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This presentation was current at the time it was submitted.

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# PA and NP Roles and Responsibilities

## Maximizing Utilization

### Recognized as providers by Medicare

- Not clinical support staff
- Not scribes

### Harvard Business School: Potential Cost Per Employee Category

<table>
<thead>
<tr>
<th>Total Clinical Costs</th>
<th>Surgeon</th>
<th>PAs</th>
<th>RN</th>
<th>X-Ray Tech</th>
<th>Scribe</th>
<th>Office Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$346,400</td>
<td>$120,000</td>
<td>$100,000</td>
<td>$84,000</td>
<td>$51,000</td>
<td>$61,000</td>
</tr>
<tr>
<td>Personnel Capacity (minutes)</td>
<td>$1.006</td>
<td>$0.506</td>
<td>$0.506</td>
<td>$0.506</td>
<td>$0.506</td>
<td>$0.506</td>
</tr>
<tr>
<td>Personnel Capacity Cost Rate /min</td>
<td>$6.00</td>
<td>$1.35</td>
<td>$1.12</td>
<td>$0.72</td>
<td>$0.57</td>
<td>$0.68</td>
</tr>
</tbody>
</table>
Interrelated Elements Determine Scope of Practice

State Law, Rules & Regs
- Practice Act
- Insurance laws
- Corporate law
- Ionizing radiation law
- Laser laws
- DMV laws
- Death Certificate laws
- Disaster law
- Camp/Sports/School Physicals laws
- Impaired practitioner laws
- Public Health Code
- Medicaid law/Rules and Regs
- Workers' Comp law/Policies
- State Medical Board

Supervising/Collaborating Physician(s)
- Delegation Agreement
- Protocols

Federal Law
- Medicare
- Dept. of Transportation
- EMTALA
- Dept. of Labor
- Federal Workers’ Comp
- Federal Employee Health Benefit Plan

Payer Policy
- MACs (Medicare Administrative Contractors)
- Private Payers
- Worker’s Comp (state and federal)
- State Medicaid

Employer
- Employment Contract
- Employer policies
- Payer policy/contract with employer

Hospital/SNF/NF/FQHC/RHC/LTC/IRF
- Medical Staff bylaws, rules/Regs
- Joint Commission standards
- Medicare CoPs (Conditions of Participation)

Scope of Practice

PAs and NPs Must Have NPI and Enroll in the Medicare Program

Jan 6, 2014

Date all providers must have established their Medicare enrollment record

Medicare Fundamentals PA/NP Practice
PA & NPs
Recognized by Medicare since 1998

PA/NP Services defined:

“...are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO).


PA and NP provide Part B Professional services

No longer clinical support staff: not included in the Medicare Part A Cost Report

(b) Inpatient hospital services does not include the following types of services:

4. Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.
5. Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

Source: Social Security Act

Collaboration Similar For PAs and NPs Under Medicare

Access to reliable electronic communication

Personal presence of the physician in generally not required

Medicare policies will not override state law guidelines or facility policies
NP Collaboration: Medicare

Medicare Benefit Policy Manual: Chapter 15
§200 Nurse Practitioner (NP) Services
D. Collaboration

Collaboration is a process in which an NP works with one or more physicians (MD/DO) to deliver health care services, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished.

In the absence of State law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice.

Medicare: Physician Presence
PA and NP Services

NOT REQUIRED

Medicare Benefit Policy Manual
§190 Physician Assistant (PA) Services

“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.”

Medicare Benefit Policy Manual
§200 Nurse Practitioner (NP) Services

“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 Part B Services
Traditionally Reserved for Physicians
Including ALL Levels of E/M

Medicare Benefit Policy Manual
§190 Physician Assistant (PA) Services

“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.”

Medicare Benefit Policy Manual
§200 Nurse Practitioner (NP) Services

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

Under Medicare, PAs and NPs Can Evaluate 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 PANP’s NPI for Medicare.

- Reimbursement will be at 85% of the physician rate.

Fiction

What about the 15% left on the table!?

Contribution Margin Is Higher

- NPs/PAs are paid approximately 1/2 to 1/3 the salary of their physician counterpart.
- The profit/contribution margin is higher when the NP/PA provides the service, even at the 85% reimbursement rate.

*This is a broad generalization, but supported by MGMA data.
Margin

<table>
<thead>
<tr>
<th>Physician Ortho</th>
<th>PA/NP Ortho</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Median Compensation</td>
<td>$576,677 = $277/hr</td>
</tr>
<tr>
<td>Encounter (E/M) Reimbursed</td>
<td>100% for $100</td>
</tr>
<tr>
<td>Profit</td>
<td>-$177</td>
</tr>
</tbody>
</table>

*2016 MGMA, Data extracted from MGMA DataDive

Contribution Margin

**General Orthopaedics**

- Assumptions:
  - 15 minute appointment slots = 4 visits/hour or 28 visits/day
  - 8 hour days

<table>
<thead>
<tr>
<th></th>
<th>Physician</th>
<th>NP-PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receipts providing same level of service</td>
<td>$2,800 ($100 x 28 visits)</td>
<td>$2,380 ($85 x 28 visits)</td>
</tr>
<tr>
<td>Compensation per day</td>
<td>$2216 ($277/hour x 8 hours)</td>
<td>$432 ($54/hour x 8 hours)</td>
</tr>
<tr>
<td>Contribution margin</td>
<td>$584</td>
<td>$1948</td>
</tr>
</tbody>
</table>

“So the point is...”
Medicare Payment policy: “Incident-to”

“We bill everything under the physician...”
"Incident-to Billing"

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

The "extra 15%" reimbursement appears enticing.

Only applies in the office or "clinic".

Does not apply in a facility/hospital outpatient or inpatient setting.

Incident-to

Facility

Incident-to: Not Applicable in Facility Settings

Incident-to billing NEVER applies to Part B services provided in the hospital or facility (SNF/NF/LTAC/IRF) setting.

Some physician practices that have been purchased by hospitals are now considered hospital outpatient clinics, (Place of service 22) rendering them ineligible for "incident-to" Part B billing.

"Incident-to" is a Medicare term of art. Incident-to" does not apply to commercial payers unless specified in policy. (Example Aetna).
Incident-to” Rules for Office Settings (POS 11)

Initial Visit

1. 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.)

Follow Up Visit

2. A 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. PA/NP follows the treatment plan as established by the physician. Any variation not specified by the physician negates incident-to.

3. The physician must have some ongoing participation in the patient’s care.

4. 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/NP’s NPI; reimbursement will be at 85%.

Resource: MLN Matters SE0441 “Incident-to Services”

Incident-to” Rules

NGS Part B News Article:

Clarification of Documentation Requirements for “Incident to” Services

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
US settles health fraud case against SC physician

COLUMBIA, S.C. (AP) — The U.S. attorney in Columbia has settled a health care fraud case against a Myrtle Beach doctor accused of overbilling government-sponsored health plans for patients he didn’t see.

U.S. Attorney Bill Netles says in a release the claims were filed against Dr. James Test, who operates a trio of clinics in the Myrtle Beach area. Netles says Test settled for $25,000.

Test设立他的investigation began in 2010 after a whistleblower lawsuit was filed by a nurse practitioner in test’s practice. The whistleblower will receive 20% of the settlement.

The release says Test submitted 100 of claims by Medicare and Tricare for services actually provided by nurse practitioners and physician assistants, and the false billing allowed the two to collect higher fees.


Trend Analysis

Mintz Levin Health Care Qui Tam Update: Recent Developments & Unsealed Cases - September 2015

Subject matter of claims:
- A number of cases involved claims that the defendants billed for products or services that were not actually provided, engaged in up-coding, or billed for services of non-physician providers under physicians’ names.

2015 Billing using the Physician's provider number

Department of Justice
Office of Public Affairs

FOR IMMEDIATE RELEASE

Friday, August 14, 2015

Doctor at Brooklyn, New York, Clinic Sentenced to Two Years in Prison for Engaging in $13 Million Health Care Fraud Scheme

A doctor at a Brooklyn, New York, clinic was sentenced to two years in prison for his role in a $13 million health care fraud scheme.

From 2010 to 2012, Oussema was the medical director of Capitol Medical Care PLLC (Capitol), a health care clinic located in Brooklyn, Brooklyn. In connection with his guilty plea, Oussema admitted that many of Capitol's medical services were provided by a physician's assistant who was acting without supervision by a medical doctor, and that Capitol nevertheless billed Medicare and Medicaid for the services using Oussema's provider number. In addition, Oussema admitted that in seeking 


2015 Medicaid: Billing under the physician NPI for services provided by NPs and PAs

From AHLA today:

Audit: Northgate, Asaker Overbilled MassHealth, Medicaid, CHIP For Services Provided By Nurse Practitioners, PAs.

The Springfield (MA) Republican (2/25, Berry) reports a state audit revealed Northgate Medical PC, of Springfield, Massachusetts, “substantially overbilled MassHealth for services that cost more than the actual services provided.” Over three years, the provider overbilled MassHealth by more than $191,000. In addition, Asaker Medical Associates, based in Brockton, “improperly billed MassHealth for over $24,000 in doctor-provided services that were actually performed by nurse practitioners.” State Auditor Suzanne M. Bump said “both Northgate and Asaker received overpayments from MassHealth, the state’s combined Medicaid and Children’s Health Insurance Program, for services ostensibly provided by doctors,” when in reality, nurse practitioners or physicians’ assistants provided the services.

Florida hospital settles part of whistleblower suit

ORLANDO, Florida (Reuters) - A Florida hospital on Monday settled for $80 million to $90 million part of a federal whistleblower lawsuit that accused it of Medicare fraud and kickbacks to its cancer doctors and neurosurgeons, according to a lawyer for the whistleblower.

“After reviewing her claims, the U.S. Department of Justice agreed to prosecute the hospital itself for what the government called illegal “profit-sharing” plans with its cancer doctors and neurosurgeons…”

Baklid-Kunz will continue to pursue her other allegations at trial in July, including charges that the government was overbilled for excessive spinal fusions performed by one neurosurgeon, and for patient services performed by nurses or physician’s assistants but billed at doctor rates, Wilbanks said.”

United States of America and Elin Baklid-Kunz v. Halifax Hospital Medical Center and Halifax Staffing, Inc.
Case No. 6:09-cv-1002-Orl-31TBS
2015: Failed to meet “incident to” and improper global surgery claims

06.02.2015
After a undisclosed conduct to OIG, Premier Imaging Associates, LLC (Premier), New Jersey, agreed to pay $265,662 to allegedly violating the Civil Monetary Penalties Law, OIG alleged that Premier submitted false or fraudulent claims to Federal health care programs as follows: (1) claims identified a physician as the rendering provider where the services were provided by a physician assistant and billed to a “incident to” physician supervisor requirements, (2) claims were submitted for evaluation and management (E&M) services using G0262, on the same day as other services were billed, where medical record documentation did not support the separate E&M service charge, and (3) claims were submitted by a physician for services that were already covered by global surgical package claims submitted by Premier.

Twitter Fall 2015

10 Compliance Issues for 2015
- Physician/Independent Contractor
- Medicaid Recruit
- 24/7 Rule/Inpatient Orders
- Provider Panel Status
- Physician Supervision
- Place of Service
- Evaluation and Management
- Incident to Services
- Use of modifiers, discharge codes, and condition codes
- Individual Accountability for Corporate Wrongdoing

JUNE 2016

06-24-16
After undisclosed conduct to OIG, Premier Imaging Associates, LLC (Premier), New Jersey, agreed to pay $31,735,519 to allegedly violating the Civil Monetary Penalties Law. OIG alleged that Premier submitted false or fraudulent claims to Federal health care programs as follows: (1) claims identified a physician as the rendering provider where the services were provided by a physician assistant and billed to a “incident to” physician supervisor requirements, (2) claims were submitted for evaluation and management (E&M) services using G0262, on the same day as other services were billed, where medical record documentation did not support the separate E&M service charge, and (3) claims were submitted by a physician for services that were already covered by global surgical package claims submitted by Premier.

06-20-16
After undisclosed conduct to OIG, Medical Group of Florida, Inc. (FD), Florida, agreed to pay $26,928,556 to allegedly violating the Civil Monetary Penalties Law. OIG alleged that Medical Group of Florida, Inc. submitted false or fraudulent claims to Federal health care programs as follows: (1) claims identified a physician as the rendering provider where the services were provided by a physician assistant and billed to a “incident to” physician supervisor requirements, (2) claims were submitted for evaluation and management (E&M) services using G0262, on the same day as other services were billed, where medical record documentation did not support the separate E&M service charge, and (3) claims were submitted by a physician for services that were already covered by global surgical package claims submitted by Premier.

06-17-16
After undisclosed conduct to OIG, Premier Imaging Associates, LLC (Premier), New Jersey, agreed to pay $595,643 to allegedly violating the Civil Monetary Penalties Law. OIG alleged that Premier submitted false or fraudulent claims to Federal health care programs as follows: (1) claims identified a physician as the rendering provider where the services were provided by a physician assistant and billed to a “incident to” physician supervisor requirements, (2) claims were submitted for evaluation and management (E&M) services using G0262, on the same day as other services were billed, where medical record documentation did not support the separate E&M service charge, and (3) claims were submitted by a physician for services that were already covered by global surgical package claims submitted by Premier.
Medicare Payment Policy: Hospital Shared Visits

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 substantive 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
Re-think the Shared Visit
Your Processes/Work Flow & the Workforce

- Are the physicians “wasting” time trying to re-see all of the patients? When the PA/NP performed the admission H&P, there was already a positive contribution margin. Should the physician forego seeing another patient or doing something else in order to get that “extra 15%” on the service provided by the PA/NP?

- Could they be seeing additional patients, increasing patient volume/ access?

- EFFICIENCY is the required for Shared Visits to be profitable. Minimize the time spent by the physician.

- Documentation requirements must be met. Physicians need to be educated on what those requirements are.

- Who gets the RVUs??????
AAPA 2016 Scientific Poster
Pilot Study: Utilization of Physician Assistants at Academic Teaching Hospitals
Travis L. Randolph, PA-C, ATC
E. Barry McDonough, MD
Eric D. Olson, PhD

Introduction of Pilot Study
• A 6 month pilot study was conducted in Orthopaedics to compare the difference between using PAs in shared clinics vs split clinics at academic teaching institutions
• Shared Clinic Model: PA functions similar to a resident and each patient is staffed with Supervising Physician; PAs in this model function very similar to a scribe and billing is captured by the physician; very common in academic institutions
• Split Clinic Model: PA functions autonomously in clinic as a healthcare provider while Supervising Physician is in clinic or in the operating room; more common in private practice setting

6 Month Results of Pilot Study
• Results averaged per month
• 17% in total patient volume
• 41% in New Patients
• 16% in Return Patients
• 14% in patient No Shows for Supervising Physician's clinic
• Clinic wait time for patients from 3 weeks to less than 1 week within 3 months
• 95% percent of patients rated the PA as a good or excellent clinician in survey
6 Month Results of Pilot Study

- PA's total patient volume by over 700%, payments over 600% while RVUs by more than 500%
- Supervising Physician experienced a 5% in total payments and RVUs during this 6 month study
- YTD numbers in 2016 show a 20% in RVUs/Charges and a 16% in net payments for the Supervising Physician when compared to 2015

Conclusion of Pilot Study

- Utilizing a split clinic model allows PAs to function at the highest scope of their practice and provide quality patient care at academic teaching institutions
- This study illustrates that utilizing PAs appropriately can significantly increase patient access to care and generate increased revenue for the department
- It was determined that additional nursing support was needed to reduce administrative duties (forms, patient calls, etc.) for PAs in order to increase clinic availability
- Resident physicians reported an improved educational experience while utilizing the split clinic model

Office/Outpatient Visit: Established Patient

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Work RVU</th>
<th>Non-facility Price* Physician</th>
<th>Non-facility Price* PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>0.97</td>
<td>$73.40</td>
<td>$62.39</td>
</tr>
</tbody>
</table>

Source: CMS Physician Fee Schedule
Accessed March 25, 2016
*National Payment Amounts, actual practice amount will vary by geographic index
### Office/Outpatient Visit: New Patient

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Work RVU</th>
<th>Non-facility Price* Physician</th>
<th>Non-facility Price* PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>99203</td>
<td>1.42</td>
<td>$108.85</td>
<td>$92.52</td>
</tr>
</tbody>
</table>

15% = $16.33

Source: CMS Physician Fee Schedule
Accessed March 25, 2016
*National Payment Amount: actual practice amount will vary by geographic index

### Procedures

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Work RVU</th>
<th>Non-facility Price* Physician</th>
<th>Non-facility Price* PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>20610 (Asp/inj joint)</td>
<td>0.79</td>
<td>$61.23</td>
<td>$52.05</td>
</tr>
</tbody>
</table>

15% = $9.18

Source: CMS Physician Fee Schedule
Accessed March 25, 2016
*National Payment Amount: actual practice amount will vary by geographic index

### Post-op Global Visit

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Work RVU</th>
<th>Non-facility Price* Physician</th>
<th>Non-facility Price* PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>99024</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

Source: CMS Physician Fee Schedule
Accessed March 25, 2016
*National Payment Amount: actual practice amount will vary by geographic index
The Challenges

AMCs have hired PAs/NPs in large numbers, with little guidance for deployment.

The ACGME duty hour reforms of 2003 and 2011 created a need for increased manpower and resident “substitution” in the Academic Medical Centers.

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.

Teaching Hospital Nuance/Compliance

The resident/teaching attending rules for supervision do not apply to PA/NPs, nor do the resident documentation rules. No need to apply “attestation” documentation to PA/NP charts.

Physicians in many academic settings are challenged by the reduction of resident availability and participation in clinic and patient rounds; need to rethink approach to workflow and documentation.

Physicians must be educated on their documentation responsibilities and associated billing rules for residents, PAs/NPs and scribed services.

PA/NPs while they may function similarly to residents at first, they are not “substitute residents.” Major job “dis satisfier” affecting retention.
Resident “Substitution”

There are specific rules associated with utilizing PAs/NPs in the OR in AMCs.

The outpatient clinics and the inpatient settings otherwise do not have any limitations for PAs and NPs on resident teams.

There has been an uptick in investigations and settlements from the Office of the Inspector General (OIG) at HHS involving University settings and PAs/NPs.

False Claims Liability- Resident Available

Hospital Lied About Resident Availability, Says FCA Suit


Global Surgical Package (and the Pre-op History & Physical)
Global Surgical Package - Medicare/CPT

Each procedure has a defined number of days of follow-up included.

The components of this package include the following services.

**Intraoperative Work = 69%**
**Postoperative Work = 21%**
**Pre-Op Work = 10%**

Global Package: Pre-Op H&P

There must be medical necessity in order to bill for a “Pre-op H&P” under Medicare. It is otherwise considered part of the global surgical package.


Typically, the surgeon/surgeon’s team does not address the medical management.

“The hospital requires it” does not make it billable/reimbursable.
Pre-Op H&P

From the AMA

Q: Are preoperative visits billable?

A: If the decision for surgery occurs on the day of surgery or day before and includes the pre-op evaluation and management services, then the visit is reportable. Modifier-57 Decision for Surgery, is appended … to indicate that this is the decision-making service, not the History and Physical (H&P) alone.

Continued...

Pre-Op H&P (Continued)

From the AMA

Q: Are preoperative visits billable?

A (…Continued): If the surgeon sees the patient and makes a decision for surgery, and then the patient returns for a visit where the intent of the visit is the pre-operative H&P, and this visit occurs between the decision-making visit and the day of surgery, regardless of when the visit occurs (1 day, 3 days or 2 weeks) the visit is not separately billable as it is included in the surgical package.

Source: AMA CPT Assistant, May 2009/Volume 19 Issue 5, pp. 9, 11

Pre-op H&P

“For the record, it is never a good idea to trick the system and schedule an H&P more than 24 hours prior to surgery just to get paid.”

~ Laura Evans
Medical Necessity

“These examinations are payable if they are medically necessary (i.e., based on a determination of medical necessity under §1862(a)(1)(A) of the Act) and meet the documentation requirements of the service billed.”

Preoperative Evaluations

“This instruction provides further clarification to payment policy for preoperative evaluations obtained outside of the global surgical period, and establishes a clear hierarchy for denying such services...”

Pre-op H&P RAC Audits

Issue: “E&M services are not allowed to be billed prior to a major surgical service without the proper modifiers. Therefore, an issue may exist when these services are billed and reimbursed under Medicare Part B without these modifiers.”

DC, CT, MA, MD, ME, DE, NJ, NY, NH, PA, RI, VT

Date Posted: June 17, 2010

Dates of service: October 1, 2007-present

Hot Topics in Orthopaedic Reimbursement
X-ray Interpretation: Medicare

PAs/NPs may provide & bill for the PROFESSIONAL COMPONENT:

"Examples of the types of services that PAs may provide include services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient’s condition."

Source: Medicare Benefit Policy Manual: §190 - Physician Assistant (PA) Services
3. Types of PA Services That May Be Covered

X-ray Interpretation Billing

• A separate report must be provided when billing for interpretation. Applies to physicians as well.

"The interpretation of a diagnostic procedure includes a written report."

• Be sure interpretation is also included in the body of the E/M documentation to garner higher E/M score, in addition to separate report.

Guidance: AAOS Now: Professional interpretation of X-rays
Mary LeGrand, RN, MA, CCS-P CPC, and Margi Maley, BSN, MS
IMPORTANT CLAIMS INSTRUCTION!!

- Bill Medicare with Modifier -26 for the Professional Component (Interpretation) under the PA/NP's NPI;
- The Technical component is billed under the practice/physician NPI;
- PAs and NPs cannot supervise the technical component and therefore cannot bill for it.

**Note: Denials reported since January 2013 for incorrect claims submission when billed as a global radiology (70000) charge under the PA/NP's NPI in the NGS and Novitas Jurisdictions: (Northeast, North Central, South Central, Southeast).

Fracture Care: Global vs. Itemized Billing

Medicare Denials for Global Fracture Care codes billed by PAs/NPs

- Emerged as a problem in 2011 in NY & CT with NGS. Cropped up in TX years ago, with Trailblazer creating a "list".
- The consolidation of the Medicare Administrative Contractors (MACs) has led to a widespread practice of denying fracture care codes billed by PAs along the Eastern seaboard and South Central states.
- Denials that have been appealed have been successful when pursued to the Administrative law judge level. Very labor intensive.
Recently, several providers have asked about the Medicare guidance for nonphysician practitioners (NPPs) billing for surgical procedures. NPPs include nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs).

Continued….

Minor surgical procedures (10-day global period) are generally covered when billed by an NPP if determined:
• to be within the usual training of a PA/NP/CNS;
• that the risk of performing the procedure would be acceptable when provided by a nonphysician practitioner, and
• that the usual training includes expertise required to make the decision to perform the procedures.

Major surgical procedures (90-day global period) are generally not a covered service when billed by a NPP.

Fracture Care Claims: Consider Global vs. Itemized Billing Option

• Do not use the fracture code, but bill fracture care by encounter, with application of spint/castcodes, if applicable. The 90 day global does not apply.
• AAOS NOW article by Mary LeGrand of Zupko Associates a must read: http://www.aaos.org/news/aaosnow/jul08/managing2.asp
• For any procedure, be sure there is a separate procedure note. Should be able to stand alone to meet standard for the code. (Including cast changes.)
Injections with Ultrasound Guidance: 20611

New codes for injections with ultrasound guidance published in 2015 Physician Fee Schedule

CPT® code 20611

- 20611 being denied when submitted by PAs and NPs in ortho, primary care, and rheumatology.
- Calls to carriers have not resulted in any resolution.
- Be aware of the MAC policies for provider qualifications to bill for ultrasound (ability to demonstrate training, etc...).
Concurrent Surgeries

Emerging False Claims Liability

UPMC Inks $2.5M Deal To Settle Neurosurgery FCA Claims

By Dan Koeck

Law360, New York (July 27, 2016, 6:44 PM ET) — The University of Pittsburgh Medical Center has agreed to pay more than $2.5 million to the federal government to settle whistleblower claims that some of its neurosurgeons billed Medicare for participating in surgeries in which they weren’t sufficiently involved, in violation of the False Claims Act.

The qui tam suit in Pennsylvania federal court alleges the neurosurgeons billed for assisting in or supervising procedures by other surgeons, residents, fellows and physician assistants that they weren’t participating in to the required degree, according to the U.S. Department of Justice...


