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The 411 on Reimbursement Compliance and Advocacy

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- 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.
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Disclosure

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Regulatory & Compliance Overview

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Compliance

- Conforming to laws, regulations, policies, and standards
- Purpose is to ensure patient safety & improve patient care

- Benefits
  - Patient safety
  - Avoid trouble and penalties from government agencies and accrediting organizations
  - Reduce fraud and abuse

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Federal Law	State Law	Regulations
Accrediting Body	PA Practice	Case Law
Institutional Bylaws & Policies	Payer Policy	Accepted Standards

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Laws

- Passed by legislative branch & approved by executive branch
- Legally binding and enforceable

Regulations

- Rules that govern how laws are interpreted, executed, and enforced
- Often have the same force as laws

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Federal versus State

- Equally applicable
- Most restrictive must be followed

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Medicare Conditions for Coverage & of Participation

Conditions of Payment

- Conditions that must be met to lawfully request and receive Federal healthcare funds
- Apply to beneficiaries

Conditions of Participation

- Conditions that organizations and facilities must meet to participate in and receive funds from a Federal healthcare program
- Typically relate to the quality of care provided
- May apply to non-beneficiaries

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Medicare Conditions of Payment for PA Services

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

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

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

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General Supervision

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

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

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When State Law Does Not Require Supervision

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

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When State law does not require “supervision”…

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Federal statutory requirement is met if:

- There is any mention of collaboration or working relationships between PAs and physicians in State law

OR

- In the absence of any State requirements, documentation at the practice level of
  - PA scope of practice
  - Relationships with physicians

https://www.law.cornell.edu/cfr/text/42/410.74

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42 CFR Part 482 - CONDITIONS OF PARTICIPATION FOR HOSPITALS

- Subpart A - General Provisions (§ 482.1 - 482.2)
- Subpart B - Administration (§ 482.11 - 482.15)
- Subpart C - Basic Hospital Functions (§ 482.21 - 482.45)

§ 482.21 Quality assessment and performance improvement program
§ 482.22 Medical staff
§ 482.23 Nursing services
§ 482.24 Medical record services
§ 482.25 Pharmaceutical services
§ 482.26 Radiologic services
§ 482.27 Laboratory services
§ 482.28 Food and dietetic services
§ 482.30 Utilization review
§ 482.41 Physical environment
§ 482.43 Discharge planning
§ 482.42 Infection prevention and control and antibiotic stewardship programs

- Subpart D - Optional Hospital Services (§ 482.51 - 482.58)
- Subpart E - Requirements for Specialty Hospitals (§ 482.60 - 482.104)

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42 CFR Part 410 - CONDITIONS OF PARTICIPATION FOR MEDICAL SERVICES

- § 410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests
- § 410.38 Durable medical equipment, prosthetics, orthotics and supplies
- § 410.78 Telehealth services
- § 410.20 Physicians' services
- § 410.69 Services of a certified registered nurse anesthetist or an anesthesiologist's assistant
- § 410.74 Physician assistants' services
- § 410.75 Nurse practitioners' services
- § 410.76 Clinical nurse specialists' services
- § 410.77 Certified nurse-midwives' services

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Healthcare organizations must be certified as complying with Conditions of Participation

State agency on behalf of CMS

Accreditation organization with Deemed Status

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Implied Certification

Submission of claim “certifies” compliance with CMS conditions

If a healthcare provider or organization is out of compliance with a State or Federal statute, CMS regulation, or accreditation standard = basis for false claims

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- Federal Laws & Regulations
- State Laws & Regulations
- Accreditation Standards
- Hospital/Employer Policies & Bylaws
- Scope of Practice & Privileges

All must be met to meet Conditions of Participation & to submit claim for payment

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Credentialing & Privileging

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Credentialing

process of confirming practitioner qualifications

Privileging

granted permission of services a provider may perform in hospital or facility

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Privileging

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- Required in hospitals and facilities of “all practitioners who provide a medical level of care and/or conduct surgical procedures” (e.g. PAs)
- Verifies ability of practitioner to provide care and perform procedures
- Decision to grant, deny, or revoke privileges based on established, objective criteria via a systematic and non-biased process
- May ‘bundle’ privileges (e.g. core versus specialty privileges)

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCletter05-04.pdf

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Privileging

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- Granted based on individual competency
  - Demonstrating knowledge, skill, ability
- Methods of demonstrating competency
  - Completion of training programs, certifications, and/or continuing education
  - Procedure logs or professional portfolios
  - Attestation of peers
  - Simulation or supervised demonstration
  - Other methods

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCletter05-04.pdf

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Privileging

- CMS requires that practitioners undergo ‘periodic’ assessment for continuation or revision of privileges
  - “defined as no less frequently than every 24 months”

- For Joint Commission accredited facilities, must complete Professional Practice Evaluations
  - Focused Professional Practice Evaluations
    - Upon request of new privileges and/or upon safety or performance issues
  - Ongoing Professional Practice Evaluations
    - Must occur more frequently than every 12 months

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCletter05-04.pdf

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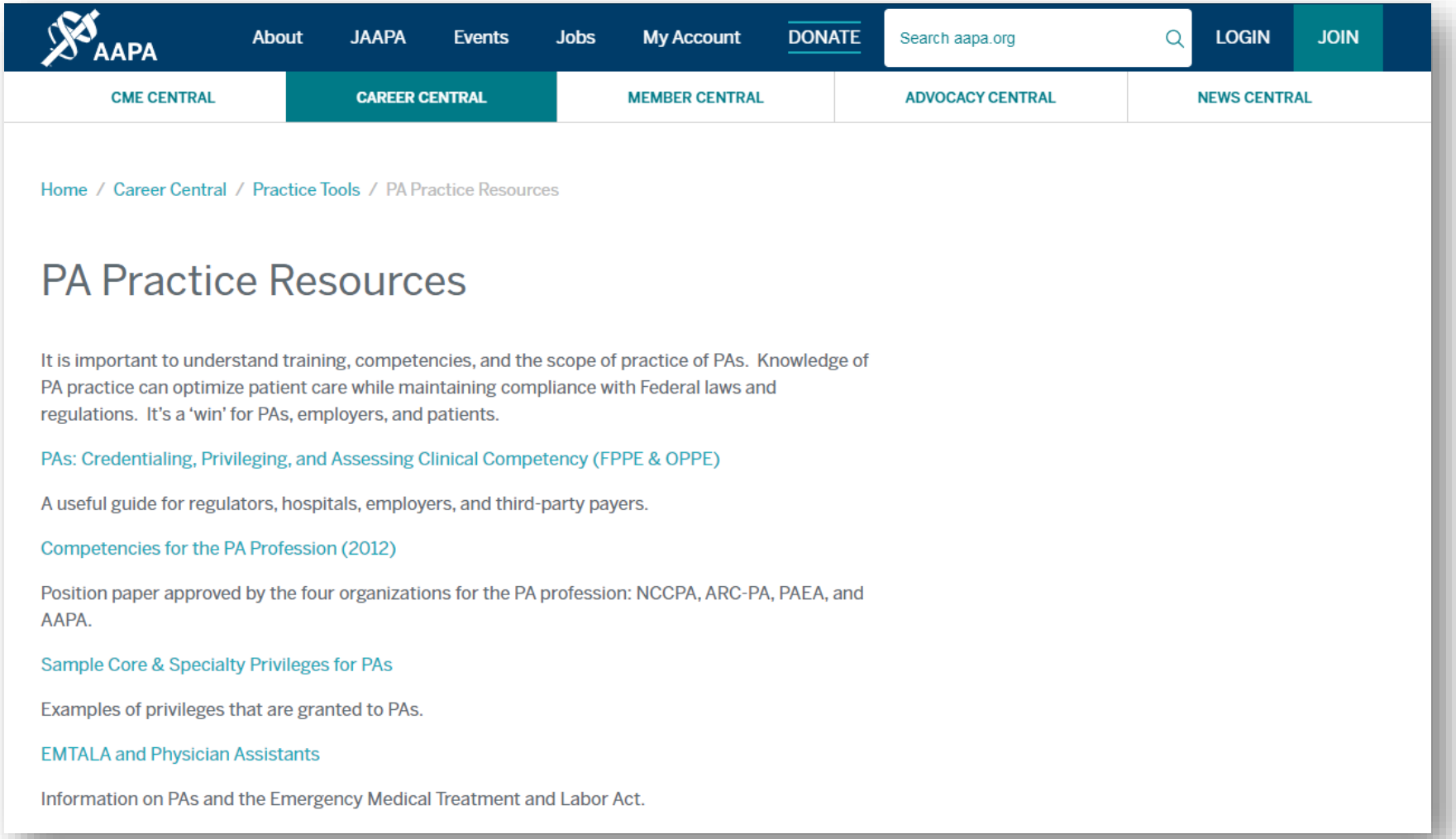
AAPA Resources: PA Practice Resources



https://www.aapa.org/career-central/practice-tools/pa-practice-resources/

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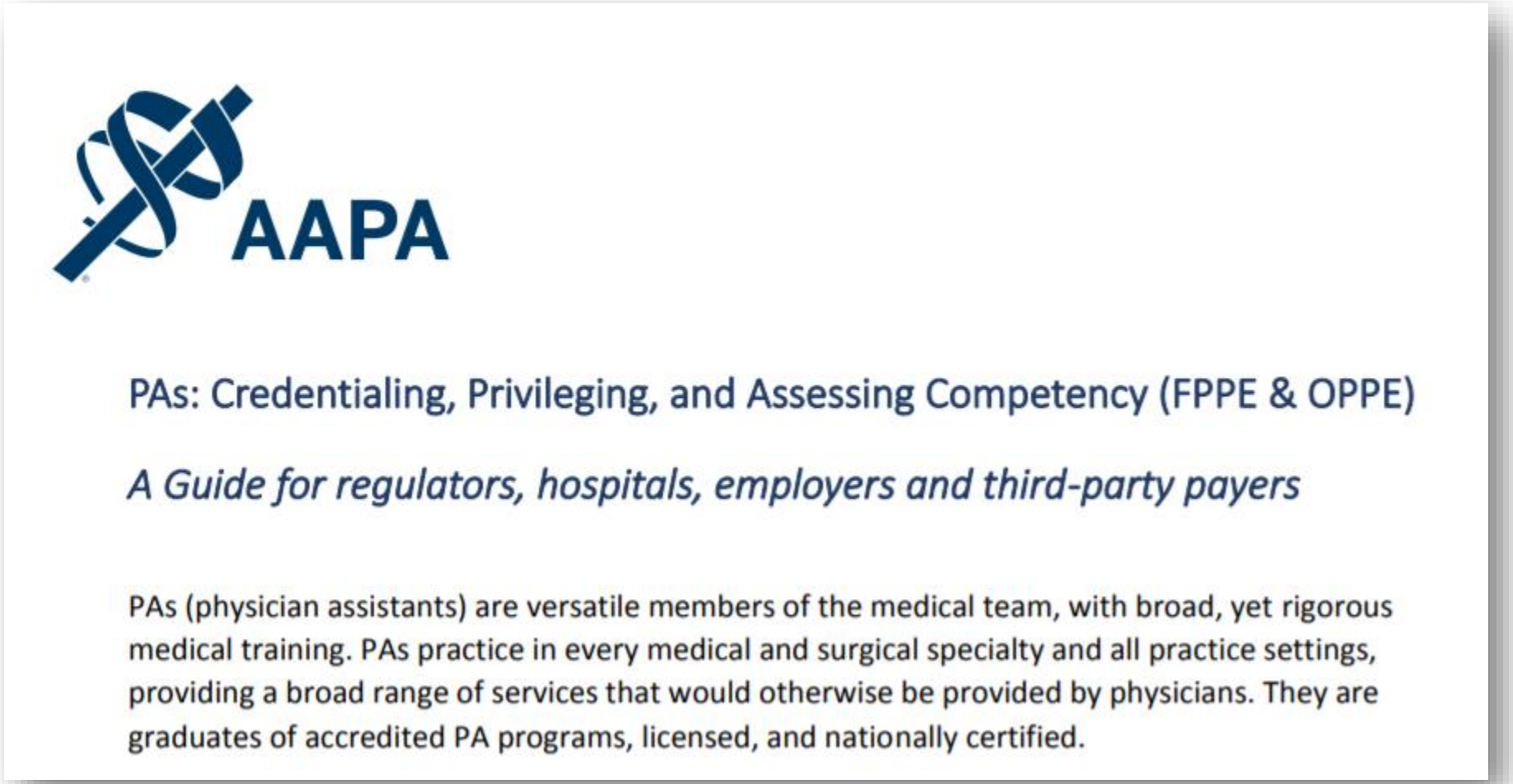
AAPA Resources: PA Practice Resources



https://www.aapa.org/download/68765/

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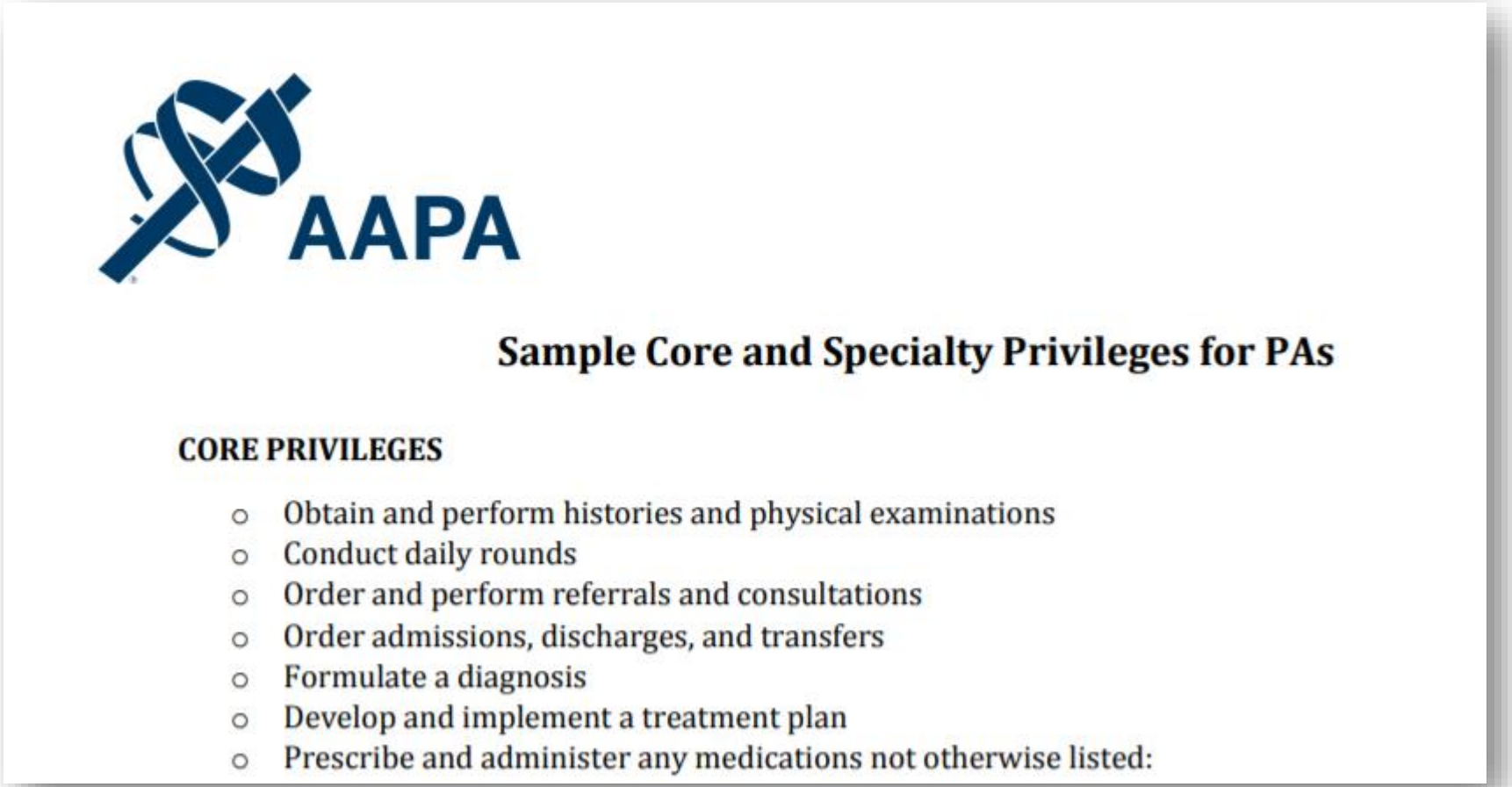
AAPA Resources: PA Practice Resources



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Sample Core and Specialty Privileges for PAs

CORE PRIVILEGES

- Obtain and perform histories and physical examinations
- Conduct daily rounds
- Order and perform referrals and consultations
- Order admissions, discharges, and transfers
- Formulate a diagnosis
- Develop and implement a treatment plan
- Prescribe and administer any medications not otherwise listed:

https://www.aapa.org/download/68754/

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Fraud Issues

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Error

Mistakes

Errors in coding & documentation

Abuse

Improper or Inappropriate Actions

Misrepresentation of services, billing for non-medically necessary services, pattern of waving copayments and deductibles, inadequate medical or financial records

Fraud

Intentional Deception

Falsifying records, falsifying eligibility, billing for services not provided, charging excessively for services or supplies

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Medicare Fraud & Abuse: By the Numbers

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Fiscal Year 2020

$ 4 billion
recovered

624
criminal actions in FY 2019

791
civil actions

2,148
excluded from participation

https://oig.hhs.gov/reports-and-publications/archives/semiannual/2020/2020-fall-sar.pdf

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Top Fraud Issues

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- Opioids
- Services lacking medical necessity
- Kickbacks
  - Hospitals paying physicians above market prices or offering items/services below market value
  - Pharmaceutical and device manufacturers incentivizing use of products
  - DME and other suppliers incentivizing use of products or services
- “Incident to” and split/shared billing
- Critical care billing

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Fraud Alert: Opioids

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- Prescribing limitations based on Federal and State law, regulations, and Medicare policy
  - Opioids can only be prescribed for “legitimate medical purpose” and when “medically necessary”
  - Require at least one in-person medical evaluation (can *temporarily* be fulfilled by real-time audiovisual communication)
  - Prescriptions paid under Part D Medicare subject to Drug Management Programs
- Marijuana (cannabis) is classified as a Schedule 1 drug and its prescription (even in states where legalized) violates the Controlled Substance Act of 1970

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Fraud Alert: “Incident to” & Split/Shared Billing

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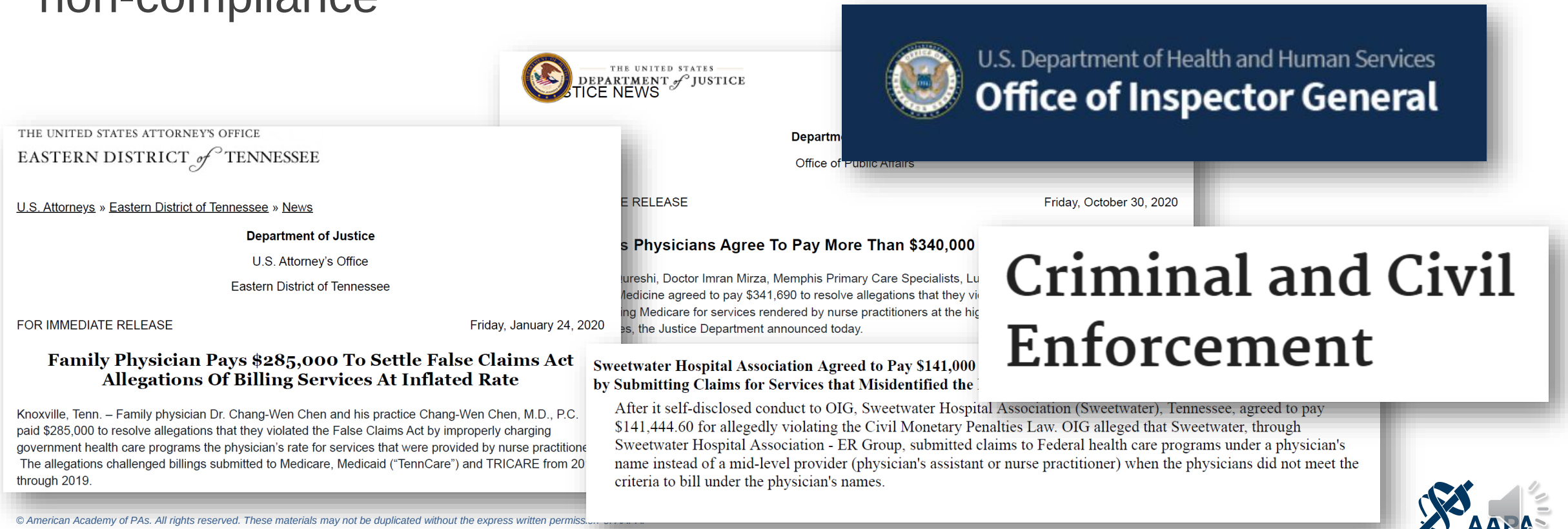
- MedPAC recommends eliminating billing PA & APRN services “incident to” a physician
- ↑ allegations and penalties for “incident to” and split/shared non-compliance



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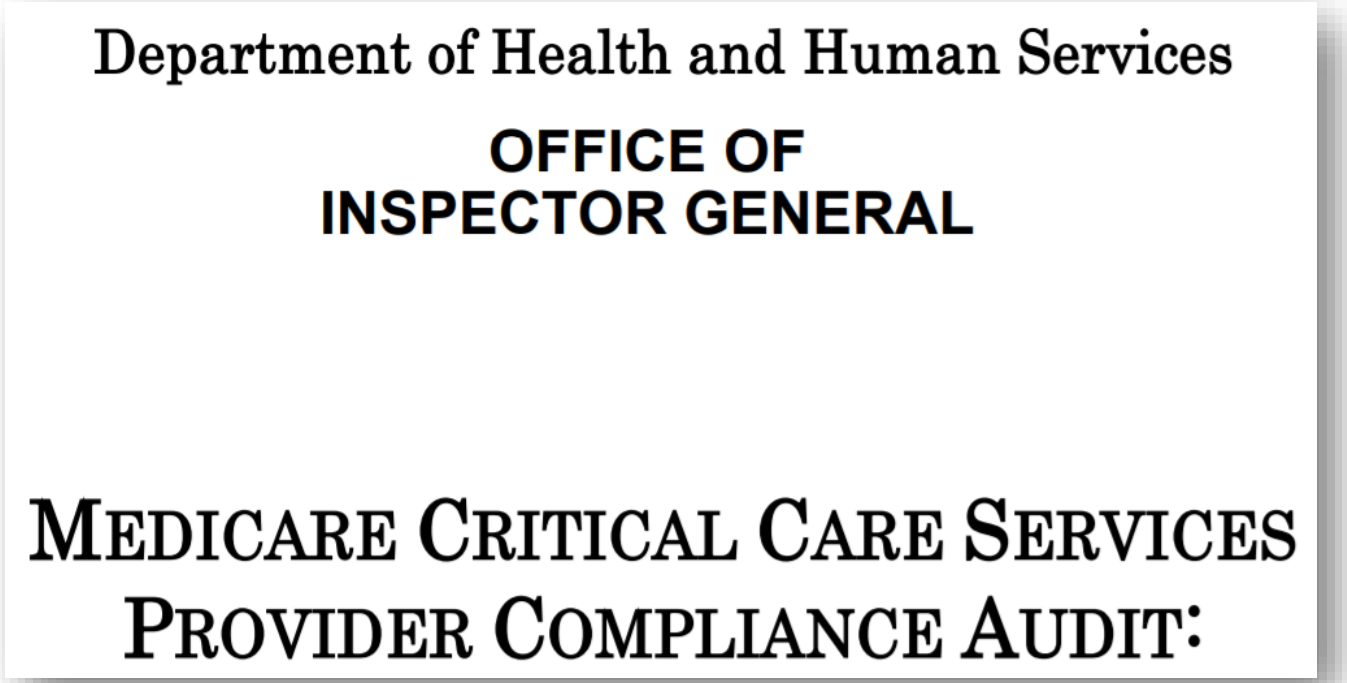
Fraud Alert: Critical Care Billing

~ 10% of cases billed as critical care services “did not indicate that the critical care services were medically necessary”



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https://oig.hhs.gov/oas/reports/region3/31800003.pdf

Qui Tam

- From Latin phrase “qui tam pro domino rege quam pro se ipso in hac parte sequitur”, meaning “who as well for the king as for himself sues in this matter”
- AKA “Whistleblower”
- Allows individuals with knowledge of abuse/fraud who assist prosecution to receive part of money recovered by the government

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Qui Tam: By the Numbers

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Fiscal Year 2019

600+
whistleblower cases each year

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

30%
of recovered funds eligible to whistleblowers

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

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Compliance Issues: Part 2
Stark Law & Anti-Kickback Statute

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The Compliance Scenario

- A hospital in the Midwest paid back $210,739 for allegedly violating the Civil Monetary Penalties Law.
- The HHS Office of Inspector General alleged improper billing for services delivered by PAs but billed under the physician's name under Medicare's split/shared billing provision.
- The OIG stated the documentation requirements for a split/shared visit were not properly met. The services should have been billed under the PAs.

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Who Is Responsible?

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The chain of responsibility is multi-faceted.

- Health professionals are responsible for claims submitted for services they deliver.
- Federal programs will typically expect recoupment/repayment from the entity that received the reimbursement.
- The biller (private billing company, practice or hospital billing staff) may also share in the responsibility if a mistake was made on their part in the electronic filing of the claim.

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Compliance

- In reality, most health professionals never see the actual electronic claim being submitted to Medicare, Medicaid or other payers.
- Suggests the need for communication between all parties to ensure a basic comfort level with payer rules/requirements.
- PAs should be proactive in supplying basic reimbursement information to billers based on payer mix and the practice sites where PAs deliver care.

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Following the Rules Depends on Where You Practice

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Location, location, location

- Office/clinic
- Inpatient or outpatient hospital setting
- Ambulatory surgical center (ASC)
- Critical access hospital
- Federally Qualified Health Center/Community Health Center
- Certified Rural Health Clinic
- Skilled nursing facility,
- Inpatient rehabilitation facility or psych hospital

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Promise to the Federal Government

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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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List of Excluded Individuals/Entities

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

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Stark Law

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- Stark law prohibits physicians from referring Medicaid & Medicare patients for certain designated health services (DHS) to an entity in which the physician or the physician's immediate family has a financial relationship, unless an exception (e.g., safe harbor) applies.

- Stark is specific to physicians, however physicians can't utilize PAs or NPs to intentionally circumvent Stark law provisions.

- Designated health services include clinical laboratory services, physical therapy, and home health services, among others.

- Proof of intent is not necessary.

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Examples of Stark Violations

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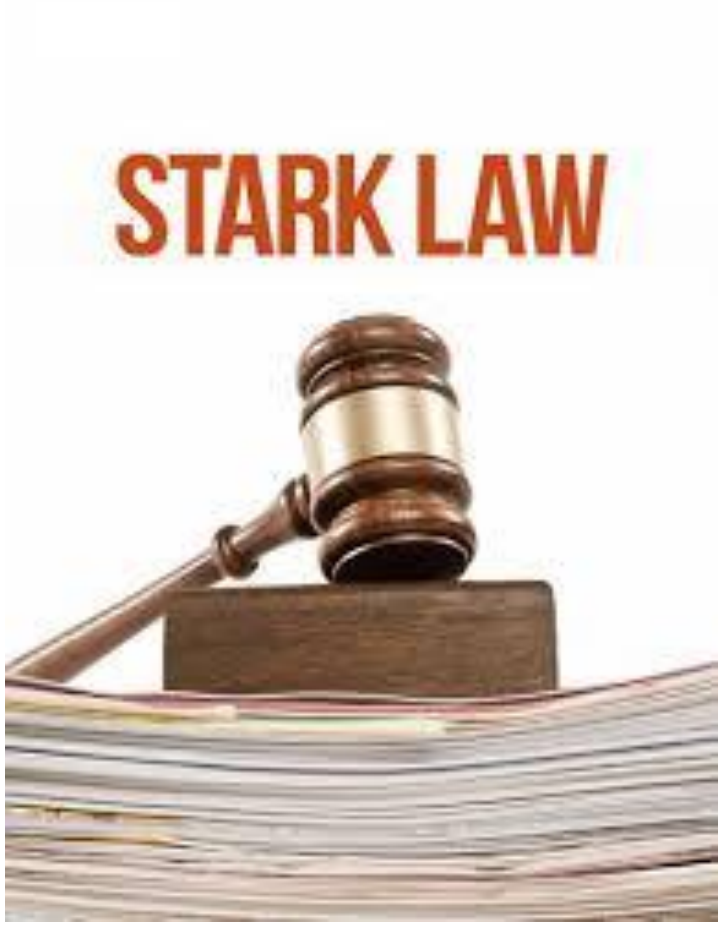
- Paying unlawful remuneration to doctors in exchange for referring cardiac patients to a particular hospital.
- Hospital financial transactions with a physician practice, such as leasing office space for a price well below fair market value, with the intent of inducing referrals.
- A physician referring patient to an imaging center owned by his spouse.



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Anti-Kickback Statute

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- Federal law prohibiting individuals from directly or indirectly offering, providing or receiving kickbacks or bribes in exchange for goods or services covered by Medicare, Medicaid and other federally funded health care programs.

- These laws prohibit someone from knowingly or willfully offering, paying, seeking or receiving anything of value in return for referring an individual to a provider to receive services, or for recommending purchase of supplies or services that are reimbursable under a government health care program.

- Requires some level of proof of intent.

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Examples of Anti-Kickback Violations

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- A health professional who has a general policy and practice of routinely waiving member copayments and deductibles to induce Medicare and/or Medicaid beneficiaries to receive services from the professional

- Payments to a health professional by a supplier (e.g., DME) to induce the purchase of Part B products from that supplier.

- Allowing reimbursement or professional work by a hospital-employed PA or NP to be received by a private physician/physician group that is not employed by that same hospital.

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

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

Only the PA's employer.

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

Only the PA's employer.

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

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Clinical Scenario

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- Patients of a non-hospital employed physician are in the local hospital.
- A hospital-employed PA is asked to deliver evaluation and management services (e.g., subsequent hospital visits, post-op care) to the physician's patients in the hospital.
- There is not necessarily a problem with this scenario from a fraud and abuse perspective.
- The question in determining if there could be a Stark/Anti-Kickback violation is who receives a benefit – either reimbursement or non-reimbursed "free labor" – from the PA's services.

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PA's Professional Services

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

- Any transfer of value, including PA work/productivity, must not accrue to a physician that doesn't appropriately compensate or have a leasing agreement with the PA's employer.

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Leasing PAs from the Hospital to Avoid Stark and Anti-Kickback Concerns

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- Leasing means a written agreement between a PA's employer (e.g., hospital) and private physician or group for the PA delivering specified services.
- The terms of a lease agreement should specify the type, extent and duration of services.
- Compensation for such services must be at a fair market value.
- The agreement must be signed and dated by the parties and must be updated on a regular basis to reflect changes in fair market value.

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Open Payments

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Open Payments Program

National database designed to improve transparency by identifying financial relationships between the pharmaceutical and medical device manufacturing industries, and healthcare professionals and teaching hospitals

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Open Payments Program

- Public, searchable website
- Operated by the Centers for Medicare and Medicaid Services (CMS)
- PAs (and NPs) included for the first time as of 1/1/21
- Physicians already included in the program

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Open Payments Program

- Receiving gifts, promotional products, food and beverage, entertainment or lodging are deemed to be a transfer of value. CMS provides a more complete list of examples of applicable financial relationships.

- Payments include those made directly to the health professional, or indirect payments made to health professionals through a third party, if that party instructs, directs, or otherwise causes the third party to provide the payment or transfer of value.

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Open Payments Program

- The program provides information to the public and other interested parties to assess whether any of these financial relationships are beneficial or might represent a potential conflict of interest.
- CMS states the existence of a financial relationship between a health professional or teaching hospital and a medical device or pharmaceutical company is not an indication of improper behavior or legal wrongdoing.
- CMS does not offer an official position or opinion regarding which financial relationships may cause conflicts of interest.

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Open Payments Program

Legitimate reasons for payments or transfers of value to health professionals captured on the Open Payments site may include:

- Serving as faculty or as a speaker for an accredited or certified continuing education program, such as speaking at a medical conference.
- Providing consulting services, advice or expertise to a pharmaceutical or medical device company regarding the use of a particular drug, product or treatment regimen.
- Engaging in research activities including coordination a study or enrolling patients into studies.

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Open Payments Program

- The 2021 calendar year will be an information collection year for transactions on PAs and NPs.
- No information on PA/NP eligible financial transactions will appear on the Open Payments website in 2021.
- Beginning on approximately June 30, 2022, CMS will place financial relationship data collected during 2021 on the site.

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Open Payments Program

- Health professionals aren't required to but must register to gain access to the information collected and stored in the database.
- Register at the CMS.gov Enterprise Portal. After registering through the Enterprise Portal, you will be able to request access to view information.
- After reviewing the information, health professionals have an opportunity to dispute entries on the website believed to be incorrect before any information is made available to the public.

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Open Payments Program

- It is the responsibility of pharmaceutical and device manufacturers to collect and report data (based on a health professional's name and NPI number).
- Pharmaceutical and medical device companies are likely to be diligent in tracking and reporting payments or transfers of value provided to health professionals.
- To encourage timely and accurate reporting, CMS has the legal ability to impose civil monetary penalties on companies that do not collect and report applicable data to the Open Payments program.

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Open Payments Program

- The Open Payments system does not generate individual notifications to health professionals when attributable information has been reported/added.
- Each health professional is responsible for ensuring the accuracy of data contained on the Open Payments site.

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“Educational” Speaker Programs – Special Alert

- The HHS Office of the Inspector General (OIG) has found that a number of speaker programs sponsored by drug and device manufacturers violate the federal Anti-Kickback Statute.
- OIG has concerns about the educational value of speaker programs provided under circumstances that are not conducive to learning and to audience members who have no legitimate reason to attend.
- OIG questions the value of such events given that health care providers can access the same or similar information online, on the product’s package insert, third-party educational conferences, medical journals, and more.

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Speaker Program Potential Problems

- Little or no substantive information is actually presented by the speaker.
- Alcohol (especially when provided at no charge) or a meal exceeding modest value is provided.
- Environment/location is not conducive to the exchange of educational information (e.g., restaurants, entertainment or sports venues).
- Fair market value of honorarium or compensation exceeds standards paid for speaking service.
- Speakers or attendees selected based on past or future expected revenue from prescribing or ordering the company's product(s).

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Medicare Administrative Contractors

Michael Powe, Vice President

Reimbursement & Professional Advocacy

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Medicare Administrative Contractors

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- A Medicare Administrative Contractor (MAC) is a private, commercial health care insurer that processes Medicare Part A and Part B (A/B) and home health/hospice medical claims or Durable Medical Equipment (DME) claims in a particular jurisdiction (state/region).

- In 2020 MACs processed approx. 1.1 billion claims and $400 billion in Medicare FFS benefits were paid out.

- MACs “compete” for contracts through a federal “bidding” process.

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MACs

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- Central point of contact for Medicare coverage/payment issues for health professionals.
- While Medicare is a national program with many national coverage policies, MACs play a role in determining local coverage policies which can include interpreting scope of practice.
- MACs have medical directors who may use their own experience and understanding of PA practice to make coverage decisions.

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MAC Responsibilities

- Process Medicare fee-for-service (FFS) claims
- Enroll providers in Medicare
- Handle redetermination requests (1st stage appeals process)
- Respond to provider inquiries
- Educate providers about Medicare FFS billing requirements
- Establish local coverage determinations (LCD's)

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MACs

- AAPA has concerns with policy inconsistencies and policies that appear to be more restrictive compared to national Medicare coverage policies.
- **Example** - shared visit billing in the hospital/hospital outpatient departments and what a physician must do to demonstrate involvement in the encounter.
- A shared visit is when both a PA and a physician deliver care to the same patient on the same calendar day.
- Medicare requires the physician to perform a professional service in a face-to-face encounter with the patient.

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Shared Visit Billing – Inconsistent Policies Regarding Physician Involvement

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CMS National Policy

- Physician must perform all or some portion of the history, exam, or medical decision-making key components of an E/M service.

MACs

- 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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MACs – Policy Concerns

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- AAPA has had discussion with CMS about bringing more consistency to Medicare coverage policies and ensuring that policies don't hinder patient access to care.
- If you believe a local MAC coverage/payment policy is overly restrictive or inconsistent with national Medicare policy contact AAPA's Reimbursement Department.
- We need specifics.
- Was there a denial?
- Is there a link to the problematic policy?

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Payer Advocacy & Resources

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Billing & reimbursement rules are **subject to change and interpretation can vary**

Get the facts.

Review written policies, statutes, regulatory language and citations.

Don’t assume

Follow the rules & advocate for change (if needed)

You’re responsible

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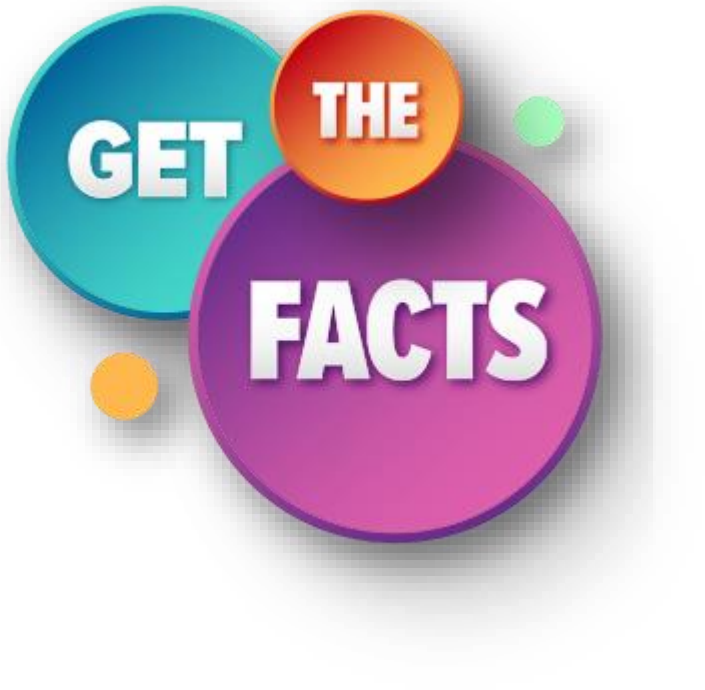
Get the Facts



- Be familiar with State & Federal laws and regulations
- Know facility/employer policies
- Review payer policies
- Ask for source of any information you're told
- Look to AAPA

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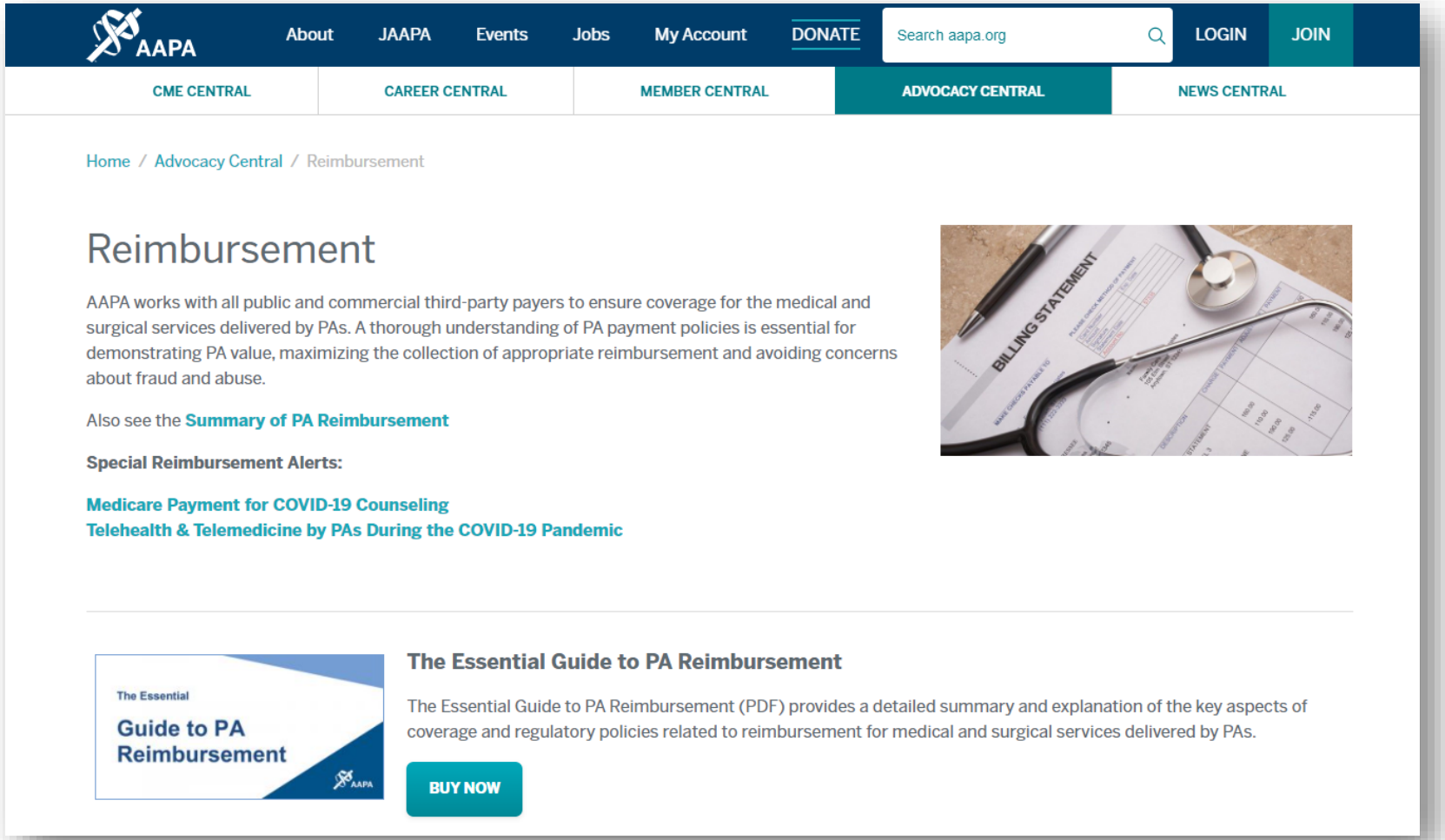
AAPA Resources



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

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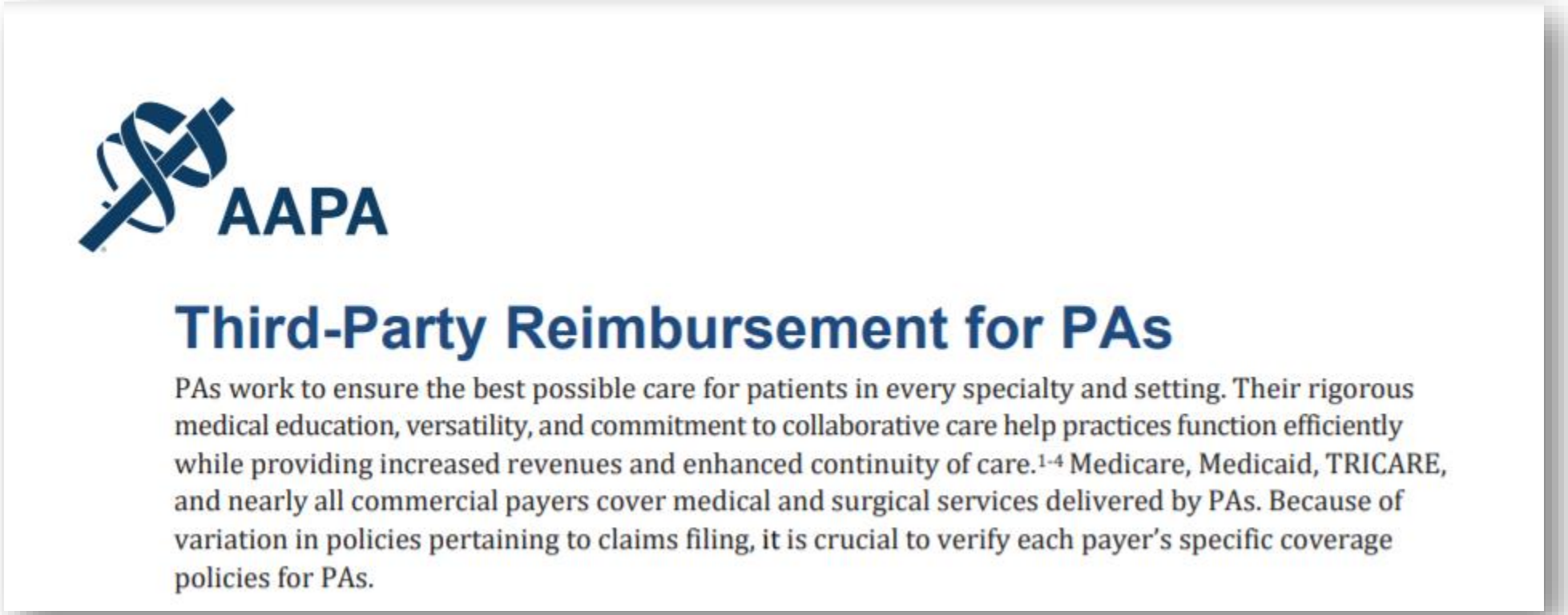
AAPA Resources: Third-Party Reimbursement for PAs



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Third-Party Reimbursement for PAs

PAs work to ensure the best possible care for patients in every specialty and setting. Their rigorous medical education, versatility, and commitment to collaborative care help practices function efficiently while providing increased revenues and enhanced continuity of care.[1-4] Medicare, Medicaid, TRICARE, and nearly all commercial payers cover medical and surgical services delivered by PAs. Because of variation in policies pertaining to claims filing, it is crucial to verify each payer's specific coverage policies for PAs.

https://www.aapa.org/download/48117/

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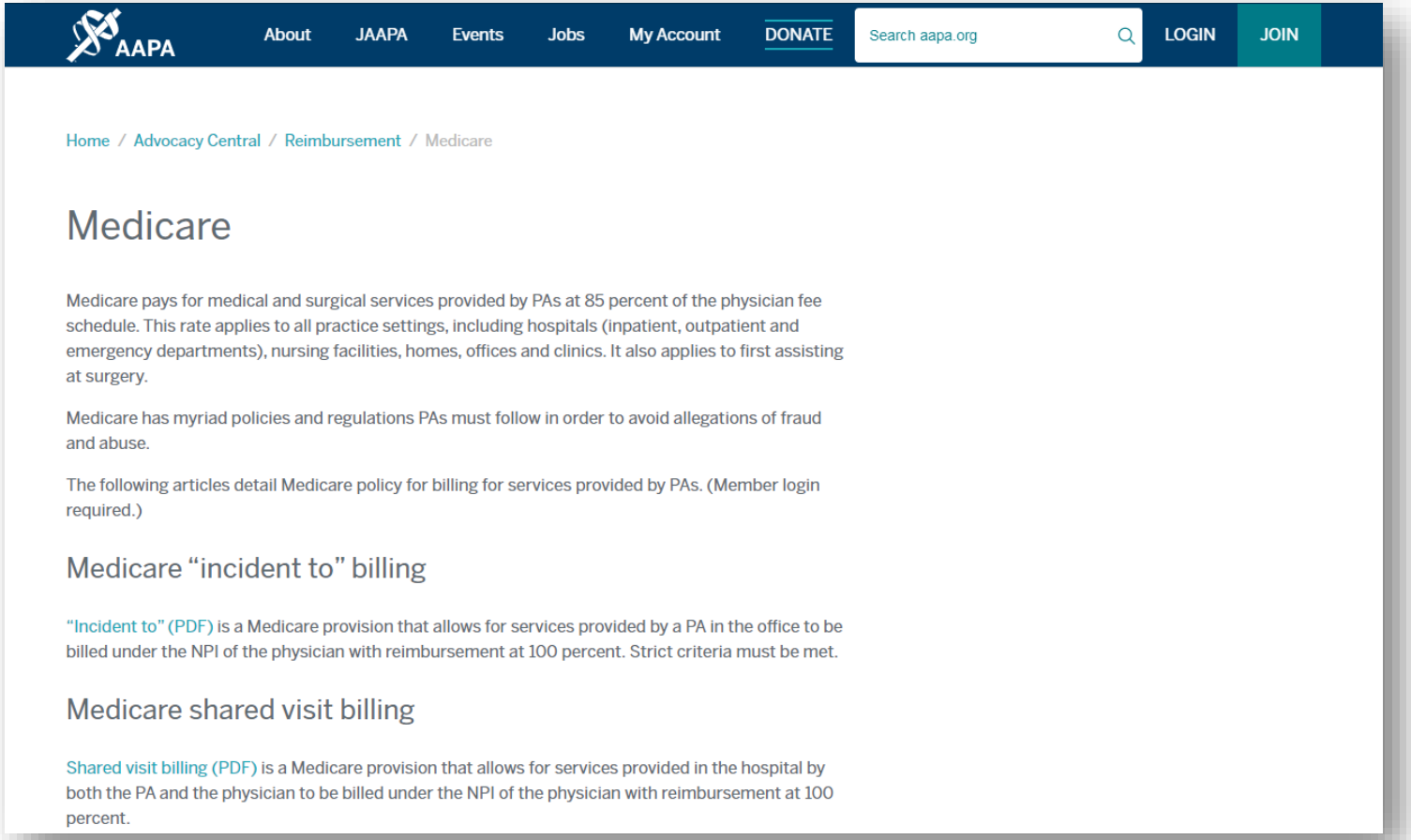
AAPA Resources: Medicare



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

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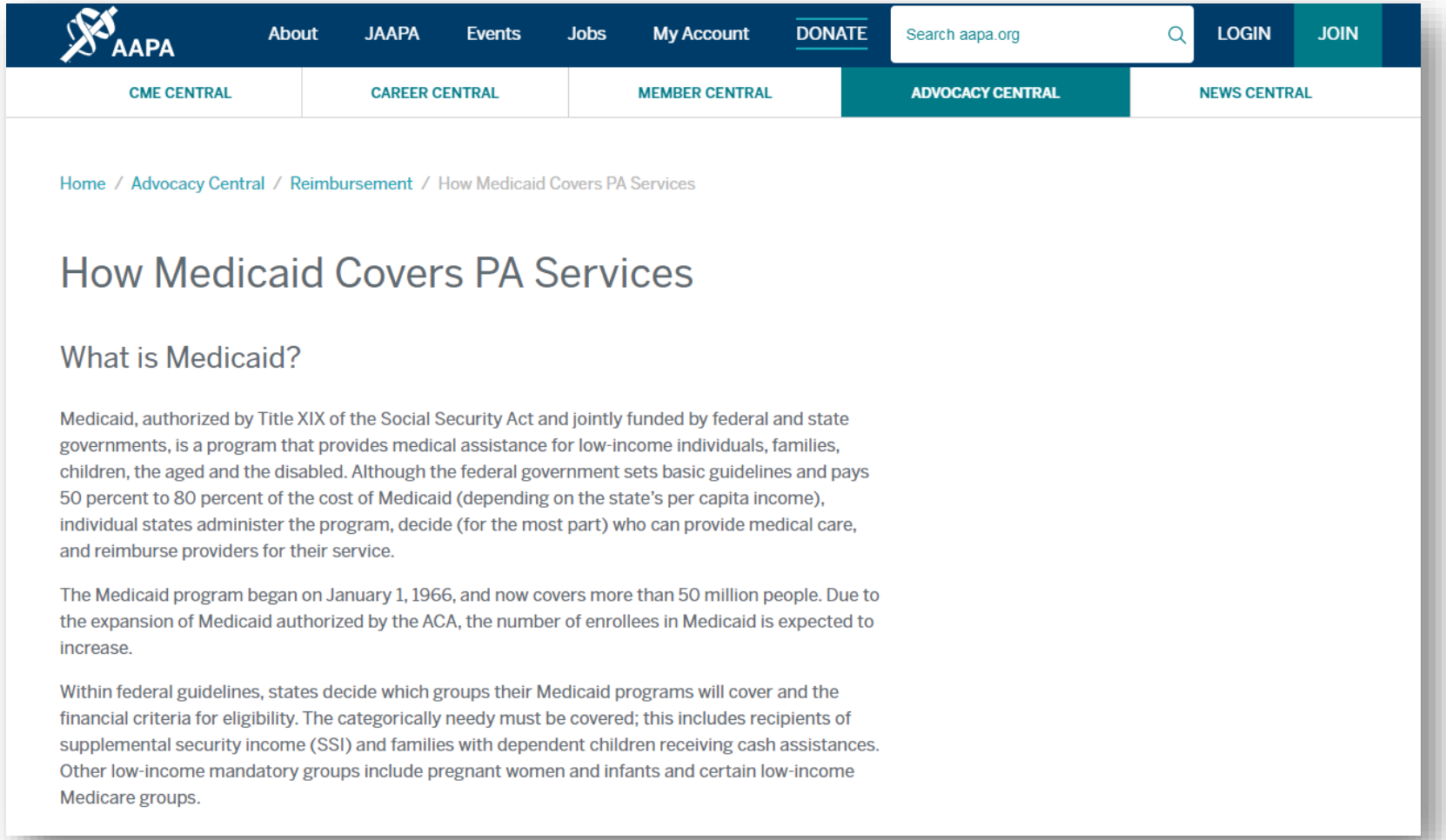
AAPA Resources: Medicaid



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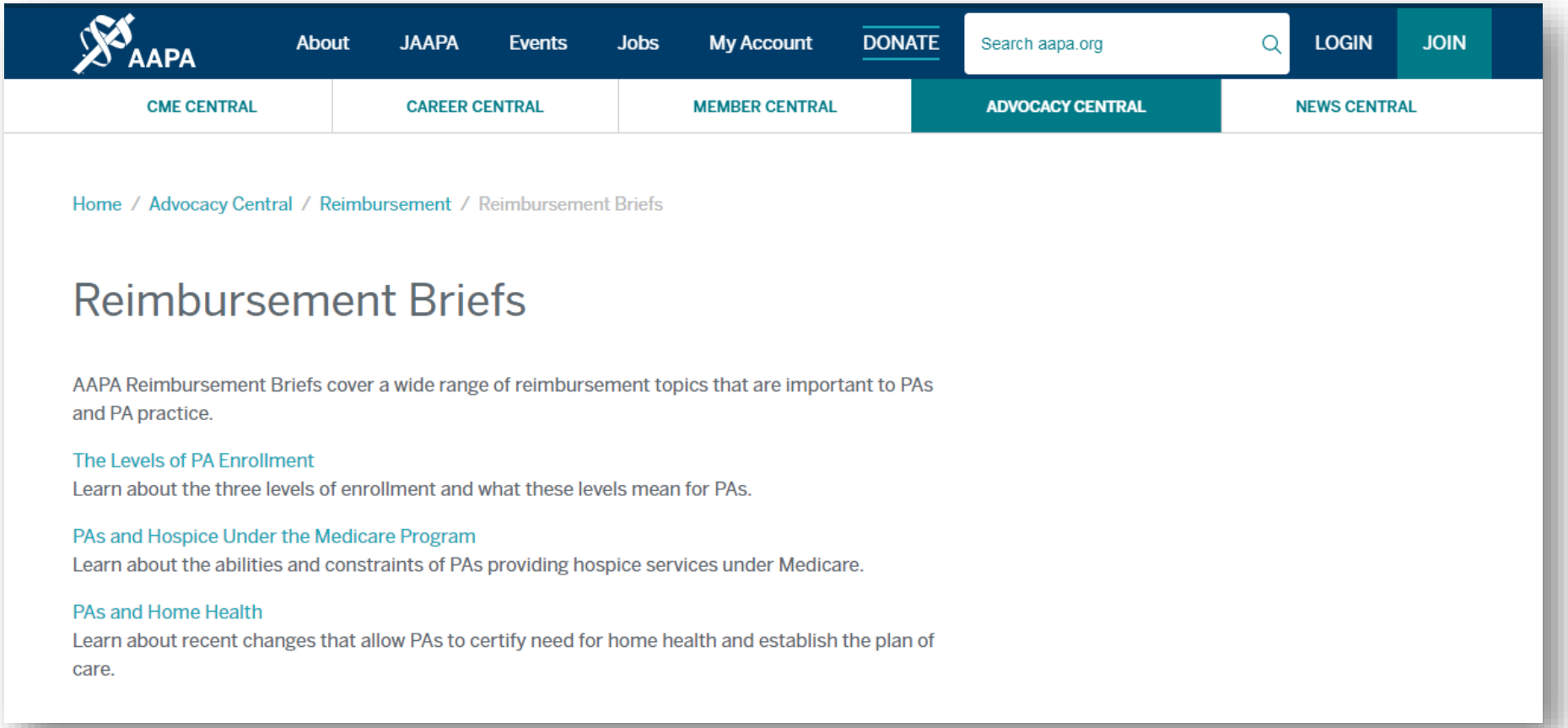
AAPA Resources: Reimbursement Briefs



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

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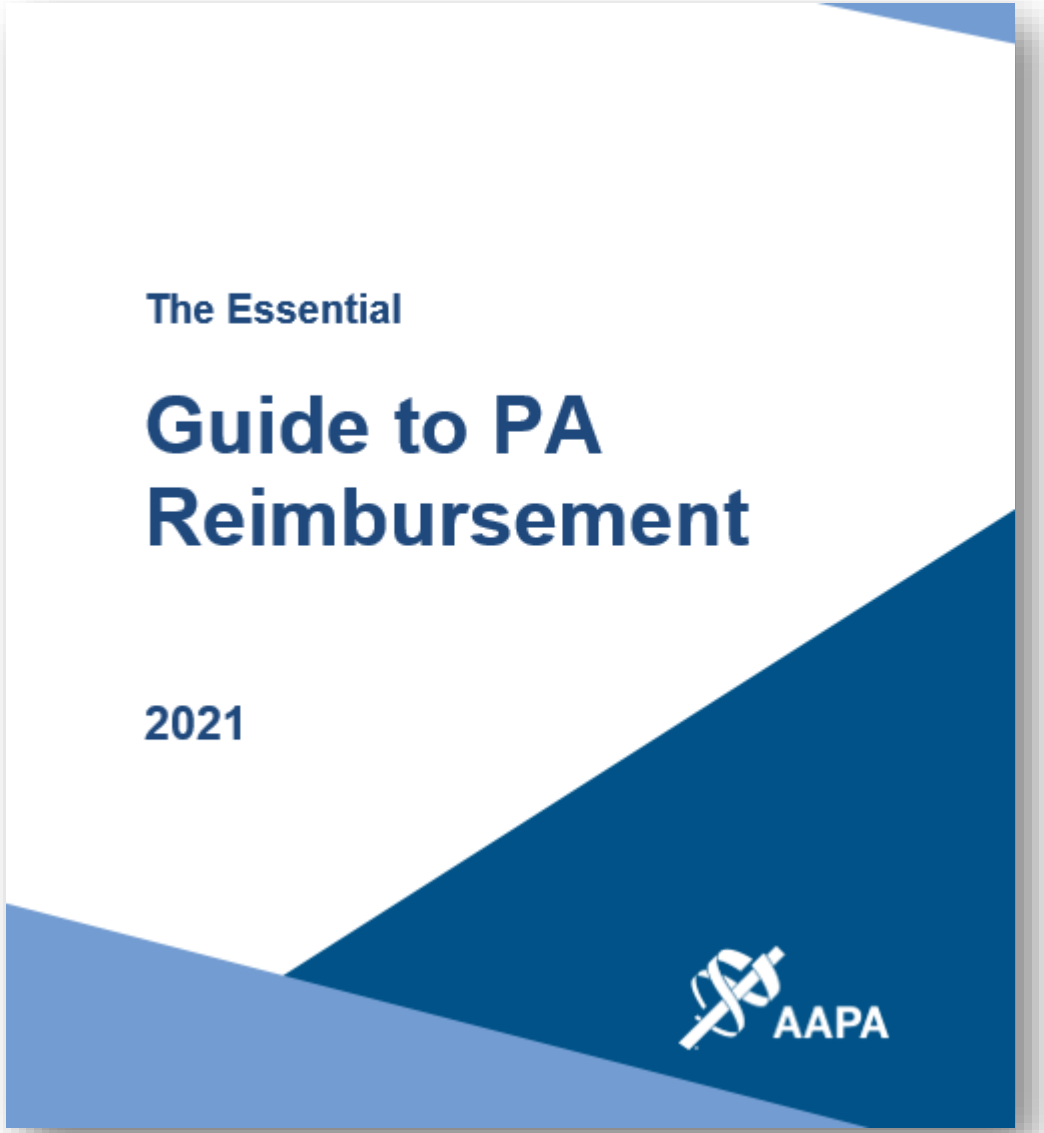

What makes it ‘essential’?

- Nearly 100 pages of description, analysis, and implications of reimbursement policy affecting PAs in all settings
- More than 300 pages of appendices compiled into a perfect tool for reference and research
- A comprehensive glossary of reimbursement terms

Member Price - $25

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Advocate for Change (when needed)

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- Support professional organizations advocating on behalf of the profession
  - General membership
  - Political Action Committee donations
- Work with societies and stakeholders to enact change
- Get involved in grassroots advocacy
  - AAPA Advocacy Action Center
  - Communicate with your representatives

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Key Takeaways

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- Knowledge of reimbursement policy and compliance is important
- Failing to follow applicable rules can result in fines & penalties
- Payer policies can change. **Stay up-to-date!**

reimbursementteam@aapa.org

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