PA Reimbursement Update

Association of PAs in Oncology

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Seattle, WA

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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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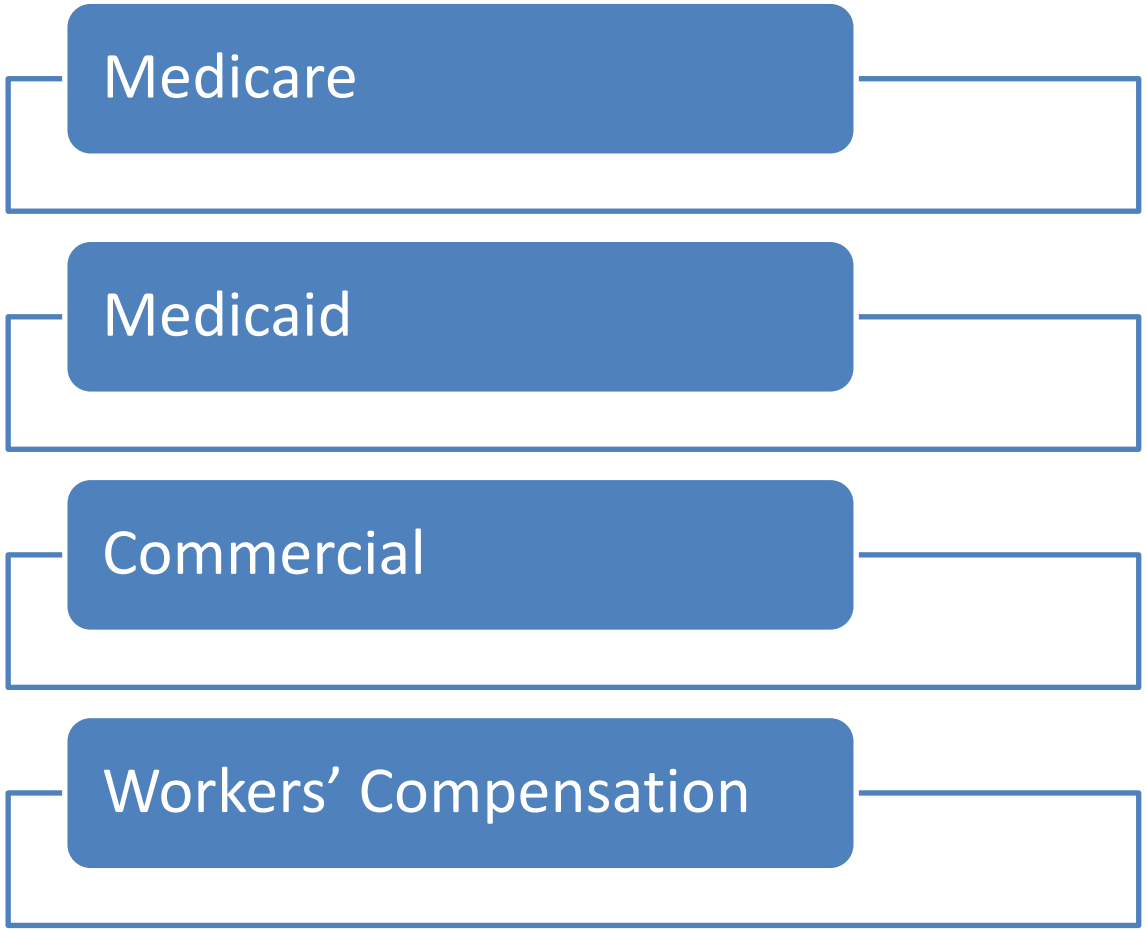
PAs, NPs and Medicare Payment Policies

- 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 both professions.
- 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.

Payers Often Have Multiple Plans/Policies



- Medicare Fee-for-service
- Medicare Advantage
- Medicaid managed care options
- State, federal and employer (self-funded) health plans administered by commercial payers

Attempt to Add New “Certification” for First Assisting

- The American Board of Surgical Assistants (ABSA) attempted to require that professionals who first assists be required to obtain an additional certificate.
- ABSA is a private company headquartered in Wisconsin (https://absa.net/)
- A large health care system with several hospitals began to implement the requirement.
- Advocacy by AAPA and individual PAs convinced the health system to eliminate the requirement.

Important Issues in the 2023 Proposed Physician Fee Schedule

- Medicare conversion factor cut for all specialties (proposed reduction of 4.4%).
  (practice expense payments for infusion and hematology lowered)
- Clinical Labor Price update which lowers payments to specialties that use expensive equipment, such as radiology oncology.
- CMS taking another look at payment for post-op surgical visits.
- Elimination of remote supervision (e.g., for “incident to” billing).
- Telehealth coverage changes (e.g., radiation treatment management no allowed via telehealth 151 days after the PHE ends).

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CMS Approves New Cancer Payment Model

- The Enhancing Oncology Model, which is aimed at improving equity and care coordination for cancer treatments will start in July 2023 and run through 2028.

- Participating practices in the model can receive a monthly payment for enhanced services (e.g., development of detailed care plans, 24/7 access to an appropriate health professional, assistance in accessing clinical trials) provided to patients.

- Participants can also get retrospective performance-based payments by meeting quality and savings metrics. Practices must take on downside risk from the start of the model. Must appy by Sept. 30.

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Additional Proposals in the 2023 Physician Fee Schedule

- Reducing the minimum age requirement for certain colorectal cancer screening tests to 45 years.

- Coverage for one follow-on screening colonoscopy after a Medicare covered, non-invasive, stool-based colorectal cancer screening test returns a positive result. No beneficiary co-pays would be required for these tests.

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Proposed PFS Update on Post-op Visits

- CMS is soliciting comments regarding strategies for improving global surgical package valuations.
- The agency believes there are fewer post-op visits occurring in recent years.
- CMS has been trying to collect information from practices to make a determination.
- Questions:
  - ❑ Are there fewer post-op visits than in past years?
  - ❑ Is a surgical post-op office visit as intense as a traditional office visit?
  - ❑ What is the impact on first assisting payments?

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Proposed PFS Update on Remote Supervision

- During the PHE Medicare relaxed its definition of direct supervision. Direct supervision typically requires the on-site presence of the physician.
- A PHE temporary flexibility allows direct supervision to be met via real-time, interactive audio-video technology.
- Currently, physicians can bill PA/NP-provided services “incident to” in the office under their name, without being in the office.
- AAPA argued against remote direct supervision as it would lead to more PA services being attributed to physicians, hiding the impact of PA-provided care.

Hospital E/M Documentation Guidelines

- CPT Editorial Panel published new hospital E/M documentation guidelines on its website in July. CMS proposes to implement the new guidelines as of 1/1/23.

- Purpose: to streamline and make medical record documentation more efficient.
- Tutorial can be found here.

- Guidelines will impact:
  - Hospitals (including observation care)
  - Emergency departments
  - Nursing facilities
  - Home & Domiciliary
  - Prolonged services

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New Hospital E/M Documentation Guidelines

- Time or medical decision-making will be used to select the E/M visit level.
- Documenting a medically appropriate history and physical exam will be required but would no longer be used to select/determine the E/M visit CPT code level.
- Goal is to reduce the amount of time health professionals spend documenting excess information (for billing purposes) that may not be relevant to the care/treatment of the patient.

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Direct Payment to PAs from Medicare

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.

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, not Medicaid or commercial payers. 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.

CMS Open Payments Program

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.

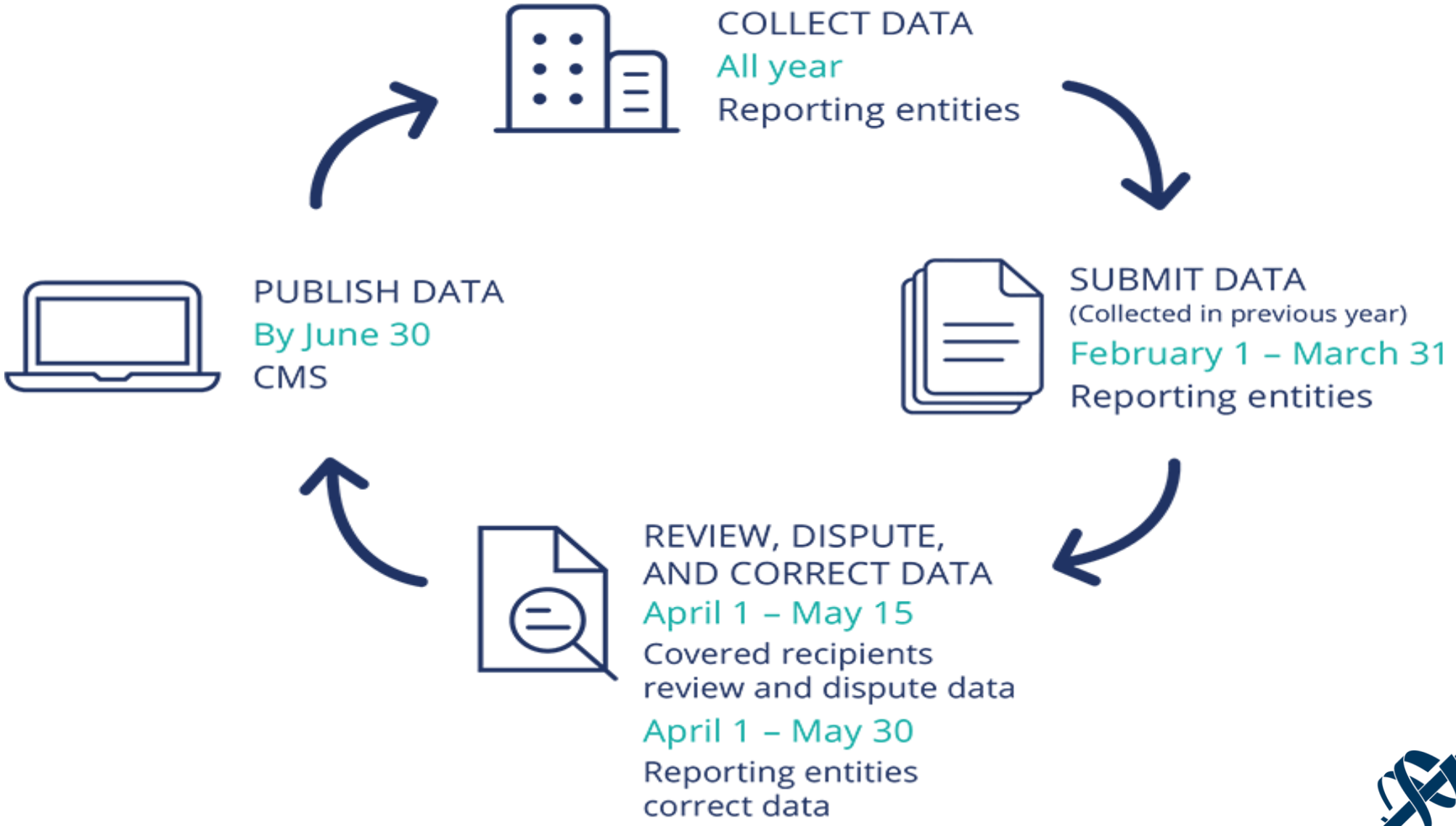
- CMS does not offer an official opinion regarding whether financial relationships are appropriate, or cause conflicts of interest.

- 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.

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 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 thru Oct. 13, 2022.
- 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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Reducing Fraud and Abuse Concerns

Compliance Scenario #1

- 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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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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Who Is Responsible?

The "chain of responsibility" is multifaceted.

- 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.

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Who is Entitled to Reimbursement for a PA's Professional Work?

Who should receive reimbursement for the PA's professional services?

Only the PA's employer.

Who should receive a benefit (work product) from the PA's professional services?

Only the PA's employer.

Appropriate leasing arrangements are an option when the physician with whom the PA works is not the employer, and the physician wants to utilize the professional services of the PA.

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Payment to the Employer

- Physicians who are not employed by the same entity as the PA(NP) have no ability to bill/receive payment for work provided by PAs/NPs unless the physician provides market rate compensation (e.g., salary, leasing arrangement) for the PA's/NP's time.

  - Potential False Claims, Stark &Anti Kickback Violations

Particularly problematic with a hospital-employed PA/NP working with a non-hospital employed physician.

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, . . . 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 less complete or limited 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.
- NP Medicare policy uses the term collaboration and also defers to state law.

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Medicare Billing Rules

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Billing in the Office/Clinic

“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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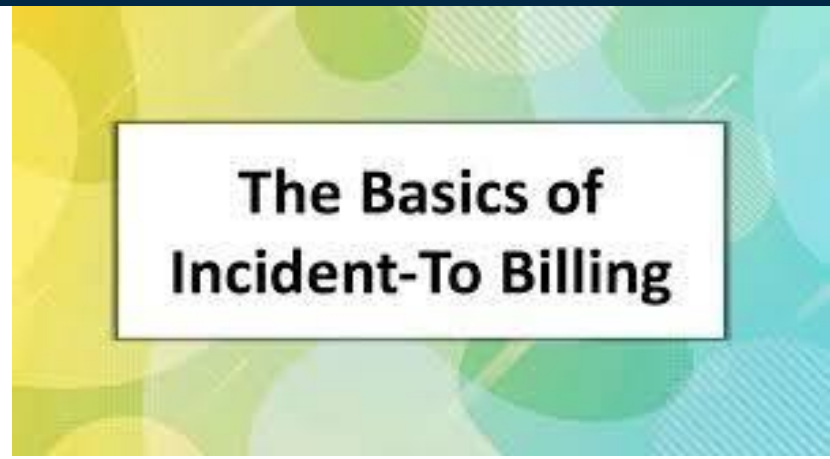
“Incident to” Billing



- 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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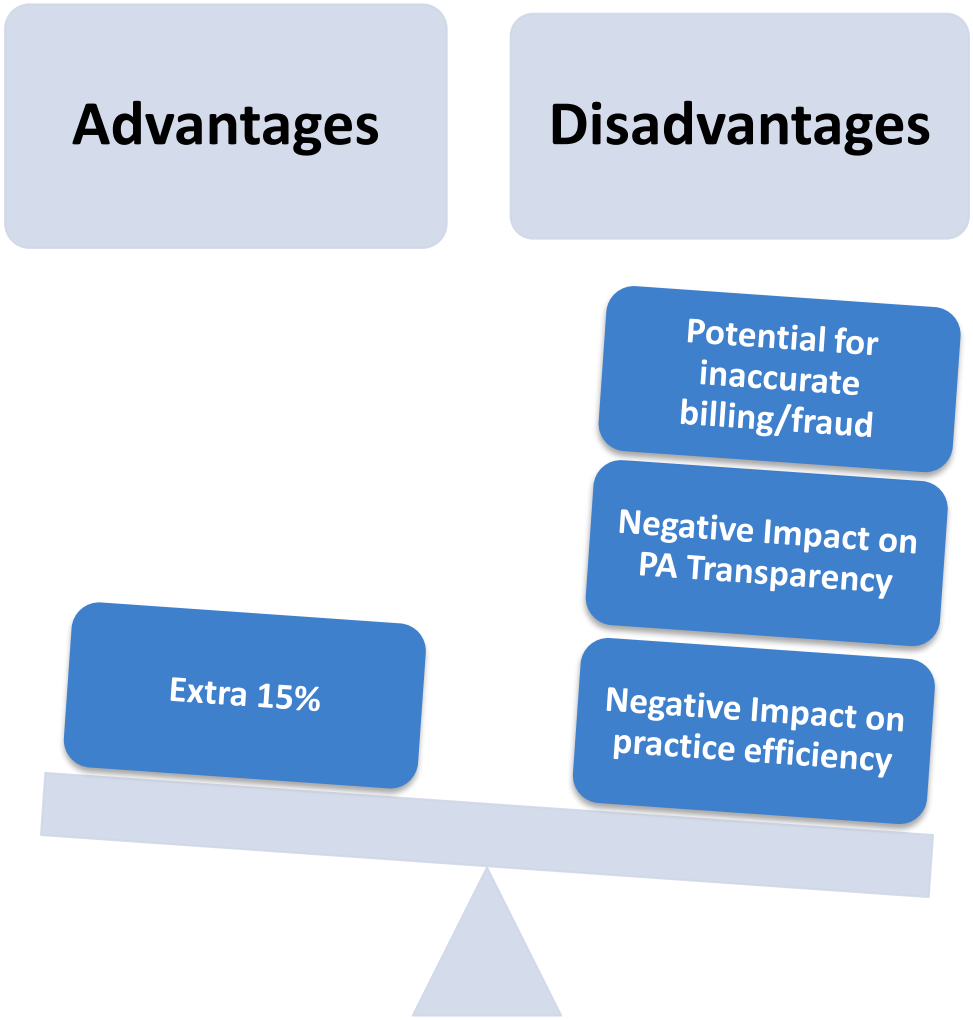
“Incident to” Billing

When must a Medicare service be submitted/billed under a PA’s name and NPI ?

- New patients
- Established patients with new medical 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

Is Billing “Incident to” Worth it?



CMS' Evolving Split/Shared Hospital Billing Policy

Split (or Shared) Billing

Medicare hospital billing provision that allows services performed by a PA and a physician to be billed under the physician's name/NPI at 100% reimbursement. PAs can treat new or established patients when billing under their own name and NPI.

Must meet specific criteria and documentation requirements

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Split/Shared Visit Billing

Services eligible for split (or shared) billing

- Evaluation and management services (e.g., hospital inpatient and observation services, emergency department services, etc..)
- Critical care services (effective 1/1/22)
- Certain SNF/NF services (effective 1/1/22)

<u>Option for split/shared billing does NOT apply to procedures</u>

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

PA and physician must be involved the patient on the **same calendar day**

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

Either PA or physician must have face-to-face encounter with patient

Documentation must identify the practitioners who contributed to the service and the billing physician must sign & date the medical record

-FS Modifier must be included on claim to identify service as split (or shared)

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"

Substantive Portion

For 2022 for Physician to Bill

Physician must perform one of the key components (history, exam, or medical decision-making) "in its entirety"

-OR-

Spend more than half of the total visit time with the patient (already required for critical care and discharge management)

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

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Key Component as “Substantive Portion”

- The “substantive portion” performed by the physician is what determines the level of service.

- A PA and a physician can both contribute to the history, exam, and medical decision making – but only the portion or service provided by the physician can be used to determine the level of service

https://www.cm .gov/files/document/r11181CP.pdf#page=6

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Split/Shared Visit Quiz

- PA performs and documents the history, examination, and medical decision making and orders medication and a diagnostic test.

- Physician comes in after the PA and reviews results of diagnostic tests and response to medications, sees the patient, and documents “I saw and examined the patient who reports decreased dyspnea since initiation of treatment by PA. I reviewed and agree with the PA’s assessment and plan.”

- **Can this be billed as a split (or shared) service under the physician’s name/NPI?**

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Split/Shared Visit Billing

The answer is No. The physician did not personally complete either the history, exam or medical decision making in its entirety. Also, in this example the physician did not spend more than half the total visit time involved with the patient.

Using Time as “Substantive Portion”

- Only use time of PA/NP/physician (not RN/LPN nurses, medical assistants)
- When practitioners jointly meet with or discuss a patient, only the time of one of the practitioners can be counted toward total time.
- It may be helpful for each health professional providing the split/shared visit to directly document and time their activities in the medical record.

https://www.cms.gov/files/document/r11181CP.pdf#page=6

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Using Time as “Substantive Portion”

- ✓ Preparing to see the patient (e.g., review of tests, medical records)
- ✓ Counseling and educating the patient/family/caregiver*
- ✓ Ordering medications or tests*
- ✓ Documenting clinical information in the electronic or other health record*
- ✓ Care coordination
- ✓ Referring and communicating with other healthcare professionals*

*even after the patient has left the appointment

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Substantive Portion

CMS Policy Starting ~~2023~~ 2024*

If billing under the physician, physician must account for more than half of the total visit time.

*proposed

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

First Assisting at Surgery

- PAs covered by Medicare for first assist
- Reimbursed by Medicare at 85% of the physician's first assisting fee
  - Physician who first assists gets 16% of primary surgeon's fee – PAs get 85% or 13.6% of primary surgeon's fee
- -AS modifier for Medicare
- Special rules for PAs/NPs/physicians when residents/fellows are available in the hospital.

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Teaching Hospitals

- Medicare does not generally reimburse for first assistant fees if there is a qualified resident available.
- Applies when hospitals have an approved, accredited program in the particular surgical specialty.

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. traumatic injuries)

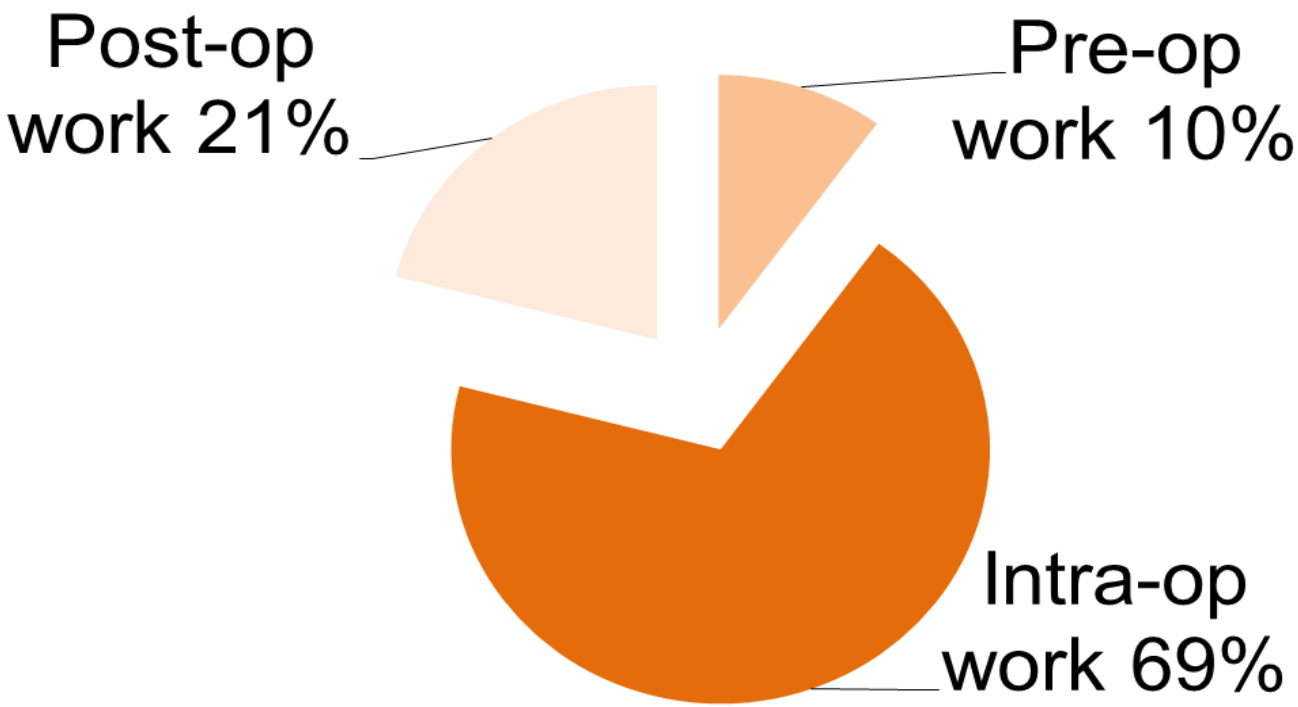
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Teaching Hospitals

When no qualified resident available

- Physician must certify
  - I understand that § 1842(b)(7)(D) of the Social Security Act 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 (teaching hospital) (in addition to –AS)

Global Surgical Package



Surgical Global Work Breakdown

- **31%** of the global payment is for work outside the OR.
- If the PA is doing the pre-op H&P, the post-op rounds, and the post-op office visits, then up to **31%** of the global payment could, theoretically, be attributed to the that professional.
- Additionally, **31%** of the Work RVU attributed to the procedure could be “credited” to the PA. Important not to set up a productivity system of direct competition with physicians for RVUs.

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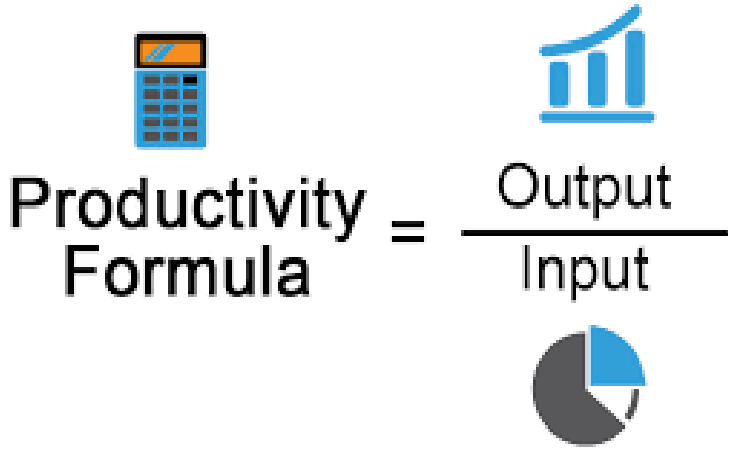
Global Work Breakdown



Example

27130 Total Hip (payable at $1,322*)

Pre-op work (10%): **$ 132.20** → **PA**

Intra-op work (69%): $ 912.18 Surgeon

Post-op work (21%): $ **277.62** → **PA**

*Final figure impacted by geographic index

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Global Work Contribution

- If a PA does pre-op exam and post-op rounding/ office visits, **$409.82** could be “credited/allocated” to PA.
- An additional separate payment of **$179.79** can be officially credited to PA for the first assist (13.6% of surgeon’s fee) which does not reduce the surgeon’s fees.
- However, billing records would show $1,322 being attributed to the surgeon.

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Potential PA Value or Contribution

True measure of global "value" might be:

First assist payment of	$179.79
plus	
E&M share of global payment	$409.82
	Total = $589.61 per THR

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CPT Code 99024

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

Captures post-op work provided in Global Surgical Package

Tracking Clinical Work in the Global Surgical Period

- While not separately payable, track “global” visits by using the 99024 code in the EMR.
- The global visits performed by the PA would otherwise have to be performed by the physician. **Note:** post-op visits are not separately reimbursed so split/shared billing does not apply.
- If the PA provided 300 post-op global visits, for example, theoretically 300 appointment slots were then made available for the physician to see other “revenue generating” new visits.

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What about that 15%

Without utilizing split/ shared or “incident to” billing, Medicare payment for PAs 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)?

Office/Outpatient Visit: Established Patient

CPT Code	Work RVU	Non-facility Price Physician (national average)	Non-facility Price PA
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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Contribution Model 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 practices).
- 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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Enhancing Efficient Clinical Workflow

Starts when patient contacts the practice

Are PAs listed in provider directories; can patients choose first available professional (physician or PA) or does physician have to be the first touch point?

Understanding

Charge capture and payer rules for PA-provided services.

Utilization

Practitioner utilization based on current state law/facility policies and each patient's care needs.

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Productivity Take Home Points

- Calculating PA productivity requires knowledge of billing and reimbursement policy and claims methodology for the various payers.
- Some claims are submitted under the physician's identification number (NPI), rendering PA's work invisible in the claims data.
- Unless a PA's patient care and financial contribution can be accurately measured, a fair production- based compensation formula is extremely difficult to implement.

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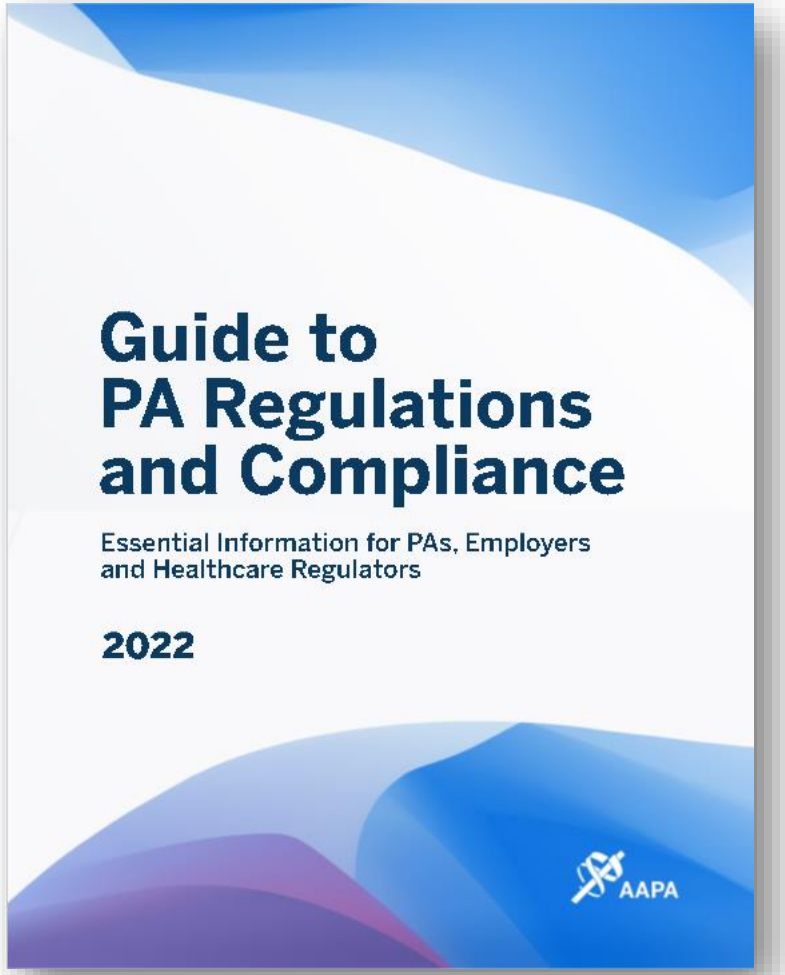

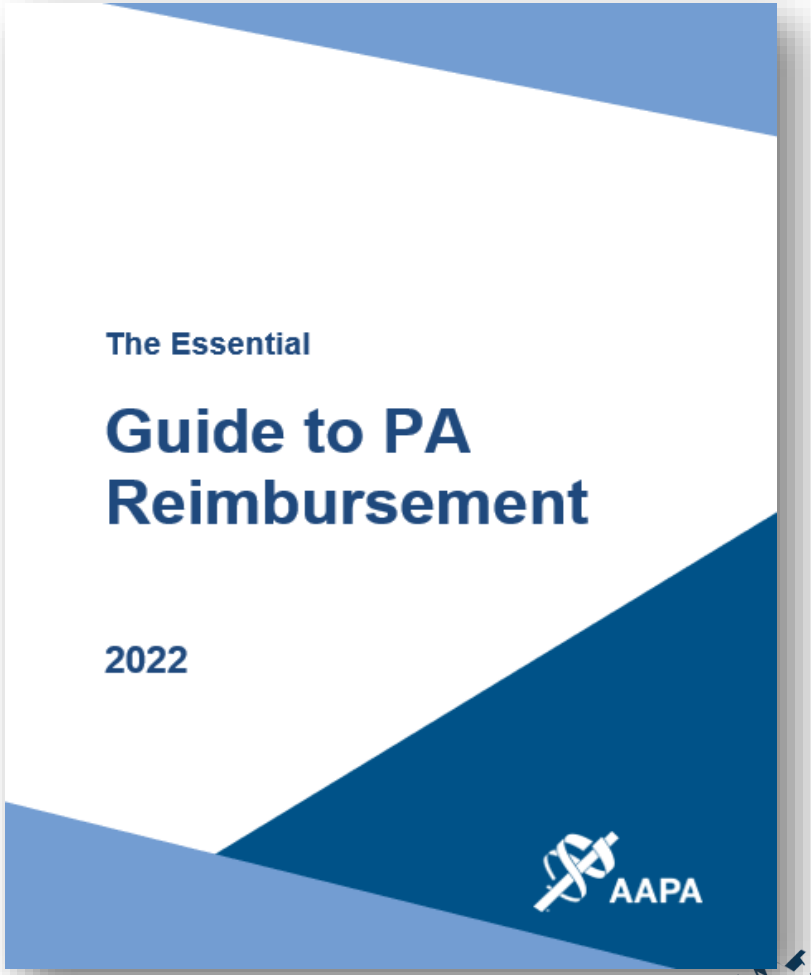

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