Reimbursement for Family Medicine

We Are Family (Medicine) Conference

February 21, 2022

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Reimbursement & Professional Advocacy

American Academy of PAs

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- **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.**
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Learning Objectives

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

- Explain the policy changes and coverage updates implemented by Medicare in 2022
- Describe the components of reimbursement policies that will impact PAs and NPs as payment systems transition to value-based reimbursement
- Identify strategies to improve the recognition and tracking of the contributions and productivity of PAs and NPs in family medicine

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Direct Payment to PAs from Medicare

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Previous Medicare Policy on PA Reimbursement

- Medical and surgical services delivered by PAs were billable to Medicare under a PA's name.
- Medicare was required (by law) to make the payment for PA-provided services only to the PA's employer (solo physician, physician group, hospital, nursing facility, ASC, professional corporation, or a professional/medical corporation up to 99% owned by a PA).
- There are limited number of commercial payers that paid directly to PAs and/or PA corporations.

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

- Practice as independent contractors (1099 relationship).
- Want to work part-time without having to deal with additional administrative paperwork associated with a formal employment relationship.
- Choose to own a practice/medical or professional corporation.
- Work in rural health clinics (RHCs) and want to ensure they receive reimbursement for “carved out” (Part B) services.

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PA Direct Payment

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

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CMS Open Payments Program

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Open Payments

- National disclosure database aimed at improving transparency by identifying financial relationships between the pharmaceutical and medical device manufacturing industries, and health care professionals.
- CMS does not offer an official position or opinion regarding which financial relationships may cause conflicts of interest.
- Legitimate reasons for payments or transfers of value to health professionals captured on the Open Payments site may including delivering CME, performing research.
- To view collected data beginning April 1, register through the CMS.gov Enterprise Portal.

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No Surprises Act

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No Surprises Act

- Designed to protect patients from the financial impact of unexpected medical bills and excessive cost-sharing (deductible and/or co-insurance).

- If an out-of-network health professional does not accept a health plan's/insurer's (in-network) payment for services rendered, he/she cannot bill a patient more than the in-network cost-sharing amount.

- Health professional may initiate a negotiation period with the health plan/insurer not to exceed 30 business days. If those negotiations fail to result in an agreed upon payment amount, the two parties may enter into an independent dispute resolution (IDR) process.

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Provider Nondiscrimination – Section 2706(a)

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Provider Nondiscrimination Provision

- The nondiscrimination language states that insurers "offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan for any health care provider who is acting within the scope of their license or certification under state law."

- If a service is covered the nondiscrimination provision would seem to prevent a health plan or insurer from denying coverage to a class or specific type of health professional, if state law allows the professional to perform that service.

- CMS/HHS beginning the process of promulgating regulations/clarifications.

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Provider Nondiscrimination

- Will not impact services not already covered/included in the patient's benefit package.
- Could induce coverage of mental health services, allowance of primary care provider status with patient panels.
- Lack of clarity whether the provision will impact the concept of reimbursement parity (same payment for same services).

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COVID Public Health Emergency

- The PHE was extended until April 16, 2022.
- CMS will give a 60-day notice before canceling the PHE.
- Be cautious of inconsistency between Medicare, Medicaid and commercial policies.
- There was a higher degree of alignment earlier in the pandemic.

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COVID Public Health Emergency

- Medicare telehealth still authorized in urban areas; a patient's home remains an appropriate site of service.

- Continued ability to have patients under the care of PAs/NPs (as opposed to under a physician) in hospitals.

- NPs/PAs authorized to perform physician services in skilled nursing facilities (comprehensive and alternating "physician" visits).

Note: always understand and adhere to state law requirements

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

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Former 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

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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)

The level of MDM is the same level of MDM as previous documentation guidelines.

Providers must still use 2 of the three broad categories to determine code level:

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

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MEDICAL DECISION-MAKING

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:
Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: 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.)	Elements of Medical Decision Making: 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, 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
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

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

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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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Reduce The Risk of Fraud and Abuse Allegations

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Compliance Scenario #2

- A family 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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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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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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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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List of Excluded Individuals/Entities

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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 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/NPs 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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Medicare Billing Rules

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Following the Rules Depends on Your Practice Setting

Location, location, location

- Office/clinic
- Outpatient clinic owned by a hospital
- Certified Rural Health Clinic
- Ambulatory surgical center (ASC)
- Critical Access Hospital
- Federally Qualified Health Center/Community Health Center
- Skilled nursing facility,
- Inpatient rehabilitation facility or psychiatric hospital

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Medicare Billing Policy

- Medicare statutes
- Conditions of Participation & Payment
- Medicare Administrative Manuals
- Medicare Interpretive Guidelines
- Medicare Administrative Contractors (MACs)

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Medicare Reimbursement Myths

- NPs/PAs can't treat new patients
- Physician must be on-site when PAs/ NPs deliver care.
- Physician must, at some point, see every patient.
- A physician co-signature is required whenever PAs/NPs treat patients.
- State, facility and commercial payer policies may be different/more restrictive than Medicare.

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Overarching Scope of Practice

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

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

- Commercial payers often have incomplete or limited PA coverage policy details in writing.

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Billing in the Office Setting

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Office/Clinic Billing under Medicare

- PAs/NPs 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” Billing

- Allows a “private” **office or clinic**-provided service performed by the NP/PA to be billed under the physician’s name (payment at 100%) (*not used in hospitals or nursing homes unless there is a separate, private physician office – which is extremely rare*).

- Terminology may have a different meaning when used by private payers (second notice!).

www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

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“Incident to” Rules

- “Incident to” billing is an option, and not required to be used.
- The PA/NP must be a W-2 employee (or have a 1099 Independent contractor) or have a leasing arrangement.
- 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).

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“Incident to” Limitations

- When treating new medical problems/conditions, “incident to” billing can’t be used.
- Changes to the existing plan of care require reinvolvement of the physician or billing the service under the PA/NP with reimbursement at 85%.
- Be cautious of fraud and abuse concerns due to the unique rules surrounding “incident to” billing.

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“Incident to” Billing

- The original treating physician (or another physician in the group) must be physically present in the same office suite.
- Physician must remain engaged to reflect the physician’s ongoing involvement in the care of that patient.
- How is that engagement established? Physician review of medical record, NP/PA discusses patient with physician, or physician provides periodic patient visit/treatment.

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“Incident to”

When must a Medicare claim have a NP’s/PA’s name and NPI ?

- New patients
- Established patients with new problems
- A physician is not physically present in the office suite

www.cms.hhs.gov/MLNMattersArticles/downloads/SE0441.pdf
www.hgsa.com/newsroom/news09162002.shtml

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CMS' New Split (or Shared) Billing Policy

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Split (or Shared) Billing

Billing provision that allows services performed by a PA/NP and a physician to be billed under the physician's name/NPI at 100% reimbursement.

Must meet certain criteria and documentation

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Split (or Shared) Billing

Services provided must be E/M, critical care, or certain SNF/NF services (does not apply to procedures)

PA and physician must **work for the same group**

PA and physician must treat the patient on the **same calendar day**

Physician must provide a "**substantive portion**" of the encounter

Physician must **clearly document** their contribution and **sign & date** the medical record

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Split (or Shared) Billing

Substantive Portion

Prior to 1/1/22

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

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Split (or Shared) Billing

Substantive Portion

For 2022

One of the key components (history, exam, or medical decision-making) "in its entirety" – and that component determines the level of the visit

-OR-

More than half of the total time spent by the PA and physician (required for critical care and discharge management services)

https://public-inspection.federalregister.gov/2021-23972.pdf

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Split (or Shared) Billing

Substantive Portion

Starting 2023

More than half of the total time spent by the PA and physician

https://public-inspection.federalregister.gov/2021-23972.pdf

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-FS Modifier

Must be added to all split (or shared) claims

https://public-inspection.federalregister.gov/2021-23972.pdf

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Split (or Shared) Billing

- Physician did not perform a "substantive portion"
- 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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Split (or Shared) Billing Too Much Hassle???

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Procedures (Performed in the Office or Hospital)

- PAs/NPs are covered by Medicare for personally performing procedures and minor surgical procedures.
- Can’t be shared; must be billed under the name of the health professional who personally performed the procedure.
- Presence of the physician is not required to bill for procedure.

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What about that 15%

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

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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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The Cost of Delivering Care – Contribution Margin

a) What is the cost of providing the service?

b) What is the reimbursement/ revenue?

c) What is the margin (difference)?

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PA/NP-Physician “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 salary $110,000 ($53/hr.)
- 2,080 hours worked per year

Example does not include overhead expenses (office rent, equipment, ancillary staff, etc.) which don’t change based on the health professional delivering care

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Contribution Model 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) [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 NPs/PAs will 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).
- PAs/NPs generate a contribution margin for the practice even when reimbursed at 85% of the physician fee schedule.
- An appropriate assessment of “value” includes revenue generation, delivery of non- revenue generating professional services (e.g., post op care) and the cost to employ health professionals.

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Cost to Employ PAs/NPs

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

Cost to employ PA/NP is lower

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Added Value of NPs/PAs

- 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 care from other practices.

- NPs/PAs 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 necessarily show up as practice revenue, but are essential to an effective, patient-centered practice.

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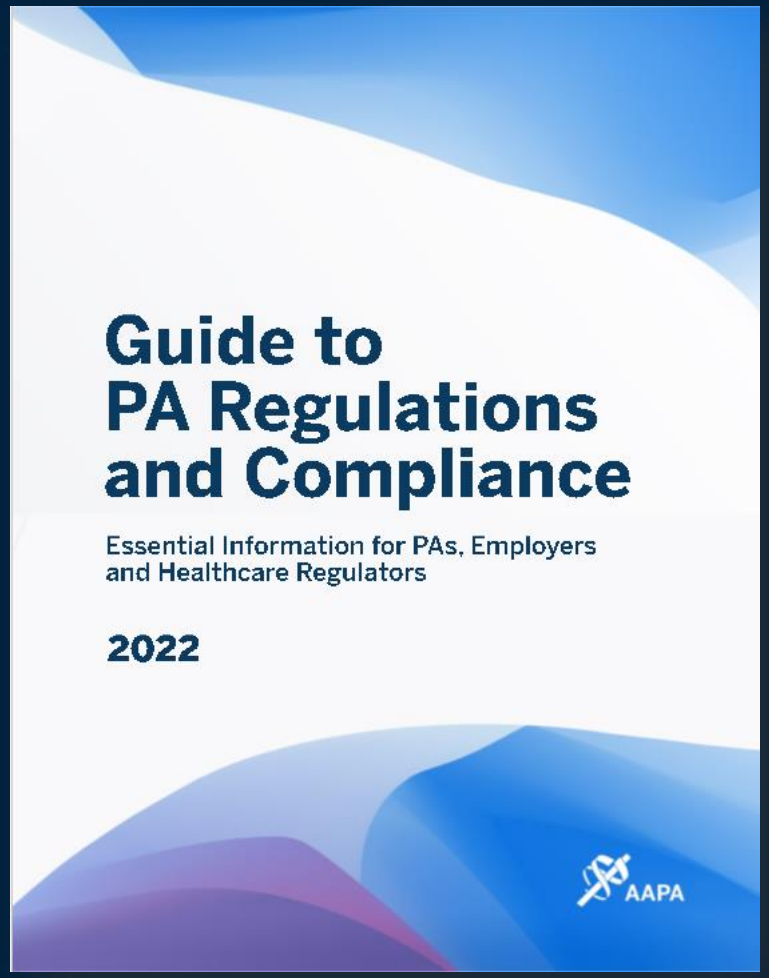
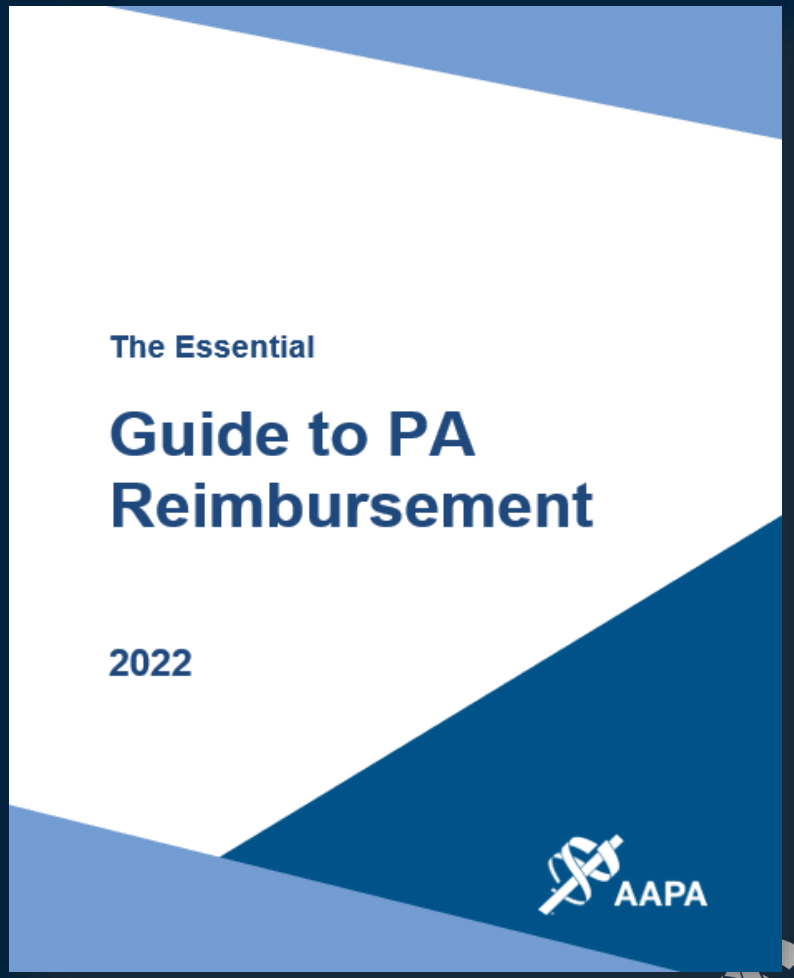
New Free AAPA Member Resources!!!





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