LEADERSHIP AND ADVOCACY SUMMIT
LEAD. ENGAGE. INSPIRE.

Trending Topics in #PA_Reimbursement

Michael Powe
Vice President, Reimbursement & Professional Advocacy, American Academy of PAs

Trevor Simon, MPP
Director, Regulatory Policy, American Academy of PAs

AAPA

Disclaimer

- This presentation does not represent payment or legal advice.
- Payer guidelines differ and regulations can change.
- It is your responsibility to understand and apply reimbursement and payment rules relative to your particular state, practice setting and payer.
- The American Medical Association has copyright and trademark protection of CPT.

Disclosure

- We are employed by the American Academy of PAs

LEADERSHIP AND ADVOCACY SUMMIT

LEAD. ENGAGE. INSPIRE.

PAs and the Public Health Emergency (PHE)

Trevor Simon, MPP

Director, Regulatory Policy, American Academy of PAs

AAPA

PHE Response to Healthcare Needs

LEADERSHIP AND ADVOCACY SUMMIT

- **Federal Response**

1135 Waivers

Interim Final Rules

PREP Act Declarations

Coronavirus Aid, Relief, and Economic Security (CARES) Act

Coronavirus Relief & Budget Omnibus Act

- **Many State practice requirements suspended or waived**

AAPA

1135 Waivers During COVID-19 Pandemic

LEADERSHIP AND ADVOCACY SUMMIT

- Many “blanket waivers” issued for healthcare professionals and hospitals/facilities
- Section 1135 of the Social Security Act authorizes the Secretary of HHS (under certain circumstances) to temporarily waive certain Medicare, Medicaid, CHIP, and HIPAA requirements
- Retroactive to March 1, 2020 and end “no later than when the emergency declaration's ended”
- Temporarily* relaxes regulations to provide flexibility to help beneficiaries access care

* The Administration stated the PHE is likely to remain in place through 2021

AAPA

Interim Final Rules

LEADERSHIP AND ADVOCACY SUMMIT

- Issued when good cause to issue a final rule without first publishing a proposed rule
- Effective immediately upon publication
- May be altered if warranted by public comment

IFC 1744
March 2020

IFC 5531
April 2020

AAPA

Public Readiness and Emergency Preparedness (PREP) Act

LEADERSHIP AND ADVOCACY SUMMIT

- Provides immunity from liability (except for willful misconduct) for entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of medical “countermeasures” (as defined in a PREP Act Declaration)

- 4th Amendment to the Act
  - Authorizes healthcare providers who are permitted to order/administer a ‘covered countermeasure’ through telehealth in a state to do so for patients in any state by means of telehealth (in compliance with requirements of the state in which the license is held)

- 5th Amendment to the Act
  - Authorizes healthcare professionals to prescribe, dispense, and administer COVID-19 vaccines in any state

AAPA

Coronavirus Aid, Relief, and Economic Security (CARES) Act

LEADERSHIP AND ADVOCACY SUMMIT

- Bipartisan legislation signed into law on March 27, 2020

- Included > $2 trillion economic relief package and important amendment to Social Security Act related to Home Health benefit (discussed later)

Sample of Flexibilities & Changes

LEADERSHIP AND ADVOCACY SUMMIT

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 or another qualified practitioner	Duration of PHE	Waiver
Physicians may delegate any tasks (such as physician-only requirements) in a SNF/LTCF 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

AAPA

Sample of Flexibilities & Changes

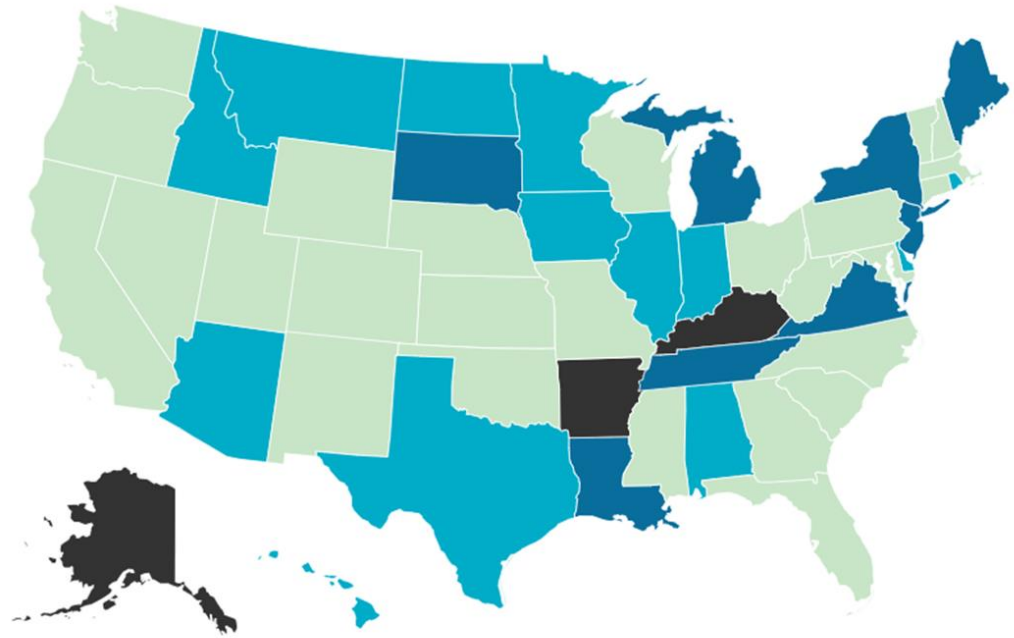
LEADERSHIP AND ADVOCACY SUMMIT

Regulatory Change	Duration	Authority
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
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	Permanent	CARES Act, IFC 1744, IFC 5531

APA

Interactive Map of Suspended/Waived Practice Requirements by State

LEADERSHIP AND ADVOCACY SUMMIT



- Suspension/waiver of supervision requirements by Executive Order
- Suspension/waiver of all or partial supervision requirements by existing statute or regulation
- Only suspension/waiver of select practice requirements (licensure, ratios, telemedicine, etc.)
- No action taken

https://www.aapa.org/news-central/covid-19-resource-center/covid-19-state-emergency-response/

AAPA

- New ‘COVID-19 Treatment & Management’ section
- New ‘Health Equity’ section
- Updated Policy resources
- Updated CME
- And more!

https://www.aapa.org/news-central/covid-19-resource-center/

Medicare Telehealth & Telemedicine – A Primer

LEADERSHIP AND ADVOCACY SUMMIT

Telehealth – services performed via interactive audiovisual telecommunications in real-time

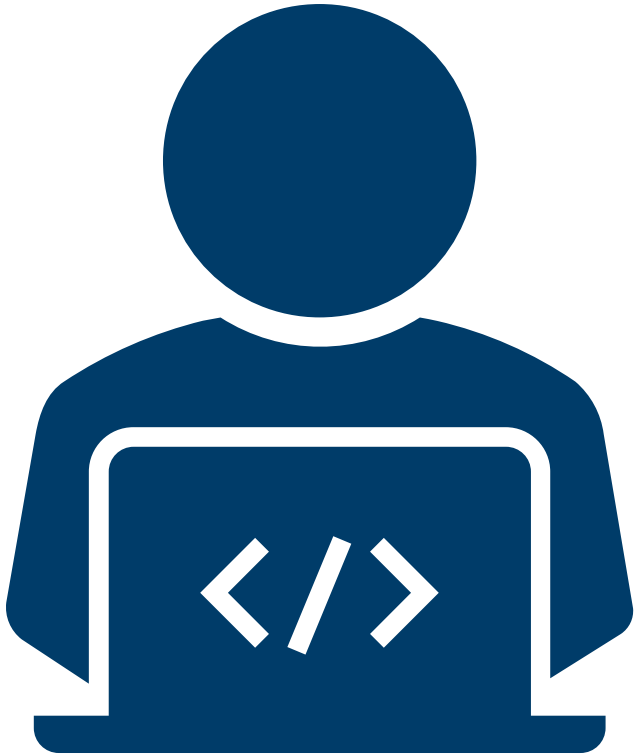
Telemedicine – services involving asynchronous (store-and-forward) or telephone-only interaction

Originating Site – location of the beneficiary

Distant Site – location of the provider

AAPA

Medicare Telehealth Visits During COVID-19



- Patients may be new or established
- Patient may be located anywhere, including their home
- Patient may use smart phone/device or personal computer (video requirement not waived)
- Similar services that would be provided during in-person visits
- Paid at same rate as in-person visit
- Coinsurance and deductibles may be waived

Examples of Services Usually Covered as Telehealth
Office/outpatient visit new (CPT® codes 99201-99205)
Office/outpatient established (CPT® codes 99211-99215)
Subsequent hospital care (CPT® codes 99224-99226)
Subsequent observation care (CPT® codes 99224-99226)

Examples of Expanded Services Temporarily Covered as Telehealth

Emergency department visits (CPT® codes 99281-99285)
Initial hospital care and (CPT® codes 99221-99223)
Hospital discharge day management (CPT® codes 99238- 99239)
Critical care services (CPT® codes 99291-99292)
Initial and subsequent observation and observation discharge day management (CPT® codes 99217- 99220; CPT® codes 99224- 99226; CPT® codes 99234- 99236)
Initial nursing facility visits and nursing facility discharge day management (CPT® codes 99304-99306; CPT® codes 99315-99316)
Home visits, new and established (CPT® codes 99341- 99345; CPT® codes 99347- 99350)

Medicare Telehealth & Telemedicine During COVID-19

LEADERSHIP AND ADVOCACY SUMMIT

CMS waived requirements for Medicare payment that out-of-state providers be licensed in the state where they are providing services (with license in another state)

HOWEVER

Unless State waivers are granted, telehealth and telemedicine must be provided in accordance with State laws and regulations

AND

Must be in accordance with institutional policies, practice agreements (if applicable), malpractice coverage

AAPA

Medicare changes to telehealth requirements during the COVID-19 pandemic

Elements	Usual Requirement	Exemption During Pandemic
Documentation	Based on 1995 or 1997 documentation criteria.	For office/outpatient E/M: • Level of service may be based on time or medical decision making • No requirements regarding documentation of history or examination (but should be based on necessity for quality & continuity of care)

Medicare Telehealth Visits During COVID-19

LEADERSHIP AND ADVOCACY SUMMIT

- For non-Office/Outpatient Telehealth Visits:
  - Documentation requirements have not been changed
  - Document that service performed via audio/visual technology and limitation of examination due to telehealth
  - May document pertinent observations
    - Patient appears in no acute distress
    - Respirations appear non-labored, with no accessory muscle use
    - Patient is oriented to person, place, and time

AAPA

Medicare Telehealth Visits During COVID-19

LEADERSHIP AND ADVOCACY SUMMIT

Submit claim as follows:

- With place of service (POS) indicating where the service would have been had the service been in-person
- Along with modifier 95, indicating that the service rendered was performed via telehealth

LEADERSHIP AND ADVOCACY SUMMIT

LEAD. ENGAGE. INSPIRE.

Home Health and PAs

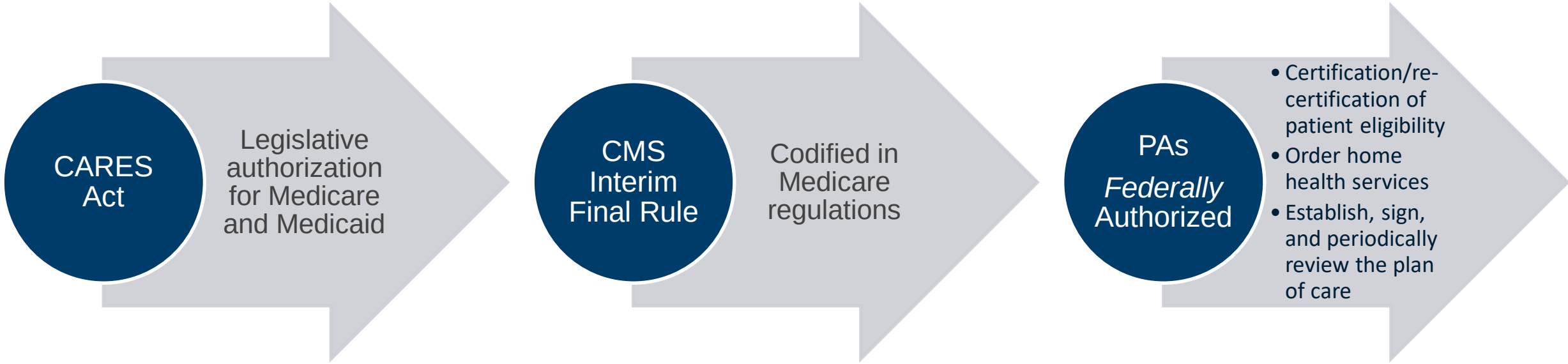
Trevor Simon, MPP

Director, Regulatory Policy, American Academy of PAs

AAPA

PAs and Home Health – Pre-2020

- Historically, policies pertaining to PAs and advanced practice registered nurses (APRNs) for home health were restrictive.
- PAs and APRNs were able to provide face-to-face visit prior to certification of a patient's eligibility and provide certain care plan oversight services
- Only a physician could certify or recertify a patient's eligibility for home health care and sign the patient's plan of care



But the work is not done. The advocacy focus has shifted from Federal to State

Possible Conflicts Between Medicare Policy, State Law/Regulations and Medicaid Rules

LEADERSHIP AND ADVOCACY SUMMIT

- CARES Act and CMS regulations defer to state law
- PAs must ensure that state laws/regulations (including Medicaid rules) contain no PA-restrictive or physician-centric home health language
- AAPA is aware that many states still have such language in state law

AAPA

What this means for Durable Medical Equipment

- PAs and APRNs have long been authorized by Social Security Act to order DME for Medicare beneficiaries
- Prior to 2020, authority unclear for Medicaid beneficiaries
  - No stand-alone category for DME in Medicaid statute, included in home health benefit
- Recent changes should address the issue, but state law and Medicaid language may still need to be changed

LEADERSHIP AND ADVOCACY SUMMIT

LEAD. ENGAGE. INSPIRE.

New Flexibilities? Not so fast!

Trevor Simon, MPP

Director, Regulatory Policy, American Academy of PAs

AAPA

Important Caveat

- There have been many regulatory victories
- These regulatory victories have largely been federal changes
- HHS/CMS still defers to state law

What does this mean?

Deference to State Law

There may still be state laws and regulations that prohibit you from utilizing recently authorized federal flexibilities

What Can Be Done?

- State chapters can identify if any such limitations exist
- Begin legislative or regulatory efforts necessary to remove prohibitive language

LEADERSHIP AND ADVOCACY SUMMIT

LEAD. ENGAGE. INSPIRE.

Diabetic Shoes and PAs

Trevor Simon, MPP

Director, Regulatory Policy, American Academy of PAs

AAPA

Therapeutic Shoes

Social Security Act § 1861(s)(12) provides coverage for therapeutic shoes and inserts for persons with diabetes if:

- Certified to be medically necessary by a physician
- Patient's diabetes is being managed by a physician

new Coverage determination, effective November 2020

Therapeutic Shoes – New Coverage Determination

LEADERSHIP AND ADVOCACY SUMMIT

- PAs and NPs may serve in the role of "certifying physician" ONLY if practicing **"incident to"** a supervising physician and **"certifying requirements"** are met.

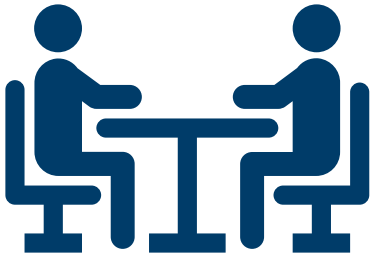
- PA/NP must certify that therapeutic shoes are part of the comprehensive treatment plan for diabetes

Therapeutic Shoes – Ongoing physician involvement

LEADERSHIP AND ADVOCACY SUMMIT

The Physician Must

- Personally treat patient and establish the diagnosis
- Provide ongoing care to patient under a “comprehensive management program”
- Be physically present in the office when services by PA/NP are performed
- Review and verify (sign and date) all PA/NP notes in medical record pertaining to the provision of the therapeutic shoes AND acknowledge agreement with actions of the PA/NP



AAPA

LEADERSHIP AND ADVOCACY SUMMIT
LEAD. ENGAGE. INSPIRE.

PAs and the Supervision of Diagnostic Tests

Trevor Simon, MPP
Director, Regulatory Policy, American Academy of PAs

AAPA

Diagnostic Tests – The Context

LEADERSHIP AND ADVOCACY SUMMIT

- For Medicare payment, diagnostic tests must be performed with a specified level of supervision

General – under general direction of supervisor

Direct – supervisor presence in the office and immediately available

Personal – supervisor in attendance in the room

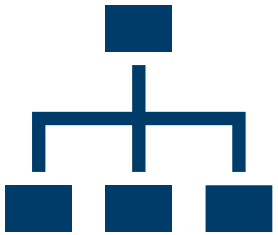
- PAs and APRNs can perform diagnostic tests under "general" physician supervision <u>when they personally perform</u> the tests

AAPA

Diagnostic Tests – The Problem and the Change

- Although PAs and APRNs could order diagnostic tests and perform diagnostic tests under general supervision, they could not provide the required level of supervision to others performing a test
- Supervision of diagnostic tests could only be provided by a physician

- The 2021 Physician Fee Schedule final rule contained language to authorize PAs and APRNs to supervise clinical staff who perform diagnostic tests when direct supervision is required
- Must be consistent with State law, scope of practice, and facility policy



Diagnostic Tests – Continued Caveats

LEADERSHIP AND ADVOCACY SUMMIT

- PAs and APRNs are still **not** authorized to provide “personal” supervision of clinical staff

- PA and APRN “direct” supervision may also be limited due to unchanged regulatory language
  - Physician direct supervision still required for some tests such as advanced diagnostic imaging

LEADERSHIP AND ADVOCACY SUMMIT

LEAD. ENGAGE. INSPIRE.

Medicare Direct Pay for PAs

Michael Powe, Vice President
Reimbursement & Professional Advocacy

AAPA

The Problem

PAs are the only health professionals authorized to bill Medicare for their services, but not able to receive direct payment for those services.

Current Medicare Policy on PA Reimbursement

LEADERSHIP AND ADVOCACY SUMMIT

- Medical and surgical services delivered by PAs can be billed/have the claim submitted to Medicare under a PA's name.
- However, Medicare must make payment for those services to the PA's employer which could be a solo physician, physician group, hospital, nursing facility, ASC, professional corporation, or a professional/medical corporation substantially owned by a PA.
- There are limited examples of commercial payers paying directly to PAs/PA corporations.

AAPA

Why Is This an Issue?

LEADERSHIP AND ADVOCACY SUMMIT

- The inability to be paid directly hinders PAs from fully participating in certain practice, employment and/or ownership arrangements.

- When PAs can't be paid directly, they are unable to reassign their payments in a manner similar to physicians and APRNs.

- Creates an unfair distinction with physicians and NPs.

AAPA

Legislative Change

LEADERSHIP AND ADVOCACY SUMMIT

- Language in the Coronavirus Relief & Omnibus Agreement (Section 403) authorized PAs to receive direct payment under Medicare.
- Direct pay had been a top AAPA legislative priority.
- One of the pillars in Optimal Team Practice.

AAPA

So, what does this policy change mean?

LEADERSHIP AND ADVOCACY SUMMIT

The benefits of direct payment will be seen by PAs who:

- Practice as independent contractors
- Want to work part-time or as needed without having to deal with additional administrative paperwork associated with a formal employment relationship
- Choose to own their own practice/medical corporation
- Work in rural health clinics (RHCs) and want to ensure they receive reimbursement for “carved out” RHC services
- Work with staffing companies or medical groups and want the flexibility of re-assigning reimbursement for their services

AAPA

Overarching Impact

LEADERSHIP AND ADVOCACY SUMMIT

Raises the overall stature of PAs

Eliminates what may have been perceived as an adverse distinction between PAs and APRNs

Allows PAs to avoid excessive paperwork and administrative requirements

AAPA

Why Many PAs Will Not Be Affected

LEADERSHIP AND ADVOCACY SUMMIT

Most physicians and APRNs do not opt for direct payment.

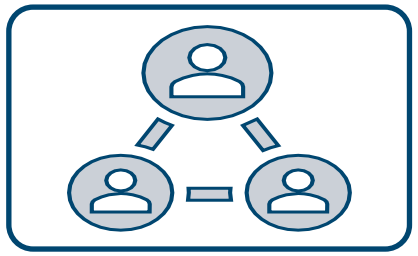
Instead, they assign reimbursement to their W-2 employers.

Many PAs will likely do the same.

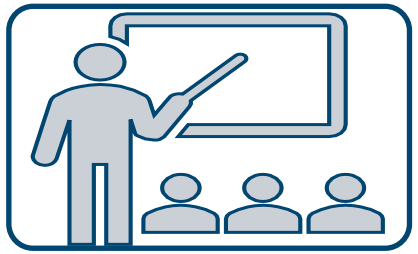
AAPA

Important Qualifiers

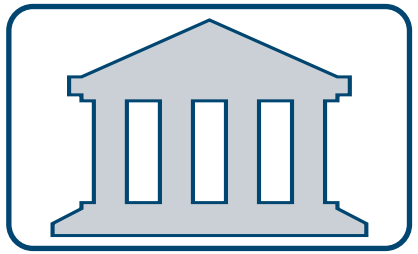
- The effective date of the provision is **January 1, 2022**
- The change in policy applies to the **federal Medicare program** and does not change reimbursement policies of state Medicaid programs or commercial payers
- Medicare regulations **defer to state law.** If state law or regulation prohibit a PA from receiving direct pay, those restrictions will have to be removed before Medicare will directly pay PAs.



AAPA will produce educational resources explaining the implementation of direct payment



Goal to educate PAs, physicians, employers and commercial payers, and work with CMS to change the 855I and 855R application forms



Chapter efforts should be aimed at confirming there are no state restrictions that may prevent PAs from utilizing this new authority

What About PA Ownership of Professional Corporations?

LEADERSHIP AND ADVOCACY SUMMIT

- Medicare authorizes a PA to own up to 99 percent of a state-approved corporation which can receive reimbursement from Medicare.
- Someone who is not a PA must own the remaining 1 percent.
- Often confusion over Medicare's interpretation as to whether the one percent owner needs to be a physician.

AAPA

What About PA Ownership of Professional Corporations?

LEADERSHIP AND ADVOCACY SUMMIT

- Requiring someone else to own one percent of the corporation may be inconsistent with state law/corporate practice of medicine rules.

- PA direct payment should eliminate any federal requirements for one percent of the corporation going to a non-PA or prohibitions on a group of PAs owning a corporation.

48

Additional Points

LEADERSHIP AND ADVOCACY SUMMIT

- PAs will have the same flexibility as physicians and NPs for employment and practice ownership options under Medicare. This change will help encourage employers to make hiring decisions based on clinical skills and not on who is more easily reimbursed.

- AAPA will use Medicare's example and work with commercial payers and Medicaid programs to advocate for direct pay to PAs.

- If starting a business/corporation or working as an independent contractor, you must be aware of the policies of commercial payers!

AAPA

Additional Points

LEADERSHIP AND ADVOCACY SUMMIT

- Direct pay for PAs does not change Medicare's rate of reimbursement (85%) or PA scope of practice.
- Medicare billing mechanisms such as "incident to" (office/clinic) and split/shared visit billing (hospital/hospital outpatient dept.) remain as options.
- This means billing PA/NP services under the name of the physician can still occur and the problem of PAs/NPs being "hidden providers" is a possibility.

AAPA

LEADERSHIP AND ADVOCACY SUMMIT

LEAD. ENGAGE. INSPIRE.

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

AAPA

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**

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

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.

2021 Table of MDM for Example #1

LEADERSHIP AND ADVOCACY SUMMIT

99204 & 99214 Moderate

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

AAPA

Clinical Example #2

LEADERSHIP AND ADVOCACY SUMMIT

- 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.

AAPA

2021 Table of MDM for Example #2

99203 & 99213
Low

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
				Example
				• Pre
				• Dec
				pro
				• Dec
				pati
				• Dia
				of h

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

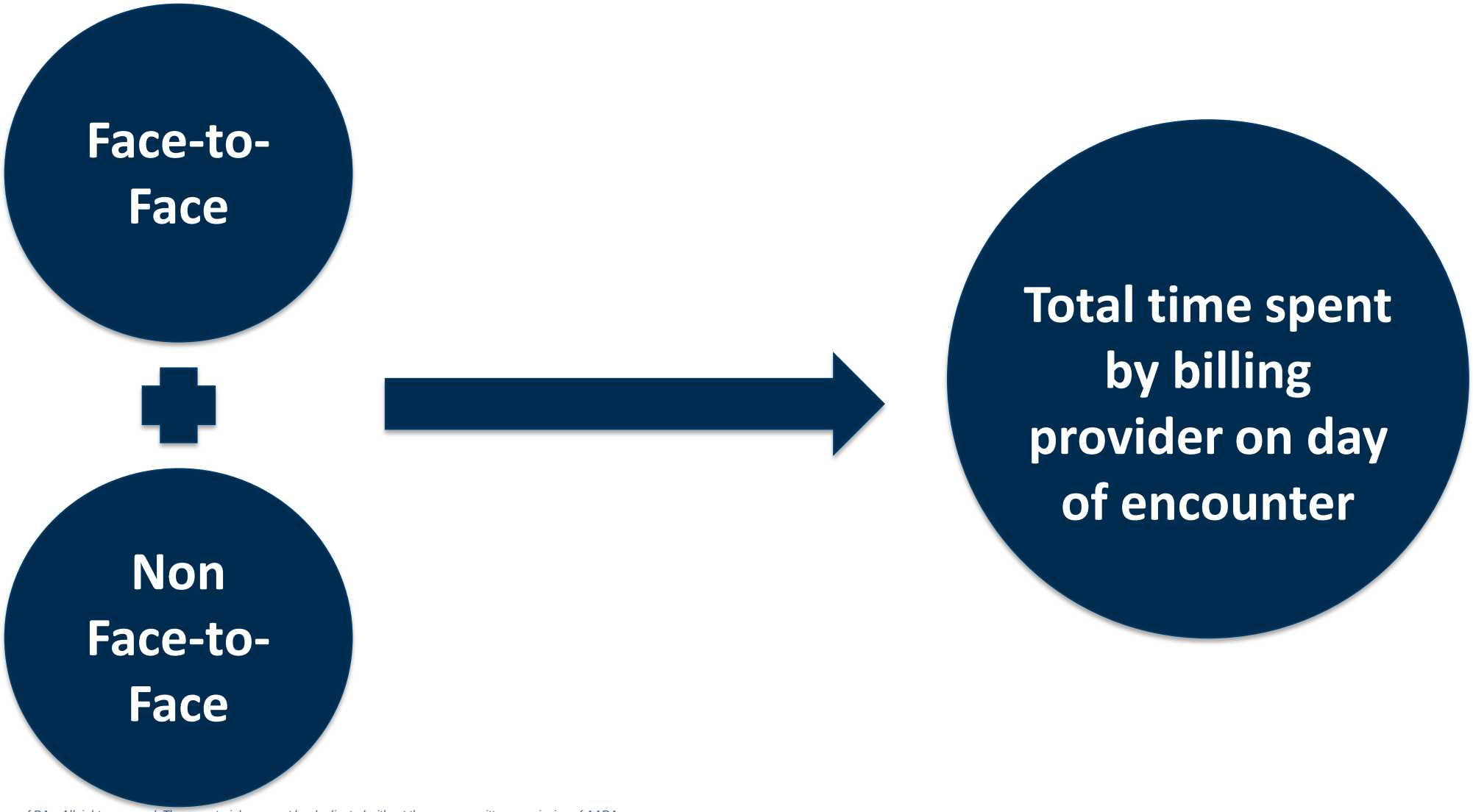
1 stable chronic illness

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 or an assessment from a historian**

Example: RX Drug Management

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

Time-Based Example



Clinical Example #2

LEADERSHIP AND ADVOCACY SUMMIT

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

AAPA

Time Reporting for Office Visits

LEADERSHIP AND ADVOCACY SUMMIT

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

AAPA

Additional Resources

LEADERSHIP AND ADVOCACY SUMMIT

- AAPA E/M Guidelines presentation now available on Learning Central-
  - Evaluation and Management Services in 2021
- 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

AAPA

LEADERSHIP AND ADVOCACY SUMMIT

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

AAPA

Office/Outpatient Visit: Established Patient

LEADERSHIP AND ADVOCACY SUMMIT

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

AAPA

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

LEADERSHIP AND ADVOCACY SUMMIT

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).

AAPA

Cost-effectiveness at 85% Reimbursement

LEADERSHIP AND ADVOCACY SUMMIT

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

AAPA

Cost-effectiveness Take Away Points

LEADERSHIP AND ADVOCACY SUMMIT

- 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/family medicine/internal medicine practices).
- However, PAs are a value add to the practice/facility in terms of net revenue even when reimbursed at 85% of the physician level.
- An appropriate assessment of value includes both expense and revenue generation.

AAPA

The PA Value Proposition - ROI

LEADERSHIP AND ADVOCACY SUMMIT

- How PAs are utilized will determine their revenue generation capacity.

- Most PAs, when utilized appropriately, will more than cover their salary in revenue generated for the practice. PA value in surgery, due to global bundled payments, must be calculated differently.

- Also consider opportunity costs. When 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.

AAPA

Beyond Revenue Generation

LEADERSHIP AND ADVOCACY SUMMIT

- PAs increase access to the practice – reduce patient waiting time for appointments
- PAs facilitate improved communications with patients, other health care professionals and office staff.
- Essential to consider overall productivity/professional work whether revenue is produced or not.

AAPA

Value-based Payments

LEADERSHIP AND ADVOCACY SUMMIT
LEAD. ENGAGE. INSPIRE.

AAPA

Value-based Payment (VBP) Models

LEADERSHIP AND ADVOCACY SUMMIT

- 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

Value-based Payment (VBP) Models

LEADERSHIP AND ADVOCACY SUMMIT

- 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.

AAPA

Value-based Payment (VBP) Models

LEADERSHIP AND ADVOCACY SUMMIT

- 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 or 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 PA care limit transparency.

AAPA

Value-based Payment (VBP) Models

LEADERSHIP AND ADVOCACY SUMMIT

- 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.

AAPA

Take Home Points

LEADERSHIP AND ADVOCACY SUMMIT

- Each PA 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 PAs to demonstrate value to employers.
- PAs must be their own advocates in dispelling negative myths and providing accurate information surrounding PA practice.

AAPA

Key Takeaways

LEADERSHIP AND ADVOCACY SUMMIT
LEAD. ENGAGE. INSPIRE.

- The public health emergency has led CMS to authorize numerous flexibilities in PA practice, some temporary, some permanent
- PAs can reduce time spent adding information in the medical record by understanding Medicare's new E/M documentation requirements
- Understanding economic and non-economic contributions will allow PAs to demonstrate their full value to employers

reimbursementteam@aapa.org

AAPA

Contact Information

LEADERSHIP AND ADVOCACY SUMMIT

Reimbursement Team Email

- reimbursementteam@aapa.org

AAPA Reimbursement Website

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

AAPA