Ohio Association of PAs

Reimbursement Seminar

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Columbus, Ohio

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Disclaimer

Every reasonable effort is made to assure accuracy for this presentation. The final responsibility for the correct submission of claims and the understanding of payer regulations and requirements remains with the provider of the service those who submit claims. Medicare, Medicaid, and private payer policies change frequently.

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

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Agenda
Tips to avoid fraud & abuse concerns.
In-depth look at payer reimbursement & coverage policies.
A brief look at what's on the horizon.
Questions/Discussion

Priorities

It's business - the business of caring for patients. It's also the business of medicine with a financial bottom line.

Goals of PA utilization:

- Maintain/improve patient care/satisfaction/outcomes
- Implement practice efficiencies for the team
- Improve physician productivity & quality of life
- Avoid allegations of fraud and abuse

While

- Maximizing legitimate reimbursement

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Unique Practice Settings

- Certain billing rules for Certified Rural Health Clinics (RHCs), and federally-qualified health centers (FQHCs) are different from Medicare's fee-for-service (FFS) reimbursement rules.

- RHCs & FQHCs are paid on an all0inclusive, cost-based reimbursement system for most office services as opposed to FFS. FFS remains intact for certain services in a RHC (i.e., hospital visits, skilled nursing home services, certain diagnostic tests).

- Much of Medicare's coding, documentation and compliance rules apply in all practice settings.

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Advanced Practice Nurses

- My comments pertain to PAs.
- Detailed information about APNs should come from the Ohio Association of Advanced Practice Nurses http://www.oaapn.org/ or the American Association of NPs https://www.aanp.org/
- Nearly all of Medicare's reimbursement & coverage policies are similar between the two professions (differences include direct payment & hospice care).

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Working with “Experts”

- Ask for references, statutes and regulatory language.
- Realize that billing & reimbursement can be subject to interpretation and change over time.
- When in doubt, be conservative in your billing practices until the issue is clarified in writing.
- Ultimately, those who provide the care and bill for the service are responsible for knowing and following the rules.

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Issues Update

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Hospital Admissions

- Medicare released regulations/language “clarifying” who may admit patients to hospitals.
- Medicare’s goal was to provide guidance about the observation versus inpatient status of patients.
- Threatened to change how PAs (NPs and residents) are utilized in hospitals

Hospital Admissions

IPPS Rules indicated that:

- Physicians could not delegate the writing of admission orders to those without admitting privileges.
- State law had to be specific in allowing for PAs/APNs to admit.
- Physician has to certify the admission (H&P, demonstrate medical necessity).

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CMS Issues Additional Admission Guidance

- CMS issued a 5-page guidance document.
- PAs can write admission orders (applies to APNs & residents as well).
- PAs can perform the admission H&P.
- As allowed by state law and facility policy.
- Does State law does not have to specifically mention the admitting responsibility? It's unclear.

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Hospital Admissions

- 2015 Hospital Outpatient Prospective Payment rule provided additional clarity.
- CMS eliminated the long-standing physician certification requirement.
- PAs can perform the pre-admission H&P; PAs can admit a patient (to the physician's service).

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Hospital Admission – Physician Co-Signature

- Required by Medicare's Conditions of Participation (IPPS rule) for an admission order for Medicare beneficiaries.
- Required on discharge summaries for patients treated solely by PAs (or APNs).
- Medicare's CoPs requires "evidence in the chart" that the patient is under the care of a MD/DO has led some to require a co-signature on the admission H&P and/or admission order.
- A physician's co-signature on a note does not necessarily mean that the bill can be submitted under the physician.

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Durable Medical Equipment

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Medicare DME Regulations

- CMS policy from the ACA requiring greater oversight of DME (section 6407 of the Patient Protection and Affordable Care Act - P.L. 111-148).
- Items costing of over $1,000 or that are high volume, high risk items (gel beds to glucose monitors).
- These items required a face-to-face visit within 6 months of the DME order.
- Previous rule required that a physician document that a face-to-face visit took place.

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Medicare DME Regulations

- Scheduled to go into effect July 1, 2013
- Delay #1 – until Oct. 1, 2013
- Delay #2 - indefinitely into 2014
- MACRA (2015) created new regulatory language specifically authorizing PAs and APNs to document the face-to-face visit.

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Medicare DME Regulations

PAs (and APNs) can:

- Order DME.
- Perform the required face-to-face visit.
- Document the face-to-face visit.
- No active involvement by the collaborating physician is necessary.

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Medicare Rule to Change Surgery Payments Put on Hold

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CMS Changes Would Have Changed the Manner Surgical Payments Are Calculated

- Would have dramatically change how Medicare pays for surgery.
- Elimination of the -10 and 90-day post-operative payment.
- Could reduce global surgical payments by 15-20%.

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CMS Changes to Surgical Payments Postponed

- Post-op surgery visits would be billed as traditional E/M visits by the professional who actually performs the service.
- Potential for increased recognition of hospital-employed PAs who often provide post-op care.
- Must be cautious about the impact on first assist payments.

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CMS Change to Surgical Reimbursement Postponed

- First assisting fees are based on a percentage of the surgical payment.
- If surgical payments get cut then the first assist payment goes down – with no change in the amount of professional work being performed.

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CMS Change to Surgical Reimbursement Postponed

- CMS currently engaged in a project to review the number and intensity of post-op services performed by the surgeon/surgeon's team.
- Results could lead CMS to propose reducing the post-op payments if actual number of post-op visits is substantially lower than fee schedule estimates.
- Surgical specialties and AAPA are supplying CMS/Rand with information.

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Now, back to our normal scheduled programing

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Prevention

I believe in prevention.

I want to prevent . . .

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The Government is Watching

List of Excluded Individuals/Entities (LEIE)

- http://oig.hhs.gov/exclusions/transition-faq.asp
- List health professionals and health organizations that have been sanctioned for inappropriate activities.
- Can be reinstated after exclusion period ends. Must officially apply to be reinstated.

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Seeing It Up Close

- Expert testimony at a major fraud and abuse trial.
- Just because it’s complicated . . .
- Honest mistakes versus egregious patterns of behavior.

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Fraud & Abuse

- Health care fraud is an intentional misrepresentation, deception, or intentional act of deceit for the purpose of receiving greater reimbursement.

- Health care abuse is reckless disregard or conduct that goes against and is inconsistent with acceptable business and/or medical practices resulting in greater reimbursement.

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Fraud and Abuse Activities

- Government reports that certain program integrity activities collect $7.60 in recoveries for every $1 expended.
- Fine line between confusion and conspiracy.
- Healthcare professionals must be proactive in understanding current regulatory requirements.

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University of Louisville Hospital

- Operated a separate fast track unit with the ED to address non-urgent care know as FirstCare. Staffed by PAs/APNs.
- Private physician group that did not pay salaries or benefits for the PAs/APNs used those same PAs/APNs as their “employees.”
- $2,833,408.60 settlement paid.

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Issues of Concern

- Only the actual employer of the PA/PN is authorized to receive Medicare reimbursement for the PA's/APN's professional services.
- Issues of anti-kickback violations are a real concern when someone other than the PA's/APN's employer captures reimbursement for non-employed PAs.
- This is a basic Medicare requirement that has been in place for decades.

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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

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Medicare Administrative Contractor (MAC)

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

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Medicare Administrative Contractor (MAC)

- Combining of Medicare A & B at the Carrier level – Medicare Administrative Contractor (MACs)

- Be aware of Local Coverage Determination (LCD) that restrict PAs and fail to understand/properly interpret state law (decisions are sometimes based on personal opinion of a medical director)

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RACs

Recovery Audit Contractors

- Four private companies throughout the country engaging in post-payment audits.
- They make money when they find payment mistakes (varies by contract, but often between 9-12.5%).
- Place on their web site issues on which they are focusing.

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Recovery Audit Contractors

- CGI for Ohio (Region B)
- https://racb.cgi.com/default.aspx; click on issues.
- Majority of work in inpatient settings.
- Web site contains list of types of letters practices and hospitals receive for various audit inquiries.

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HHS Office of Inspector General

- 2016 Work Plan http://oig.hhs.gov/reports-and-publications/archives/workplan/2016/oig-work-plan-2016.pdf
- Site of service
- Coding patterns – “moderate” codes repeatedly used does not equate to safety.

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Possible Fraud and Abuse Remedies by the Federal Government

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

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Responsibility versus Knowledge

- Most PAs don’t see claims or participate in the actual claim submission.
- Responsibility will remain with the person who delivers care whether personally involved in the claim submission process or not.
- Potential criminal liability rests with those who commit fraudulent behavior (upcoding the claim, bill for services not delivered, unbundling claim when not permitted).

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CPT Codes

- PAs have access to virtually all CPT codes, as authorized by state law, to describe the services they deliver.
- Beware of local medical review decisions trying to impose limitations.
- State law & facility (credentialing, Medicare Conditions of Participation, regulations) policies must always be followed.

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Documentation Requirements – General Rule

- Avoid the language trap of:

  - “saw patient and agree with care plan”
  - “agree with above”

- “See and agree means no fee”

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Documentation

- The old rule was, “If it isn’t documented in the chart, it didn’t happen.” That’s still true.
- New rule, “Even if it is documented in the chart, if it isn’t medically necessary payers will often try to disallow payment.”
- Use caution with EHR – cut and paste or prompts.

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ICD-10: What Happened?

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Shift to ICD-10 Codes

- After two delays CMS has established Oct. 1, 2015 as the “new” implementation date.
- Every industrialized country in the world is using ICD-10 except the US.
- Number of potential usable codes increases from 14,000 to 69,000.

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It either happened to someone or is likely to happen . . .

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Have We Gone Too Far?

- V9733xD Sucked into jet engine, subsequent encounter
- Y91.07XA Burned when water skis caught on fire
- Y92146 Hurt at a prison swimming pool
- W56.22xA Struck by orca, initial & subsequent encounter

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ICD-10

- CMS elected (compromised with the AMA) to not withhold reimbursement if the ICD-10 code used for a claim was in the appropriate family (even though it was not the most accurate code).

- 12-month grace period expires October 15, 2016

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Medicare

Navigating Through the Regulations

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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

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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

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Physician Involvement & Billing – In Any Setting

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%

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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

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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

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Medicare Scope of Practice

PAs may bill (as allowed by state law):

- All E/M codes
- Critical care
- Initial hospital care, subsequent hospital care, H&Ps, and discharge summaries
- All diagnostic tests/procedures

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PA Supervision under Medicare

- Access to reliable electronic communication device
- No requirement for the physician to be on site when the PA delivers care
- Generally no requirement for physician chart co-signature (unless required by state law, facility policy, or federal conditions of participation)

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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

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Understanding Reimbursement

- Can you articulate the reimbursement policy relevant to your practice setting?
- Do you show up as a revenue center or cost center?
- Can you make the case for your value to the practice (financially and non-financially)?

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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

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Medicare Payment Percentage

- For virtually all services in all settings, Medicare will cover PAs at 85% of the physician fee schedule (state law and hospital requirements must be met)

- Services should be billed at the full physician rate. Use of the PA's NPI triggers the 85% payment

[Medicare Transmittal AB-98-15]

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"Incident to" Billing

- *(Section 2050-2050.2 of the Medicare Carriers Manual; Transmittal 1764, Aug. 28, 2002)*

- Allows an **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 physician office*)

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

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“Incident to” Billing

- Requires that the physician personally treat the patient for a particular medical condition presented, and provide the diagnosis and treatment plan (plan of care)
- 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

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“Incident to”

Physician personally treats means that the physician personally performs:

- HPI
- Physical examination
- Medical decision making

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Patient Care Billing Scenario

- 60 y.o. male, established pt. previously diagnosed by physician with HTN and CKD; seen by PA for follow up and review of blood work.

- Pt. doing well on low dose anti-hypertensive, but BP is creeping up. Renal fx unchanged.

- PA reviews labs & increases dosage of hypertensive meds and arranges for a follow up visit.

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Is this Incident to?

- Yes as long as a physician in the group is on site when care is delivered. Condition was diagnosed and plan of care established by physician. PA is adjusting existing meds and reviewing lab results.

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Patient Care Billing Scenario

- 60 y.o. male, established pt. previously diagnosed by physician with CKD; seen by PA for follow up and review of blood work.

- During exam pt. complains of redness, swelling and pain at the base of the right toe and at the ankle joint.

- PA diagnoses gout and prescribes medication.

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Is This “Incident to”?

- Probably not for the *new* diagnosis of gout, even though the new problem is common based on the patient’s medical condition/diagnosis.

- New problems (or new patients) must be first diagnosed by the physician with a plan of care developed by the physician; on a subsequent visit PA can provide care “incident to” the physician for that new problem (gout).

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“Incident to” Billing

- PAs can always treat new Medicare pts. and new medical conditions when billing under their name and NPI.
- Restrictions (physician treats first, physician on site) exist only when attempting to bill “incident to” the physician with payment at 100% (as opposed to 85%)
- May have situations when one condition is “incident to” and the other was diagnosed by the PA.

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“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 provides visit/treatment.

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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

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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

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Medicare Incentive Programs

PAs eligible professionals for:

- PQRS
- E-prescribing (benefits/penalties)
- Part of eligible group members for Physician Feedback/Value-Based Payment Modifier Program
- PAs will be eligible MIPS professionals.

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Private Payers

- Many require billing under the physician's name/provider number or the hospital's tax ID.
- Billing under the physician for private payers is not necessarily the same as Medicare's "incident to" or shared visit policy (except with Aetna).

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Private Payers

- It is not fraud to bill under the physician/hospital if that is the payer's required method of PA recognition.
- Obtain written policies.
- Never assume payer policies.

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Credentialing & Payment

- Payer enrollment or credentialing is not necessarily directly related to payment policy (not to be confused with hospital credentialing).

- Credentialing and the issuance of provider numbers depend on the particular payer's policy.

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Contract Negotiations

- Continue to ask that language be placed in contracts with private payers (renewed each year) recognizing PAs as providers of care.
- Clears up any misunderstanding regarding coverage policy.

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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 non-clinical, 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]

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Medicare Hospital Billing

- Whether employed by the hospital or not, PAs are covered by Medicare at 85%

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

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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

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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]

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Shared Visit Billing

- What is a portion of the E/M?
- Substantive/substantial portion
- National versus local carrier guidelines.

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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, employed by solo physician)

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Shared Visit

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

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Scribes

- A scriber is a “living recorder” documenting in real time the actions and words of a healthcare professional.
- E/M services performed and documented by a PA/APN and then reviewed and co-signed by physician is not an example of a scribed service.
- Scribes can’t augment, alter, or expand upon information in the medical record.
- In most situations using a PA as a scribe is a big waste of n employer’s money and a quick way to lose a PA.

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Place of Service Codes

- Office – 11
- Inpatient Hospital – 21
- Hospital Outpatient – 22
- What about a “private” physician office that was purchased by the hospital/hospital system?

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Credentialing

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

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

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

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Issues that Traditionally Hinder Hospitals Billing for PAs

- Fear of making a mistake/fraud & audits
- Lack of clarity related to residents/fellows
- No clear payer contracting guidelines
- The Part B/Part A Medicare rules
- Services being “captured” by physicians

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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 (typically 30 days)

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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)]

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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

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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]

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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)

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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]

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Skilled Nursing Facilities

- Comprehensive visit – provided by physician
- PA can perform “first” visit (does not suffice for comprehensive)
- After comprehensive visit, physician and PA can alternate every other visit

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Skilled Nursing Facilities

Scheduled (required) Visits

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

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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

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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)

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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	

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Workers' Compensation

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

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Medicaid

- Enrollment for PAs; UD modifier unless physician involvement. If physician involved bill under PA without modifier.
- Services delivered by PAs in hospitals (ED), nursing facilities, intermediate care facility now covered
- Payment at **85%** can be made to PA, physician, physician group, or clinic
- First assisting – not covered
- http://emanuals.odjfs.state.oh.us/emanuals/GetDocument.do?docId=Document(storage%3DREPOSITORY%2CdocID%3D%24REP_ROOT%24%23node-id(1813768))&locSource=input&docLoc=%24REP_ROOT%24%23node-id(1813768)&version=8.0.0

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Denied Claims by Any Payer

- Must challenge denials
- Determine who has the authority to adjudicate the claim – insurance company or self-insured employer
- Explanation of Benefits/Remittance Notice– will detail reason a claim was denied

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The Rationale for Identifying and Tracking Professionals

- You can’t manage what you can’t measure
- You can’t assess, what you can’t quantify

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PA Value

- PAs/APNs are paid ½ to 1/3 the salary of their collaborating physician (broad generalization, but generally supported by salary information from the Medical Group Management Assn.)

- PA's profit/contribution margin is higher even when PAs are paid at a discounted rate (e.g., 85%).

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PA Value

Physician (Gen. Peds.)	PA
Salary $226,408 ($109/hr.)	$94,051 ($45/hr.)
Office visit $100	Office visit $85
First visit of the day $9 loss	First visit $40 profit

First visit of each hour repeats the same scenario. Not negating the fact that physicians are the highest profit margin. Simply saying that PAs are a consistent profit margin to the practice/hospital even when their reimbursement is discounted.

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“Productivity Proxies”

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

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Tracking Productivity

- Productivity includes services performed by PAs 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

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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 3 or 4 additional surgical cases brings in more reimbursement than the assist fees.

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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.

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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

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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.
- That doesn't mean they aren't extremely valuable.

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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.

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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

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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

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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)

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Value

True measure of PA “value” might be

- first assist payment of $240.58 +

- share of global payment $424.56

Total = $665.14

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Looking Ahead

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Transformation

A process of profound and radical change that orients an organization in a new direction and takes it to an entirely different level of effectiveness. Unlike a turnaround (which implies incremental progress on the same plane) transformation implies a basic change of character and little or no resemblance with the past structure.

Business Dictionary.com

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Transformation

- You may not have to dramatically adjust in the short term.
- Health professionals can decide to adopt a “wait and see” attitude.
- Or, you can . . .

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Getting on the Same Page

- Much of the conversation about value-based care and alternative payments models for professional services is conceptual.
- Definitive guidelines for many specific payment policies have yet to be determined.
- The divide between theory and practice is a big one.

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Value-based Reimbursement

- Many value-based payment contracts are structured based on a shared savings model. Shared savings arrangements incentivize health professionals to reduce spending for a defined patient population by offering them a percentage of any net savings they realize.

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Fee-for-Service

How It's been:

- Health professionals do the best they can in the amount of time allocated (patients scheduled every 13-14 minutes/let's take the most pressing concerns first).
- Medical records may be complete - - or not (poor interoperability; was the last encounter entered into the system? are all test results noted?)
- Limited options if patients are not compliant.
- Incentives are given for completing a particular task (the E/M visit or the procedure) not necessarily for results.

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Fee-for-Value

Success (and reimbursement) based on:

- Patient outcomes
- Objective & measurable delivery of high quality care
- Efficient use of resources (lack of duplication of tests, procedures, exams)
- Timely access to complete, accurate medical records
- Consumer/patient involvement
- Care coordination
- Recognition and financial rewards for team care

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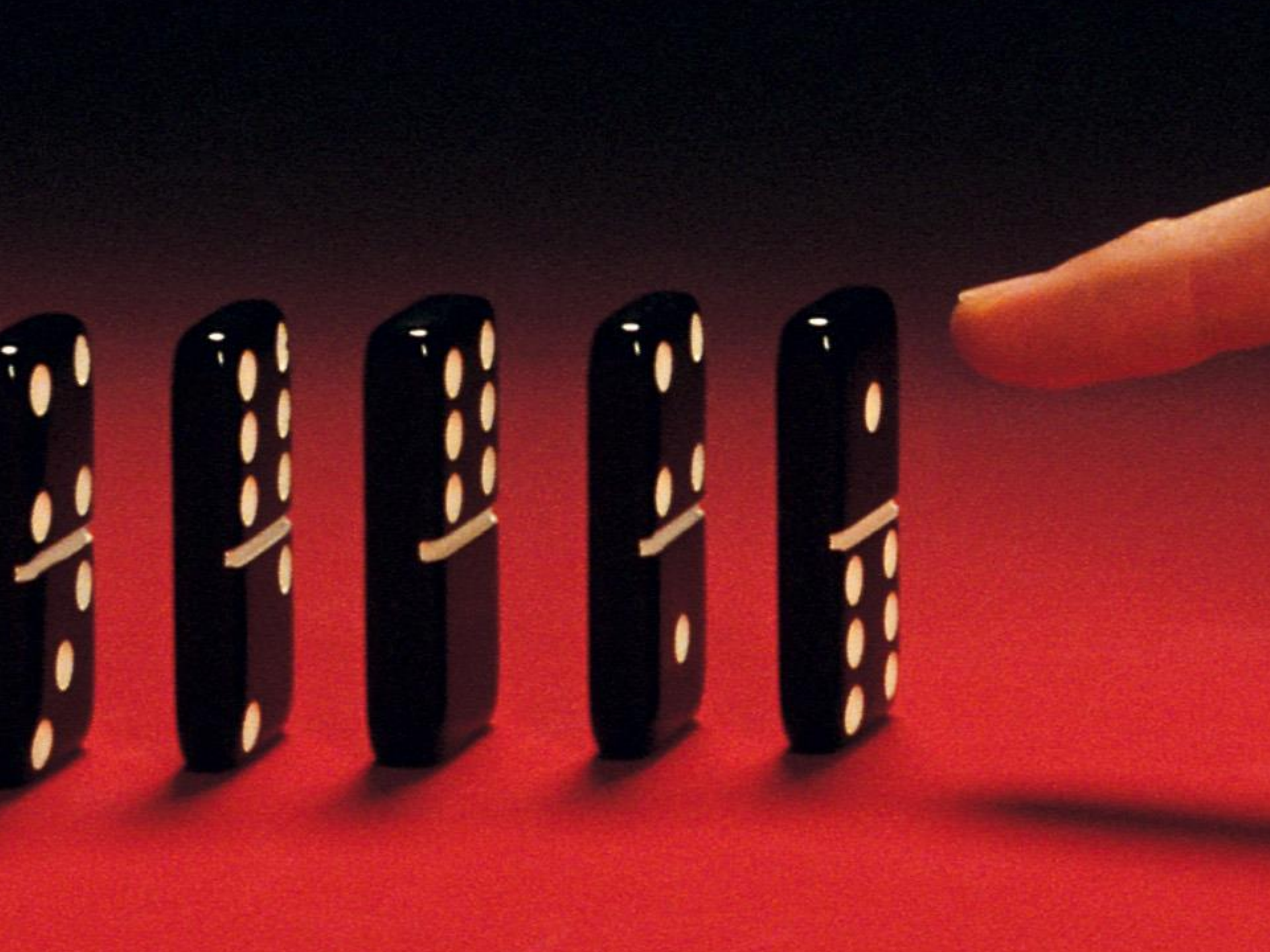

HHS Creates a Tsunami

- Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume.
- January 26, 2015 announcement with very aggressive goals.
- When you are the biggest payer in the country you have influence about reimbursement policies.

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Overall HHS Goals

- HHS seeks to have 85 percent of Medicare fee-for-service payments in value-based purchasing categories 2 through 4 by 2016 and 90 percent by 2018

- HHS is working with private payers, including the Health Insurance Marketplace, Medicare Advantage plans, and state Medicaid programs to move toward alternative payment models and value-based payment to meet or exceed the goals outlined above.

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CMS Value-based Payment Categories

How CMS “thinks” about payment methodologies

- category 1—fee-for-service with no link of payment to quality
- category 2—fee-for-service with a link of payment to quality
  (hospital acquired conditions payment reductions, value-based modifier, readmission penalties
- category 3—alternative payment models built on fee-for-service architecture (ACOs, bundled payments)
- category 4—population-based payment (Pioneer ACO managing patients in years 3-5

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CMS Timetable

- 30 percent of Medicare payments in alternative payment models (categories 3 and 4) by the end of 2016
- 50 percent in categories 3 and 4 by the end of 2018

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The Facts

- The Association of American Medical Colleges has projected a shortage of 90,000 physicians over the next ten years.
- Clear need to adopt an “all hands on deck” philosophy
- Shortage versus utilization?

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The Approach

- All healthcare professionals working to the top of their education and expertise.
- Full utilization of the team approach to healthcare delivery.
- From PAs and physicians to community heath workers.

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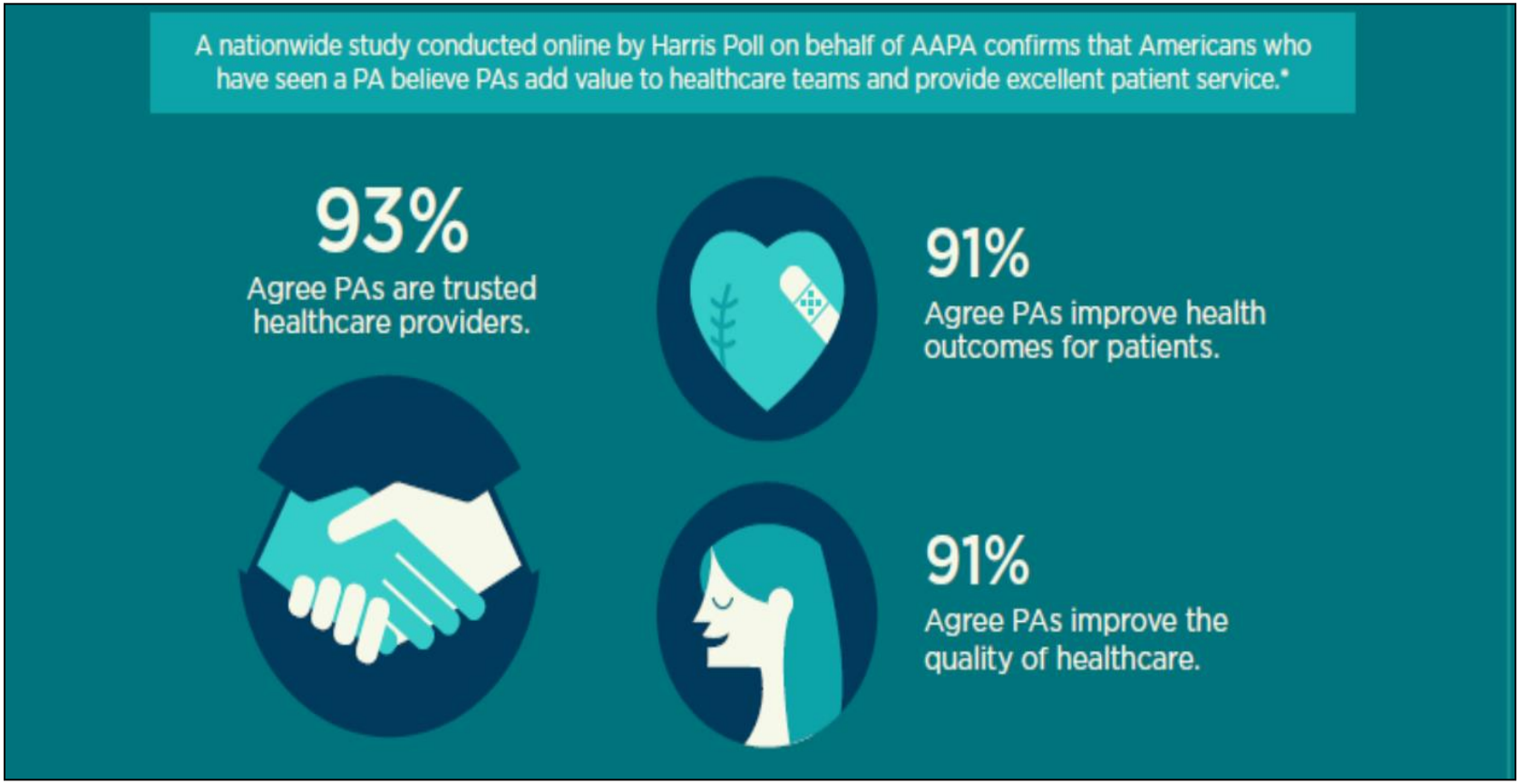
PA's are Trending UP!

Most Importantly: Patients Recognize the Value of PAs



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Commitment

Am I committed to this reimbursement thing or what?!

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JAMESTOWN
AMERICA'S 400TH ANNIVERSARY
200

Resources/Contact Information

- AAPA Web site: www.aapa.org

  Click on Your PA Practice; then click on Reimbursement

- E-mail: michael@aapa.org

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Questions?

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