BASIC CONCEPTS OF PA REIMBURSEMENT: A PRIMER

PAs (physician assistants) at every stage of their career need to have the latest and most accurate information on reimbursement. With this introduction, PAs can quickly familiarize themselves with basic reimbursement concepts.

You'll find sections on each type of payer (Medicare, Medicaid, and commercial payers). Keep in mind that policies will vary with Medicaid and commercial payers. The section on coding is applicable under all payers.

This information serves as a primer and not an exhaustive list of policies. For more details, please consult the Essential Guide to PA Reimbursement (https://www.aapa.org/shop/essential-guide-pa-reimbursement-2018/) or contact the American Academy of PAs (AAPA) and relevant payers.

MEDICARE

Eligibility Requirements for a PA to be a Medicare Provider
(Medicare Benefits Policy Manual, Chapter 15, section 190, subsection A)
- Have graduated from an accredited PA program; or
- Have passed the national certification exam; and
- Be state licensed.

Practical Steps to Becoming a Medicare Provider
- Obtain a National Provider Identifier (NPI) (https://nppes.cms.hhs.gov/)
- Enroll in Medicare through PECOS (https://pecos.cms.hhs.gov/)

Determinants of a PA's Scope of Practice under Medicare
- Medicare regulations/Medicare's Conditions of Participation.
- State law.
- Hospital guidelines/credentialing requirements/bylaws.
- The supervising/collaborating physician.

Required Level of Supervision under Medicare
- Requires access to the collaborating physician by reliable electronic communication.
  - Personal presence of the physician is generally not required.
  - Medicare policies will not override state law guidelines or facility policies.

Medicare Reimbursement
- Claims for services are submitted on the 1500 Claim Form.
- Medicare does allow PAs to submit claims under their own NPI as the rendering provider.
- Medicare does not allow PAs to "direct bill" (receive payment directly).
- Reimbursement is made to the PA's employer.
- Services provided by PAs and Nurse Practioners (NPs) are generally reimbursed at 85% of the Physician Fee Schedule.
- There are provisions for 100% reimbursement ("Incident to" and "Shared Visits" discussed later).

Medicare Assisting at Surgery
- Bill the surgical code followed by the AS modifier.
- Use PA's NPI as rendering provider for the first assist.
- Reimbursement 13.6% of primary surgeon's allowable fee.
- Note that PAs are authorized to personally perform certain minor surgical procedures.
- There's a 'restricted list' of surgeries for which Medicare will not reimburse – applies to all health professionals.
- Surgical procedures are bundled services (a 'global period') and generally cover the pre-op H&P and follow-up care.
- No payment is made for a PA assisting at surgery when it is provided in a teaching hospital that has an approved, accredited training program related to the specialty required for the particular surgical procedure, unless:
  - Resident not available.
  - Surgeons that have an across-the-board policy of not including residents in the care of patients.
  - Trauma surgery.

Medicare Policies Regarding Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)
- The patient must be seen every 30 days for first 90 days, then every 60 days, thereafter.
- The initial comprehensive visit must be done by a physician.
- Required visits may be alternated with a PA.
- Additional visits (non-planned) may be done exclusively by PAs (alternating schedule remains intact).

- Differences between SNFs and NFs:
  - Who pays: Services performed in SNFs are typically reimbursed by Medicare, while services performed in NFs are typically reimbursed by Medicaid.
  - Certain services in NFs are identified as only able to be provided by a physician, or "physician only." However, in some states, state law permits PAs to perform these services.
- PAs not employed by the facility may order SNF and NF care as allowed by state law.

Notable PA Restrictions under Medicare

- Medicare and Home Health
  - Only a physician may order home health services and sign the home health plan of care.
  - PAs may provide the required face-to-face visit prior to certifying eligibility, as well as provide care plan oversight.
- Medicare and Hospice
  - PAs not reimbursed for certifying terminal illness, certifying/re-certifying need for/ordering hospice care. Beginning in 2019, PAs will be permitted to manage and provide hospice care.
- Medicare and Diagnostic Tests
  - Diagnostic tests are assigned one of three levels of supervision: general (least restrictive), direct, or personal (most restrictive).
  - PAs can personally perform all diagnostic tests under general supervision according to state law, but for those tests designated as requiring direct or personal supervision, PAs may not supervise other ancillary staff who perform the tests.

"Incident to"

- A Medicare billing provision that allows reimbursement for services delivered by PAs at 100 percent of the Physician Fee Schedule.
- Requirements:
  - Only applies in the office or clinic—does not apply in the hospital inpatient or outpatient setting.
  - Does not apply to commercial payers unless specified in policy.
  - The physician must have personally treated the patient on his or her initial visit for the particular medical problem and established the diagnosis and treatment plan.

- A physician (does not need to be the same physician who performed the initial visit) is within the suite of offices when the PA renders the service upon the patient's return for follow-up for the same problem.
- The physician must have some ongoing participation in the patient's care.
- This physician involvement must be reflected in the medical record, in the event of an audit.
- If ALL requirements are met, the encounter can be billed under physician's NPI for 100% reimbursement. If ANY are not met, bill under the PA's NPI; reimbursement will be at 85%.
- What's NOT "Incident to":
  - Part B services provided in the hospital or facility setting
  - Some payers do not enroll PAs and request that claims be submitted under the physician. This is NOT incident-to billing.
- Remember, when not billing "incident to":
  - PAs may see new patients as well as established patients with new problems.
  - In these circumstances, PAs must be billed under the PA's NPI number (Medicare) for 85%.
  - When not billing "incident to," physician is not required to see the patient or be onsite when care is provided.

Shared Visits

- Only applicable in hospital-owned inpatient and outpatient facilities or offices.
- State law guidelines for supervision.
- Applicable hospital by-laws and privileging which could change this:
  - No "incident to" billing.
- Shared Visit allows for a claim to be submitted under a physician for 100% reimbursement in a hospital setting by allowing a PA and physician to "share" the encounter.
- Requirements:
  - Only for Evaluation and Management (E/M), not procedures or critical care.
  - The physician and PA must be employed by the same entity.

- – Encounters must occur on the same calendar day (not simply within the same 24 hours).
  - – The physician must perform some part of the service in a face-to-face encounter with the patient.
- • What documentation is required?
  - – A clear note detailing the physician's professional service (avoid terms such as "agree with above" or "see and agree").
- • Need a clear distinction between the PA's work and the physician's work.

Fraud and Abuse

- • Examples of violations:
  - – Improper billing
  - – Over coding or unbundling services that should be billed as a bundle
  - – Anti-kickback: solicitation/transfer of something of value to induce/reward behavior
- • Potential Fraud and Abuse Remedies:
  - – Take back of reimbursement dollars paid
  - – Civil monetary penalties ($21,563 per incident)
  - – Exclusion from Medicare, Medicaid, and other government-related health programs

MEDICAID

PA Coverage

- • Unlike the Medicare program, which has federal laws mandating the coverage of medical services provided by PAs, each state can determine whether PAs are eligible providers under its Medicaid program and which services PAs are able to provide.
- • Currently, all 50 states and the District of Columbia cover medical services provided by PAs in their Medicaid fee-for-service and managed care plans at either the same or a lower rate than that paid to physicians.

PA Enrollment

- • Medicaid enrolls PAs in 43 states and DC, so that a PA's name and NPI can be included on a claim to indicate that they rendered a service.
- • Trending in the right direction as more states are poised to enroll PAs each year.
  - – All states are required to enroll PAs for the purpose of ordering services and referring patients.

COMMERCIAL INSURERS

Commercial insurers may have their own rules that are similar, the same, or different than those policies found under Medicare and Medicaid.

- • Many choose not to enroll PAs and instruct a PA to bill under the physician' number (reminder, this is NOT "incident to" billing).
  - – For those that enroll PAs, some do not discount services provided by PAs
  - – Must not assume

Payer Policy May Vary

- • The billing and coverage policies must be clearly ascertained by every individual practice for every individual payer with whom they contract.

CODING

Current Procedural Terminology (CPT)

- • Coding system that provides a common language to describe and document services provided.
- • Provides payers with a summary of patient care: Medicare, Medicaid, private payers.
  - – Used for billing purposes
- • Over 8,000 five-digit codes – constantly updated – PAs have access to virtually all CPT codes.

International Classification of Diseases (ICD-10)

- • Describes patient's symptom, condition, complaint or problem.
- • Used to justify medical necessity.
- • ICD-10 was implemented on Oct. 1, 2015.
- • Every industrialized country in the world has been using ICD-10 except the US.
- • Number of codes increased from approximately 14,000 to 69,000 in switch from ICD-9 to ICD-10.
- • Not as daunting as it seems: Typically used to provide greater specificity (location on the body, initial vs. subsequent encounter, etc.).
- • AAPA has a ICD-10 resource website: www.aapa.org/icd10

AAPA

Quality Payment Program

Eligible Clinicians (ECs), which include PAs, who have been enrolled in the Medicare program for a full calendar year, may be required to participate in the Quality Payments Program (QPP). The QPP seeks to incentivize health professionals by utilizing value-based reimbursement incentives to deliver more coordinated, cost-effective care to Medicare beneficiaries.

PAs, physicians and advanced practice nurses will follow one of two reporting tracks under the QPP. The first is the Merit-based Incentive Payments System (MIPS). The second track is Advanced Alternative Payment Models (Advanced APMs). The 2017 reported data will affect reimbursement in 2019. More information about QPP can be found on AAPA's web site (https://www.aapa.org/advocacy-central/reimbursement/macra/) and the official website (https://qpp.cms.gov/).