Reimbursement Overview
for Surgical Physician Assistants

American Association of Surgical Physician Assistants
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Disclaimer

Although every reasonable effort was made to assure accuracy for this presentation, the final responsibility of the correct submission of claims lies with the provider of the service. Medicare 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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Be Cautious of “Experts”

• Ask for references, statutes and regulatory language.
• Realize that billing & reimbursement are subject to interpretation and constant change.
• When in doubt, be conservative until the issue is clarified in writing.

Fraud & Abuse

• Recovery Audit Contractors
  – Four private companies engaging in post-payment audits
  – Must place on their web site the issues on which they are focusing

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

Health Care Reform

• Patient-Centered Medical Homes
• Accountable Care Organizations
• Insurance Exchanges

Reaching Out to Physician Organizations

• Attempt to clarify the PA-physician/surgeon relationship
• Separate PAs from other health care professionals
• Establish a document that better exemplifies how PAs practice
Scribes

- Prefer not to have PAs act as scribes in most cases
- Waste of resources
- A scribe only documents what another person does, they do not augment, clarify, or make changes to the medical record/chart

Medicare Bonus Payments

- E-prescribing
- Physician Quality Reporting Initiative (PQRI)

Medicare Payment

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

[Medicare Transmittal AB-98-15]

Medicare Payment Policies

- State law, the supervising physician, Medicare regulations/CoPs, and hospital guidelines determine scope of practice
- Hospital credentialing requirements/bylaws must be met

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 and (Ptan #) triggers the 85% payment

Practice Settings

- Hospitals (inpatient, outpatient, ED, OR)
- Hospital-based office or clinic
- First assisting at surgery
- Outpatient office or clinic
- Ambulatory Surgical Center
National Provider Identifier (NPI)

- NPI number replaces PINs, UPINs and the host of other public and private payer provider numbers
- 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

Medicare Enrollment

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

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

CPT Codes

- PAs have access to virtually all CPT codes to describe the services they deliver
- Beware of Medicare Local Medical Review Policy attempts to impose limitations
- Requirements of state law must always be followed

Supervision under Medicare

- Access to reliable electronic communication
- Personal presence of the physician is generally not required (except for “incident to” billing – outpatient office)
- Medicare policies will not override state law guidelines
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 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 (could be 2-3 lines) detailing the physician’s professional service
  – Need a clear distinction between PA’s work and the physician’s work
  – Avoid “agree with above” type of language

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.

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 (payment at 100%) (not used in hospitals or nursing homes unless service is delivered in a private physician office)
• Terminology may have a different meaning when used by private payers

“Incident to” Billing

• Requires that the physician personally treat the patient for a particular medical condition presented, 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” 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

Physician Involvement & Billing

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

“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 treated by the physician when the results are in - Yes

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

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

**Other Regulatory Policies/Entities that Impact 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

**Credentialing**

- Joint Commission’s standards require that hospitals credential and privilege PAs through the medical staff or by another “equivalent process”
  
  [Standard HR 1.20, EP13 CAMH Refreshed Core, 1/2008]

**Hospital Credentialing**

- AAPA believes that all hospital should use the medical staff process and that PAs should be members of the medical staff
- Basic belief is that the HR method is not truly equivalent to the medical staff process

**Chart Co-Signature**

- Generally, Medicare does not require chart co-signature
- Exceptions are discharge summaries; this requirement also applies to outpatients, including outpatient surgery and Emergency patients not admitted to the hospital
  
  [42CFR §482.24(c)(2)(vii)]
- PAs may perform these services, but a physician co-signature is required (generally, time frame not specified)
Chart Co-signature

- Physician countersignature no longer required by Medicare on H+Ps (admit or pre-op) as of 2/2008

[42CFR §482.22(c)(5)(ii)]

Teaching Hospital Rules

- Any restrictions on billing apply only to first assisting at surgery, not to other services delivered in the hospital
- Resident billing rules do not apply to PAs
- PAs are authorized to bill Medicare and most other payer programs, residents typically are not

[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]

“Never Events”

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

- Wrong surgical 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, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity
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

AAPA Data base

- Contains information on over 350 private and public payers
- Available via the AAPA website (www.aapa.org)
  – Click on professional affairs, then reimbursement

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 E/M services
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 an extra surgical case or two brings in more reimbursement than that of an assist fee.

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*

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.”
  — CPT 2009 ©AMA

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

- 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

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

Resources/Contact Information

• AAPA Web site: www.aapa.org
  Click on Advocacy & Practice Resources; then click on Reimbursement

• E-mail: michael@aapa.org

Questions?