# Reimbursement Update: What PAs Need to Know

## AAPA 2022

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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 and commercial payer policies are subject to change. Be sure to stay current by accessing information posted by your local Medicare Administrative Contractor, CMS and commercial payers.**
- I am employed by the American Academy of PAs.
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# Learning Objectives

- Review changes in reimbursement policies and how PAs will be impacted.
- Discuss the current reimbursement landscape for PAs within both fee-for-service and value-based payment models.
- Identify strategies to improve recognition and tracking of the productivity and value PAs provide to their employers.



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# Nurse Practitioners & Medicare Policies

- This presentation pertains to PAs/PA students.
- Detailed information about NP reimbursement can be obtained from the American Association of NPs (AANP) https://www.aanp.org/
- Nearly all of Medicare's reimbursement & coverage policies are the same for the two professions.
- Many similarities exist between the utilization and practice of PAs and NPs. AAPA works closely with AANP on reimbursement, legislative and regulatory issues of mutual interest.



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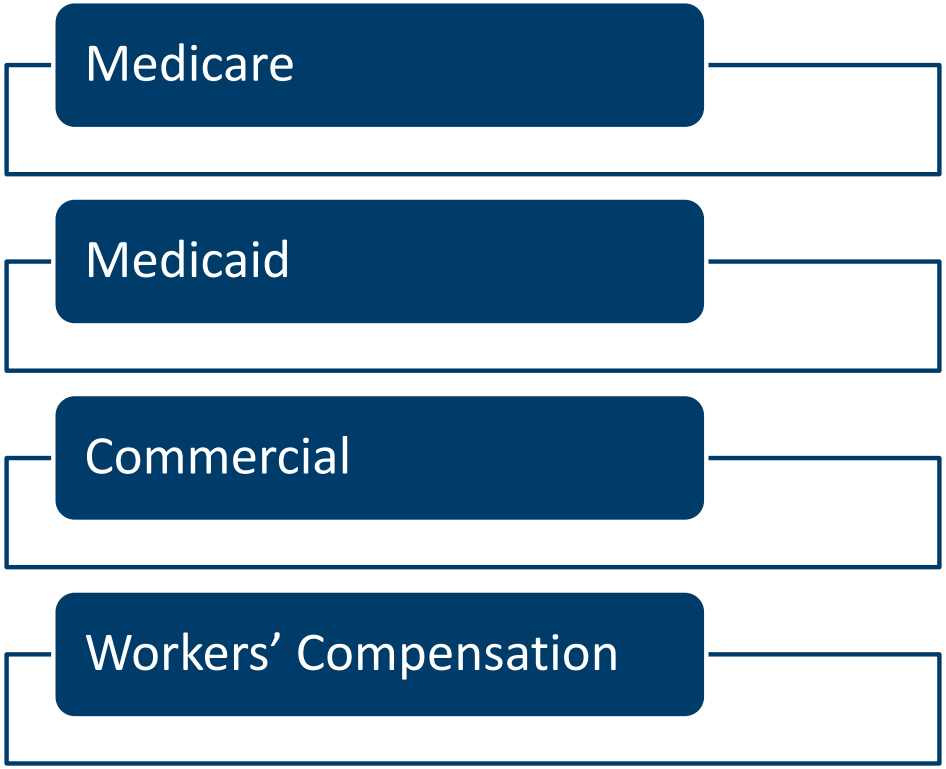
# Payers Often Have Multiple Plans/Policies




- Medicare Fee-for-service
- Medicare Advantage
- Managed care options
- State, federal and employer health plans administered by commercial payers



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# Direct Payment to PAs from Medicare



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# Previous Medicare Policy on PA Direct Payment

- Medical and surgical services delivered by PAs could be billed/submitted 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).

- A limited number of commercial payers paid directly to PAs.



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# New Medicare Policy on PA Payment

- Due to AAPA advocacy efforts, PAs now have access to Medicare direct payment.
- Policy change was effective January 1, 2022.
- Places PAs on a level playing field with all other health professionals.
- Eliminates administrative burdens that previously hindered PAs.



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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 state-approved practice/medical professional corporation or limited liability company.
- Work in rural health clinics (RHCs) and want to ensure they receive payment for Part B covered services not included in the all-inclusive RHC rate.



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# PA Direct Payment

- Just as with NPs, direct payment does not change scope of practice.
- Only applies to Medicare. Rate of reimbursement (85%) does not change.
- Similar to physicians and NPs, the majority of PAs will likely maintain their W-2 salaried employment arrangement and not opt for direct payment.
- PA direct payment is an option (not a requirement) for PAs.



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# CMS Open Payments Program




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# CMS Open Payments Program

- 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 opinion regarding whether financial relationships are good or bad, or cause conflicts of interest.

- Legitimate reasons for payments or transfers of value to health professionals captured on the Open Payments site may including honorarium for delivering CME, participating in research, consulting activities, etc.



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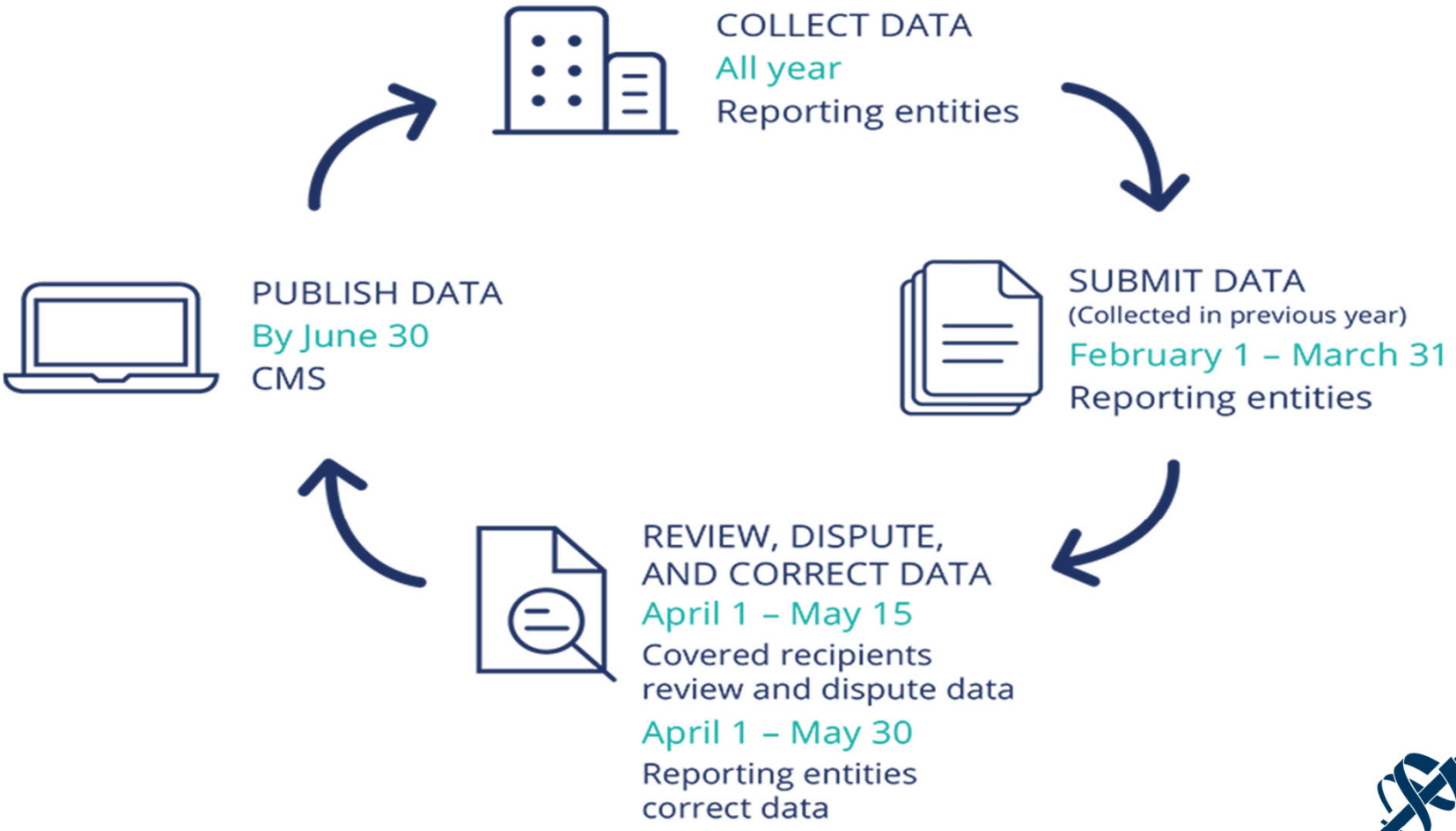
# CMS Open Payments Program

- CMS will not reach out to health professionals when information is placed in the Open Payments data base under their name.
- To view collected data beginning April 1, register through the CMS.gov Enterprise Portal.
- For more information, please view CMS' Open Payment explanatory video

# OPEN PAYMENTS CALENDAR




Attribution to CMS

# COVID Public Health Emergency

- The PHE was extended to July 15, 2022. Barring a severe COVID spike this will probably be the last extension.
- HHS stated it would give a 60-day notice before canceling the PHE.
- Be cautious of inconsistent coverage and payment policies between Medicare, Medicaid and commercial policies.
- There was a high degree of PHE coverage policy consistency among payers earlier in the pandemic. That is changing.



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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. Congress passed legislation to maintain telehealth flexibilities to Medicare beneficiaries for 5 months after the PHE ends.

- POS 10 is now known as "Telehealth Provided in Patient's Home", while the original telehealth place of service (02), was renamed to "Telehealth Provided Other than in Patient's Home" per CMS.

- PHE waiver authorizing PAs to perform "physician services" in skilled nursing facilities (the comprehensive and alternating "physician" visits) **was eliminated as of May 7.**



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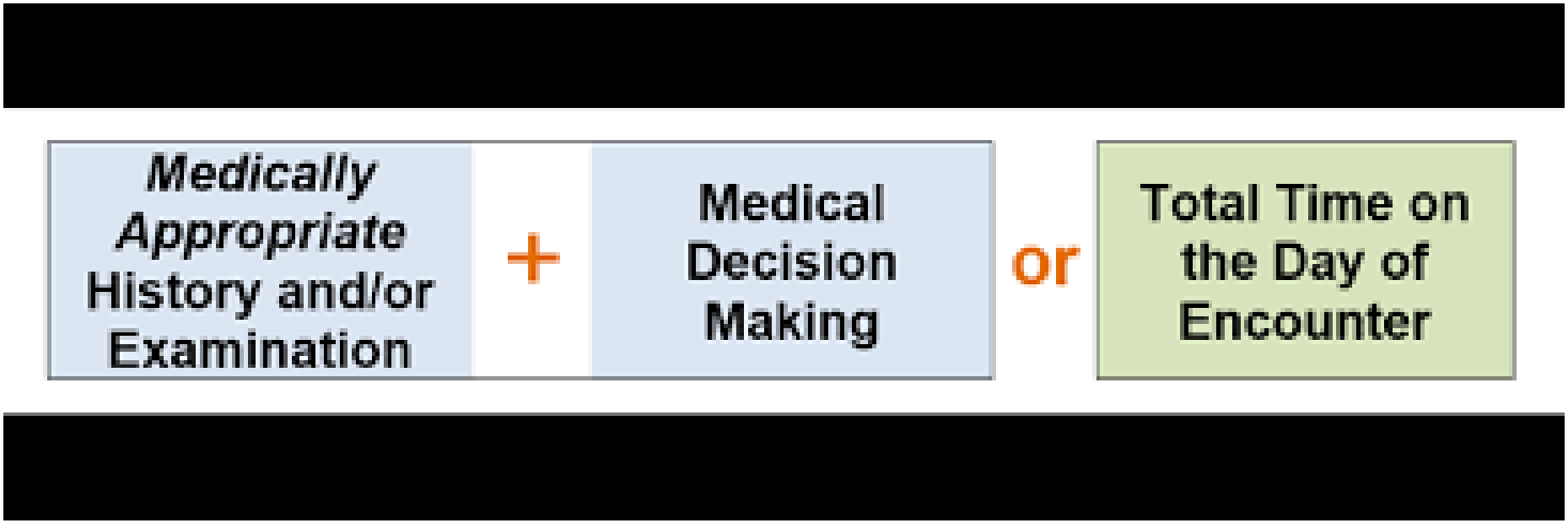
# Medicare Office-based Evaluation & Management (E/M) Outpatient Documentation



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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 unnecessary 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)

**Health professionals utilize a "ranking system" using 2 of the 3 elements/categories to determine code level selection.**

- The number and complexity of the problem or problems being addressed during the E/M encounter (not the number of issues the patient has).
- The amount and/or complexity of the data to be reviewed and analyzed.
- The risk of complications, morbidity, and/or mortality of patient management decisions made during the visit. These might be associated with the patient's problems, the diagnostic procedures, or the treatment.



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# Medical Decision-making

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|---|---|---|---|---|
| | | Number and Complexity of Problems Addressed | Amount and/or Complexity of Data to be Reviewed and Analyzed<br>**Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.* | Risk of Complications and/or Morbidity or Mortality of Patient Management |
| 99211 | N/A | N/A | N/A | N/A |
| 99202<br>99212 | Straightforward | **Minimal**<br>• 1 self-limited or minor problem | **Minimal or none** | **Minimal risk of morbidity from additional diagnostic testing or treatment** |
| 99203<br>99213 | Low | **Low**<br>• 2 or more self-limited or minor problems;<br>or<br>• 1 stable chronic illness;<br>or<br>• 1 acute, uncomplicated illness or injury | **Limited**<br>*(Must meet the requirements of at least 1 of the 2 categories)*<br>**Category 1: Tests and documents**<br>• **Any combination of 2 from the following:**<br>  • Review of prior external note(s) from each unique source*;<br>  • review of the result(s) of each unique test*;<br>  • ordering of each unique test*<br>or<br>**Category 2: Assessment requiring an independent historian(s)**<br>*(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<br>99214 | Moderate | **Moderate**<br>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;<br>or<br>• 2 or more stable chronic illnesses;<br>or<br>• 1 undiagnosed new problem with uncertain prognosis;<br>or<br>• 1 acute illness with systemic symptoms;<br>or<br>• 1 acute complicated injury | **Moderate**<br>*(Must meet the requirements of at least 1 out of 3 categories)*<br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>or<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>or<br>**Category 3: Discussion of management or test interpretation**<br>• 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**<br><br>*Examples only:*<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |

# Time-based Documentation

| New Patient Code | Time | Established Patient Code | Time |
|---|---|---|---|
| 99202 | 15-29 | 99212 | 10-19 |
| 99203 | 30-44 | 99213 | 20-29 |
| 99204 | 45-59 | 99214 | 30-39 |
| 99205 | 60-74 | 99215 | 40-54 |



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# Time-based Billing

- Time spent by clinical staff does not count toward the total time of an E/M visit when code selection is based on time.

**Examples of activities that can be counted in total time (before, during and after the visit):**

- Preparing to see the patient (e.g., reviewing tests)
- Reporting test results to a patient by phone
- Ordering medications, tests or procedures
- Referring the patient to and communicating with other health care professionals (when not separately reportable)



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# Summary (using either MDM or Time-based Documentation)

- Always write a clinically relevant note, including history and exam, as necessary.
- Be mindful of medical-legal considerations required for an appropriate medical record.
- History and exam documentation will not be used to determine CPT code level selected.



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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

# Hospital Inpatient/Outpatient Documentation Guideline Changes on the Horizon


- AMA CPT work group currently reviewing changes to facility documentation guidelines.
- Expect revised guidelines to be transmitted to CMS this summer.
- CMS likely to recommend new guidelines in proposed 2023 Physician Fee Schedule rule this summer (with an implementation date of 1/1/23).



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# Value-based Reimbursement


- Movement from a health care delivery and reimbursement system based upon volume (fee-for-service) to one based upon value.
- Value-based reimbursement comprises the interconnection between quality, outcomes, patient satisfaction and the cost of care/resources expended over a specified time frame.
- **Goal:** to clinically coordinate and align health professionals and hospitals with metric-driven payment incentives that eliminate duplicate and unnecessary, low-value services and foster higher quality care, better outcomes and patient satisfaction.



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# Value-based Reimbursement (VBR): Slow Adoption

- One of the main issues with the acceptance of VBR is the fear of downside risk (losing money) and a lack of trust in payer fairness in both establishing and compensating for quality/outcome metrics.

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

- In fact, many of the existing value-based reimbursement models are built on a fee-for-service framework.



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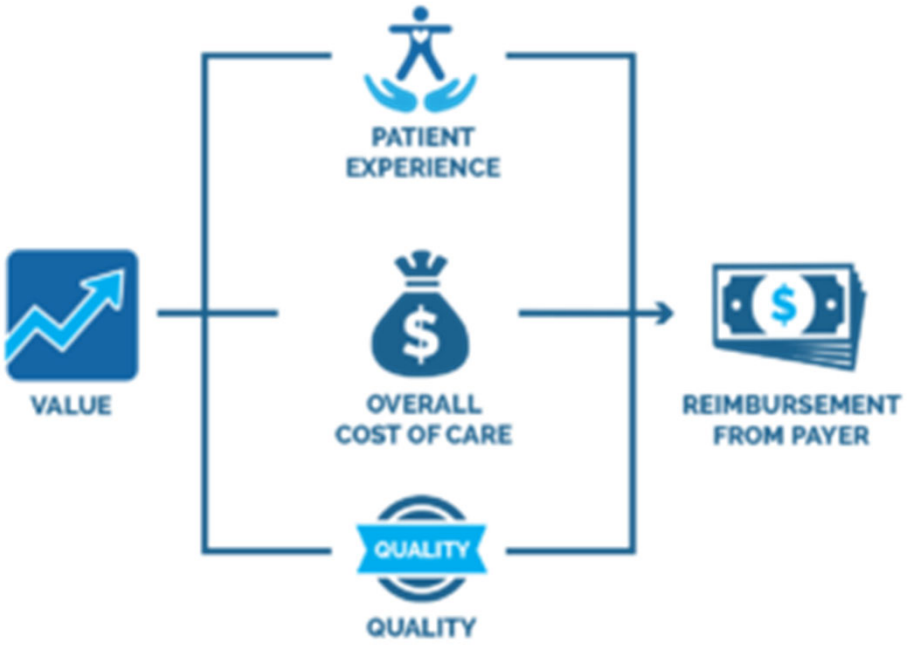
# Value-based Reimbursement

- Accountable care organizations (ACOs) and bundled payment models are options to move health professionals toward VBR.
- Cost of care can vary widely among patients based on medical status/co-morbidities.
- Risk adjustment is used to bring fairness to payment/reimbursement amounts based on the number and severity of illness for each patient.



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# Value-based Reimbursement

- Hierarchical Condition Categories (HCCs) are used by CMS as part of a risk-adjustment payment model that identifies individuals with serious acute or chronic conditions.
- The risk adjustment data identifies patients in need of disease management and establishes the financial payment/reimbursement provided by CMS and other payers towards the annual cost to care for each patient.
- PAs and other health professionals must report on each patient's risk adjustment diagnosis which is based on clinical medical record documentation



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# Reduce The Risk of Fraud and Abuse Allegations



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# Compliance Scenario #1

- 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 #2


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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# 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 should be proactive in supplying basic reimbursement information to billers based on payer mix and the practice sites where they deliver care.

# Medicare Billing Rules




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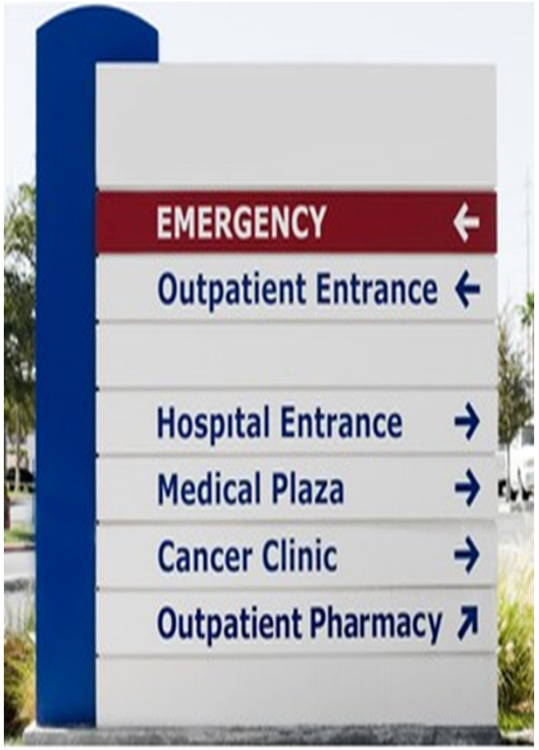
# Following the Rules Depends on Your Practice Setting

**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 Reimbursement Myths

- PAs can't treat new patients
- Physician must be on-site when PAs deliver care.
- Physician must see every patient a PA treats in the office/clinic.
- A physician co-signature is required whenever PAs 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 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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# Collaboration, Supervision and Beyond

- Medicare traditionally used the term “supervision” to describe how PAs practice with physicians.
- As of January 1, 2020, CMS modified its regulations and defers to PA state law in terms of the professional working relationship, if any, PAs have with physicians.
- The Medicare program will allow collaboration or other terms used by individual states to meet Medicare’s supervision requirement.



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# Billing in the Office/Clinic




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# “Incident to” Billing

- PAs can always treat new Medicare patients and and patients with 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 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 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” Billing

- “Incident to” billing is an option, and not required to be used.
- The PA 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” 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, PA discusses patient with physician, or physician provides periodic patient visit/treatment.



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# “Incident to” Billing

- When treating new medical problems/conditions or when making substantial changes to physician plan of care, “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 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

## When must a Medicare claim have a 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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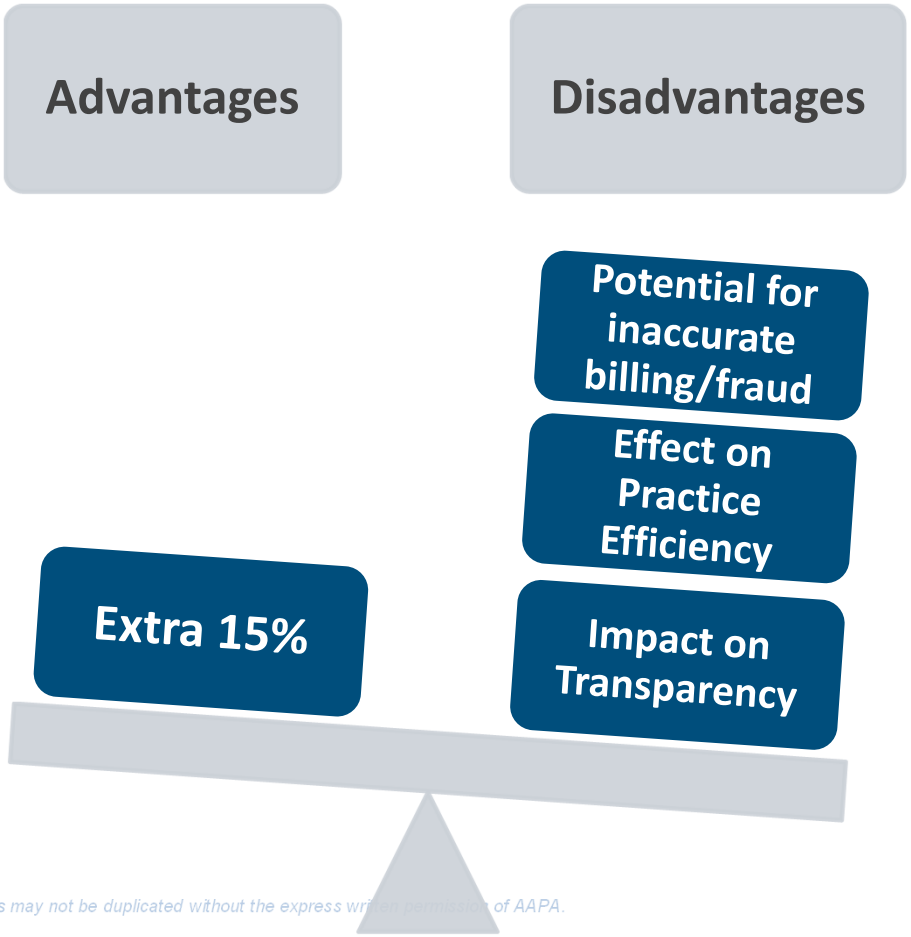
# Is Billing “Incident to” Worth it?



# CMS' New Split/Shared Hospital Billing Policy



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# Split (or Shared) Billing

Medicare 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 requirements**



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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 contribute to the service on the same calendar day
- Must add the "FS" modifier to split/shared visit claims
- Physician contribution must be noted and medical record signed & dated



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# Substantive Portion

## For 2022

One of the key components (history, exam, or medical decision-making) **"in its entirety"** – 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)

## Starting 2023

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

# Detailed Analysis of Hospital Split/Shared Billing Requirements

**CME Session provided by Sondra DePalma, DHSc, PA-C**

**Hospital Reimbursement CME Session**

**Tuesday, May 24 from 10:30-11:30**



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# Procedures

- PAs are covered by Medicare for personally performing procedures and minor surgical procedures.
- In the hospital, procedures can't be shared; must be billed under the name of the professional who personally performed the procedure.
- Options exist for "incident to" billing of procedures in the office setting.



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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

# 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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# Office/Outpatient Visit: Established Patient

| CPT Code | Work RVU | Non-facility Price Physician (national average) | Non-facility Price PA/NP |
|---|---|---|---|
| 99213 | 1.3 | $98.00 | $83.30 |

**15% = $14.70**



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# PA-Physician "Contribution" Comparison Model

**Assumptions:**

- 8-hour days (7 clinical hours worked per day)
- 20-minute appointment slots = 3 visits per hour = 21 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 | $2,058 ($98 X 21 visits) | $1,749 ($83.30 X 21 visits) [85% of $98 = $83.30] |
| Wages per day | $960 ($120/hour X 8 hours) | $424 ($53/hour X 8 hours) |
| "Contribution margin" (revenue minus wages) | $1,098 | $1,325 |



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# Cost Effectiveness Takeaway Points

- The point of the illustration is not that 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 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

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

**Cost to employ PA is lower**



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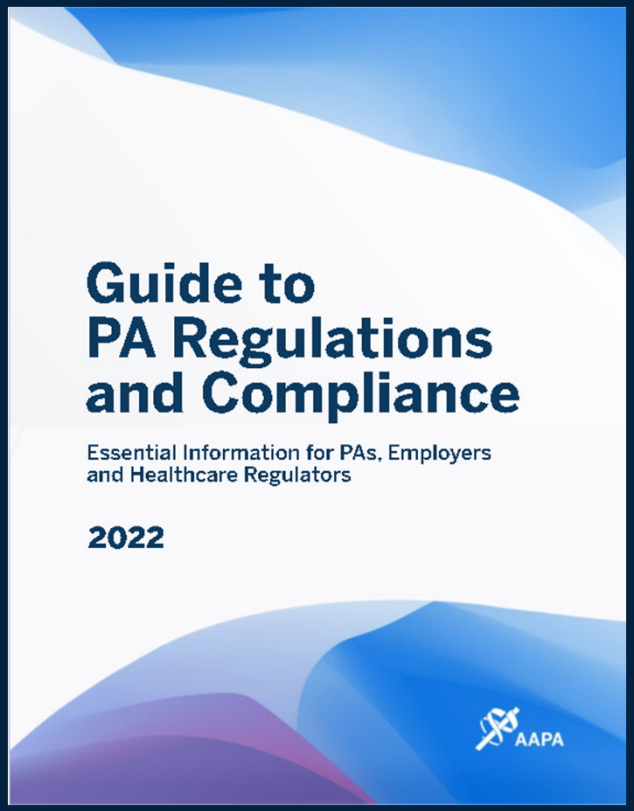
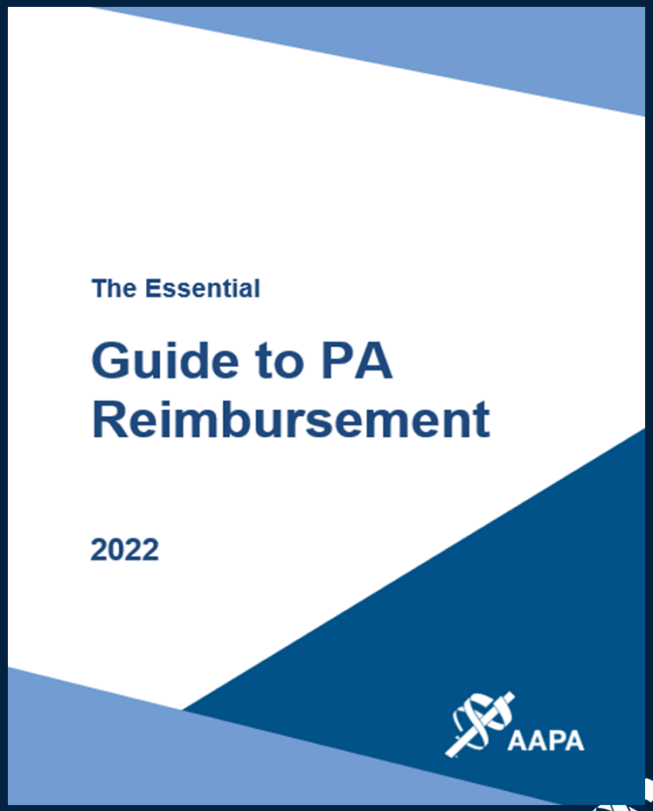
# New Free AAPA Member Resources

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# Contact Information

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- **AAPA Reimbursement Website**
  https://www.aapa.org/advocacy-central/reimbursement/

# Questions