Hospital Medicine and PAs: Rules, Reimbursement, and Productivity

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- It is the responsibility of the billing provider to ascertain and comply with all payment policy and claims methodology for each payer with whom they contract.
- This presentation was current at the time it was submitted.

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Objectives

- Review billing rules for hospital services
- Understand rules and regulations affecting PA scope of practice in a hospital setting
- Describe Medicare payment policies and requirements that effect the ability of PAs to deliver services in hospital and facility settings
- Discuss implications of fraud and abuse in healthcare

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Medicare, Medicaid, Tricare, and nearly all commercial payers cover medical and surgical services provided by PAs

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http://medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0

NPI (National Provider Identifier)

10-digit unique identifier used by insurers **mandated by HIPAA*

Medicare

PAs must enroll in PECOS (Provider Enrollment, Chain, and Ownership System)

Medicaid

State programs must enroll PAs as "rendering providers", most enroll as "billing providers" **mandated by ACA*

Commercial Payers

- May or may not enroll PAs

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Balanced Budget Act of 1997

PAs (& NPs) became recognized in the Medicare program:

- As providing Part B services typically performed by physicians
- At 85% of the physician fee schedule
- In all settings

Effective January 1, 1998

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Reimbursement Rates

Medicare (covers ~ 60 million Americans)

- Services provided by PAs covered at 85% of the Physician Fee Schedule
- *Optional* billing mechanisms may provide 100% reimbursement

Medicaid

- Rate may be same as or lower than that paid to physician

Commercial Payers

- Rate may be same as or lower than that paid to physician

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Medicare & PAs

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

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

Medicare & PAs

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

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

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Examples of PA Services
Initial & Subsequent Hospital, Discharge, and Observation Services
Critical Care & Emergency Services
New & Established Outpatient Office Visits
Minor Surgical Procedures and Assistant-At-Surgery Services
Diagnostic Tests and Interpretations
Chronic Care Management
Telehealth Services

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PAs	NPs
▪Provide services **under general supervision** of a physician	▪Provide services **in collaboration** with a physician
▪May bill under own name/NPI	▪May bill under own name/NPI
▪Reimbursed at 85%	▪Reimbursed at 85%
▪May receive direct payment (effective 2022)	▪May receive direct payment

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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."

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When State law does not require “supervision”…

- 14 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"...

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

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

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Medicare 'work around' for PA supervision is similar to that for NP collaboration

Federal statutory requirement for NPs is met if:

- There is documentation at the practice level of
  - NP scope of practice
  - Collaborative process with physicians for dealing with issues outside their scope of practice

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

AAPA

Direct Payment* by Medicare

- PAs have been the only health professionals authorized to bill Medicare for their services but not able to receive direct payment (payment went to employer)

- Most PAs (like most NPs/physicians) will reassign payment to their employer

* Effective January 1, 2022

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Direct Payment by Medicare

Why is Direct Pay Important?

- Parity with other healthcare professionals
- Reinforces PAs as distinct healthcare professionals in policy discussions
- PAs will be able to fully participate in certain employment and ownership arrangements
(including 100% practice ownership, if allowed by State law)

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Direct Payment by Medicare

What Direct Pay is Not?

Direct Pay does not change

- Reimbursement rate
- Commercial payer policies
- State law limitations against PA billing & payment
- Scope of practice

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Medicare Billing Policies

- Federal Law
- Hospital Conditions of Payment & Participation
- Medicare Administrative Manuals
- Medicare Interpretive Guidelines
- Medicare Administrative Contractors (MACs)

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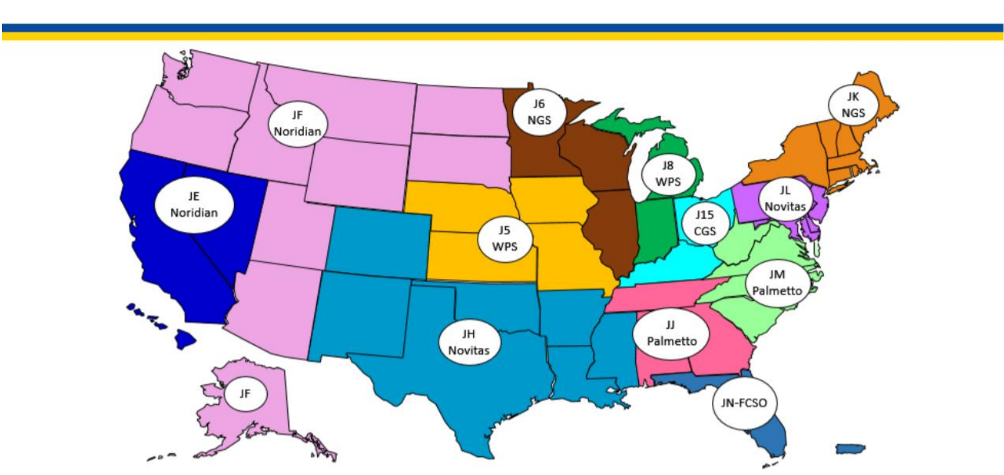
Medicare Administrative Contractors (MACs) & Jurisdictions



https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/AB-MAC-Jurisdiction-Map-Oct-2017.pdf

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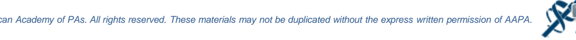
Optional Medicare Billing Mechanisms

Optional billing mechanisms to receive 100% reimbursement from Medicare:

- Split/Shared billing
- “Incident To”

Warning: may lead to inefficiency, risk for fraud and abuse, lack of transparency, and other unintended consequences



Split/Shared Billing

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

Must meet certain criteria and documentation

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Split/Shared Billing

- Services provided must be **E/M services** (does not apply to critical care services or procedures)
- Both PA and physician must **work for the same entity**
- Physician must provide a "**substantive portion**" and have **face-to-face** encounter with patient
- Professional service(s) provided by the physician must be **clearly documented** with clear distinction between the physician's and the PA's services
- Both the PA and physician must treat the patient on the **same calendar day**

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

Split/Shared Billing

Substantive Portion

"All or some portion of the history, exam, or medical decision-making key components of an E/M service" – CMS

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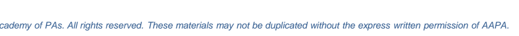
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Split/Shared Documentation

Documentation requirements vary significantly by MAC (Medicare Administrative Contractor)

- Physician must document at least one element of the history, exam and/or medical decision making
- Physician need only document attestation of face-to-face contact with patient and that a substantive portion of service was performed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Split/Shared Billing

- No physician face-to-face encounter
- Physician failed to see patient on same calendar day
- Improper documentation
- Any other criteria not met

Bill under the PA for 85% reimbursement

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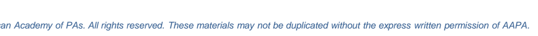
Incident-To Billing

- Office billing provision that allows services performed by PAs/NPs to be billed under physician's name/NPI at 100% reimbursement
- ONLY applies to services furnished incident to physician professional services in a physician's office

NEVER applies in a hospital or facility setting



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"Incident To" Billing

- The **physician must personally see the patient** and **initiate treatment**
- The incident to services must be an **incidental to the course of treatment initiated by the physician**
- The physician is responsible for the overall care of the patient and should perform services at a frequency that reflects his or her active and **ongoing participation** in the management of the patient's course of treatment
- The physician (or a physician in the group practice) must be **present in the office** suite when the incident to service is provided.
- Both the PA/NP and physician must **work for the same entity**

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“Incident To” Billing

- New patient or new problem
- Physician not in office
- Alteration in established plan of care
- Any other criteria not met

Bill under the PA for 85% reimbursement

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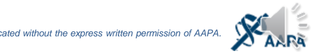

Incident-To Billing Does NOT Apply

Inpatient & Observation Services

Hospital Outpatient Services

- **Outpatient Clinic**
- Emergency Department
- Same Day Surgery Center

Inpatient Nursing & Rehabilitation Facilities

Some physician practices that have been purchased by a hospital are now considered hospital outpatient clinics, rendering them ineligible for incident-to billing

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Billing "Best Practices"

- An increasing number of employers and healthcare systems are minimizing or eliminating "incident to" and split/shared billing (instead billing under the PA's name/NPI)
  - Increased efficiency
  - Improved workflows
  - Increased patient access
  - Decreased administrative and documentation burden
  - Increased transparency and accountability
  - Reduced risk of non-compliance

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Admissions

- Based on "two-midnight" rule, it was mistakenly believed that CMS prohibited PAs from performing H&Ps or writing admission orders
- CMS issued clarification 1/30/14 acknowledging that PAs are authorized to write admission orders and perform H&Ps
- May be performed and billed under PA name/NPI (at 85%) or under physician name/NPI if split/shared rules met (100%)

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https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R234BP.pdf

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Admissions

- Every Medicare patient must be "under the care of a doctor", which was demonstrated by signature or co-signature of the admission order
- Medicare guidance - physician co-sign admission order prior to patient discharge (1 day prior to submission of the claim if a CAH)

https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec482-12.pdf

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https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf

Admissions

To cosign or not to cosign?

Effective 1/1/19, “no longer require a written inpatient admission order to be present in the medical record as a specific condition of Medicare Part A payment”

https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec482-12.pdf

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https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf

Discharges

- Time-based (< 30 min or ≥ 30 min)
- May be performed and billed under PA name/NPI (at 85%) or under physician name/NPI if split/shared rules met (100%)
- *Discharge Summary used to require cosignature by a physician within 30 days of discharge*

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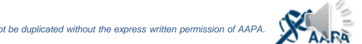

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CMS clarified in correspondence to AAPA that a discharge summary does not need to be co-signed by a physician if the following criteria are met:

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

PA is acting within their scope of practice, state law, and hospital policy; and co-signature is not required by state law or hospital policy

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

Although not required, surveyors may still look for co-signatures and cite hospitals for their absence until Medicare updates guidance documents.

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Consults

- Could be requested and performed by physicians and PAs/NPs but could not be billed as split/shared services
- Effective 1/1/10 Medicare eliminated consult codes
- No consult codes = no consult split/shared rules

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https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6740.pdf

Surgical Procedures

- PAs may personally perform and bill for minor surgical procedures
- Practitioner who does the majority of a procedure is the one under whom the procedure should be billed

Remember, procedures not eligible for split/shared billing

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https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2282CP.pdf

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Assisting at Surgery

- PAs/NPs covered by Medicare for first assist
- At 85% of the physician's first assisting fee
  - Physician who first assists gets 16% of primary surgeon's fee – PAs/NPs get 13.6% of primary surgeon's fee
- -AS modifier for Medicare
- Be aware of list of exclusion codes (procedures for which assistant at surgery is used < 5% of the time nationwide)

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

Assisting at Surgery

- **Physician** must be physically **present during all critical or key portions** of the procedure and be immediately available during the entire procedure
- Critical portions of two surgeries performed by the same physician may not take place at the same time
- If physician not immediately available during non-critical portions, must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed

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Assisting at Surgery

Teaching Hospitals

- Based on the Social Security Act, Medicare does not generally reimburse for first assistant fees if there is a qualified resident available
- Teaching Hospital Exception allowed:
  - No qualified resident available (in required training/clinic-hours or resident-hour restrictions)
  - Physician NEVER uses a resident in pre-, intra-, and post-op care
  - Exceptional medical circumstances (e.g. multiple traumatic injuries)

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

Assisting at Surgery

Teaching Hospitals

When no qualified resident available

- Physician must certify

  I understand that § 1842(b)(7)(D) of the Act (follow the link and select the applicable title) generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the A/B MAC (B).

- Must use second modifier -82
  (in addition to –AS)

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Duke University Health System, Inc. Agrees To Pay $1 Million For Alleged False Claims Submitted To Federal Health Care Programs

RALEIGH – United States Attorney for the Eastern District of North Carolina Thomas G. Walker and North Carolina Attorney General Roy Cooper announced jointly that Duke

Hospital). Duke University Health System allegedly made false claims to Medicare, Medicaid, and TRICARE by (1) billing the government for services provided by physician assistants (PA's) during coronary artery bypass surgeries when the PA's were acting as surgical assistants (along with graduate medical trainees), which is not allowed under government regulations and (2) increasing billing by unbundling claims when the unbundling was not appropriate, specifically in connection with cardiac and anesthesia

TRICARE by (1) billing the government for services provided by physician assistants (PA's) during coronary artery bypass surgeries when the PA's were acting as surgical assistants (along

https://www.justice.gov/usao-ednc/pr/duke-university-health-system-inc-agrees-pay-1-million-alleged-false-claims-submitted

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Critical Care Services

3 criteria to bill critical care:

- Patient must be critically ill

  "acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition"

- Provider must treat the critical illness using "high complexity decision making"

  care must be provided at the bedside or on the floor/unit

- Time

  must spend at least 30 minutes

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Critical Care Services

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

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICARE CRITICAL CARE SERVICES
PROVIDER COMPLIANCE AUDIT:

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

Critical Care Services

After first 30 minutes of critical care time

- Any additional care time is counted
- Time spent may be either continuous or intermittent and then aggregated
- Must document total time that critical care services were provided

The following two codes define critical care time:

- 99291 – 30-74 minutes of critical care on a given day
- 99292 - each additional 30 minutes of critical care

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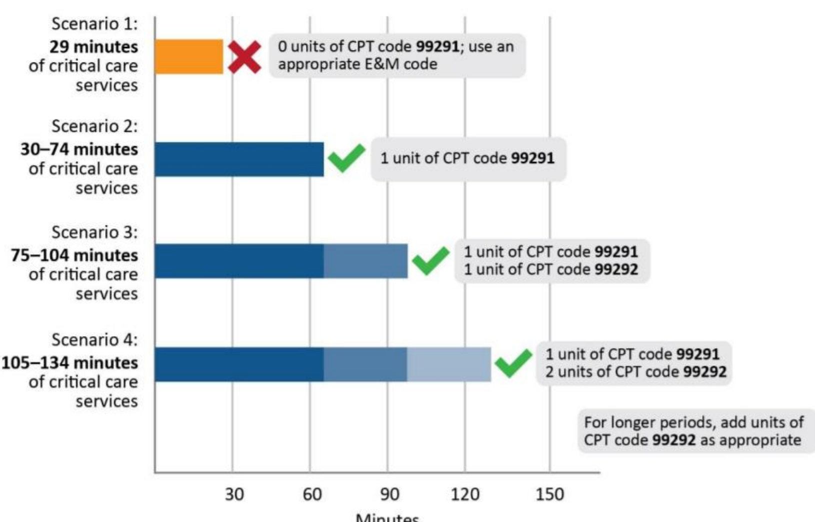
Critical Care Services



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Timothy Clark

On March 20, 2014, Chief United States District Court Judge Christopher Conner sentenced doctor Timothy Clark, age 47, to 15 months imprisonment for health care fraud and pension fraud.

Clark was ordered to pay restitution of $130,535.05 and forfeiture of $105,518.46.

On April 22, 2013, Clark pleaded guilty in federal court in Harrisburg.

Clark is a medical doctor and pulmonologist and the sole owner of Central Pennsylvania Pulmonary Associates(CPPA) and Sleep Disorder Centers of Central Pennsylvania. In June 2012 and again in July, Clark was indicted by a federal grand jury in Harrisburg in separate indictments.

In July 2012, Clark was indicted on charges that from December 2007 through September 26, 2008, Clark, who provided critical care services to patients of Holy Spirit Hospital, intentionally inflated the amount of time the healthcare providers he employed spent with each patient, thereby fraudulently inflating the health insurance claims Clark submitted to Medicare, Highmark, Inc., and Capital Blue Cross. The dollar amount of the fraudulent claims exceeded $500,000. In the

healthcare benefit programs in connection with the delivery and payment of healthcare benefits and money laundering.

The case involving the embezzlement from an employee benefit plan was investigated by the United States Department of Labor, Employee Benefits Security Administration, the United States Department of Labor, Office of Inspector General, the United States Department of Health and Human Service, Office of

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Critical Care Services

- PAs/NPs may provide services and receive payment
- More than one physician can provide critical care at another time and be paid if the service meets critical care, is medically necessary and is not duplicative care
- Critical care time provided by a physician and a PA/NP cannot be combined

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

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https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2282CP.pdf

Critical Care Services

"Unlike other E/M services where a split/shared service is allowed the critical care service reported shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified non-physician practitioner and shall not be representative of a combined service between a physician and a qualified NPP [e.g. PA & NP]."

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

Restraint & Seclusion

Prior to December 2019

Medicare Conditions of Participation stated:

§ 482.13(e)(5) use of restraint or seclusion must be in accordance with the order of a physician or licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law

Licensed Independent Practitioner

An individual authorized to provide care and services without direction or supervision

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Restraint & Seclusion

- CMS changed term "Licensed Independent Practitioner" to "Licensed Practitioner
- Effective November 29, 2019
- Resulted from ongoing AAPA advocacy

482.13(e)(5) use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law

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NEW Joint Commission Elements of Performance Effective 3/15/20

PC.03.05.05
The hospital initiates restraint or seclusion based on an individual order.

Elements of Performance for PC.03.05.05

1. A physician~~, clinical psychologist,~~ or other authorized licensed ~~independent~~ practitioner ~~primarily~~ responsible for the patient's ~~ongoing~~ care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation.

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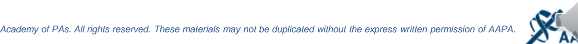
Restraint & Seclusion

For PAs to order restraint and the following criteria must be met:

- Consistent with hospital bylaws and policies
- Included as part of a PA's scope of practice, practice agreement, and granted privileges
- Not prohibited by State laws or regulations



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EMTALA

- Ensures access to emergency services regardless of ability to pay
- Requires medical screening examination (MSE) of emergency medical condition (EMC)
- Must provide stabilizing treatment of EMCs
- Must arrange appropriate transfer if not capable of providing stabilizing treatment or if patient requests

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https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/Downloads/CMS-1063-F.pdf

EMTALA

If consistent with scope of practice and hospital policy, PAs (& NPs) may perform the following in compliance with EMTALA:

Medical screening exam

Certifying false labor

Transferring patients
(if physician not present in ED)

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EMTALA

- Hospitals must maintain a list of physicians who are on call to provide treatment necessary to stabilize an individual with an EMC after initial examination
- If a physician on the list is called to provide emergency screening or treatment and fails or refuses to appear within a reasonable period of time, the hospital and physician may be in violation of EMTALA

https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/Downloads/CMS-1063-F.pdf

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https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter08-15.pdf

EMTALA

- PAs (& NPs) may respond to a call from an ED (or other hospital department) that is providing screening or stabilization mandated by EMTALA
- ONLY if directed by the responsible physician based on the individual medical needs of the patient

Physician must provide "first call" and make a case-by-case determination if care can be provided by a PA or NP

https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/Downloads/CMS-1063-F.pdf

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https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter08-15.pdf

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MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND
NON-PHYSICIAN PRACTITIONERS

"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."

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

False Claims Act

Imposes civil liability on “any person who **knowingly** presents, or **causes** to be presented a false or fraudulent claim for payment.”

Knowingly means a person has “actual knowledge of the information”, acts in “**deliberate ignorance**”, or **reckless disregard**” of the truth or falsity.

“**No proof of specific intent** to defraud is required to violate the civil FCA.”

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https://www.govinfo.gov/content/pkg/USCODE-2010-title31/pdf/USCODE-2010-title31-subtitleIII-chap37-subchapIII-sec3729.pdf

False Claims Act

In addition to refunding payments and costs to the Federal government for civil action:

- Treble damages (up to 3X amount violator received)
- Civil monetary penalties (up to $23,331 per false claim)
- Additional fines and/or imprisonment
- Exclusion from Medicare, Medicaid, and all other Federal healthcare programs

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https://www.govinfo.gov/content/pkg/FR-2020-01-03/pdf/2019-27864.pdf

Fraud & Abuse: By the Numbers

Fiscal Year 2020

4 billion recovered in FY 2019	**624** criminal actions	**791** civil actions	**2,148** excluded from participation

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https://oig.hhs.gov/reports-and-publications/archives/semiannual/2019/2019-fall-sar.pdf

Whistleblowers: By the Numbers

600+ whistleblower cases each year	$2.1 of $3 billion in FCA settlements from whistleblowers in 2019	30% of recovered funds eligible to whistleblowers

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

Anti-Kickback Statute

- Prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals that generate Federal health care program business
- False Claims Act liability, criminal fines, civil monetary penalties, prison term (up to 5 years per violation), exclusion from Federal programs

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https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1734B3.pdf

Stark Law

- AKA 'Physician Self-Referral Statute'
- Prohibits a physician from referring Medicare patients for health services to an entity with which the physician (or immediate family member) has a financial relationship
- Prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral
- False Claims Act liability, civil monetary penalties, exclusion from Federal programs

Specifically applies to physicians but implications for PAs & APRNs, and who are advised to follow law as if it directly applies to them

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https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1734B3.pdf

Medicare Payment & Employment Arrangements

- Physicians who are not employed by the same entity as the PA have no ability to bill for work provided by PAs
- OIG determined that it is improper for physicians to enter into arrangements that relieve them of a financial burden that they would otherwise have to incur

Particularly problematic with a hospital-employed PA and non-hospital employed physician

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Work being performed by a hospital-employed PA for a physician not employed by the same entity is subject to:

Anti-Kickback	**Stark Law**
Inurement for referrals to hospital	Remuneration (indirect compensation) by the hospital

False Claims Act Liability

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U.S. attorney investigating DMC over possible federal anti-kickback violations

by Jay Greene   Crain's Detroit Business

. . . **termination of the employment of 14 nurse practitioners and physician assistants was due, in part,** to the company's concerns that their prior employment did not comply with the **Anti-kickback Statute, the Stark law and False Claims Act**.

. . . **services the NPs and PAs were delivering to private doctors** might run afoul of federal laws designed to prevent improper patient referrals to the hospital.

. . . **blatant violations** would be a hospital paying fees for admissions or services, but **could** also **include** offering doctors office leases at below market value, or free or discounted services like **advanced-practice providers' coverage of private doctors' patients.**

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https://www.crainsdetroit.com/article/20180228/news/654046/us-attorney-investigating-dmc-over-possible-federal-anti-kickback

After it Self-Disclosed Conduct to the OIG, Inova Health Care Services Agreed to Pay $528, 158

Healthcare FMV Advisors

. . . agreed to pay $528,158 for allegedly **violating** the Civil Monetary Penalties Law **provisions applicable to kickbacks and physician self-referrals**.

The OIG alleged that Inova **paid remuneration** to Arrhythmia Associates (AA) **in the form of services provided by certain PAs within the office of AA**. Specifically, Inova provided PA service to AA without written contract in place and failed to bill and collect for those PA services.

http://www.healthcarefmvadvisors.com/NewsUpdates/tabid/63/EntryId/13/After-it-self-disclosed-conduct-to-the-OIG-Inova-Health-Care-Services-d-b-a-Inova-Fairfax-Hospital-Inova-Virginia-agreed-to-pay-528-158.aspx

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Chicago Hospital Scam Had "Kickback on Steroids", Jury Told

by Lance Duroni
Law 360

. . . Assistant U.S. Attorney Ryan Hedges walked the jury through . . . how the **hospital cloaked illegal payments** to doctors.

. . . the defendants took the conspiracy to a "whole new level" when they began loaning out mid-level medical professionals, including physician assistants and nurse practitioners, to doctors free-of-charge in return for patients, Hedges said, calling the maneuver **"kickbacks on steroids"**.

https://www.law360.com/articles/630708/chicago-hospital-scam-had-kickbacks-on-steroids-jury-told
https://www.justice.gov/usao-ndil/pr/sacred-heart-hospital-owner-executive-and-four-doctors-arrested-alleged-medicare

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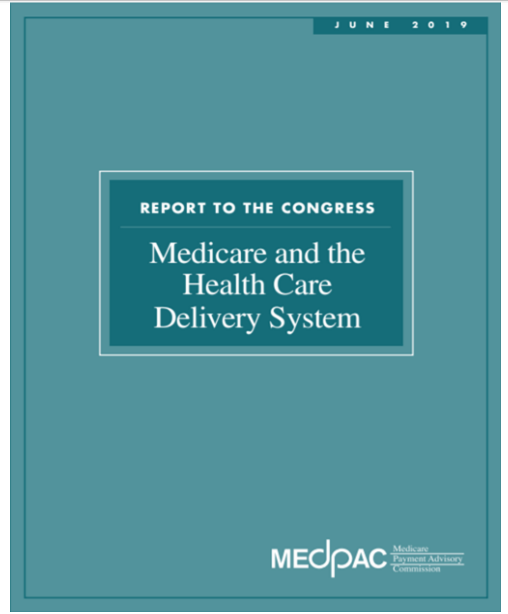

"PAs nearly always lower costs and increase profits for their employers because their salaries are less than half of physician salaries, on average, but their services can be billed at the full physician rate or at a modest discount ."

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http://medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0

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More than made up for in increased efficiency, decreased burden, and actual contribution margin.

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Reimbursement & Profit

- PA reimbursement at 85% of physician fee schedule
- PA salary is 30% - 50% that of physician salary*
- Contribution margin for a PA is no less than (and sometimes greater than) that of a physician

Contribution Margin
revenue after variable costs

*MGMA Data

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Costs of “Personnel”

Cost	Comparison
Salary	PA < physician
Benefits (PTO, CME allotment, etc.)	PA ≤ physician
Recruitment/Onboarding	PA ≤ physician
Malpractice Premiums	PA < physician
Overhead (building, staff, supplies)	PA = physician

Overall cost to employ PA ↓↓↓ physician

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PA Cost-effectiveness at 85% Reimbursement

A hypothetical day in an ED	Physician	PA
Revenue with physician and PA providing the same 99283 service	$1650 ($66 X 25 visits)	$1400 ($56 X 25 visits) [85% of $66 = $56]
Wages per day	$1440 ($120/hour X 12 hours)	$636 ($53/hour X 12 hours)
"Contribution margin" **(revenue minus wages)**	$210	$764

Example does not include personnel costs and other expenses.

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Profit and Gross Profit: Initial Hospital Care

Provider Type	Median Annual Compen-sation	Hourly Salary	Initial Hospital Care (99221)		Initial Hospital Care (99222)		Initial Hospital Care (99223)	
			Reimburse -ment	Contribu-- tion Margin	Reimburse -ment	Contribu-- tion Margin	Reimburse -ment	Contribu-- tion Margin
MD/DO	$250,000	$120	$103	**-$17**	$139	**+$19**	$205	**$85**
PA/NP	$110,000	$53	$88	**+$35**	$118	**+$65**	$174	**$121**
Difference			$15		$21		$31	

Contribution Margin
=
reimbursement
-
hourly salary

(assuming 60 minutes time spent per encounter)

https://www.medpagetoday.com/practicemanagement/salary-survey/77085
https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

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Profit and Gross Profit: Subsequent Hospital Care

Provider Type	Median Annual Compen-sation	Hourly Salary	Subsequent Hospital Care (99231)		Subsequent Hospital Care (99232)		Subsequent Hospital Care (99233)	
			Reimburse-ment	Contribu--tion Margin	Reimburse-ment	Contribu--tion Margin	Reimburse-ment	Contribu--tion Margin
MD/DO	$250,000	$120	$40	**-$20**	$74	**$14**	$106	**$46**
PA/NP	$110,000	$53	$34	**-$7.5**	$63	**$36.5**	$90	**$63.5**
Difference			$6		$11		$16	

Contribution Margin
=
reimbursement
-
0.5 hourly salary

(assuming 30 minutes time spent per encounter)

https://www.medpagetoday.com/practicemanagement/salary-survey/77085
https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

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Profit and Gross Profit: Hospital Discharge

Provider Type	Median Annual Compen-sation	Hourly Salary	Hospital Discharge (99238)		Hospital Discharge (99239)	
			Reimbursement	Contribution Margin	Reimbursement	Contribution Margin
MD/DO	$250,000	$120	$74	**$14**	$109	**$49**
PA/NP	$110,000	$53	$63	**$36.5**	$93	**$66.5**
Difference			$11		$16	

Contribution Margin
=
reimbursement
-
0.5 hourly salary

(assuming 30 minutes time spent per encounter)

https://www.medpagetoday.com/practicemanagement/salary-survey/77085
https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

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Cost-Effectiveness Take Away Points

- Point is not that PAs produce greater contribution margin than physicians
  - That may or may not happen
    (more likely in primary care versus surgical specialty)
- Point is that PAs generate a substantial contribution margin for a practice/employer even when reimbursed at 85%
- An appropriate assessment of monetary "value" includes revenue, expenses, and non revenue-generating services

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Global Surgical Package

- Bundled payment for all usual and necessary pre-, intra-, and post-operative care for a procedure or surgery
- 0-day, 10-day, and 90-day post-operative period
- PA contribution is sometimes "hidden"

Global Surgery Booklet

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf

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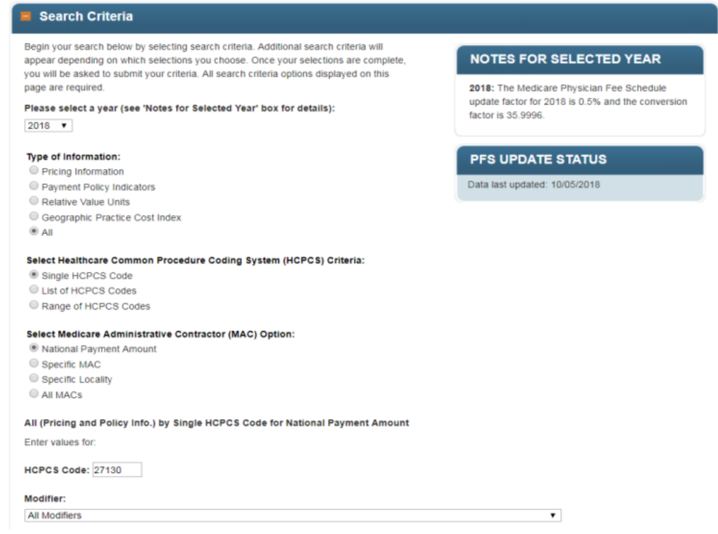
Physician Fee Schedule Search

https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx



Search Criteria

Begin your search below by selecting search criteria. Additional search criteria will appear depending on which selections you choose. Once your selections are complete, you will be asked to submit your criteria. All search criteria options displayed on this page are required.

Please select a year (see 'Notes for Selected Year' box for details):

2018

Type of Information:
- Pricing Information
- Payment Policy Indicators
- Relative Value Units
- Geographic Practice Cost Index
- All

Select Healthcare Common Procedure Coding System (HCPCS) Criteria:
- Single HCPCS Code
- List of HCPCS Codes
- Range of HCPCS Codes

Select Medicare Administrative Contractor (MAC) Option:
- National Payment Amount
- Specific MAC
- Specific Locality
- All MACs

All (Pricing and Policy Info.) by Single HCPCS Code for National Payment Amount

Enter values for:

HCPCS Code: 27130

Modifier:

All Modifiers

NOTES FOR SELECTED YEAR

2018: The Medicare Physician Fee Schedule update factor for 2018 is 0.5% and the conversion factor is 35.9996.

PFS UPDATE STATUS

Data last updated: 10/05/2018

- ✓ Type of information: All
- ✓ Single HCPCS Code
- ✓ Select MAC/Locality option
- ✓ Modifier: All Modifiers

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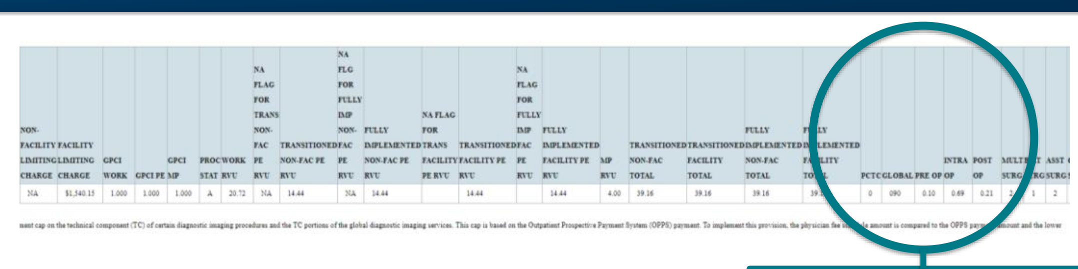

NON-FACILITY LIMITING CHARGE	FACILITY LIMITING CHARGE	GPCI WORK	GPCI PE	GPCI MP	PROC STAT	WORK RVU	NA FLAG FOR TRANS NON-FAC PE RVU	TRANSITIONED NON-FAC PE RVU	NA FLG FOR FULLY IMP NON-FAC PE RVU	FULLY IMPLEMENTED NON-FAC PE RVU	NA FLAG FOR TRANS FACILITY PE RVU	TRANSITIONED FACILITY PE RVU	NA FLAG FOR FULLY IMP FAC PE RVU	FULLY IMPLEMENTED FACILITY PE RVU	MP RVU	TRANSITIONED NON-FAC TOTAL	TRANSITIONED FACILITY TOTAL	FULLY IMPLEMENTED NON-FAC TOTAL	[illegible]	PCTC	GLOBAL	PRE OP	INTRA OP	POST OP	MULT SURG	[illegible]	ASST SURG
NA	$1,540.15	1.000	1.000	1.000	A	20.72	NA	14.44	NA	14.44		14.44		14.44	4.00	39.16	39.16	39.16	[illegible]	0	090	0.10	0.69	0.21	2	1	2

nent cap on the technical component (TC) of certain diagnostic imaging procedures and the TC portions of the global diagnostic imaging services. This cap is based on the Outpatient Prospective Payment System (OPPS) payment. To implement this provision, the physician fee [illegible] amount is compared to the OPPS paym[illegible] amount and the lower

HCPCS CODE	SHORT DESCRIPTION	GLOBAL	FACILITY PRICE	WORK RVU	**PRE OP**	**INTRA OP**	**POST OP**
27130	Total hip arthroplasty	90	$1,409.74	20.72	**0.1**	**0.69**	**0.21**

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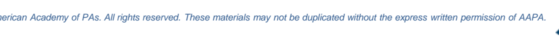
https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

Hypothetical Work Attribution for Total Hip Arthroplasty

27130	Global Surgical Surgical Package	Physician	PA
Pre-operative (0.1)	$140.97 2.07 wRVU		$140.97 2.07 wRVU
Intra-operative (0.69)	$972.72 14.30 wRVU	$972.72 14.30 wRVU	
Post-operative (0.21)	$296.05 4.35 wRVU		$296.05 4.35 wRVU
Total	$1,409.74 20.72 wRVUs	$972.72 14.30 wRVU	$437.02 6.42 wRVU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CPT Code 99024

- *Postoperative follow-up visit, normally included in the surgical package*
- No fee, no RVUs
- Captures services normally included in the surgical package

Captures post-op work provided in Global Surgical Package

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PA Value = More than $

- Increase revenue and decrease health care costs
- Improve access to care and patient throughput
- Increase patient and staff satisfaction
- Contribute to process/quality improvement and outcomes
- Facilitate care coordination and communication

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Payer polices are often unclear. Health professionals and billing/compliance staff
should receive ongoing education and training.

Just because Medicare or a payer has been reimbursing for a service does not mean the organization is billing appropriately.

Pre- and post-payment audits are in use by most payers.

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

Don't assume

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

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

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

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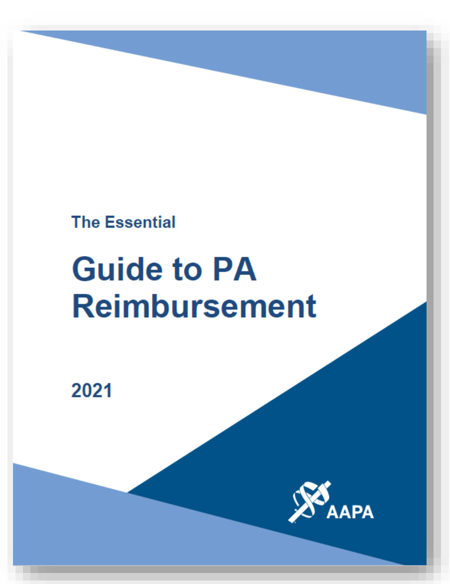

$25 for members

https://www.aapa.org/shop/essential-guide-pa-reimbursement/

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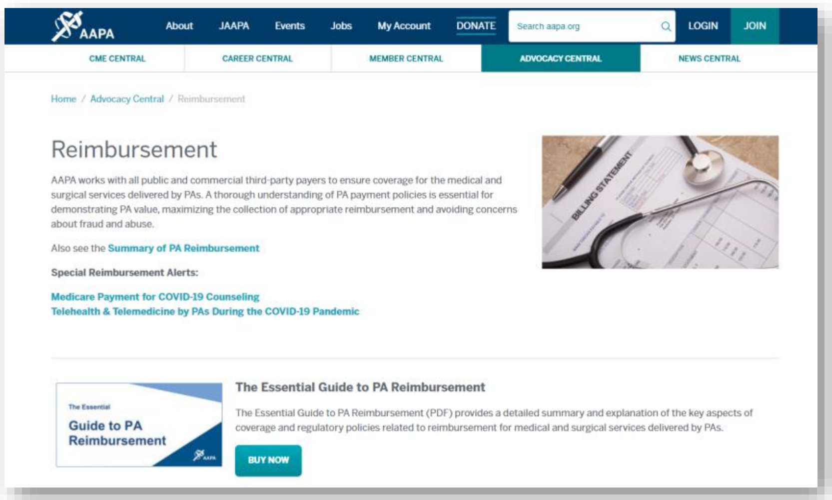
AAPA Resources



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

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Additional References & Resources

- Medicare Claims Processing Manual
  - Chapter 12 – Physicians/Nonphysician Practitioners

    https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf
  - Chapter 15 – Covered Medical and Other Health Services

    https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Code of Federal Regulations
  - Title 42 – Public Health

    https://www.ecfr.gov/cgi-bin/text-idx?SID=28cbafbbd980d94723375b715d900a73&mc=true&tpl=/ecfrbrowse/Title42/42tab_02.tpl

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Key Takeaways

- PAs are valuable, cost-effective members of the healthcare team!
- Know Medicare laws and policies that affect your practice
- Understand implications of Medicare fraud and abuse, and how to avoid them
- Call on AAPA as a resource for guidance

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thank you!

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