We Are Family (Medicine)

Reimbursement 101: What You Need to Know

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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.**

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Disclosure

- I am employed by the American Academy of PAs.
- I have no commercial relationships to disclose.

Learning Objectives

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

- Describe the important Medicare reimbursement policy changes implemented for 2021
- Identify strategies to improve the recognition and tracking of the contributions and productivity of PAs and NPs in various specialties and practice settings
- Explain the unique role that PAs and NPs play in driving increased efficiencies and expanding access to care in new value-based payment models

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

Practicing Medicine Successfully Requires at Least a Basic Understanding of Reimbursement Issues

- Your greatest asset will always be your ability to treat patients in a professional, competent and compassionate manner.

- However, if you ignore the business aspects of healthcare you may put at risk your ability to practice.

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Benefits of Being Knowledgeable About Reimbursement Policies

- Finding or keeping a job
- Improving patient access to PA/NP-provided care
- Driving team efficiency and productivity
- Maximizing NP/PA value and appropriate revenue generation
- Avoiding allegations of fraud and abuse

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CMS Response to COVID-19

Flexibilities Authorized by CMS

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Medicare Flexibilities During the COVID-19 Public Health Emergency (PHE)

- The PHE is scheduled to expire April 20, 2021.
- PHE flexibilities expanded the availability of telehealth services, telephone visits, increased PA/NP roles in delivering care in skilled nursing facilities and hospitals, in addition to other opportunities.
- AAPA and AANP jointly asked CMS to make many of the COVID-19 flexibilities permanent to ensure increased patient access to care.

Examples of Flexibilities & Changes

Regulatory Change	Duration	Authority
Medicare patients do not need to be "under the care of a physician" and may be under the care of a PA/NP	Duration of PHE	Waiver
Physicians may delegate any tasks (such as physician-only requirements) in a SNF/LTCF to PAs/NPs	Duration of PHE	Waiver
PAs/NPs may provide required supervision of personnel performing diagnostic tests	Duration of PHE	IFC 5531

Sample of Flexibilities & Changes

Regulatory Change	Duration	Authority
PAs/NPs do not need to be licensed in the state they are performing services as a condition of Medicare payment (state laws still apply)	Duration of PHE	Waiver
Opted-out practitioners may terminate their opt-out status early and enroll as a Medicare providers	Duration of PHE	Waiver
Telehealth & telemedicine expansion and flexibilities	Duration of PHE	Waiver, IFC 1744, IFC 5531
Home Health & DME for PAs/NPs	Permanent	CARES Act, IFC 1744, IFC 5531

Recent Medicare Program Policy Changes for PAs/NPs

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Ordering/Certifying Home Health for Medicare Beneficiaries

- Legislation (CARES ACT) passed by Congress and signed by the President (effective 3/1/20) authorized PAs and NPs to order/certify home health under Medicare.
- Includes certification (ordering)/re-certification, developing and changing, as needed, the patient's plan of care.
- CARES Act also defers to state law, so PAs/NPs must ensure that state laws/regulations (including Medicaid program rules) authorize NPs/PAs to order.

https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

Medicaid

- The CARES Act also authorized state Medicaid programs to implement home health policies that mirror Medicare.
- A separate interim final rule made permanent the immediate authorization for NPs/PAs to order home health under Medicaid.
- States maintain final authority regarding authorizing PAs/NPs to order/certify home health within their Medicaid programs.

https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

PA/NP Supervision of Diagnostic Tests

- For years, Medicare policy authorized PAs/NPs to personally perform diagnostic tests (in accordance with state law).
- In the past, only physicians could supervise technicians/clinical staff who perform certain diagnostic tests.
- During the COVID-19 Public Health Emergency, CMS authorizes NPs/PAs to supervise personnel performing diagnostic tests.
- CMS permanently authorized PAs/NPs to supervise other individuals who perform diagnostic tests in the 2021 Physician Fee Schedule rule. Some question if this applies to supervising a diagnostic test state law doesn't authorize a PA/NP to perform.

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PA Medicare Direct Payment

- The Coronavirus Relief & Omnibus Agreement will authorize PAs to receive direct payment under Medicare beginning January 1, 2022.
- Provides increased flexibility for PA employment relationships and for PA owned practices and medical corporations.
- NPs already have direct Medicare payment.

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Medicare Office-based Evaluation & Management (E/M) Outpatient Documentation Changes for 2021

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Outpatient Level of Service Selection Based on Either

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

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 (MDM)

Levels of MDM based on:

- Number & Complexity of Problems Addressed
- Amount & Complexity of Data Reviewed
- Risk of Complications, Mortality or Morbidity

Medical Decision Making

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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Clinical Example #1

- Established patient, is in the office for a follow-up of his diabetes and hypertension. He is on metformin 500 mg BID and lisinopril HCTZ 20/12.5 mg QD. He is doing well and has no complaints. BPs (in office and at home) and last HgbA1C were within treatment goals.

- Assessment/Plan:
  - Controlled hypertension. Continue current medications. Obtain a basic metabolic profile.
  - Controlled diabetes. Continue current medication. Recheck HgbA1C.
  - Follow up in 6 months, sooner if needed.

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2021 Table of MDM for Example #1

99203 & 99213
Low

99204 & 99214
Moderate

99205 & 99215
High

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204 99214	Moderate	**Moderate** • 1 or more chronic illnesses with exacerbation	**Any combo of 3 of the following:** ***Review of each unique test (1)** ***Ordering of each unique test (2)** *** Review of each external note from unique source**	**Moderate risk of morbidity from additional diagnostic testing or treatment** **Example: RX Drug Management**

99205
99215
	High	**High**
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

2 or more stable chronic illnesses

https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Clinical Example #2

- Established patient, has advanced dementia, stable CAD, and controlled diabetes. You saw him one month ago for his CAD and diabetes, but he is in the office with his daughter to discuss prognosis and treatment options for his dementia.

- Assessment/Plan:
  - Advanced dementia. Continue current medication. Reviewed previous evaluation note by neurologist.
  - CAD and diabetes addressed at last office visit.
  - Follow up in 6 months, sooner if needed.

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2021 Table of MDM for Example #2

99203 & 99213
Low

99204 & 99214
Moderate

99205 & 99215
High

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem		**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213	Low	**Low** • 2 o • 1 o • 1		**Low risk of morbidity from additional diagnostic testing or treatment**

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
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99205
99215
	High	**High**
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

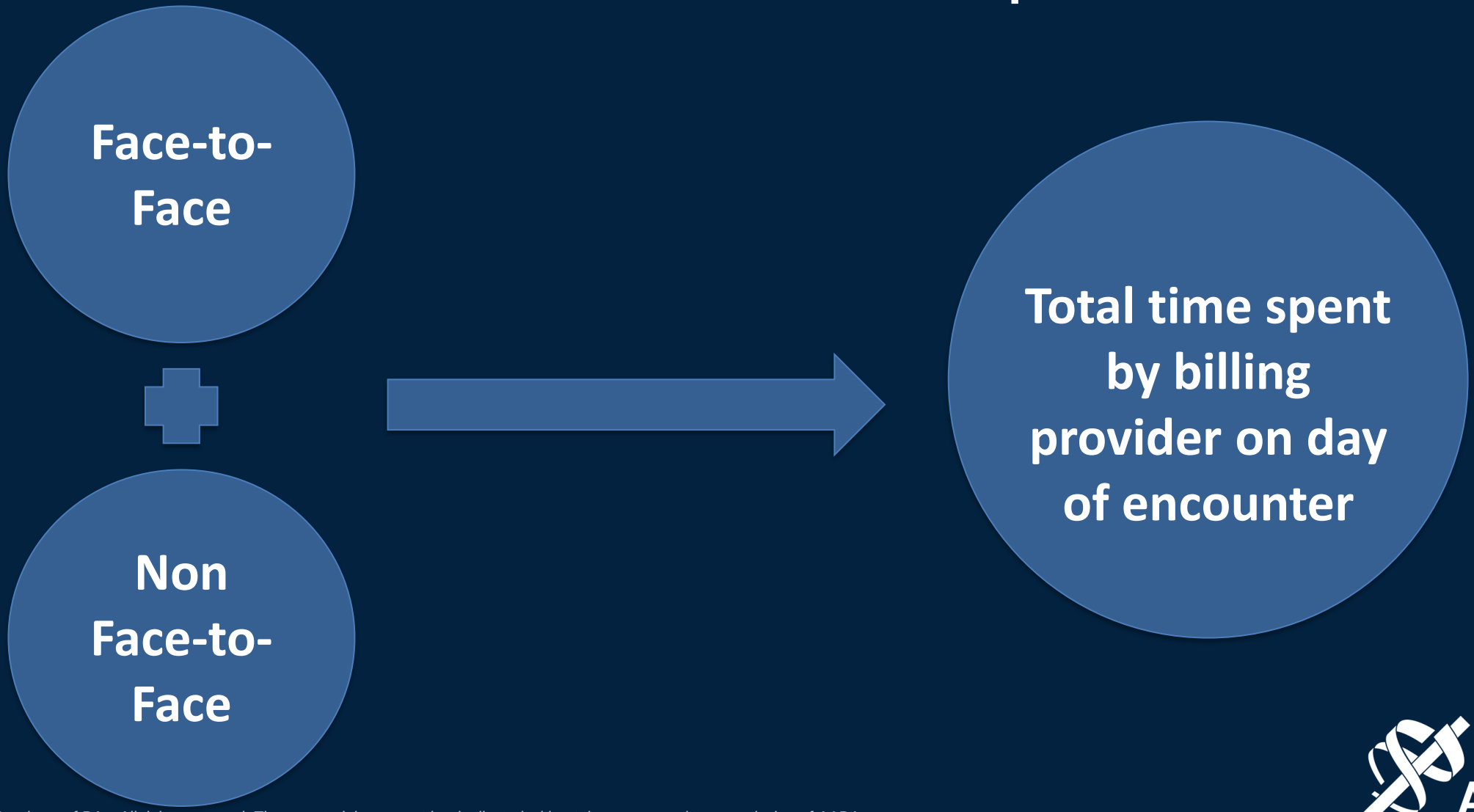
1 stable chronic illness

Any combo of 2 of the following:
***Review of each unique test**
***Ordering of each unique test**
***Review of each external note from unique source (1)**

Example: RX Drug Management

https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Time-Based Example



Clinical Example #2

But . . .

- 5 minutes prior to visit spent reviewing note from neurologist and other data in the EHR
- 20 minutes spent face-to-face with patient and daughter discussing prognosis and treatment goals/options
- 20 minutes after visit spent documenting in the EHR and completing home health plan of care and certification

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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

Additional Resources

- AAPA E/M Guidelines presentation now available on Learning Central
- AMA CPT E/M Office or Other Outpatient and Prolonged Services Code & Guideline Changes

  https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf
- AMA CPT E/M Office Revisions Level of MDM Table

  https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

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Reduce Your Risk of Fraud and Abuse Allegations

Promise to the Federal Government

On the Medicare Enrollment Application

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

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

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

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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.
- “Generally, **no proof of specific intent** to defraud is required to violate the civil FCA.”

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The Government is Watching

Government Fraud and Abuse Detection 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 (maximum of $22,927 per incident), in addition to treble damages.
- Exclusion from the Medicare, Medicaid, and other government-related healthcare programs and imprisonment.

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List of Excluded Individuals/Entities

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

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But Don’t Leave Money on the Table

- Billing for Medicare Part B services left an estimated **$250 million** on the table by undercoding claims in 2020, according to the CMS 2020 SUPPLEMENTAL IMPROPER PAYMENT DATA 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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Medicare Billing Rules

Medicare Billing Policy

- Medicare statutes/regulations
- Conditions of Participation & Payment
- Medicare Interpretive Guidelines
- Medicare State-specific Administrative Contractors (MACs)

Under Medicare: Physician Presence Not Required; PAs/NPs Bill All E/M Levels at 85% Reimbursement

Medicare Benefit Policy Manual §190 PA/NP Services

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

Medicare Benefit Policy Manual Chapter 15, §190 NP/PA services

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

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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 receive payment or work product for work provided by NPs/PAs unless the physician provides market rate compensation (e.g., renumeration/salary offset, leasing arrangement) for the PA's/NP's time.

- This requirement does not preclude NPs/PAs from working with physicians employed by a different entity. The issue is the flow of reimbursement.

  - Potential False Claims, Stark &Anti Kickback Violations

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

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“Incident to” Billing

“Incident to” Billing

“Incident to” is a ***Medicare billing provision*** that allows reimbursement for services delivered by PAs/NPs at 100 percent of the physician fee schedule, provided that all “incident to” criteria are met.

- “Incident to” billing only applies in the office or clinic. Does *not* apply in the hospital or skilled nursing facility setting.

- “Incident to” does not apply to commercial payers unless specifically detailed in policy.

“Incident to” Rules

- The physician must **personally** treat/examine the patient on the patient’s **initial*** visit for a particular medical problem and established the diagnosis and treatment plan.

*This requirements appears to be in transition. Evolving Medicare policy suggests physician involvement can occur after the initial visit to start the process of “incident to” billing.

- Each new medical problem/condition must be personally treated by the physician to create the potential of “incident to” billing with a PA/NP on the patient’s follow up visit.

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“Incident to” Rules (cont.)

- A physician (does not need to be the same physician who initiated treatment) must be on-site and within the suite of offices when the PA/NP renders care upon the patient’s return for follow-up treatment for the same problem.

- Physician can’t be across the street at the hospital (even if it is attached by a walkway). Availability by phone may meet state law guidelines, but not “incident to” requirements.

- PA/NP must be employed by the practice, leased to the practice or an independent contractor.

“Incident to” Rules (cont.)

Changes to plan of care:

- Previously, Medicare guidelines suggested any PA/NP change to treatment plans established by the physician meant “incident to” could not be utilized. That included medication changes or even changes in medications dosage.
- More current Medicare guidance suggests increased flexibility in PA/NP changes to the physician established plan of care.
- Check your local Medicare Administrative Contractor’s website policy for details in your particular state.

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“Incident to” Rules Cont.

- The physician must have some ongoing participation in the patient’s care.
- That ongoing participation should be noted in the medical record, in the event of an audit.
- If ALL requirements are met, encounter can be billed under physician’s NPI for 100% reimbursement.
- *If ANY “incident to” conditions are not met, bill under the PA’s/NP’s NPI with reimbursement at 85%.*

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Remember

- **PAs/NPs can treat new patients and established patients with new problems under Medicare.**

- When they do, the service must be billed under the NP's/PA's name and NPI number. Bill at 100% of the physician rate. Payment will be at 85%.

- When not billing "incident to," the physician need not see or treat the patient or be physically on-site; PA/NP must follow state law guidelines regarding collaboration/ required relationship with the physician, if any.

Billing in the Hospital Setting

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Hospital Billing for PAs

- Services delivered by PAs/NPs are covered and reimbursed at 85% (submit bill at the full physician rate).
- Personal presence of the physician is not required.
- Generally, no requirement for physician co-signatures.
- Hospital credentialing, privileging and bylaws must be followed.

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Hospital Billing for PAs – Shared Visit Billing Option

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

- Must meet specific Medicare criteria.

Split/Shared Billing Rules

- Services provided must be **E/M services.**
  (does not apply to critical care services or procedures)

- Both NP/PA 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 services.

- Both the PA or 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 by Medicare Carrier

- 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 Terms that We Discourage

- "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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More Acceptable 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.

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!

Performing Procedures

Performing Procedures - Office/Hospital

- PAs/NPs are covered for personally performing procedures (e.g., I&D, excision of lesion) and minor surgical procedures.
- Can’t be shared; must be billed under the name of the professional who personally performed the procedure.
- The physical presence of the physician is not required for billing.

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What about the 15% reimbursement differential between PAs/NPs and physicians?

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Office/Outpatient Visit: Established Patient

15%=$12.45

CPT Code	Work RVU	Non-facility Price* Physician	Non-facility Price* PA/NP
99213	0.97	$83.00	$70.55

Source: CMS Physician Fee Schedule
*National Payment Amount: actual practice amount will vary by geographic index

Subsequent Hospital Care

15%= $11.09

CPT Code	Work RVU	Non-facility Price* Physician	Non-facility Price* PA/NP
99232	1.39	$73.88	$62.79

Office-based Contribution Model Example

Assumptions:

- 15-minute appointment slots = 4 visits per hour = 28 visits per day
- 8-hour days (7 clinical hours worked per day)
- Physician salary $300,000; PA/NP salary $105,000
- 2,080 hours worked per year

(Does not include overhead expenses which would impact all health professionals).

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Cost-effectiveness at 85% Reimbursement

A Typical Day in the Office	Physician	PA/NP
Revenue with physician and NP/PA providing the same 99213 service	$2,324 ($83 X 28 visits)	$1,975 ($70.55 X 28 visits)
Wage per day	$1,152 ($144/hour X 8 hours)	$400 ($50/hour X 8 hours)
"Contribution margin"	$1,172	$1,575

Cost-effectiveness Take Away Points

- The point is not that PAs/NPs will necessarily produce more revenue than physicians.
- Most of the time that will not occur (although it can happen in primary care/internal medicine practices).
- However, NPs/PAs are a value add to the practice/facility in terms of revenue even when reimbursed at 85% of the physician level.
- An appropriate assessment of value includes both expense and revenue generation.

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The PA Value Proposition - ROI

- How PAs/NPs are utilized will determine their revenue generation capacity.
- Most NPs/PAs, when utilized appropriately, will more than cover their salary in revenue generated for the practice. PA/NP value in surgery, due to global bundled payments, must be calculated differently.
- Also consider opportunity costs. When NPs/PAs are handling patient care issues that are not separately billable (e.g., bundled post-op services, patient phone calls, ordering electronic prescriptions) the physician is able to provide additional revenue- generating services.

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Beyond Revenue Generation

- PAs/NPs increase access to the practice – reduce patient waiting time for appointments
- PAs/NPs provide post-op global visits, freeing up surgeons to see new patients, consults, and surgical candidate visits.
- PAs/NPs facilitate communications with patients, the hospital, and office staff.
- Essential to consider overall productivity/professional work whether revenue is produced or not.

Value-based Payments

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Value-based Payment (VBP) Models

- As opposed to basic fee-for-service payments, VBP includes:
  - Fee-for-service with payment incentives/penalties tied to quality; Medicare's Quality Payment Program/Merit-based Incentive Payment System
  - Accountable care organizations (ACOs); Medicare Shared Savings Program
  - Alternative payment models
  - Population-based payments

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Value-based Payment (VBP) Models

- Almost everyone supports the general concept of paying higher reimbursement for better quality care and improved clinical outcomes. The challenge is how to implement such a system in a fair and consistent manner.

- Practices participating in ACOs/certain VBP care models are responsible for the health outcomes and care costs of a defined, attributed population of individuals.

- Existing Medicare VBP programs such as MACRA and MIPS have not worked well due to the number of health professionals excluded from the programs and a reluctance to “financially punish” low performing professionals.

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Value-based Payment (VBP) Models

- Requires an increased use of meaningful, actionable data/analytics to demonstrate the attainment of improved patient outcomes.
- Many smaller to medium-sized practices, especially those not affiliated with an ACO, struggle to gather and manage the necessary patient data.
- Having patients appropriately attributed to PAs/NPs continues to be a challenge.
- Transparency is essential. We must know who is actually delivering care if quality is to be properly acknowledged. Practice patterns or billing systems that hide NP/PA care limit transparency.

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Value-based Payment (VBP) Models

- Requires clinically integrated teams with an interest in controlling costs, ensuring patient-centered quality care and monitoring data.
- Most effective when all health professionals practice to the top of their license, education and expertise.
- Results (quality increases and system savings) of VBP have been mixed.
- Despite movement toward VBP, some form of fee-for-service continues to be a major method of reimbursement.

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Overall Session Take Home Points

- Each PA/NP is responsible for protecting their ability to practice by knowing basic reimbursement policies and rules.
- Being able to articulate economic and non-economic contributions will enable NPs/PAs to demonstrate value to employers.
- Understanding Medicare's new reimbursements and scope of practice authorizations will expand your ability to deliver care to patients.
- Medicare's new office-based documentation guidelines will reduce the amount of time health professionals spend on electronic health record/medical record entries.

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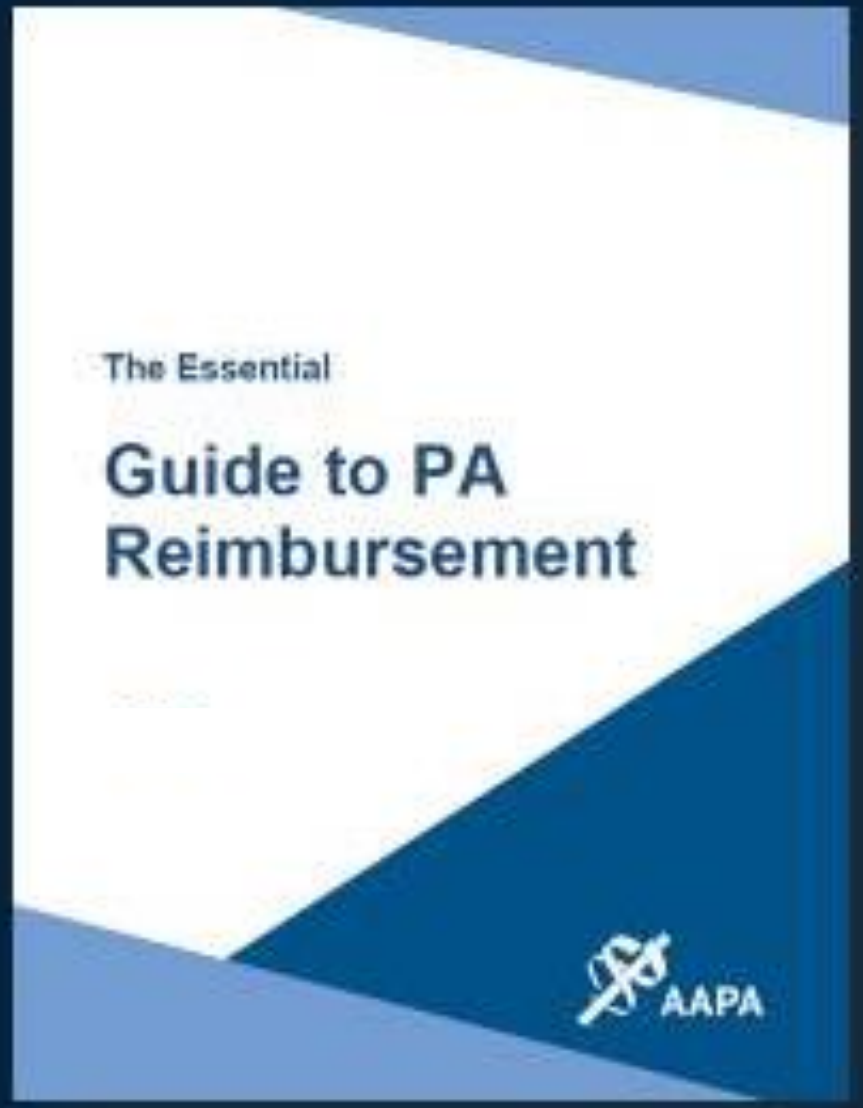

$25 for AAPA Members

Updated version will be available 2/15/2021

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AAPA Reimbursement Website

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

Reference Material

Additional References for Public Health Emergency Regulatory Flexibilities

1135 Waivers During COVID-19 Pandemic

- Coronavirus Waivers & Flexibilities

  https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

- 1135 Waiver – At A Glance

  https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/1135-Waivers-At-A-Glance.pdf

- Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

  https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

- COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

  https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

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https://www.aapa.org/download/66700/

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FEDERAL FLEXIBILITIES DURING COVID-19*		
PA Scope of Practice		
Regulatory Change	**Duration**	**Waiver or IFC**
PAs and other qualified practitioners may "certify, establish and periodically review the plan of care, as well as supervise the provision of items and services" for beneficiaries under the Medicare home health benefit	Permanent	IFC 5531
PAs and other qualified practitioners may order durable medical equipment and order home health services, establish the plan of care, and perform the required face-to-face visit under Medicaid	Permanent	IFC 5531
Medicare patients do not need to be "under the care of a physician" and may be under the care of a PA or another qualified practitioner	Duration of PHE	Waiver
A physician need not be physically present at a Critical Access Hospital and can, instead, provide supervision and direction remotely to PAs and other qualified practitioners	Duration of PHE	Waiver
Required "physician visits" in Long Term Care Facilities may be performed by PAs and other qualified practitioners	Duration of PHE	Waiver
Physicians may delegate any tasks (such as physician-only requirements) in a Skilled Nursing Facility to PAs and other qualified practitioners	Duration of PHE	Waiver
PAs and other qualified practitioners may provide required supervision of personnel performing diagnostic tests	Duration of PHE	IFC 5531
Clarified ability of PAs to write progress notes in psychiatric hospitals and changed related Conditions of Participation regarding qualified clinicians from "licensed independent practitioner" to "licensed practitioner"	Permanent	IFC 1744

General Flexibilities		
Regulatory Change	**Duration**	**Waiver or IFC**
Physicians, PAs, and other qualified practitioners do not need to be licensed in the state they are performing services as a condition of Medicare payment	Duration of PHE	Waiver
Physicians, PAs, and other qualified practitioners credentialed at a dialysis facility may provide care at designated isolation locations without the need for separate credentialing or medical staff appointment	Duration of PHE	Waiver
Opted-out practitioners may terminate their opt-out status early and enroll as a Medicare providers	Duration of PHE	Waiver
"Direct supervision" can be provided using real-time interactive audio and video technology	Duration of PHE	IFC 1744
A billing practitioner, whether or not they are acting in a teaching role, may review and verify ("sign and date") rather than redocument any information made in the medical record by any practitioner, student (regardless of clinical discipline), or other member of the medical team	Duration of PHE	IFC 5531
Clarification that pharmacists may provide services "incident to" PAs and other qualified practitioners	Permanent	IFC 5531

Telehealth & Telemedicine		
Regulatory Change	**Duration**	**Waiver or IFC**
Telehealth services may be furnished to patients wherever they are located, including the patient's home	Duration of PHE	IFC 1744
An interactive telecommunication system means any communication equipment that includes two-way, real-time audio and video communication, including a patient's personal computer or smartphone	Duration of PHE	IFC 1744
Penalties waived for HIPAA violations against health care providers that serve patients in good faith through everyday communication technologies, such as FaceTime or Skype	Duration of PHE	IFC 1744
Practitioners may render telehealth services from their homes without reporting the home address on their Medicare enrollment and may continue to bill with their enrolled location	Duration of PHE	Waiver
Remote evaluations, virtual check-ins, and e-visits may be provided to new (not just established) patients	Duration of PHE	Waiver
Audio only communication is allowed for telephone E/M services, behavioral health counseling, and educational services	Duration of PHE	Waiver
Payment for telephone only E/M services, CPT codes 98966-98968 and 99441-99443	Duration of PHE	IFC 1744
Crosswalk payment and RVUs for CPT codes 99441-99443 with office/outpatient E/M services CPT codes 99212-99214	Duration of PHE	IFC 5531
Expanded services that may be provided via telehealth, such as Nursing Facility and Skilled Nursing Facility visits, emergency department visits, critical care services, etc.	Duration of PHE	Waiver
Providers may reduce or waive cost-sharing for telehealth visits paid by federal health care programs	Duration of PHE	Waiver

***Must be consistent with State laws and regulations, scope of practice, hospital/facility bylaws and policies, and granted privileges, as applicable.**

References

Waivers: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
IFC 1744: https://www.cms.gov/files/document/covid-final-ifc.pdf
IFC 5531: https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

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Medicare changes to telehealth requirements during the COVID-19 pandemic		
Element	**Usual Requirement**	**Exemption during Pandemic**
Qualified Providers	Physicians, PAs, APRNs, Clinical Psychologists, Clinical Social Workers, Registered Dieticians	No Change
Eligible Beneficiaries (aka Relationship Requirement)	Limited to beneficiaries with an established relationship with a provider	HHS will not enforce the requirement that a patient be established with the provider
Originating Site (location where a Medicare beneficiary is receiving telehealth services)	Rural areas and in a medical facility. A patient's home is not usually an allowable originating site.	Telehealth services may be performed in all locations and settings, including a patient's home.
Distant Site (location of the provider)	No restrictions but location(s) must be enrolled through PECOS.	Practitioners may "render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location."
Equipment	Secure telecommunication technology with audio AND visual, two-way, real-time interaction.	HHS has authorized the use of telephones and devices that have audio/video capabilities. Video requirement has not been waived. Office for Civil Rights will waive penalties for HIPAA violations for providers serving patients in good faith through available communication methods, such as FaceTime or Skype.
Cost	Medicare beneficiaries are liable for deductible and coinsurance.	Providers may reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.
Approved Services	Covered telehealth services	Expanded

https://www.aapa.org/download/62597/