Physician Assistant Reimbursement Seminar

Ohio Association of Physician Assistants

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Disclaimer

Although every reasonable effort is made to assure accuracy for this presentation, the final responsibility of the correct submission of claims remains with the provider of the service. Medicare, Medicaid, and private payer policies change frequently.

The information presented is not meant to be construed as legal, medical or payment advice.

Unique Practice Settings

- Billing rules for Certified Rural Health Clinics (cRHCs), and federally-qualified Health Centers (FQHCs) are often different from Medicare's fee-for-service (FFS)rules.

- Cost-based reimbursement for most office services as opposed to FFS. FFS remains intact for certain services in a RHC (i.e., skilled nursing home services).

- Coding, documentation and compliance rules generally apply in all practice settings

PA Value Is Beyond Reimbursement

- Financial contribution to the practice is important, but

- **It's not just about the reimbursement**
  - Quality of care is still the PA's most important contribution
  - Physician quality of life (time off, sharing call)
  - Patient satisfaction (less wait time, continuity of care, adherence to treatment/medication plans)

Be Cautious of “Experts”

- Ask for references, statutes and regulatory language.
- Realize that billing & reimbursement are subject to interpretation and change.
- When in doubt, be conservative in your billing practices until the issue is clarified *in writing*. Have some idea of the answer before asking the question

Prevention

Like you, I believe in prevention.

I want to prevent . . .

Assuring Proper Billing?

- Just because Medicare or a private payer

  has been reimbursing for a service doesn't mean that you are billing appropriately

- Poor system edits and/or human error may be in play

Medicare Administrative Contractor (MAC)

- Combining of Medicare A & B at the Carrier level – Medicare Administrative Contractor (MACs)
- **Cigna Government Services** – Jurisdiction 15 is the MAC for Ohio (http://www.cgsmedicare.com/)
- Be aware of local medical review policies (LMRPs) that fail to properly understand state law

Highmark Medicare Carrier

- Highmark Medicare conducted a post-payment audit and reports that 73% of codes **99204 and 99205** did not have appropriate documentation.

- The most common error was **miscoding the level of service.**

- Covers Pennsylvania, Maryland, Delaware, parts of Virginia

Highmark Medicare

As a result of these findings, **a pre-payment edit** will be implemented on codes 99204 and 99205 for physicians and non-physician practitioners of all specialties.

Auditing Activities

Recovery Audit Contractors

- Four private companies throughout the country engaging in post-payment audits
- Must place on their web site the issues on which they are focusing
- RACs extending reach to Medicaid claims

Recovery Audit Contractors

- CGI for Ohio (Region B)
- https://racb.cgi.com/default.aspx; click on issues
- 2nd qtr. - collected $90.9 million in underpayments and returned $3.8 million in overpayments
- Single biggest issue: inadequate documentation for cardiovascular procedures

Recovery Audit Contractors

- Web site has an FAQ/current issues section
- Just because a hospital claim (Part A) is audited does not mean that the Part B services associated with that claim is impacted
- National and local carrier determination, CPT, ICD, and CCI will all be used as part of the audit

Recovery Audit Contractors

- Five levels of appeals for a claim denial
- Information provided on the type of screening tools RACs utilize
- FAQ on operations

HHS Office of Inspector General

- 2012 Work Plan http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf
- "Incident to" services
- E/M services billed during surgical global periods
- Coding patterns – same code repeatedly used

Possible Fraud and Abuse Actions

- Take back of reimbursement dollars paid
- Civil monetary penalties ($10,000 per bad claim)
- Exclusion from the Medicare, Medicaid, and other government-related health care programs

Can PAs Act as a Scribes?

- Yes, but why?
- Potentially a waste of resources by the employer
- A scribe only documents what another person does; they can not add to or make changes in the medical record/chart

New Interpretation: PAs May Use Scribes

- Joint Commission update allows PAs to use scribes
- Scribe defines by JC as an unlicensed person hired to enter information into the electronic health record or chart at the direction of a physician or practitioner (licensed independent practitioner, advanced registered nurse or physician assistant)

Respiratory Therapy

- CMS now allows PAs to order respiratory therapy without a physician co-signature
- Joint Commission changed its rules to be consistent with Medicare

Consultations

- In 2010 Medicare eliminated payment for consultations
- Dollars paid for consults were transferred back into the fees paid for initial office and initial hospital services

Private Payer Consultations

Requested by a physician or "other qualified health care professional" for opinion or advice regarding a specific problem.

- Request can be written or verbal, but must be documented
- Must report back to the requestor (within a hospital, notation in the joint medical record is sufficient).
- Consults are different from a **transfer of care.**

PAs Deliver

- Services within their range of education and expertise, based on the delegation of the supervising physician
- Services that would otherwise be provided by a physician
- Medical services, not a separate range/set of “PA services”

National Provider Identifier (NPI)

- NPI number represents identification in the healthcare system
- NPI will not indicate the provider type, practice setting, specialty, etc.
- Can apply on-line at:

https://nppes.cms.hhs.gov/NPPES/Welcome.do

NPI Number

- PAs should have their own NPI number
- Having an NPI number does not mean that it must be used for billing purposes for every service performed by the PA
- Options exist for billing the PA's services under the supervising physician with payment at the physician rate (100%)

Medicare Enrollment

- PAs should be enrolled in the Medicare Program using the 855 form
- NPI required for enrollment
- When PAs enroll in Medicare, options still exist for capturing 100% reimbursement billing under the physician

Regulatory Policies/Entities that Impact PA Practice

- Medicare Conditions of Participation
- Joint Commission
- PA State Scope of Practice Statutes
- Statutes outside of PA practice statutes (insurance, radiography, behavioral health)
- State Medicaid Policy
- State workers' Comp plan policies

Medicare Scope of Practice

PAs may perform (as allowed by state law):

- All E/M codes (including high levels)
- Private payer consultations, observation, and critical care (time-based)
- Initial hospital admit & pre-surgical H&Ps
- All diagnostic tests/procedures

Medicare will defer to state law on scope of practice issues

Medicare Payment Policy

- Services provided by PAs are billed to Medicare at the **full physician rate**.

- Use of the PA's National Provider Identifier(NPI) number/Ptan triggers the 85% payment

CPT Codes

- PAs have access to virtually all CPT codes to describe the services they deliver

  [2012 CPT Manual, professional edition, introduction, p. x]

- Beware of Medicare Local Medical Review Policy attempts to impose limitations

- Requirements of state law must always be followed

CPT Codes

Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician or other qualified healthcare professional

Practice Settings

- Hospitals (inpatient, outpatient, ED, OR)
- Hospital-based office or clinic
- First assisting at surgery
- Outpatient office or clinic, dialysis center
- Ambulatory Surgical Center

Medicare Transmittal 1744; March 12, 2002

Supervision of PAs

- No requirement for the supervising physician to be in the same building
- PAs deliver care with a high degree of autonomy in patient care decisions and in medical decision making
- Hospital bylaws may require on-site supervision when PAs deliver certain services

Supervision under Medicare

- Access to reliable electronic communication
- Personal presence of the physician is generally not required (except for “incident to” billing – outpatient private office or clinic)
- Medicare policies will not override state law guidelines

Supervision & Diagnostic Tests

- Medicare developed a list of supervision requirements for a wide range of diagnostic tests
- Code of Federal regulations 410.32 states that PAs are treated as physician for the performance of diagnostic tests and not subject to the supervision requirements
- PAs can't supervise techs providing these diagnostic services, PA need to be in the room when the test/procedure is being performed

Documentation Requirements – General Rule

- Avoid the “resident language” trap of
  - see and agree
  - agree with above

- “See and agree means no fee”

Documentation and Billing

- Having the physician:
  - Step into the room
  - Co-sign a chart
  - Review the chart

  Does not necessarily equate to the ability to submit a bill under the physician's name

Documentation

- The old rule was, “If it isn’t written on the chart, it didn’t happen.”
- New rule, “Even if it is written on the chart, if it isn’t medically necessary we won’t pay for it.”

Shift to ICD-10

- Current ICD-9 system has approx. 13,000 code sets
- Organized medicine will shift to ICD-10 in 2014 (unless CMS grants yet another delay)
- ICD-10 has some 68,000 codes sets

Medicare's Preventive Services

- Welcome to Medicare (IPPE) exam and a annual wellness visit (AWV) – PAs are eligible providers

- Other preventive services – no deductible for beneficiaries

Medicare's Preventive Services

- AWV can be performed in a hospital or an office
- AWV is not an E/M service. It's the collection and documentation of information, and a review of functional ability and status
- A number of health care professionals can assist in the performance of the visit

Medicare Payment

For virtually all medically necessary, covered services Medicare will cover PAs at 85% of the physician fee schedule, if the same service would have been covered if performed by a physician

[Medicare Transmittal AB-98-15]

Private Physician's Office

- Billing under the PA's name and NPI
- Payment at 85% of the fee schedule
- Can treat new patients and/or established patients with new problems (no need for direct physician involvement)

Billing under the PA's Name

- Despite billing under the PA's name, payment goes to the PA's employer (via physician or practice tax ID number)

- Employers tax ID is associated with the PA when filling out Medicare's enrollment application

Medicare's "Incident to" Provision

- Often misunderstood
- Concerns about fraud allegations
- Concept has evolved over time

“Incident to” Billing

- Still allowed by Medicare [Medicare Carriers Manual; [Transmittal 1764, Section 2050-2050.2 , Aug. 28, 2002]

- Allows an **office or clinic** provided service performed by the PA to be billed under the physician’s name with payment at 100% (*almost never used in hospitals or nursing homes*)

- Terminology may have a different meaning when used by private payers

“Incident to” Billing

- Requires that the physician personally examine & treat the patient for a particular medical condition, and provide the diagnosis and treatment plan

- PAs may provide subsequent (follow up) care for that same condition without the personal involvement of the physician

- Physician (or another physician in the group) must be physically present in the suite of offices when the PA delivers care

Incident to

Physician personally treats means:

- HPI
- Physical examination
- Medical decision making

Incident to

What does in the suite of offices mean?

- In the contiguous office suite
- Hospital attached by a walkway?
- In a lab on the fourth floor of the office building?

Incident to

- Contiguous suite of offices – Yes
- Hospital attached to office by walkway – No
- In a lab on the fourth floor (practice is on the first floor) – Probably not unless lab is part of the offices owned by the physician/group practice

Incident to

- Physician must remain engaged in the care of the patient to reflect the physician's ongoing involvement in the care of that patient

- Review medical record, PA discusses patient with physician, or physician visit/treatment

“Incident to” Billing – New Problem

- Does not apply to new problems/new conditions

- PA has the option of treating the new problem (85%) or having the physician treat the new problem (setting up the possibility of “incident to” on a subsequent visit)

“Incident to” Billing – New Problem

- Can the PA treat the patient on the first visit and have the physician see the patient on the second visit to establish “incident to” billing? – No

- Can the PA order a test and have the patient come back to be examined, diagnosed, and treated by the physician once the lab results are in - Yes

Hospital Billing

- Inpatient or outpatient hospital setting – typically falls under hospital billing guidelines

- Hospital-owned or provider-based clinics generally fall under hospital billing rules

Hospital Billing - Part A/Part B

- Medicare requires that medical and surgical services delivered by hospital-employed PAs (NPs & physicians) be billed under Medicare Part B (exception for administrative responsibilities).

- In the past, Medicare allowed hospital-employed PA salaries to be covered under Part A through the hospital's cost reports. That has changed.

  [Medicare Claims Processing Manual, Chapter 12, Section 120.1]

Medicare Hospital Billing

- Whether employed by the hospital or not, PAs are covered by Medicare

- No need for on site physician presence under Medicare; electronic communication (telephone) meets supervision requirements (hospital bylaws/policies and state law must also be followed)

Medicare Hospital Billing

- Is it a physician or PA bill if both provide service to the same patient on the same visit?

- Medicare's previous rules said that whoever did the exam and medical decision making (majority of care) had to bill for the service

Hospital Billing (cont.)

- 2001 split billing policy created confusion, frustration and administrative difficulties
- AAPA and others pushed CMS to adopt a more user friendly policy
- October 2002 - shared visit policy allowing more PA patient interaction with 100% billing/reimbursement

Shared Visit Policy

- Ability to “combine” hospital services provided by the PA and the physician to the same patient on the same calendar day (this is not “incident to” billing).

- Requires that the physician provide a face-to-face portion of the E/M service to the patient

[Medicare Transmittal 1776, October 25, 2002]

Shared Visit

- Applies to evaluation and management services, not procedures or critical care

- PA and physician must be employed by the same entity (same hospital, same group practice, PA employed by solo physician)

Shared Visit

- What documentation is required?
  - Clear note (can be brief) detailing the physician's personal professional service
  - Make a clear distinction between PA's work and the physician's work
  - Avoid "agree with above" type of language

Hospital-employed PAs Delivering Care to Patients of Private Physicians/Surgeons

- Concerns about inducement, inurement, Stark
- Medicare requires that only the employer of the PA should receive reimbursement or professional services from the PA
- If the private physician/surgeon does not contribute to PA's salary the PA can't provide professional work

Hospital-employed PAs Delivering Care to Patients of Private Physicians/Surgeons

- Leasing options may be available to private physicians
- Lease must be at fair market rate
- Must meet Medicare guidelines

Physician Involvement & Billing
(Warning #2)

Generally, having the physician greet the patient, stick his/her head in the room, co-sign the chart, or discuss the patient's care with the PA in the hallway does not lead to the ability to bill under the physician at 100%

Modifier Code – First Assisting

- AS is the only unique modifier that Medicare uses for PAs (PAs may also use the numeric modifiers that physicians use) [Medicare Claims Processing Manual , Chapter 12, Section 110.3]

- Medicare's payment is 85% of the 16% a physician's receive for first assisting

- Net is 13.6% of the primary surgeon's fee

Credentialing

- Joint Commission's standards require that hospitals credential and privilege PAs through the medical staff

- The old guidelines allowed for privileging through another "equivalent process"

  [Standard HR 1.20, EP13 CAMH Refreshed Core, 1/2008]

Chart Co-Signature

Generally, Medicare does not require chart co-signature

- Exceptions are hospital discharge summaries; this requirement also applies to outpatients, including outpatient surgery and patients treated in the emergency department, but not admitted to the hospital [42CFR §482.24(c)(2)(vii)]

- PAs may perform and be reimbursed for these services, but a physician co-signature is required (time frame not specified, but 30 days may be a state requirement)

Chart Co-signature

- Physician countersignature no longer required by Medicare on H+Ps (admit or pre-op) as of 2008

[42CFR §482.22(c)(5)(i)(ii)]

Teaching Hospital Rules

- Any restrictions on billing apply only to first assisting at surgery, not to other services delivered in the hospital
- Resident/fellow “billing” rules **do not** apply to PAs
- PAs are authorized to bill Medicare, residents do not (their services are covered through the precepting physician)

[Medicare Carriers Manual Section 15106]

Teaching Hospital Rules

Any restrictions to billing for PA first assist services apply only to hospitals that have an approved, accredited surgical program in a particular surgical specialty (i.e., neuro, ortho, CT)

Teaching Hospital Rules

PAs can be used for first assists even when there is an accredited program at the hospital if:

- The surgeon never involves residents in the care of patients
- There is no “qualified” resident available
- The residents have a scheduled training session/ educational conference, or is involved in another surgical case
- Trauma surgery

  [If resident is not used, I suggest a notation in the operative report as to why]

[Medicare Claims Processing Manual Chapter 12, Section 100.1.7]

Teaching Hospital Rules

- New guidelines in July 2011
- Limits on continuous hours for residents and weekend work
- Has led to a greater utilization of PAs in hospital

“Never Events”

Preventable medical errors that result in serious consequences for the patient, such as:

- Wrong surgery or other invasive procedures performed on a patient/body part

POA vs. HAC

- Effective October 1, 2008, hospitals do not receive additional payment for cases in which one of the selected conditions was *not present on admission (POA).* Documentation of all conditions on admission essential.

Hospital Acquired Conditions

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma: Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, Burn, Electric Shock

Hospital Acquired Conditions

6. Manifestations of Poor Glycemic Control such as DKA, Nonketotic Hyperosmolar Coma

7. Catheter-Associated Urinary Tract Infection (UTI)

8. Vascular Catheter-Associated Infections

Hospital Acquired Conditions

9. Surgical Site Infection s/p(CABG)Mediastinitis; s/p Bariatric Surgery, including Laparoscopic Gastric Bypass, Gastroenterostomy, Lap Gastric Restrictive Surgery; s/p Orthopedic Procedures of the Spine, Neck, Shoulder, and Elbow

10. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) s/p Total Knee or Hip Replacement

Private Third Party Payers

Private Payer Hospital Surgical Billing

- For first assisting at surgery typically use 80, 81, 82, or AS modifier, depending on instructions from the payer
- Don’t assume that private payers use Medicare’s “AS” modifier
- Private payers pay between 10% and 25% of the surgeon’s fee (depending on the contract)

Private Payers

- Most private payers cover services delivered by PAs
- Some payers require billing for PAs under the physician's name and/or provider number or the group's/hospital's tax ID
- Not necessarily the same as Medicare's "incident to" or shared visit policies

Private Payers

- It is not fraud to bill under the physician/hospital if authorized by the payer
- It ‘s a mistake to assume that all payers follow the same billing rules
- Must have specific, written policies from payers in your region/state

Credentialing By Private Payers

- Private payer credentialing is not necessarily related to payment policy
- Credentialing and the issuance of provider numbers depend on the particular payer and does not determine coverage

Company	Billing	% Reimbursement	Covered for First Assisting at Surgery?	
Aetna	PA	85%	Yes	
Anthem-BCBS	PA's PIN	85%	Yes	
United	PA NPI	contracted	Yes	

Private Payers

Medical Mutual

- PAs credentialed and issued PIN
- Bill under PA's number
- First assist covered at 13.6% (82 modifier)

Medicaid-2012 Policy Changes

- 85% reimbursement
- Bill with UD modifier, except when physician also provides an identifiable service or for services provided by ancillary medical personnel
- No coverage for first assisting

Medicaid Changes

- Enrollment for PAs
- Services delivered by PAs in hospitals (ED), nursing facilities, intermediate care facility now covered
- Payment can be made to PA, physician, physician group, or clinic

Workers' Compensation

- 85% reimbursement
- Bill under PA's PIN
- First assisting covered at 17%
- Physician must sign forms

Denied Claims

- Must challenge denials
- Determine who has the authority to adjudicate the claim – insurance company or self-insured employer

Denied Claims

Explanation of Benefits/Remittance Notice– will detail reason a claim was denied

Patient-Centered Medical Home

- Numerous state & payer definitions as to who is included
- National Committee on Quality Assurance changed their list to include PAs
- Patient-centered Primary Care Collaborative definition does not officially include PAs and NPs.

Patient-Centered Medical Home

- Some private insurance companies are beginning medical home projects on their own
- Concerns over the concept of who may lead a medical home (sometimes reserved for “independent” health care professionals)
- Concepts of supervision/collaboration become blurred.

Determining PA Value

- Definition
- Breadth
- Competition with physicians is a prescription for disaster
- Healthcare is a team sport

“Productivity Proxies”

- Charges-what the practice bills to payers
- Collections-what the practice receives from payers
- Patient encounters
- Relative Value Units (RVUs)

Productivity

- Billing software programs may or may not allow the tracking of a health care professional's work/codes, even though that information will not be sent on to the third party payer (place for a rendering provider in addition to a billing provider)

- Virtually every service performed can be tracked by CPT code (often with the use of modifier codes) or relative value units (RVUs), even if the service is not submitted for billing purposes

Tracking Productivity

- Productivity includes services performed by you that are:
  - billed under your PA's name
  - billed under the supervising physician
  - not separately billable (global surgical services)
  - PA contribution to a physician E/M service
  - Research, teaching

Productivity

- Physicians may choose to have PAs first assist on cases in which no first assist fee is paid

- A PA assisting in hand cases or scope cases will result in increased efficiency, allowing the physician to perform more cases in the same amount of block time. Payment for 2 or 3 extra surgical cases brings in more reimbursement than the assist fees.

Productivity

- PAs increase patient access to the practice. Same day appointment availability improves customer service. Avoid having new patients wait 3-6 weeks for an appointment.
- PAs can provide global visits, freeing up the physicians to see new patients, consults, and surgical candidate visits.
- PAs can facilitate communications with patients, the hospital, the community, and with office staff.

Productivity

If the PA didn't perform these services –

- global visits
- hospital rounds/notes/discharge summaries
- patient phone calls,
- pharmacy phone calls
- insurance paper work/authorizations,

- the physician would

Productivity

- Productivity, billing, and reimbursement are distinctly separate issues

- Depending on utilization and payer billing requirements, PAs may not appear to bring in large amounts of revenue under their names

Productivity

- Patients treated/patient volume
- Amount billed to third party payers
- Collections from third party payers
- Relative Value Units (RVUs) generated

Productivity

- No difference between physician and PA RVUs
- Same service with similar quality outcomes

Global Work

- While not separately payable, track “Global” visits by using the global visit code on the super-bill or in the EMR.

- 99024: “Postoperative follow-up visit included in global service.

Surgical Productivity

Medicare fee breakdown (neuro/spine numbers applied to total knee):

- 11% for pre-op work (H&P)
- 76% for intra-operative (surgical procedure)
- 13% for post-op care (10/90 days)

24% of global payment is for non-OR services

Surgical Productivity

Example:

27447 Total Knee (payable at $1,769*)

Pre: $194.59

Intra: $1,344.44

Post: $229.97

*Final figure impacted by geographic index

Surgical Productivity

- If PA does pre-op exam and post-op rounding, $424.56 could be “credited/allocated” to PA.
- Billing records would show $1,769 being allocated to the surgeon.
- Separate payment of $240.58 officially credited to PA for the first assist (13.6% of surgeon’s fee)

Value

True measure of PA “value” might be

- first assist payment of $240.58 +

- share of global payment $424.56

Total = $665.14

Economic Value = Revenue Less Expenses

There is a cost for:

- Exam rooms
- Mortgage/rent payments
- Medical assistants
- Utilities
- Receptionist
- Etc.

Physician Quality Reporting System

Pay for performance/reporting system

- Linking pay to reporting patient care information (PQRS)
- Bonus payment to report data on meeting “quality standards”
- Program is voluntary, but some expect it to become mandatory in the next few of years

PQRS
http://www.cms.hhs.gov/PQRS

- As of 2012, 264 individual PQRS quality measures
- Which measures to use depend on patient population mix; registries may be utilized
- PAs and NPs are “eligible providers”

PQRS

- Bonus payment is .5% for 2012
- Can use claims data process, registry, or EHR

PQRS

- Reporting example:

  Perioperative Care: Timing of Ordering an Antibiotic

  Percentage of patients 18 or older undergoing procedures with the indications of prophylactic parenteral antibiotics within one hour prior to the surgical incision

PQRS

- Reporting Example

Diabetic Patient:

Making sure that diabetic patients have their hemoglobin A1c checked at least once per reporting period

Medicare's E-Prescribing

Incentive Program:

- 1% bonus in 2012.
- .5% bonus in 2013

Skilled Nursing Facilities

- Comprehensive visit – provided by physician
- PA can perform “first” visit
- After comprehensive visit, physician and PA can alternate every other visit

Skilled Nursing Facilities

Scheduled (required) Visits

- One visit every month for the first 90 days
- Then one visit every 60 days, thereafter

Skilled Nursing Facilities

- Unscheduled visits can be provided by the PA without disrupting the existing physician-PA alternating schedule

- More than 18 visits per year may require an explanation to Medicare

EHR

- Valuable tool with some level of risk
- Medical necessity
- Do EHR prompts provide incentives to avoid medical necessity?
- Authenticate entries/verify added documentation?

EHR

- When physician goes into the EHR to co-sign does that “convert” the visit to a physician bill?

- What are the implications on quality assessment and productivity tracking?

Resources/Contact Information

- AAPA Web site: www.aapa.org

  Click on Your PA Practice; then click on Reimbursement

- E-mail: michael@aapa.org

Questions?