2021 Executive Leadership Tuesdays

Trends in Reimbursement

April 13, 2021

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

- **Medicare policy changes frequently. Be sure to keep current by accessing the information posted by your local Medicare Administrative Contractor and by CMS on www.cms.gov.**
- I am employed by the American Academy of PAs.
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Aligning Practice Models for the Future

- Many hospitals, health systems and practices were shifting their business/operations model before the pandemic.
- That shift includes transforming care delivery models, re-designing locations of care, developing payer-provider partnerships and adjusting to value-based care and payment arrangements.
- During and post-COVID, there may be an enhanced need to accelerating cost-containment efforts, maximize reimbursement, better understand and manage risk, and improve workforce efficiencies.

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Revenue Cycle Management

- Fiscal/financial process put in place to manage the administrative activities and functions associated with claims processing, reimbursement and revenue generation.

- Can start when a potential patient first attempts to make an appointment (wait times/scheduling, available health professionals, determining if the patient is in your network and has active coverage).

- Knowing the rules (billing, coding and coverage) of submitting claims to different payers with potentially unique requirements.

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Revenue Cycle Management

- Maximizing payer contracts - - be intentional about the utilization, opportunities and reimbursement for PAs.
- Understand PA practice - - state laws and regulations, PA scope of practice, positive enhancements in Medicare/Medicaid policies.
- Avoid compliance concerns and prevent payment recoupment and penalties.

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Value-based Reimbursement (VBR): Slow Adoption

- One of the main problems is provider fear of downside risk.
- Despite optimistic "reports" Catalyst for Payment Reform

  "53% of commercial payments to hospitals and doctors in 2017 could be designated as value-oriented."
- The fact is the same report indicated:

  90% of value-oriented payments were built on fee for service, with 6% involved downside financial risk—about the same % as in 2012.

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Value-based Reimbursement

- True VBR has risk sharing. Most reimbursement models we call VBR are actually pay for performance type programs (with payments only marginally impacted by quality or cost of providing care metrics).

- In many cases, the potential loss of predictable revenue from the existing fee-for-service payment system makes a transition to an uncertain value-based model unattractive.

- Because payers are reluctant to levy large penalties against poor performers as part of a VBR model, payers have not been able to appropriately reward (incentivize) high performers.

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Value-based Reimbursement

- Accountable care organizations (ACOs) appeared to be one answer to move providers toward VBR.
- However, an April 2020 survey found that of more than 220 ACOs contacted nationwide almost 60% said they were likely to drop out of their risk-based model to avoid financial losses.
- During a financial crisis, the tendency may be to rely on more familiar business patterns, namely, fee-for-service.

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Payer-Provider Relationships

- Traditional payer-provider (health care professionals, facilities) relationships have been transactional - - and adversarial.

- Value-based care delivery will require some level of cooperation/partnership between payers and providers to successfully achieve improvements in quality and outcomes, and lower costs.

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Improving Payer-Provider Relationships

NEED TO OVERCOME HISTORICAL DISTRUST

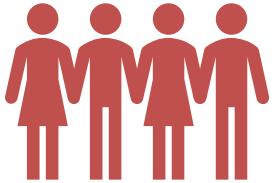
WILLINGNESS TO SHARE RISK & FINANCIAL INCENTIVES

SHARED DATA MUST BE ACTIONABLE AND CONCISE

Improving Payer-Provider Relationships

Limited, mutually agreed upon & attainable goals/metrics

Consistent goals/metrics across numerous public and commercial payers



Recognizing social determinants of health; non-traditional interventions

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PAs and the Public Health Emergency (PHE)

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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 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	Permanent	IFC 5531

Examples of Flexibilities & Changes

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

Medicare Flexibilities During the COVID-19 Public Health Emergency

- The Administration indicates the PHE is extended until December 31, 2021.
- PHE flexibilities impacting telehealth, PAs delivering additional care in skilled nursing facilities and not requiring a hospitalized patient to be under the care of a physician continue.
- AAPA asking CMS to make many of the COVID-19 flexibilities permanent to ensure continued patient access to care.

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Result of Increased Flexibilities

- Increased utilization of PAs (in most specialties) and other health professionals with an eye toward broader range of offered services.
- Movement toward a redesign in clinical workflow.
- Regulatory changes on a national level (Medicare) causing changes in state laws, regulations, state programs.

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Polling Question #1

Were you aware that the Medicare program made these coverage and payment flexibilities available to PAs?

Yes

No

Direct Payment to PAs Under Medicare

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Current Medicare Policy on PA Reimbursement

- 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.

Why Is This an Issue?

- 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 between physicians and NPs.

- One of the pillars in Optimal Team Practice.

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So what does this policy change mean?

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

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.

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Medicare Office-based 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 – 2 of 3 Determine Level

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 (taken in the 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

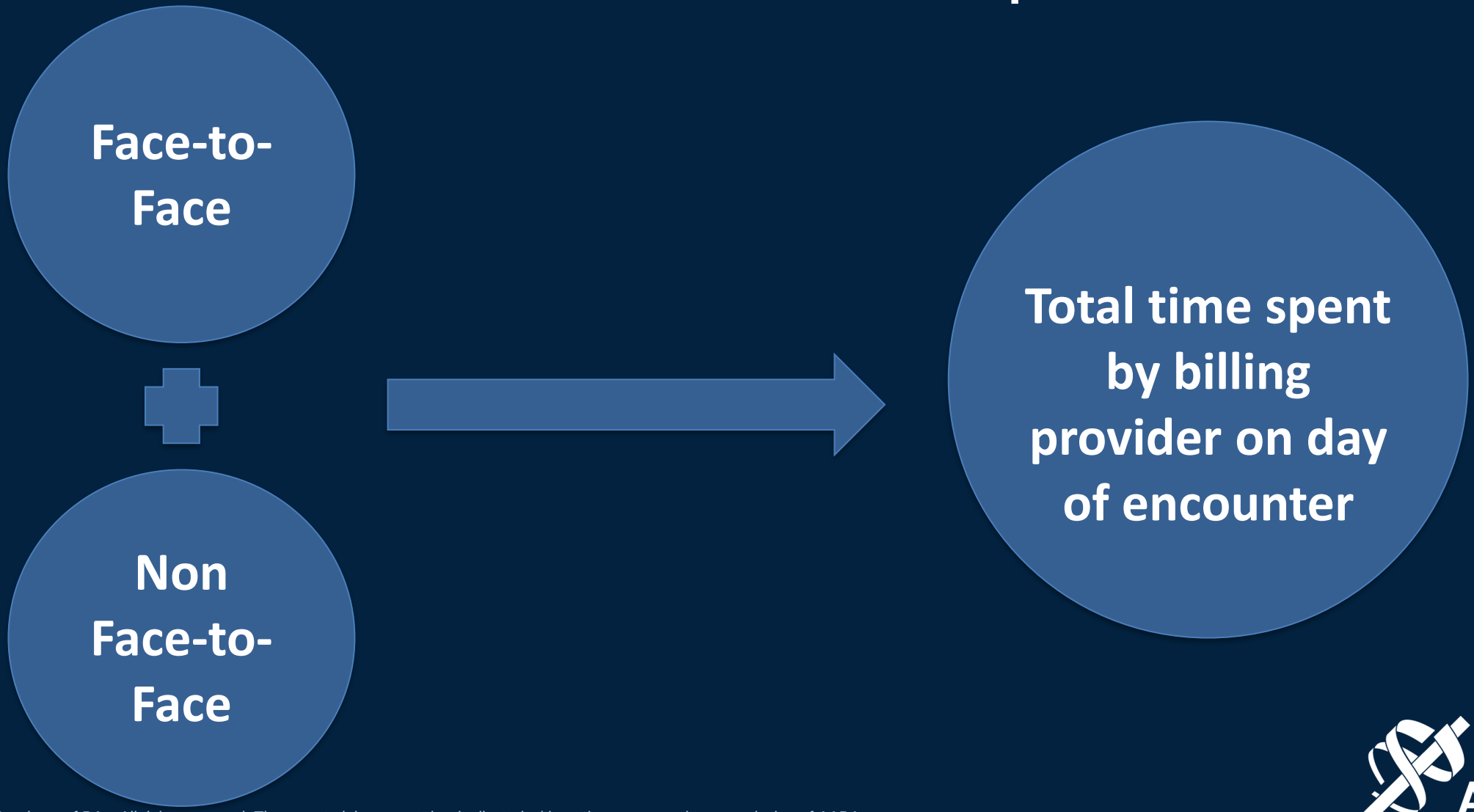
1 stable chronic illness

Any combo of 2 of the following:
***Review/order of each test**
***Review of each external note from unique source**
***Use of an 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

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

Office-based Documentation Changes for 2021

- The American Medical Association states that commercial payers are “on board” with and using the new documentation guidelines.
- Less clear if electronic health record (EHR) systems have made the transition.
- Due to COVID-19, less attention was paid to the documentation guidelines changeover potentially slowing the implementation.

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Additional Resources

- 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

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Polling Question #2

Have you personally received training regarding the new 2021 office-based evaluation and management documentation guidelines?

Yes

No

Reduce The Risk of Fraud and Abuse Allegations

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?

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

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

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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Stark Law

- 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 requirements are 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 specific intent to violate Stark laws is not required.

Examples of Stark Violations

- 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 patients to an imaging center owned by his spouse.

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Anti-Kickback Statute

- 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

- 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.
- Waiving patient co-payments or deductibles.
- Allowing reimbursement or professional services 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?

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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Practice Scenario

- 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 non-hospital employed physician's patients in the hospital.
- There is not necessarily a problem with the PA being able to provide clinical services to those patients (I would prefer some type document indicating a relationship)
- The question in determining if there could be a Stark/Anti-Kickback violation is who receives a benefit – either reimbursement or the benefit of professional services – from the PA-provided care.

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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, even if not reimbursed, must not accrue to a physician that doesn't appropriately compensate the PA's employer.

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

- 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.

Medicare Billing Rules – Brief Review

Polling Question #3

Currently, nearly all commercial payers follow Medicare coverage and reimbursement guidelines and policies.

True

False

Impacting Medicare Billing/Coverage Policies

- Medicare statutes and regulations
- Codes of Federal Regulations
- Conditions of Participation and Payment
- Interpretative guidelines/State Operations Manuals
- State-specific Medicare Administrative Contractors

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

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

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

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

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

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PA Relationship with Physicians Under Medicare

- As of January 1, 2020, Medicare altered its policy for the manner in which PAs work with physicians.
- Medicare will authorize the required PA-physician relationship in state law to meet the Medicare “supervision” requirement.
- States are moving from the term and concept of supervision to collaboration or other terms, or removing the requirement for a specific relationship with a physician altogether.

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Billing in the Office Setting

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Office/Clinic Billing under Medicare

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

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

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

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“Incident to” Rules

- E/M service provided in a private office/clinic by a PA can be billed under the name of a physician.
- The PA must be employed/or leased by the physician.
- Requires that the physician personally treat the patient on their first visit for a particular medical condition/illness, and provide the exam, diagnosis and treatment plan (plan of care).
- The physician (or another physician in the group) must be physically present in the same office suite.
- The physician has an active role in the ongoing care of the patient. Subsequent services by the physician must be of a frequency that reflects his/her continuing active participation in, and management of, the course of the treatment.

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Billing in the Hospital Setting

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Hospital Billing for PAs

- Services delivered by PAs are covered and reimbursed at 85% (billed at the full physician rate).
- Personal presence of the physician is not required.
- Generally, no requirement for physician co-signatures.
- PAs must meet credentialing, privileging and hospital bylaw requirements.

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Hospital Billing for PAs – Shared Visit Billing Option

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

- Must meet very specific Medicare criteria.

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Procedures (performed in the office or hospital)

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

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Commercial Payers

- Each commercial payer promulgate its own rules.
- Some may not enroll/credential PAs/NPs, however services are reimbursed.
- Many instruct the practice to bill under the physician's name and NPI number. Reminder: this is not necessarily "incident to" billing unless specifically stated.

Discussing Economic Value

Let’s talk about the 85% reimbursement issue

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 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

Contribution Model

Assumptions:

- 15-minute appointment slots = 4 visits per hour = 28 visits per day
- 8-hour days (7 clinical hours worked per day)
- Physician salary $250,000; PA 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
Revenue with physician and PA providing the same 99213 service	$2,324 ($83 X 28 visits)	$1,975 ($70.55 X 28 visits)
Wage per day	$960 ($120/hour X 8 hours)	$400 ($50/hour X 8 hours)
"Contribution margin"	$1,364	$1,575

Contribution Model

- This example does not necessarily mean PAs will generate more revenue than a physician (may occur in primary care/internal medicine).
- In most cases, especially surgical and other specialties, physicians typically generate more revenue than PAs/NPs.
- The point is to demonstrate how PAs remain profitable even at an 85% rate of reimbursement.

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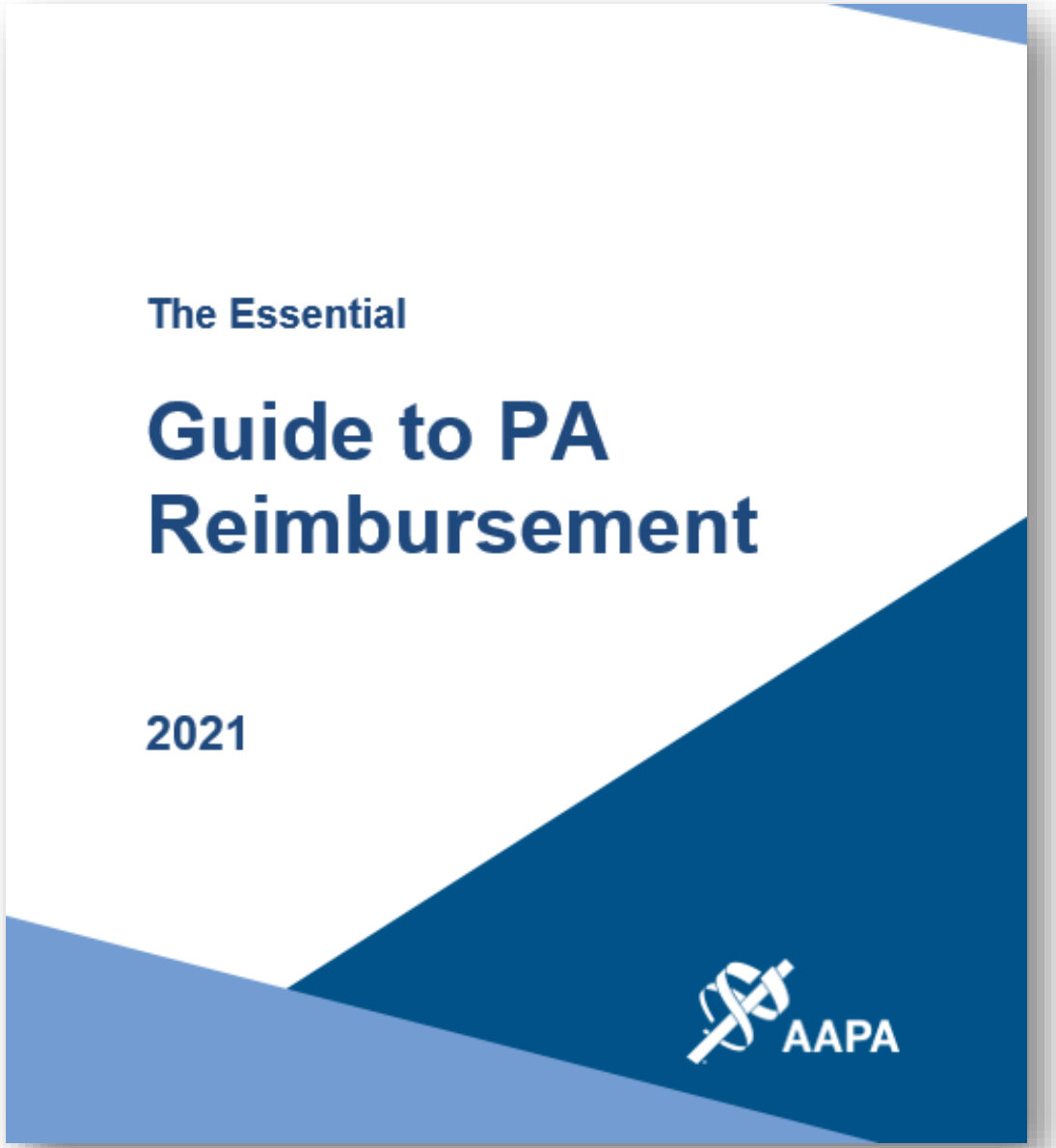

What makes it ‘essential’?

- 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 tool for reference and research
- A comprehensive glossary of reimbursement terms

Member Price - $25

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Thank you for your time and attention!