Reimbursement Strategies for 2022

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Disclaimer/Disclosure

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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 payment 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.
- The American Medical Association has copyright and trademark protection of CPT ©.

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Learning Objectives

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

- Explain the reimbursement policies that will impact health professionals as payment systems attempt to further transition to value-based reimbursement.
- Describe payment strategies and methods to improve PA/NP utilization in various health care settings.
- Identify approaches to improve the recognition and tracking of the financial and non-financial contributions and productivity of PAs and NPs.

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PA Title Change

- In May 2021, the AAPA House of Delegates voted to adopt “Physician Associate” as the official title of the profession.
- This change will more accurately describe the profession, better position PAs in the minds of patients and stakeholders and increase your ability to improve access to care in an ever-changing healthcare marketplace.
- AAPA’s legal counsel recommends that PAs not call themselves “physician associates” until state laws and regulations officially recognize the new title.

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PA Title Change

- AAPA is developing resources to help PAs explain and assist states in preparing for the title change effort.
- Title change will take time to complete. Specific changes will need to occur on both the state and federal levels.
- Like other laws/regulations impacting PAs, title change will occur at different times in each state.
- The official name of AAPA has been changed to the American Academy of Physician Associates.

PA Title Change: $Reimbursement Implications$

- AAPA will educate and engage with commercial third-party payers/insurers/HMOs as states begin to make changes to ensure uninterrupted reimbursement.
- Medicare, Medicaid, Workers' Comp and other state and federal entities/agencies will need to officially recognize the new title.
- AAPA Title Change FAQ https://www.aapa.org/title-change-investigation/faqs/

Direct Payment to PAs from Medicare

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, currently 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 number of commercial payers that currently pay directly to PAs and/or PA corporations.

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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 additional administrative barriers to hiring/utilizing PAs.

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The Benefits of Direct Payment Will Be Especially Important to PAs Who:

- Practice as independent contractors.
- Want to work part-time without having to deal with additional administrative paperwork associated with a formal employment relationship.
- Choose to own their own practice/medical or professional corporation.
- Work in rural health clinics (RHCs) and want to ensure they receive reimbursement for “carved out” (now Part B) RHC services.

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PA Direct Payment

- Direct payment does not change PA scope of practice.
- Medicare's rate of reimbursement (85%) will not change.
- Similar to physicians and NPs, the majority of PAs will maintain there traditional W-2 employment arrangement with employers.
- PA direct payment is an option for PAs.

Direct Payment – 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 necessarily change reimbursement policies of state Medicaid programs or commercial payers. AAPA will use Medicare's policy to advocate for direct payment with all other 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.

COVID-19 Public Health Emergency (PHE)

- Numerous Medicare program flexibilities were established for NPs and PAs due to the PHE including being authorized to:
  - provide all “physician” services in skilled nursing facilities
  - patients being “under their care” of PAs/NPs in hospitals
- PHE extended for additional 90-days by HHS Secretary Becerra. Currently in effect until January 13, 2022.
- Possibility the PHE could run through all of 2022 to maintain flexibilities and ensure against patients losing access to care.

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2022 Final Physician Fee Schedule

- Includes implementation language on PA direct pay.
- Extends certain PHE telehealth coverage policies.
- Makes significant changes to shared visit billing documentation (especially relevant for PAs/NPs who deliver care in hospitals)
- Asks whether direct supervision/collaboration (normally on-site) should occur virtually.
- AAPA's comments to CMS are available for review.

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

Previous Outpatient Office-based Documentation Guidelines

Health professionals were required to document (or use time with counseling/coordination of care):

- Past, Family, Social History
- History of Present Illness (HPI)
- Chief Complaint (CC)
- Exam (including review of systems - an inventory of body systems)
- Medical decision making

Result: reviewing too many organ systems; gathering irrelevant information; too much unnecessary data in the medical record

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

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Levels of Medical Decision Making (MDM)

Health professionals must use 2 of the 3 broad MDM categories to determine code level:

- **The number/complexity of problems**
- **Data, collected ordered or reviewed**
- **Risk levels of medical decision making**

Activities That Count Toward Total Time

Eligible time includes both face-to-face and non-face-to-face time personally spent before, during and after the visit on that same calendar day.

Examples include:

- Reviewing tests results
- Counseling or educating a patient, family or caregiver
- Reporting test results to a patient by phone
- Ordering medications, tests or procedures
- Care coordination (when not separately reportable)
- Referring the patient to and communicating with other health care professionals (when not separately reportable)

(time of RNs, LPNs & other personnel does not count toward documentation of time)

Office-based E/M Documentation Resources

- **CPT Table for Elements of Medical Decision Making**
  https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

- **AAPA coding webinar**
  https://cme.aapa.org/local/catalog/view/product.php?productid=413

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Value-based Reimbursement

Value-based Reimbursement (VBR)

- To the dismay of payers, the move toward VBR remains uneven.
- The risk of financial loss prevents many health professionals from engaging in risk-based contracts. Some hospitals and health systems have made greater progress.
- Often value-based payments continue to be implemented on fee for service framework. Certain Medicare “advanced payment models” utilize a fee-for-service reimbursement concept.

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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 Medicare has been reluctant to levy large penalties against health professionals who are “poor performers” as part of a VBR model, the program has not been able to appropriately move dollars and reward (incentivize) high performers.

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Risk Adjustment – Hierarchical Condition Category (HCC) Coding

- Different from medical visit documentation for fee-for-service coding.
- Hierarchical Condition Category (HCC) coding is a payment model used by CMS to reimburse Medicare Advantage plans/ACOs based on the comparable health of their members.
- The goal of HCC coding is to accurately reimburse for the predicted cost expenditures of patients by adjusting those payments based on demographic information (e.g., age) and the health status of patients (e.g., co-morbidities).

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Risk Adjustment – HCC Coding

- Risk adjustment methodologies need quality data to be effective.
- The goal is for HCC coding to be effective in predicting resource use by Medicare Advantage enrollees.
- PAs, physicians and NPs must thoroughly report each patient's risk adjustment diagnosis which should be based on accurate clinical medical record documentation.

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Realities of HCC Coding

- HCC coding, quality metrics and risk scores will impact, but not be the basis of payments/reimbursement.
- Health professionals will not necessarily be punished for allocating (expending) more resources toward patient care, as long as patient outcomes are improved in the process.
- The goal of HCC coding is to help identify patient's medical conditions, acuity of illness and other factors that impact costs of care.

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Reduce The Risk of Fraud and Abuse Allegations

Compliance Scenario #1

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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Compliance Scenario #2

- A physician repaid $285,000 to settle False Claims Act violations.
- Services provided by a NP were billed as “incident to” under the physician’s name.
- Medicare’s “incident to” provisions were not met. The payment should have been at the 85% rate.

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Promise to the Federal Government

On the Medicare Enrollment Application

"I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I 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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Promise to the Federal Government

On the Medicare 1500 claim form

"This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents or concealment of any material fact may be prosecuted under applicable Federal or State law."

CMS 1500 form https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500.pdf

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OIG Exclusion & CMS Preclusion of Individuals/Entities

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Who Is Responsible?

The “chain of responsibility” is multi-faceted.

- Health professionals are responsible for claims submitted for the services they deliver.
- Federal programs will typically expect recoupment/repayment from the entity that received the reimbursement.
- Those who physically submit the bill (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 paper or 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 they deliver care.

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Following the Rules Depends on Your Practice Setting

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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Medicare Billing

PA/NP Medicare Reimbursement Myths

- Can’t see/treat new patients.
- Physician must be on-site.
- Physician must, at some point, see every patient.
- Physician co-signature required.
- State, facility and commercial payer policies can be more restrictive than Medicare policies.

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Overarching Scope of Practice

- If authorized under the scope of their State license, NPs/PAs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests . . . *Current Procedural Terminology manual 2021*

- Individual commercial payers and state Medicaid programs can impose their own coverage and payment policies.

- Commercial payers often have fewer written coverage policies for PAs/NPs.

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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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Split/Shared Billing

Split/Shared Billing Rules - What Will Stay the Same for 2022

- ✓ Services provided must be E/M services (no procedures).

- ✓ The physician and PA (or NP) must work for the same group/entity.
- ✓ The physician and PA (or NP) must both treat the patient on the same calendar day.
- ✓ The services must be performed in a hospital, facility, or hospital outpatient office/department.
- ✓ The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.

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Split/Shared Billing Rules - What Has Changed for 2022

- The definition of a **"substantive portion"** of a split/shared service, which is used to determine under whom the service can be billed, will change.

- **Current definition**: if the physician performs all or some portion of the history, exam, or medical decision-making key components of an E/M service it can be a physician bill (payable at 100%)

- For 2022, a substantive portion of the service by a physician is defined as: 1) the physician personally performing either the history, exam, or medical decision making (in its entirety), or 2) the physician spending more than half of the total time by both the physician and the PA (or NP) on face-to-face and non-face-to-face patient care activities.

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Split/Shared Billing Rules - What Has Changed for 2022

- Critical care services can now be split/shared. Still billed on a time-based methodology.

- Medicare will require the use of a modifier code when a split/shared visit occurs (specific code not yet indicated).

- Certain visits occurring in skilled and non-skilled nursing facilities, which previously had been excluded, will be eligible for split/shared billing. No split/shared in private offices.
- **Beginning 1/1/2023, only time will be used to determine which professional provided the substantial portion of care**.

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Procedures (Performed in Offices or Hospitals)

- PAs/NPs are covered by Medicare for personally performing procedures and minor surgical procedures.
- Can't be shared/split billed; must be billed under the name of the professional who personally performed the procedure.
- Physical presence of the physician does not impact billing.

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Productivity

HEALTHCARE FINANCE

July 25, 2018

Beth Jones Sanborn

Non-physician providers boost revenue, practice productivity, MGMA data shows

Practices with higher ratios of NPPs to physicians made more money, despite a rise in operating costs, data shows.

https://www.healthcarefinancenews.com/news/non-physician-providers-boost-revenue-practice-productivity-mgma-data-shows

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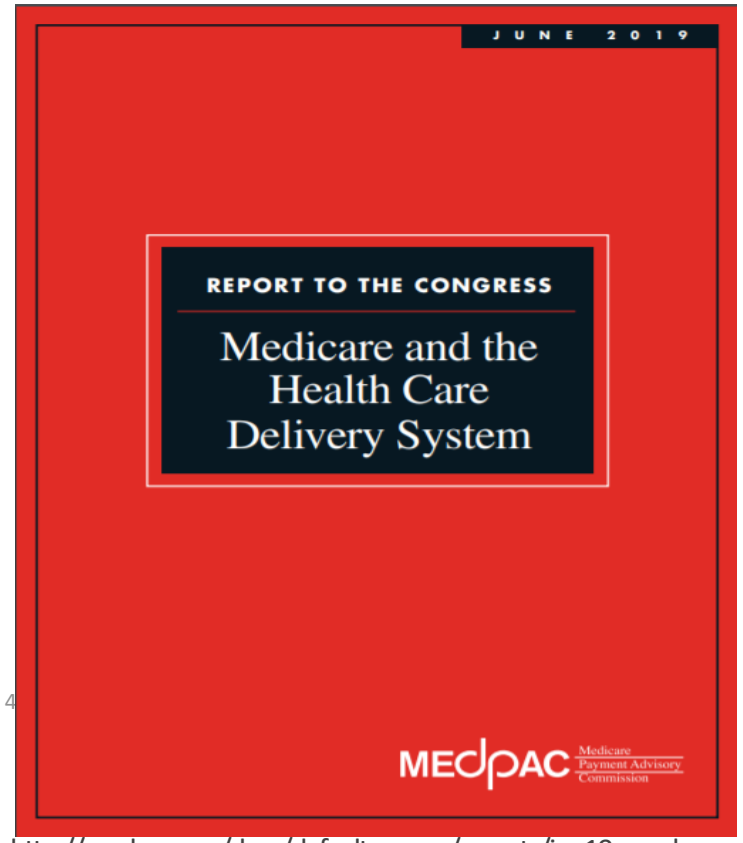
PA Productivity



"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 ."

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

What about that 15%

Without split/shared or incident-to billing, Medicare payment is at 85% of the physician rate

Office/Outpatient Visit: Established Patient

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

15%=$12.45

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Discounted Reimbursement

Contribution Margin

a) What was the cost of providing the service?

b) What was the reimbursement/ revenue?

c) What is the margin (difference)?

PA/NP-Physician Office “Contribution” Comparison Model

Assumptions:

- 8-hour days (7 clinical hours worked per day)
- 15-minute appointment slots = 4 visits per hour = 28 visits per day
- Physician salary $250,000 ($120/hr.); PA/NP salary $110,000 ($53/hr.)
- 2,080 hours worked per year

Example does not include overhead expenses (office rent, equipment, ancillary staff, etc.)

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Contribution Model at 85% Reimbursement

A Typical Day in the Office	Physician	PA/NP
Revenue with physician and PA providing the same 99213 service	$2,324 ($83 X 28 visits)	$1,975 ($70.55 X 28 visits) [85% of $83 = $70.55]
Wages per day	$960 ($120/hour X 8 hours)	$424 ($53/hour X 8 hours)
"Contribution margin" (revenue minus wages)	$1,364	$1,551

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Cost Effectiveness Takeaway Points

- The point of the illustration is not that PAs/NPs will always produce a greater office-based contribution margin than physicians.
- That may or may not happen (more likely in primary care/internal medicine vs. surgery or specialty medicine).
- However, NPs/PAs generate a substantial contribution margin for the practice even when reimbursed at 85% of the physician fee schedule.
- An appropriate assessment of “value” includes revenue generation, non- revenue generating professional services (e.g., post op surgical care) and the cost to employ health professionals.

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Cost to Employ

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

Cost to employ PA/NP is substantially lower

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Added Value

- PAs/NPs increase access to the practice. No reason for patients to wait 2 weeks to get an appointment when they can see the PA/NP in 2 days. Extended waits for appointments will cause some patients to seek out other practices.

- PAs/NPs can provide surgical post-op global visits, freeing physicians to see new patients and consults, and perform other procedures which generate additional revenue.

- PAs/NPs often facilitate communications with patients, the patient's family, hospital personnel, complete forms and order medications - activities which don't show up as revenue, but are essential to an effective, patient-centered practice.

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Take Home Points

- Payment and coverage policies frequently change, often to the benefit of PAs and NPs. Ensure that you and your employer stay abreast of those changes to maximize NP/PA utilization.

- Understand the PA/NP value proposition. Be able to articulate the positive monetary and non-monetary impact PAs/NPs provide.

- A better understanding of reimbursement policy will increase practice efficiency while helping to avoid concerns about fraud and abuse.

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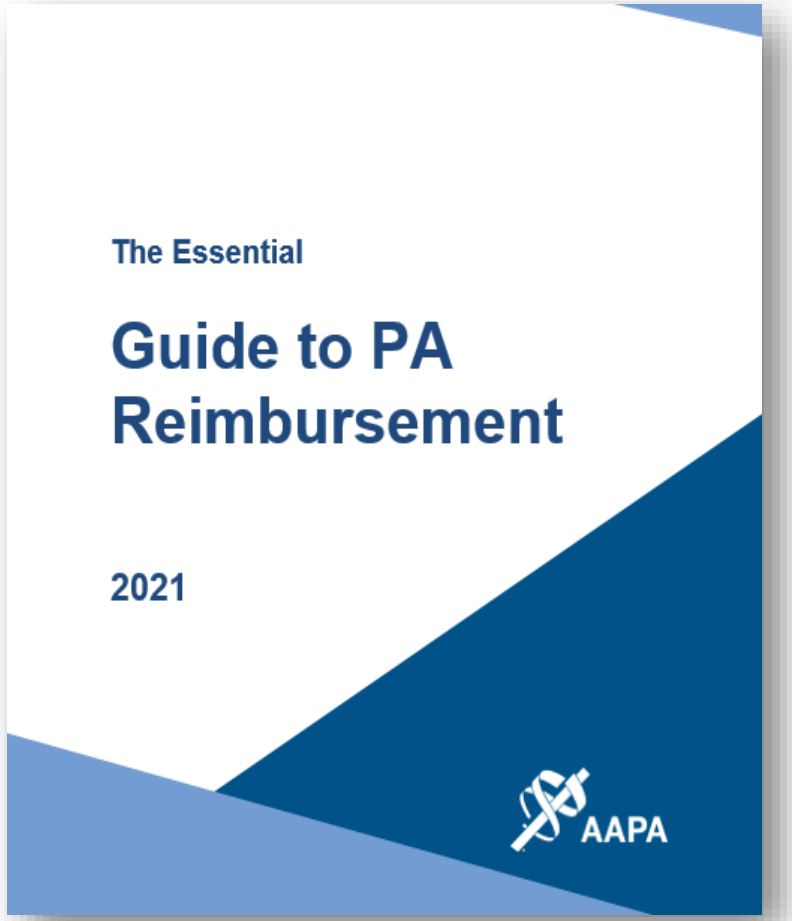
2021 Essential Guide to Reimbursement

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

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



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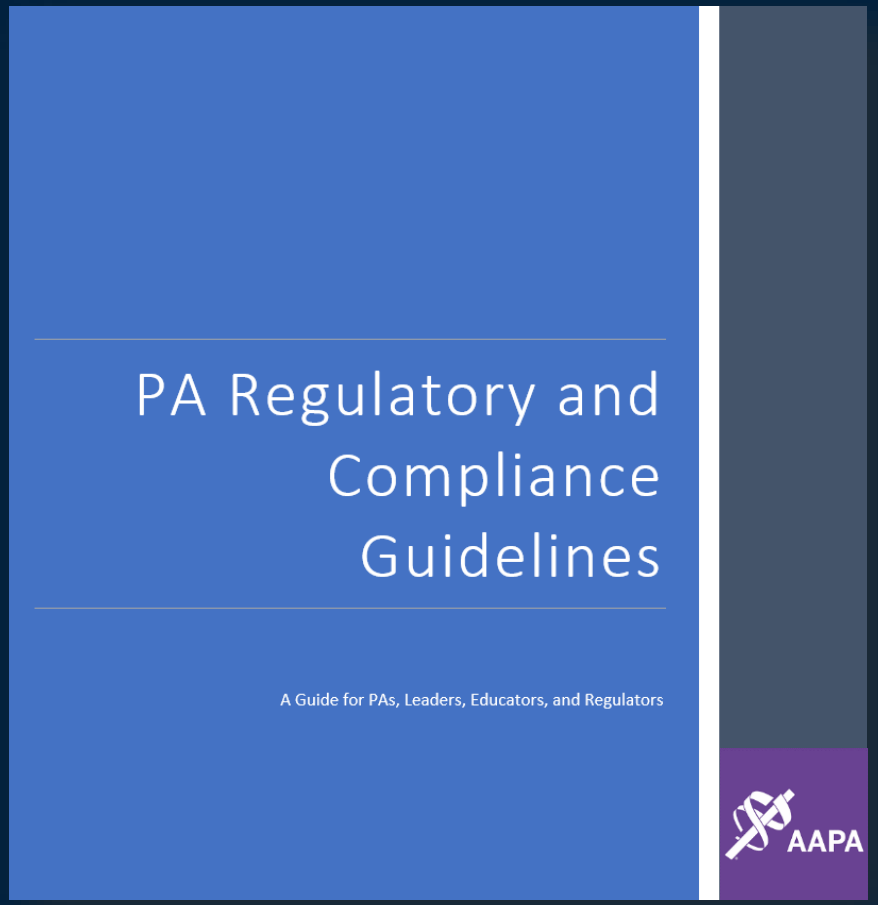

A definitive guide to PA regulations, policies, and compliance

Provides information about:

- Scope of Practice
- Clinical practice considerations
- Credentialing and Privileging
- Competency and Assessment
- Measuring Value & Productivity
- And MORE!!!

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Contact Information

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AAPA Reimbursement Website

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