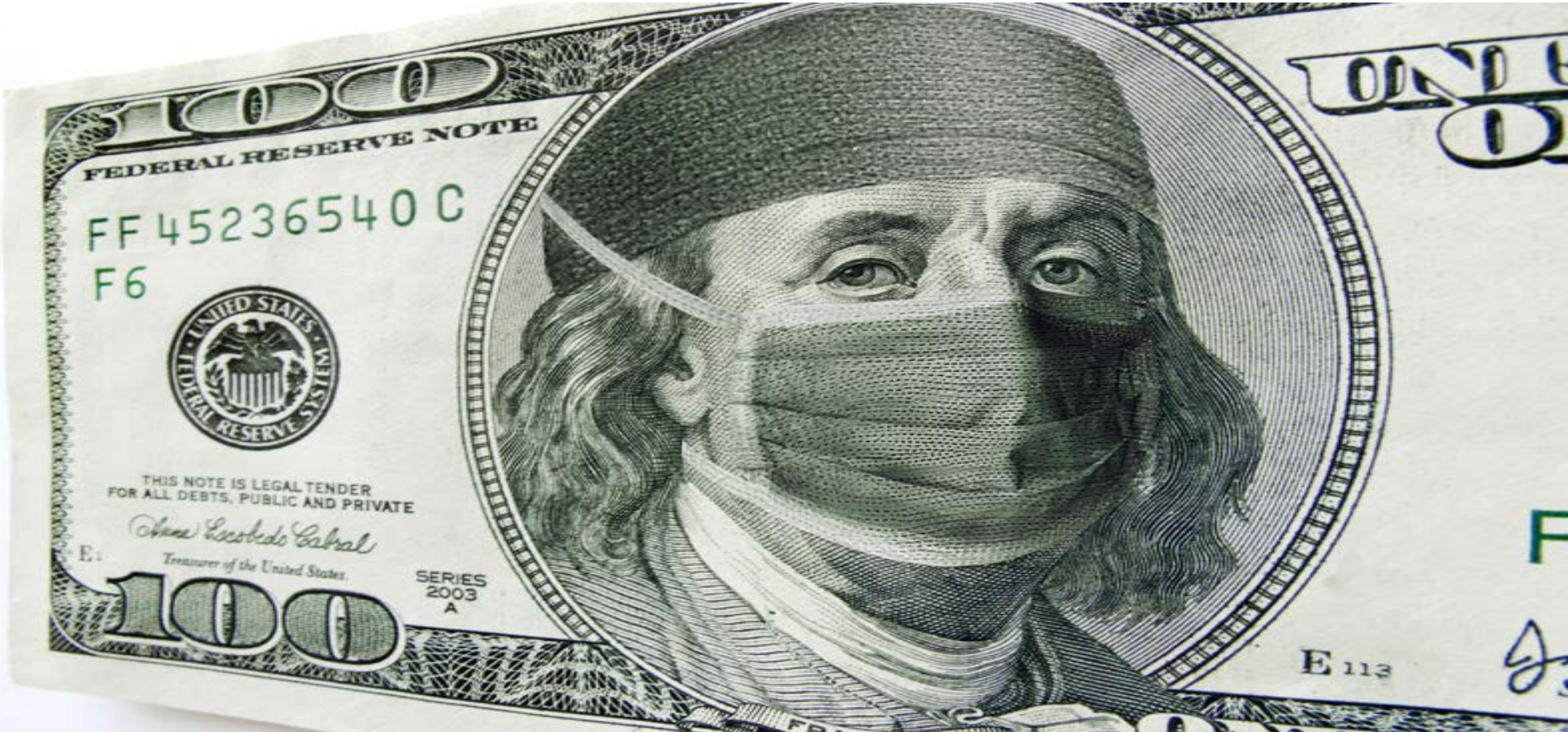
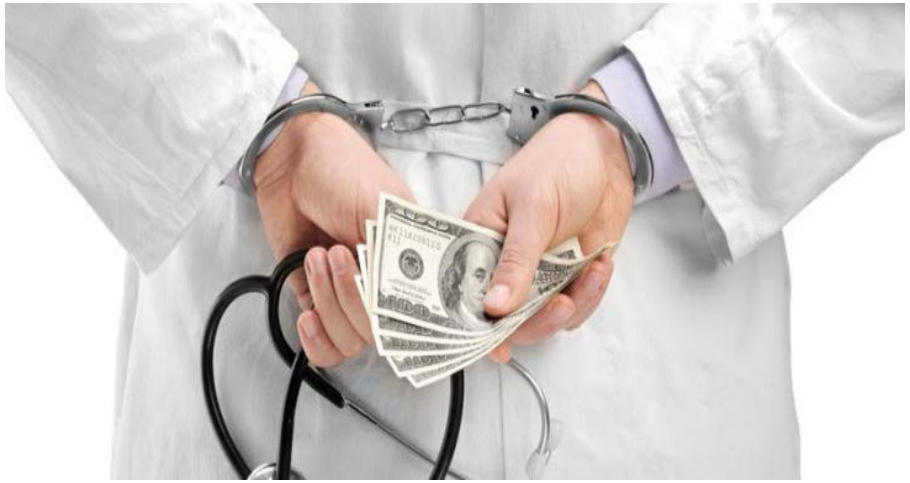
False Claims Act

- Imposes civil liability on “any person who **knowingly** presents, or **causes** to be presented a false or fraudulent claim for payment.”
- *Knowingly* includes actual knowledge that the information is false, acting 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.”

The Government is Watching



Government Fraud and Abuse Programs



- Revenue Audit Contractors (RAC)
- Office of Inspector General (OIG)
- HealthCare Fraud Prevention Enforcement Action Team (HEAT)
- Zone Program Integrity Contractors (ZPIC)
- Comprehensive Error Rate Testing (CERT)

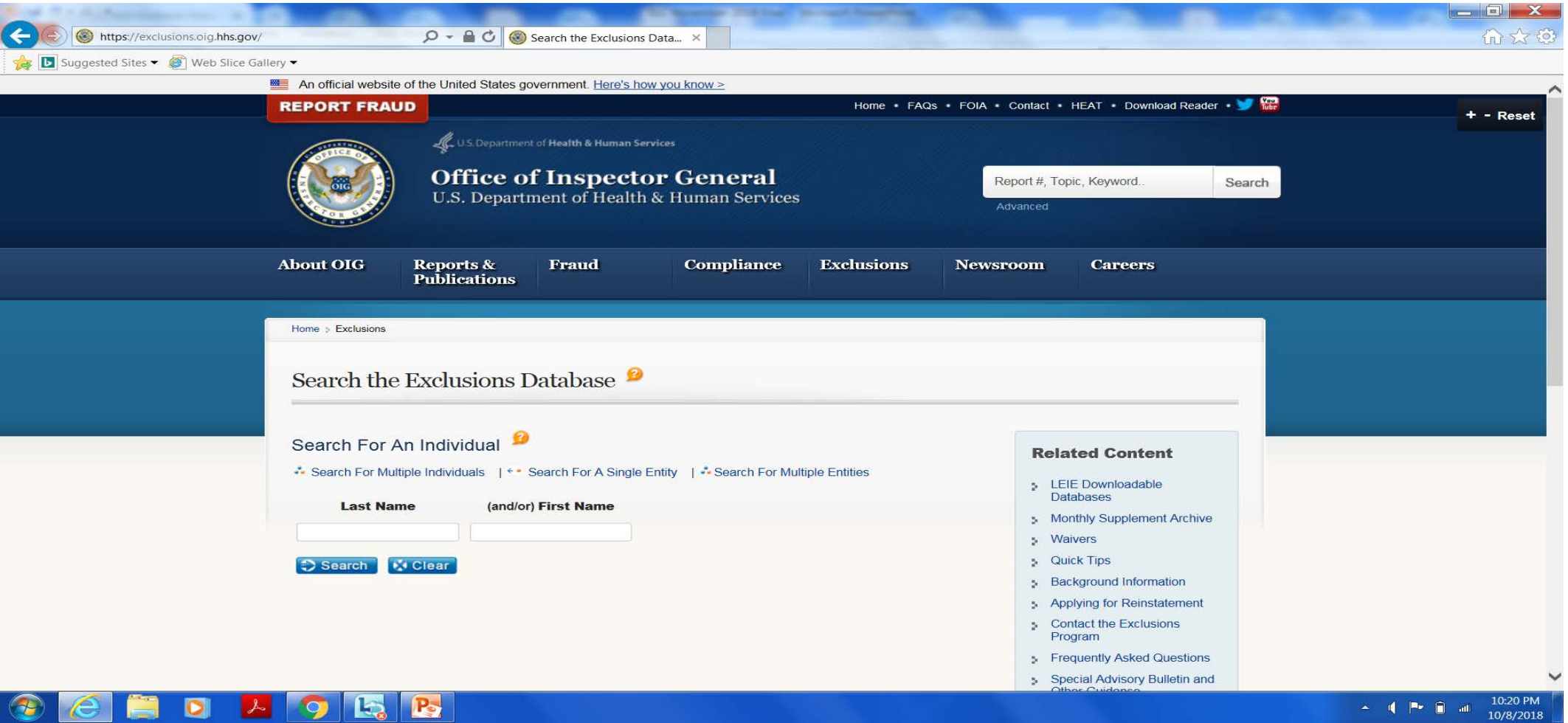
Fraud and Abuse

Potential Fraud and Abuse Penalties

- Take back of reimbursement dollars paid
- Civil monetary penalties (up to $22,363 per incident), in addition to treble damages.
- Exclusion from the Medicare, Medicaid, and other government-related healthcare programs and imprisonment.

List of Excluded Individuals/Entities

- https://exclusions.oig.hhs.gov/



But Don’t Leave Money on the Table

- Health professionals left over **$1.05 billion** on the table by undercoding claims in 2017, according to the annual **CMS Comprehensive Error Rate Testing report**.

- Downcoding visits means you are failing to maximize legitimate practice revenue.

- Technically, downcoding is non compliant. Fines for downcoding are rare, but not unheard of.

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Unique Concerns for Hospital-employed PAs

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

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

Only the PA's/NPs employer.

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

Only the PA's/NPs employer.

Appropriate leasing arrangements are an option when the physician with whom the PA/NP works is not the employer, and the physician wants to utilize the professional services of the PA/NP.

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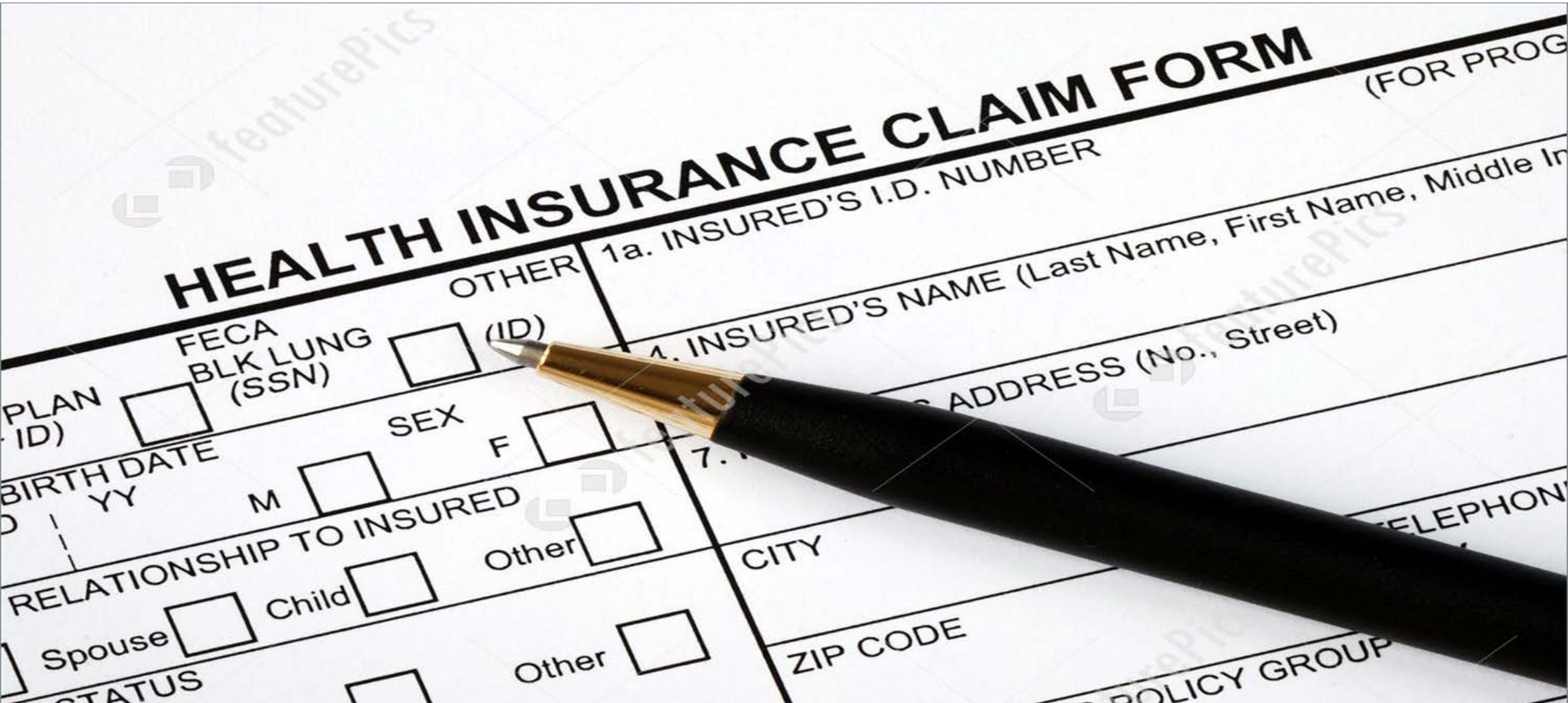
Payment to the Employer

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

  - Potential False Claims, Stark &Anti Kickback Violations

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

Medicare Billing Rules



Medicare

Part A	Part B	Part C	Part D
Hospital Facility Payments	Medical Services	Medicare Advantage Plans	Prescription Drug Coverage

Services and procedures provided by PAs, NPs and physicians

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Scope of Practice

"If authorized under the scope of their State license, PAs/NPs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests . . . "

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PAs

- May furnish services billed under all levels of E/M codes & diagnostic tests **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

- May furnish services billed under all levels of E/M codes & diagnostic tests **in collaboration** with a physician
- May bill under own name/NPI
- Reimbursed at 85%
- May receive direct payment – or reassign payment
- **Most NPs reassign payment as a condition of employment**

Medicare Billing Policy

- Medicare statutes
- Conditions of Participation & Payment
- Medicare Administrative Manuals
- Medicare Interpretive Guidelines
- Medicare Administrative Contractors (MACs)

Under Medicare: Physician Presence Not Required; PAs/NPs Bill at All E/M Levels

Medicare Benefit Policy Manual §190 Physician Assistant (PA) Services

"The physician supervisor need not be physically present with the PA/NP when a service is being furnished . . ."

Medicare Benefit Policy Manual Chapter 15, §190 Physician Assistant (PA) Services:

"PAs/NPs may furnish services billed under all levels of CPT evaluation and management codes . . ."

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Physician Involvement & Billing

Generally, having the physician greet the patient, stick his/her head in the exam room, co-sign the chart, or discuss the patient's care with the PA or NP does not lead to the ability to bill under the physician's name.

When a PA/NP performs a professional service there may be an opportunity to bill the service under the physician's name and NPI (e.g., Medicare' "incident to" or shared services billing)

Billing in the Office Setting

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Office/Clinic Billing under Medicare

- PAs/NPs can always treat new Medicare patients and new medical conditions when billing under their name and NPI with reimbursement at 85% following state law guidelines.

- Medicare restrictions (physician treats on first visit, physician must be on site) exist only when attempting to bill Medicare “incident to” the physician with payment at 100% (as opposed to 85%).

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

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“Incident to” Billing

- Allows a “private” **office or clinic**-provided service performed by the PA/NP to be billed under the physician’s name (payment at 100%) (*never used in hospitals or nursing homes unless there is a separate, private physician office – which is extremely rare*).

- Terminology may have a different meaning when used by private payers.

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

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“Incident to” Rules

- “Incident to” billing is an option, not required to be used.
- The PA/NP must be a W-2 employee, or have a 1099 Independent contractor) or leased arrangement.
- Requires that the physician personally treat the patient on their first visit for a particular medical condition/illness, and provide the exam, diagnosis and treatment plan (plan of care).

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“Incident to” Billing

Physician personally treats means that the physician personally performs:

- HPI
- Physical examination
- Medical decision making & treatment plan

Past, family and social history and the review of systems can be performed an ancillary personnel if reviewed and noted by the physician (and presumably chief complaint and history)

“Incident to” Billing

- The physician (or another physician in the group) must be physically present in the same office suite.
- Physician must remain engaged to reflect the physician’s ongoing involvement in the care of that patient.
- How is that engagement established? Physician review of medical record, PA/NP discusses patient with physician, or physician provides periodic patient visit/treatment.

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“Incident to” Billing

- Is there a requirement for the physician to co-sign the chart/medical record when a PA/NP delivers an “incident to” service?
- Nothing in national CMS policy requiring a physician co-signature each time the PA/NP treats a patient under “incident to.”
- However, always follow the specific requirements of your local Medicare Administrative Contractor.

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“Incident to” – New Problem

- Halfway through the exam, the patient tells you they have a new medical problem/condition.
- How is that new medical problem handled? Disrupt the physician’s schedule to diagnose and treat the new problem?
- You handle the new problem at 85%?
- Now you might have one medical problem billable under “incident to” and the other problem billable under the PA/NP at 85%.

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“ Incident to”

When must a Medicare claim have PA’s/NPs name and NPI ?

- New patients
- Established patients with new problems/changes to the treatment plan
- Physician is not physically present in the office suite
- In the hospital setting (except for “shared visits”)

www.cms.hhs.gov/MLNMattersArticles/downloads/SE0441.pdf

www.hgsa.com/newsroom/news09162002.shtml

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“Incident to” Billing

Pitfalls for employers:

- Increased risk for fraud and abuse audits and fines.
- Potential for less efficient practice styles (reimbursement schemes determine practice style instead of clinical efficiency).
- What appears to be maximizing reimbursement often isn’t (use the time of both the PA/NP and the physician effectively; reduce patient wait times; see a higher volume of patients).

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“Incident to” Billing

Pitfalls for PAs/NPs:

•Distorts the professional services that PAs (and NPs) deliver making PAs (and NPs) a “hidden provider.” There is no indication on claim form that a PA provided the service.

•Makes PA/NP productivity and return on investment difficult to measure.

•Potentially causes PAs (and NPs) to not be included in current Medicare value-based payment systems such as the Quality Payments Program.

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Is It Really a “Private” Office?

- Some confusion about the status of private offices that have been purchased by a hospital system.

- Is the site of service, for billing purposes, still a private office (POS 11) or an off-campus hospital (outpatient) department (POS 19)?

- Depends on attestation and meeting CMS criteria

https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/a03030.pdf

- If provider-based (POS 19) must operate under the same license as the hospital and be clinically integrated.

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Billing in the Hospital Setting

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Hospital Billing for PAs

- Services delivered by PAs are covered and reimbursed at 85% (billed at the full physician rate).
- Personal presence of the physician is not required.
- Generally, no requirement for physician co-signatures.
- Credentialing, privileging and hospital bylaws are in play for PAs.

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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 Rules

- Services provided must be **E/M services.**

  (does not apply to critical care services or procedures)

- Both PA/NP and physician must **work for the same entity.**

- Physician must provide a "**substantive portion**" and have **face-to-face** encounter with patient.

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

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Split/Shared Billing Rules

- Professional service(s) provided by the physician must be **clearly documented** with clear distinction between the physician's and the PA's/NP's services.

- Both the PA/NP and physician must treat the patient on the **same calendar day.**

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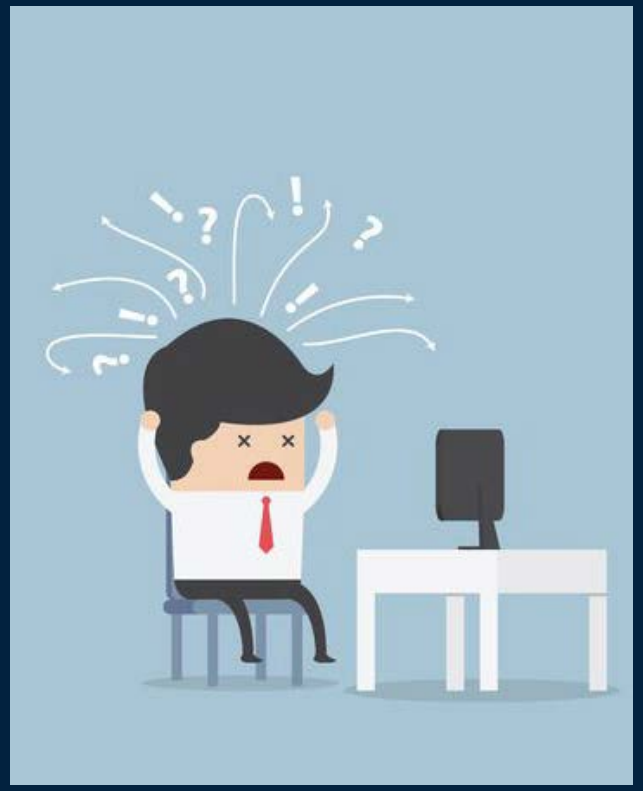
Split/Shared Billing

"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

Split/Shared Documentation



Documentation requirements vary significantly by MAC

- Physician must document at least one element of the history, exam and/or medical decision making (ex. CGS, NGS, Novitas)
- Physician need only document attestation of face-to-face contact with patient and that a substantive portion of service was performed (ex. Palmetto GBA, WPS)

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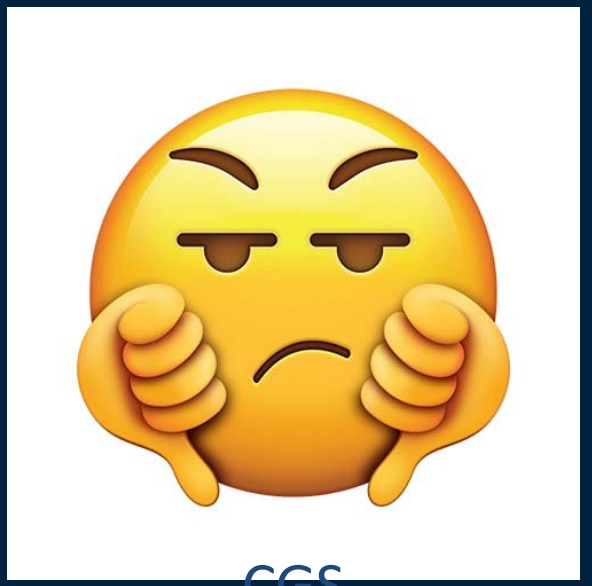
Split/Shared Billing

- “Agree with above,” signed by physician.
- “Patient seen and agree with above/plan,” signed by physician.
- “Seen and examined,” signed by physician.



CGS

https://www.cgsmedicare.com/partb/pubs/news/2013/1113/cope23908.html

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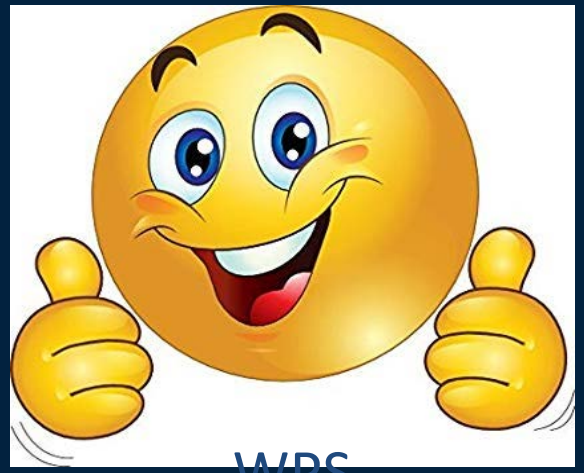
Split/Shared Billing

- “I have personally seen and examined the patient, reviewed the PA’s/NPs hx, exam, and medical decision making and agree with assessment and plan,” signed by physician.
- “Seen and examined and agree with above/plan,” signed by physician.
- “Seen and examined,” signed by physician.



WPS

https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/inpatient-split-shared-em-services/!ut/p/z0/jY1Na8MwEET_SnrwUaziQPDVLS0mxCTkUGxdipA39jbOStEqHz-_IudSehl4w2MGDHRg2N5otIk82zlzb9Zf-6ZZN8tKb3dlq3Xdfnyu3qvta3VYwgbM30JeKGP71o5ggk2TIj566MYrDSjK8qAiir9GhwIdcVYIOSkJM-WcbMRB4VkJxhs9Hejp-3IxNRjnOeEjQXcPsngCpwXyOJNMhU4-kFMudxgL7WZLZyn0b7-F_sdvOJm-kvrlBzbOiu8!

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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/NP for 85% reimbursement

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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/NP 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

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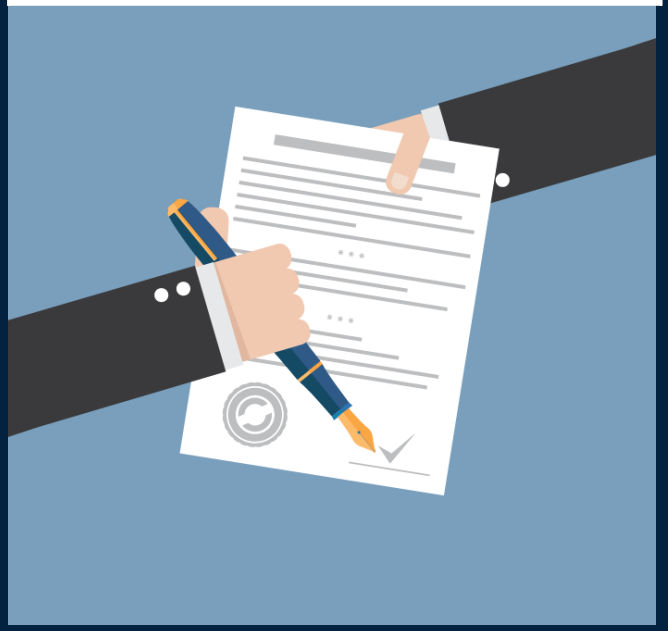
Admissions

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

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Discharges

- Time-based (< 30 min or ≥ 30 min).
- May be performed and billed under PA/NP 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.*

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

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

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

SURGICAL PROCEDURES &

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

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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

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Assisting at Surgery

- 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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Assisting at Surgery

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

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Procedures (Office or Hospital)

- PAs/NPs are covered for personally performing procedures and minor surgical procedures.
- Can’t be shared; must be billed under the name of the professional who personally performed the procedure.
- Physical presence of the physician is not material for billing.

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