Reimbursement Policy Issues

Oregon Society of PAs
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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.

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The Facts of Life

- Success will be difficult if you ignore the policy and administrative aspects of today’s healthcare environment.
- What worked before may not work in the future.
- Can’t afford to simply be reactive.

Interdependent Concepts

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<th>Reimbursement &amp; Billing Policy</th>
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<td>Maximizing PA Utilization</td>
<td>Regulatory Compliance and Scope of Practice</td>
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Regulatory Policies/Entities that Impact PA Practice

- Code of Federal Regulations
- 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
Issues That Will Impact Your Practice

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.
Why So Many Diagnosis Codes?

- Greater specificity and detail in all diagnosis codes
- 17,045 (25%) of all ICD-10-CM codes are related to fractures
  - 10,582 fracture codes to distinguish ‘right’ vs. ‘left’
- 25,000 (36%) of all ICD-10-CM codes to distinguish ‘right’ vs. ‘left’

Examples of ICD-10-CM (ER)

- S01.02xA  Laceration with foreign body of scalp, initial encounter.
- S01.02xD  Laceration with foreign body of scalp, subsequent encounter
- H65.01 Acute serous otitis media, right ear
- H65.02 Acute serous otitis media, left ear
- H65.03 Acute serous otitis media, bilateral

Have We Gone Too Far?

- V9733xD  Sucked into jet engine, subsequent encounter
- Y91.07XA Burned when water skis caught on fire
- V95.43  Spacecraft collision injuring occupant
- Y92146 Hurt at a prison swimming pool
- W56.22xA Struck by orca, initial encounter
Practical Use of ICD-10

• Currently, no ICD-9 code exists for the Ebola virus.

• Tracking is not optimal - 078.89, Other specified diseases due to viruses.

• ICD-10 has a code for the Ebola virus - A98.4.

Hospital Admission Saga

• Example of the law of unintended consequences.

• The CMS regulation was about the 2-midnight rule (admission vs. observation status).

• In the hundreds of pages of the regulation CMS decided to “clarify existing policy” as to who could perform the admission.

Hospital Admissions

IPPS Rules indicated that:

• Physicians could not delegate the writing of admission orders to professionals who did not have 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)
Hospital Admissions

- Aug. 2013 rule & a Sept. 2013 memo suggested that only physicians could perform the H&P and write the admission order.

- PAs, APNs and medical residents were in limbo.

- January 2014 memo clarified that CMS had no intention to change who was able to perform the admission work.

Hospital Admissions

- 2015 Hospital Outpatient Prospective Payment rule gives another opportunity to make comments on the admissions issue.

- CMS plans to eliminate the long-standing physician certification requirement.

- AAPA has asked CMS to allow admission orders to be written by PAs without the need for a physician signature.

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 high volume, high risk items (gel beds, glucose monitors)

- These items would require a face-to-face visit within 6 months of the DME script, and

- Physician must document in the medical record that the face-to-face encounter took place.
Medicare DME Regulations

• Scheduled to go into effect July 1, 2013
• Delay #1 – until Oct. 1, 2013
• Delay #2 - indefinitely into 2014
• PAs can currently write DME order and sign the certificate of medical necessity for DME without physician signature or a face-to-face visit (same rules apply to APNs)

Medicare Data Release

• First time in 35 years Medicare is releasing detailed claims data.
• Health professional's name, CPT code and payment is included.
• Lack of context about what this data means.

Medicare's Data Release

• April 9th CMS released billing information on 880,000 health professionals.
• Allows PAs to take a look at services billed under their name and NPI.
• Will not show services performed by PA/NP and billed under the physician.
Medicare Data Release

- Top payment $20.8 million to a single doctor, but a deeper inspection puts that number in context.

Medicare Data Release

- Physician who billed $20.8 million has approx. $18 million in costs due to drugs used in procedures.
- Hospital pathology services billed under the department head/chief physician making it look like a single physician had extremely high Medicare billing activity.

Narrow Networks

- Attempts by payers to reduce the number of health professional allowed to care for a network of patients.
- Payers claim that is saves money.
- Can lead to reduced patient access and lack of choice, and lack of participation by health professionals.
Narrow Networks

- Physicians sued United Healthcare in Connecticut to stop attempts at narrowing.
- ACA contains an anti-discrimination language, but CMS/HHS has yet to provide guidance on the provision.
- Special concern for independent contracting PAs.

CMS Proposed Changes in Surgical Payments

- Proposal to 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%.

CMS Proposed Changes to Surgical Payments

- 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.
CMS Proposes Changes in Surgical Payments

- Major concerns about patients who may now have to pay deductibles/co-pays on visits that in the past required no out of pocket payment.
- Patients with more medical problems will face the largest financial burden.
- Will some patients skip the post-op visits to save money - and end up back in the hospital (re-admission).

Understanding Reimbursement

- Can you articulate the reimbursement policy relevant to your practice setting?
- Do you know if you show up as a revenue center or cost center on the practice’s books?
- Can you make the case for your value to the practice economically and non-economically?

Just Because

- Just because Medicare or a private payer has been reimbursing for a service doesn’t mean that proper billing rules are in place.
- Poor system edits and/or human error may be in play.
- Hospital compliance officials are typically well versed in this area.
Reimbursement – Trending

• Despite the upcoming changes, fee-for-service continues to be the dominant form of reimbursement.

• Over half of the Premier ACOs retreated in the past year.

• In 2013, 500 healthcare organizations applied for Medicare’s shared savings program, but...

• Fewer than 20% of hospitals have formed Medicare or commercial ACOs.

New Care Models

• Bundled or episodic payments
• Risk plays a key role
• Data will be needed (outcomes research)
• Situations that call for cost-effective, coordinated medical/surgical care are made for PAs

New Care Models

• The particular name of evolving care model is less important than understanding the conceptual framework surrounding those models.

• ACO, PCMH, shared savings model – organizer of care

• The transformation may be gradual, but it is essential that PAs are front and center (fully recognized and authorized) to participate and lead.
Bundled/Global Payments

- One payment for an episode of care.
- Payment based on average utilization costs.
- The healthcare professional, practice and institution are at risk.
- Concerns: setting the “right price.”

Workforce

- AAMC estimates a shortage of 124,000 physician by 2025
- 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 health workers.

Staffing Mix

Need to evaluate and re-think staffing models from what has been traditionally accepted to what is innovative in terms of resource allocation, and:

- is evidenced-based
- is cost-effective
- produces the best outcomes
- is patient-centered
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<th>When Will the Real Shift Begin?</th>
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<td>• ACOs, PCMHs, risk-based payment models.</td>
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<td>• Critical mass matters.</td>
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<td>• A pivotal time frame may occur when 25-30% of the market adopts a value-based payment methodology.</td>
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<th>Key Principles Driving Healthcare</th>
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<td>• Alignment</td>
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<td>• Coordination</td>
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<td>• Evidenced-based (data driven) medical care</td>
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<td>• Reduced variations of care</td>
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<tr>
<td>• Bundled or episodic payment models</td>
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<td>• Patient engagement/consumer driven care</td>
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<th>Current Payment Policies Incentivize</th>
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<td>• Process-centric care</td>
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<td>• Pay for procedures</td>
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<td>• Piecework mentality (fee-for-service)</td>
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<td>• Identical pay whether patient’s receive the “best” or “worst” care</td>
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Healthcare Transformation

- Accountable care will generate nearly $1 billion in revenue for healthcare providers in 2014 as they transform into ACOs and patient-centered medical homes (PCMH).

- 130 million patients will receive accountable care by 2017.

- Accountable care organizations (ACOs) and value-based purchasing arrangements will be responsible for the care of 130 million patients by 2017, predicts a report by Parks Associates.

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% (exception BCBS of Michigan).

Information is Flowing

- Beyond reimbursement

- Practice information; make up of teams; determining who can do what (scope).

- But is it accurate and in context?
Be Cautious of “Experts”

- Ask for references, statutes and regulatory language. If someone says you can't do something make them prove it.
- 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.

Priorities

- Do not allow reimbursement to completely drive clinical operations or patient care decisions.
- First, develop efficient patient care models, then maximize reimbursement.
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.

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.

Medicare Administrative Contractor (MAC)

• New medical directors mean new interpretations of medical necessity and scope of practice determinations.

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

• Be aware of local medical review policies (LMRPs) that fail to properly understand state law.
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 website issues on which they are focusing.

HHS Office of Inspector General

• Incident to services.
• E/M services billed during surgical global periods.
• Coding patterns – “moderate” codes repeatedly used does not equate to safety.

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
Responsibility versus Knowledge

- Most PAs don’t see claims or participate in the claim submission.
- Some responsibility will remain with the person who delivers care whether personally involved in the claim submission process or not.
- Do your part to share information.

Intersection of EHR & Potential Fraud

- Be cautious of using cloned electronic medical records systems for documenting follow-up patient visits.
- Cutting and pasting records has its problems when clinical information is copied.
- Can promote efficiency by not redoing demographic or insurance information.

Cloned Medical Records

“Cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient. . . . Identification of this type of documentation will lead to denial of services for lack of medical necessity and the recoupment of all overpayments made.”

MAC National Government Services 9/2012
Who Might See the Medical Record?

• The patient has the ability to review
• Attorneys in a malpractice situation
• Payers who initiate a pre- or post-payment audit

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 (image guidance, procedures).
• State law & facility (credentialing, Medicare Conditions of Participation, regulations) policies must always be followed.

PAs and CPT

Per CPT:

“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”.

[2014 CPT Book, professional edition, page x]
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.

Protect Your Ability to Practice

• Understand your professional responsibility in understanding payment policy.
• Keeping up with regulations and reimbursement changes is a challenge.
• Sometimes it feels like shared confusion.

Documentation

• The old rule was, "If it isn’t written in the chart, it didn’t happen."
• Still true, but there is more . . .
• New rule, "Even if it is written in the chart, if it isn’t medically necessary it won’t be reimbursed."
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

Medicare

- Claims for services are submitted under the PA NPI and reimbursed at 85% of the physician fee schedule
- Claims for shared visits and “incident-to” are billed under the physician NPI and reimbursed at 100% of the physician fee schedule (You are INVISIBLE on the claim)

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 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

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)

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
Medicare Payment Policies

- State law, the supervising/collaborating physician, Medicare regulations/CoPs, and hospital guidelines determine scope of practice
- Hospital credentialing requirements and bylaws must be met and can be more restrictive than Medicare’s rules

Outpatient “Office”

- Make a distinction between outpatient office and private office visits
- Outpatient area of hospital may have the hospital place of service designation (22)
- Private office has a site of service of 11

Credentialing Policy Change

Previously, Joint Commission's standards allowed hospitals to credential PAs through the medical staff process or by another “equivalent process”

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

- Major policy change by the Joint Commission in January 2011 requires hospitals to use the *medical staff process* to credential PAs
- Does not require that PAs be members of medical staff

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)
Shared Visit Policy

- Ability to "combine" services provided in a hospital 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 professional service
  - Need a clear distinction between PA’s work and the physician’s work
  - Avoid "agree with above" type of language
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

- PA’s 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 always has the option of treating the new problem and new patient (with payment at 85%)

“Incident to” Billing – New Problem

- Can the PA/NP 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/NP order a test and have the patient come back to be treated by the physician (initial visit) when the results are in? - Yes

First Assisting

- AS is a unique modifier that Medicare uses for PAs/NPs (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 Surgical Billing

- For first assisting at surgery typically use 80, 81, 82, or AS modifier, depending on instructions from the payer (payers have some discretion in applying modifiers).
- 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, network status).

Private Payers

- Most private payers cover services delivered by PAs/NPs; hospital-employed PAs/NPs potentially face additional issues related to billing.
- Some payers require billing for PAs/NPs 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

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 Dept. patients not admitted to the hospital; admission orders.

• PAs may perform these services, but a physician co-signature is required (time frame not specified, but state law may indicate 30 days).

Resources/Contact Information

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

• E-mail: michael@aapa.org