Maximizing the Utilization of PAs & NPs
Rules, Realities and Reimbursement

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• I am a full-time employee of the AAPA.

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• I have no conflicts or financial disclosures to report.

Disclaimer

• This presentation was current at the time it was submitted.

   It does not represent payment or legal advice. Any reliance on such information is expressly at your own risk.

• Medicare policy changes frequently, so be sure to keep current by going to www.cms.gov.

• Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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5th “Dimension”-Unspoken Organizational Culture

- Prior experience of physicians: generational and training experiences.
- Preconceived notions of support staff and management.
- Lack understanding of how the roles have evolved and what the possibilities might be for change.
- Culture can completely derail even the best of business plans.

Academic Settings: Challenges

- The ACGME duty hour reforms of 2003 and 2011 created a need for increased manpower and resident “substitution” in the Academic Medical Centers.
- PAs/NPs have been hired in large numbers, with little guidance for deployment.
  - PAs and NPs are not residents.
    - There is no GME funding for them.
    - Teaching rules do not apply to PAs &NPs.
    - The rules are DIFFERENT.
Myths & Misperceptions

Myths

• PAs/NPs cannot see new patients
• Physician must be in the office when PA/NP sees patients.
• Physician must see every patient.
• A physician co-signature means the claim may be submitted under the physician.
• Reimbursement for services provided by PAs/NPs “leaves 15% on the table”.
• Commercial payers won’t pay.
• PAs and NPs compete with residents and medical students for patient experience.

Realities

• PAs/NPs are enrolled providers in the Medicare program who render services a PHYSICIAN would otherwise have to provide.
• Many organizations are not using PAs/NPs to their full potential or billing for their services.
• Maximizing utilization of PAs/NPs can create operational efficiencies and financial opportunities for the organization.
History Timeline

- Physician 460 B.C.
- Nurse 1854
- Nurse Practitioner 1965
  1st NP Program started at Univ Colorado by Dr. Loretta Ford and Dr. Henry Silver
- Physician Assistant 1965
  1st PA Program started at Duke by Dr. Eugene Stead; modeled after WWII “fast track” training for physicians

PAs & NPs

RECOGNIZED AS MEDICARE “PROVIDERS” IN 1998

PAYMENT POLICY
Balanced Budget Act of 1997

- Removed the restriction on settings and services furnished by PAs/NPs.
- Payments allowed for services furnished by PAs/NPs in all settings.
- Payment for services at 85% of the physician fee schedule.
- Allows payment to a PA/NP as an independent contractor to qualify as an employment relationship.
- Effective for services furnished on or after January 1, 1998.
- Prior to 1998, very little opportunity to bill for PAs/NPs other than via “incident-to” provision, and reimbursement rate in rural/healthcare provider shortage areas was 65%.

Medicare Part A Cost Report

42 CFR 409.10

*Inpatient hospital services* does not include the following types of services:

1. Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.
2. Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.
PA/NP Providers

PAs and NPs are recognized as enrolled “non-physician providers”, “ordering/referring” providers, and "eligible providers” in the Medicare program.

- PA/NP covered services are those that a physician would otherwise have to provide.
- Must be enrolled in Medicare if ordering, referring and/or billing. Effective January 2014.
- Reimbursement for services provided by PAs and NPs are reimbursed at 85% of the physician fee schedule.
- There are provisions for 100% reimbursement, such as Incident-to in the office and Shared Visits in the hospital setting; specific rules apply.

PA Direct Billing/Payment

- Medicare does allow PAs to submit claims under their own NPI.
- Medicare does not allow PAs to receive direct payment; while the claim is submitted under the PA’s NPI, the payment field is to the PA’s employer.
- Hidden Challenge: Remittance advice (the check) therefore is not directed toward the PA, but to the employer, potentially rendering the PA invisible in accounts receivable.

Medicare Manual Citations

The Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services §190 – Physician Assistant (PA) Services (Rev. 1, 10-01-03)

D. Employment Relationship

Payment for the services of a PA may be made only to the actual qualified employer of the PA that is eligible to enroll in the Medicare program under existing Medicare provider/supplier categories...


Medicare Program Integrity Manual, Pub 100-09, Chapter 10, §2.4.11

Payment for the PA’s services may only be made to the PA’s employer, not to the PA himself/herself. In other words, the PA cannot individually enroll in Medicare and receive direct payment for his or her services. This also means that the PA does not reassign his or her benefits to the employer, since the employer must receive direct payment anyway. The PA’s employer can be either an individual or an organization...

**NP Direct Billing/Payment**

- Nurse practitioners may direct bill under their NPI and receive direct payment from Medicare.
- Nurse practitioners may reassign their payment to their employer. Most NPs reassign as a condition of their employment.

**PAs can bill all levels of E/M: Medicare**

Medicare Benefit Policy Manual: Chapter 15, §190 Physician Assistant (PA) Services states:

“PAs may furnish services billed under all levels of CPT evaluation and management codes, and diagnostic tests if furnished under the general supervision of a physician.”


**NPs can bill all levels of E/M Medicare**

Medicare Benefit Policy Manual: Chapter 15, §200 Nurse Practitioner (NP) Services states:

“NPs may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.”

Supervision/Collaboration under Medicare

Medicare policy for supervision/collaboration essentially same for PAs and NPs

- Access to reliable electronic communication
- Personal presence of the physician is generally not required
- Medicare policies will not override state law guidelines or facility policies

PA Supervision

Medicare Benefit Policy Manual: Chapter 15, §190 Physician Assistant (PA) Services states:

“The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary, unless State law or regulations require otherwise.”

NP Collaboration

Medicare Benefit Policy Manual: Chapter 15, §200 Nurse Practitioner (NP) Services states:

“The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.”
Medicare: New Patients/New Problems

• PAs/NPs may provide evaluation and management services to new patients and established patients with new problems in the Medicare program.

• When they do, the encounter should be billed under the PA/NP’s NPI for Medicare; reimbursement will be at 85% of the physician rate.

Myth

What about the 15% left on the table?!

Let’s Compare (Reality)

Physician Salary/Compensation  PA/NP Salary/Compensation
PA /NP : Physician Salaries

- PAs/NPs are paid approximately 1/3rd to 1/4th the salary of their physician counterpart.
  (a broad generalization, but supported by MGMA data.)
- This is about math.
- The profit margin is higher when the PA or NP provides the service, even at 85% reimbursement.

Math: Same Service Provided

<table>
<thead>
<tr>
<th>Physician</th>
<th>PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary $300,000 ($144/hr)</td>
<td>Salary $100,000 ($48/hr)</td>
</tr>
<tr>
<td>The service/office visit is reimbursed at 100% for $100.</td>
<td>The same service is reimbursed at 85% for $85.</td>
</tr>
<tr>
<td>The physician would have to provide 3000 office visits (at the same level) to cover the salary.</td>
<td>The PA/NP would have to provide 1176 office visits (at the same level) to cover the salary.</td>
</tr>
<tr>
<td>First visit of the day: still $44 in the RED. Recurs first visit every hour thereafter.</td>
<td>First visit of the day: profit $36.</td>
</tr>
</tbody>
</table>

“Incident-to” Medicare payment policy:

“INCIDENT-TO”
"Incident-to Billing": What's the Big Deal?

- "Incident to" is a Medicare billing provision that allows reimbursement for services delivered by PAs/NPs at 100 percent of the physician fee schedule, provided that all "incident to" criteria are met.

- The "extra 15%" reimbursement appears enticing.

"Incident-to Billing": The Rules

- "Incident to" is a Medicare billing provision that allows reimbursement for services delivered by PAs/NPs at 100 percent of the physician fee schedule, provided that all "incident to" criteria are met.

- "Incident to" billing only applies in the office or clinic. Does not apply in a facility setting.

- "Incident-to" does not apply to commercial payers unless specified in policy. (Example Aetna)

"Incident-to" Rules

- 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. (This cannot be a shared visit.)

- A physician (does not need to be the same physician) is within the suite of offices when the PA/NP renders the service upon the patient’s return for follow-up for the same problem.
“Incident-to” Rules

- The physician must have some ongoing participation in the patient’s care.
- This must be reflected in the medical record somehow, in the event of an audit.
- If all requirements are met, encounter can be billed under physician's NPI for 100% reimbursement.
- If ALL are not met, bill under the PA's NPI; reimbursement will be at 85%.

Incident-to billing

- Make sure you know and understand the rules for Medicare’s “Incident-to” billing.
- Some payers do not enroll PAs. Claims are submitted under the physician’s number.
- This is NOT incident-to billing. There is no on-site or first-visit rule attached.

Incident-to Under Scrutiny

- “Incident-to” billing highlighted as a potential problem
- The OIG has included incident-to billing reviews in its 2012 and 2013 Work plans through 2014.
NGS Part B News Article: Clarification of Documentation Requirements for "Incident to" Services

In summary, Medicare “incident to” criteria include the following:

• There must be a physician service to which the service(s) of the nonphysician practitioner (NPP) or other ancillary staff relate.
• The physician must have initiated the service as part of a continuing plan of care in which he or she will be an ongoing participant.
• The physician must be present in the office suite and provide direct supervision.
• “Incident to” applies to the office/clinic setting, and is not applicable in the hospital or skilled nursing facility (SNF) setting.
• A new visit evaluation and management (E&M) service may not be performed “incident to.”
• Established patient visits may not be billed “incident to” when the patient presents with a new problem requiring a change in the plan of care.
• The visit must involve a face to face encounter. The physician must perform the initial patient visit.

NGS continued…

Documentation of incident to services should include:

• A clearly stated reason for visit
• Date of the service provided
• Signature of the person providing the service
• The patient’s progress, response to, and changes/revisions in the plan of care
• While a co-signature of the supervising physician is not required, Medicare would expect to see evidence in the documentation that the supervising physician was involved in the care of the patient and was present and available during the visit.

[Source: Archived Part B News articles http://www.ngsmedicare.com]
Split/Shared Visit - Hospital

- Can be billed for a new patient, admission, or subsequent hospital visit;
- The service performed was an evaluation and management (E/M) service, not a procedure nor a critical care service.
- PA/NP and physician must be employed by same entity (same hospital, same medical group).
- Physician must perform some element of history, exam, medical decision making and document* on the same calendar day. If physician documentation not adequate, bill under PA/NP's NPI.

“Unacceptable” Shared Visit Documentation

- I have personally seen and examined the patient independently, reviewed the PA’s Hx, exam and MDM and agree with the assessment and plan as written”, signed by the physician
- “Patient seen”, signed by the physician
- “Seen and examined”, signed by the physician
- “Seen and examined and agree with above (or agree with plan)”, signed by the physician

Source: WPS Medicare and Novitas Solutions Medicare Contractor guidance

Scribed Services

- A “scribe” does not act independently, nor perform any element of the encounter, but simply documents the practitioner’s dictation and/or activities during the visit.
- The practitioner who bills for the services is expected to be the person delivering the services and creating the record, which is simply recorded by another person/the scribe.

Do not use PAs or NPs as Scribes!

Article from WPS: Guidelines for the Use of Scribes in Medical Record Documentation
PA/NP as Scribes

- NOT recommended
- PAs/NPs are providers
- Poor Utilization
- High risk of fraud
- Scribes are a blooming profession, paid at $10-15 per hour
- If scribes are provided to physicians, should also consider providing to PAs/NPs
- Physicians in academic settings in particular are struggling with this concept.

Contractor Audit

Non-Physicians Acting as Scribes for Physicians

“Recently CGS has noted some physicians having another individual write notes in the medical record for them, and then the physician merely follows behind and signs the note … If a nurse or Non-Physician Practitioner (NPP) acts as a scribe for the physician, … The scribe is functioning as a ‘living recorder,’ documenting in real time the actions and words of the physician as they are done. If this is done in any other way, it is inappropriate. The real time transcription must be clearly documented as noted, by both the scribe and the physician. Failure to comply with these instructions may result in denial of claims.”


Payment Policy

ASSISTING AT SURGERY
First Assist

- PAs/NPs are covered under Medicare and most commercial payers as first assistants
- Reimbursement is 13.6% of primary surgeon's fee for Medicare
- Commercial payers vary from 10-25%
  - AS Modifier for Medicare
- Must ask commercial payers for modifier
- List of exclusion codes for which Medicare will never pay for first assist. (Defined in Medicare physician fee schedule.) Many payers use this list.

Assist-at-Surgery

Teaching Hospitals:
- No qualified resident available
  - this can be because they are in required training sessions (Grand Rounds) or off-duty for sleep or required to be in clinic
  - First surge in 2003, then 2011
- Physician NEVER uses the residents
- Trauma

Assist-at-Surgery

When a qualified resident is not available, the surgeon must "certify" with a statement in the OP note.

"I understand that section 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 Medicare carrier."

Medicare Claims Processing Manual Chapter 12, Section 100.1.7

An additional modifier is also required on the claim when a PA/NP first assists and no qualified resident available:
- AS in first modifier position
- 82 in second modifier position
Caveat

- For PA/NPs employed by hospitals directly, reimbursement for first assisting is problematic as payers consider the fee part of the negotiated “case rate”.
- Most hospital-employed surgeons are not directly hospital-employed; rather, they are part of a medical practice under the hospital corporate umbrella.
- PA/NPs should be considered for this type of arrangement as they are providers and not hospital “staff”.

State Medicaid Policy

- Texas Medicaid pays for services provided by PA/NPs.
- PAs/NPs can be enrolled providers in the Texas Medicaid program; reimbursement is at 92% of the physician fee schedule. There are provisions for 100 percent reimbursement by billing under the physician; proposed rules are pending.
- Texas Medicaid does cover PA first assisting in Surgery at 12.8% of the primary surgeon's fee.
- Texas Medicaid requires a order signed by a physician for outpatient therapy services.
COMMERCIAL PAYERS

Payers and
Enrollment

• Private payers may promulgate their own rules.
• Many choose not to enroll PAs/NPs. They DO however pay for services provided by PAs/NPs.
• Claim is submitted under the physician’s number.
• Many do not discount; payment is at the physician rate.
• The organization billing must ascertain claims methodology and payment rate for each payer with whom they contract.

Payer Policy Variability

The billing methodology must be clearly ascertained by every individual practice for every individual payer with whom they contract.
• Enrollment does not necessarily equate with payment.
• Many do not follow Medicare rules (such as Incident-to or Shared Visits)
• Many do not use the −AS modifier for first assisting
• Many do not discount services provided by PAs/NPs.
• Must not assume.
Example: Aetna

- Aetna enrolls PAs and NPs (since June 2010) except in Alaska, Kansas, Maine, Michigan, and Missouri.
- Discounts PA/NP services to 85%.
- It remains the responsibility of the practice to ascertain the payment policy and claims instructions for each payer with whom they contract.

CPT Code Utilization

“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 health care professional.” CPT Professional, ©AMA 2013, p. x

Instructions for Use of CPT Codebook

“E/M services may also be reported by other qualified health care professional who are authorized to perform such services within the scope of their practice.” CPT Professional, ©AMA 2013, p. 4

Caveat

Some private/commercial payers may have their own rules. It remains the responsibility of the practice to ascertain the payment policies and claim instructions for each payer with whom they contract.

Arkansas BCBS is an example. Written policy on file states that PAs and NPs may only bill lower level codes; Level 4 and 5 are limited to physicians.
CALCULATING CONTRIBUTION

Tracking Work RVUs

- A common approach to physician compensation.
- Difficult to apply to PA/NPs for many reasons, including shared visits and lack of enrollment by some payers; most practices rely on claims data
- Work is the same no matter who provides it—thus, is an equitable way of determining production.

Productivity Pitfalls/Attribution

- Global/Post-op Visits have ZERO RVUs.
- Medicare Incident-to and Shared Visits are billed under the physician.
- Many commercial and state Medicaid payers do not enroll PA/NPs so the claim is submitted under the physician's NPI.
- Practice management software is often driven solely by claims.
- Hospitals are not set-up to bill for Part B services.
- The PA/NP’s work is not captured.
Caution

• Physicians are increasingly being placed into production based compensation agreements or contracts, as they have become employees, rather than practice owners.
• PA/NPs on production based compensation can be viewed as competing with, rather than contributing to, the physician's bottom line.
• In some instances, the PA/NP's ability to seek collaboration can be compromised.

Value and Contribution

• Clinical Documentation Improvement leads to accurate CMI
• Compliance with quality measures vital to facility success.
• Finding a way to articulate the PA/NP's contribution to quality measures, patient satisfaction, length of stay and reducing readmissions is VITAL.
• This strategy may be even more important than capturing RVUs.

Published Examples


Conclusions: For the measures examined, the quality of HIV care provided by NPs and PAs was similar to that of physicians; however, quality of care for persons with HIV was higher in providers with higher levels of experience. Success in a single condition, and often participation in teams of other primary care providers, is important.


Conclusions: A physician assistant-driven VTE risk assessment process resulted in a dramatic increase in the number of patients within the health system who were prescribed appropriate orders for VTE prophylaxis according to published guidelines and according to individual patient risk.


Conclusions: The data demonstrate increased mortality and ICU transfers, with a decrease in LOS, readmission rates, and consults for patients cared for in the PA service. This suggests that the PA service is associated with decreased mortality, decreased health service use without compromising health care outcomes.

Peter L. Althausen, MD, MBA, Steven Brown, BS, Brianne Owens, MD, Daniel Coll, PA-C, Michael Cotitar, PA-C, Meggan Lu, PhD, Timothy L. Chiha, MD, Timothy J. Bray, MD. Impact of Employed Physician Assistants on a Level I Community-Based Orthopaedic Trauma System. J Orthop Trauma Volume 27, Number 4, April 2013
Published Examples


John P. Nabagiez, MD, Maxwell A. Shiffit, MD, Muhammad A. Khan, MD, William J. Molloy, PA-C, Joseph T. McGirr, Jr., MD. Physician-assistant home visit program to reduce hospital readmissions. / Annals of Internal Medicine (Aug 2013) 159: S3-S5

Conclusions: The 30-day readmission rate was reduced by 27% in patients receiving PAHC visits. The most common home intervention was medication adjustment, most commonly diuretics, medications for hyperglycemia, and antibiotics.

Matthew Steger, MD William Southern, MD John Lauther, MD Hospitalist Expansion and Organization


Results: The infusion of this oversight, which connects young, energetic, dedicated PA to well-seasoned specialists, who have deemed their careers to practice care has significantly improved the quality and organization of the private attending service. The hospitalist initiative has improved quality across a number of areas, including shorter length of stay, fewer readmissions, better compliance with orders, and better communication with referring physicians.

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Excerpt: "This time and motion study demonstrated an innovative method and tool for the quantification and analysis of time spent on revenue and non-revenue generating services provided by healthcare professionals. The new information derived from this study can be used to accurately document productivity, alter clinical practice patterns, and improve deployment strategies of healthcare providers."