

# **PAs & NPs in Orthopaedics: Rules, Reimbursement and Realities**

**Daniel Coll, MBA, MHS, PA-C, DFAAPA**  
**Dennis Gregory, MPAS, PA-C**

OTA 2018



# Acknowledgements

Tricia Marriott

PA-C, MPAS, MJ Health Law, CHC®

10+ Years regulatory and professional advocacy

30+ Years as a licensed and certified PA, currently practicing at The Yale Medical Group, Dept. of Orthopaedics and now Orthopedic Service Line Administrator at Saint Mary's Waterbury, Connecticut

Former Senior Advisor and  
Senior Director, Regulatory & Professional Advocacy  
Former Director of Reimbursement Advocacy

Staff Liaison to Joint Commission's Hospital Professional Technical  
Advisory Committee

American Academy of Physician Assistants and the AAPA Center for  
Healthcare Leadership and Management



# Disclaimer/Disclosure

This presentation and any document(s) included or referenced therein are for informational purposes only, and nothing herein is intended to be, or shall be construed as, legal or medical advice, or as a substitute for legal or medical advice. All information is being provided AS IS, and any reliance on such information is expressly at your own risk.

Although every reasonable effort has been made to assure the accuracy of the information herein, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with **the provider** of services. The provider must ascertain payment policy and claims methodology for each payer with whom they contract.

- This presentation was current at the time it was

submitted.

- **Medicare policy changes frequently. Be sure to keep current by going to [www.cms.gov](http://www.cms.gov).**
- There are no conflicts or financial disclosures to report.
- The American Medical Association has copyright and trademark protection of CPT ©.

# PA and NP Roles and Responsibilities

## Maximizing Utilization

### PAs and NPs



**Recognized as  
providers by  
Medicare**



**Services as  
defined by  
Medicare are  
“the type that  
are considered  
physician's  
services...”**



**Not clinical  
support staff**

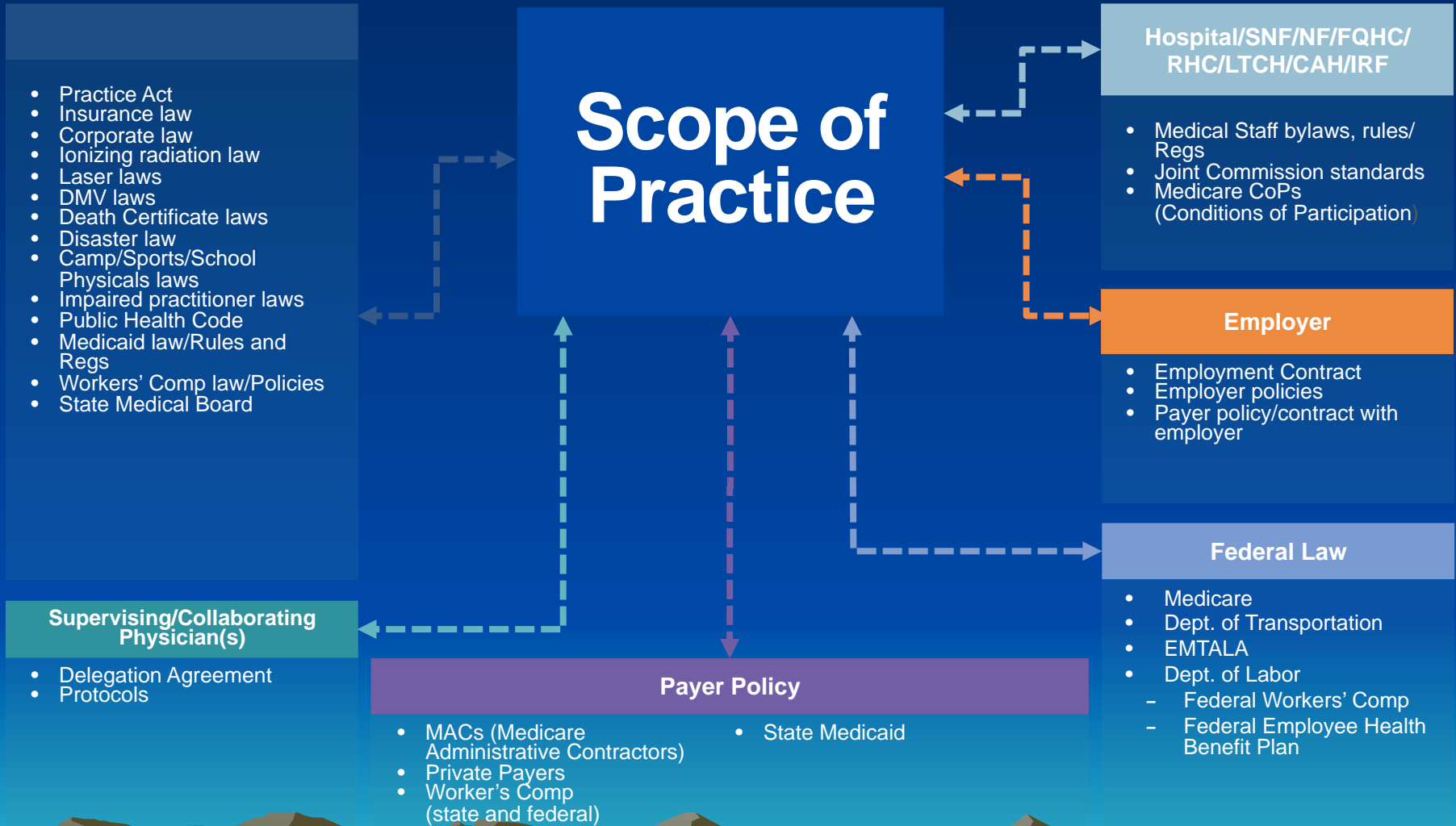


**Not scribes**

# Harvard Business School: Potential Cost Per Employee Category

	Surgeon	PAs	RN	X-Ray Tech	Scribe	Office Assistant
Total Clinical Costs	\$546,400	\$120,000	\$100,000	\$64,000	\$51,000	\$61,000
Personnel Capacity (minutes)	91,086	89,086	89,086	89,086	89,086	89,086
Personnel Capacity Cost Rate \$/min	\$6.00	\$1.35	\$1.12	\$0.72	\$0.57	\$0.68

# Interrelated Elements Determine Scope of Practice



# Medicare Fundamentals PA/NP 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



# 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).
- Medicare Benefit Policy Manual, Chapter 15, §190 PA Services & §200 NP Services,
- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>



# 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 is  
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.”

Source: Medicare Benefit Policy Manual: Chapter 15: <http://www.cms.gov/manuals/Downloads/bp102c15.pdf>

# 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 PA/ NP'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

	Physician Ortho	PA/NP Ortho
Annual Median Compensation	\$576,677* = \$277/hr	\$111,605* = \$54/hr
Encounter (E/M) Reimbursed	100% for \$100	85% for \$85
Profit	-\$177	\$31

\*©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

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









# 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.**

# “Incident-to” Rules

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”](#)

# 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>

# Fraud Enforcement Trends

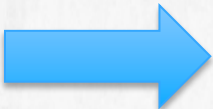


# US settles health fraud case against SC physician

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'd not seen.

U.S. Attorney Bill Nettles says in a release the claims were filed against Dr. James Vest, who operates a trio of clinics in the Myrtle Beach area. Nettles says Vest settled for \$325,000.

Nettle says his investigation began in 2010 after a whistleblower lawsuit was filed by a nurse practitioner in Vest's practice. The whistleblower will receive 20% of the settlement.



The release says Vest submitted bills to Medicare and Tricare for services actually provided by nurse practitioners and physician assistants, and the false billing allowed him to collect higher fees.

<http://www.wtol.com/story/19025730/us-settles-health-fraud-case-against-sc-physician>



# Trend Analysis

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

9/22/2015 by Brent Douglas, Hope Foster, Samantha Kingsbury, Richard Maidman, Kevin McGinty

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 upcoding, or billed for services of non-physician providers under physicians' names.



**JD SUPRA** BUSINESS ADVISOR

<http://www.jdsupra.com/legalnews/mintz-levin-health-care-qui-tam-update-57076/>



# 2015-Billing using the Physician's provider number



THE UNITED STATES  
DEPARTMENT of JUSTICE

## JUSTICE NEWS

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 2009 to 2012, Umana was the medical director of Cropsey Medical Care PLLC (Cropsey), a health care clinic located in Bensonhurst, Brooklyn. In connection with his guilty plea, Umana admitted that many of Cropsey's medical services were provided by a physician's assistant who was acting without supervision by a medical doctor, and that Cropsey nevertheless billed Medicare and Medicaid for the services using Umana's provider number. In addition, Umana admitted that in seeking

<http://www.justice.gov/opa/pr/doctor-brooklyn-new-york-clinic-sentenced-two-years-prison-engaging-13-million-health-care>

# 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 vs. 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 it self-disclosed conduct to OIG, Premier Urology Associates, L.L.C. (Premier), New Jersey, agreed to pay \$266,882.13 for 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 failed to meet "incident to" physician supervision requirements; (2) claims were submitted for evaluation and management (E&M) services using Modifier 25, 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 supported by a physician for services that were already covered by global surgical package claims submitted by Premier.





# Twitter Fall 2015

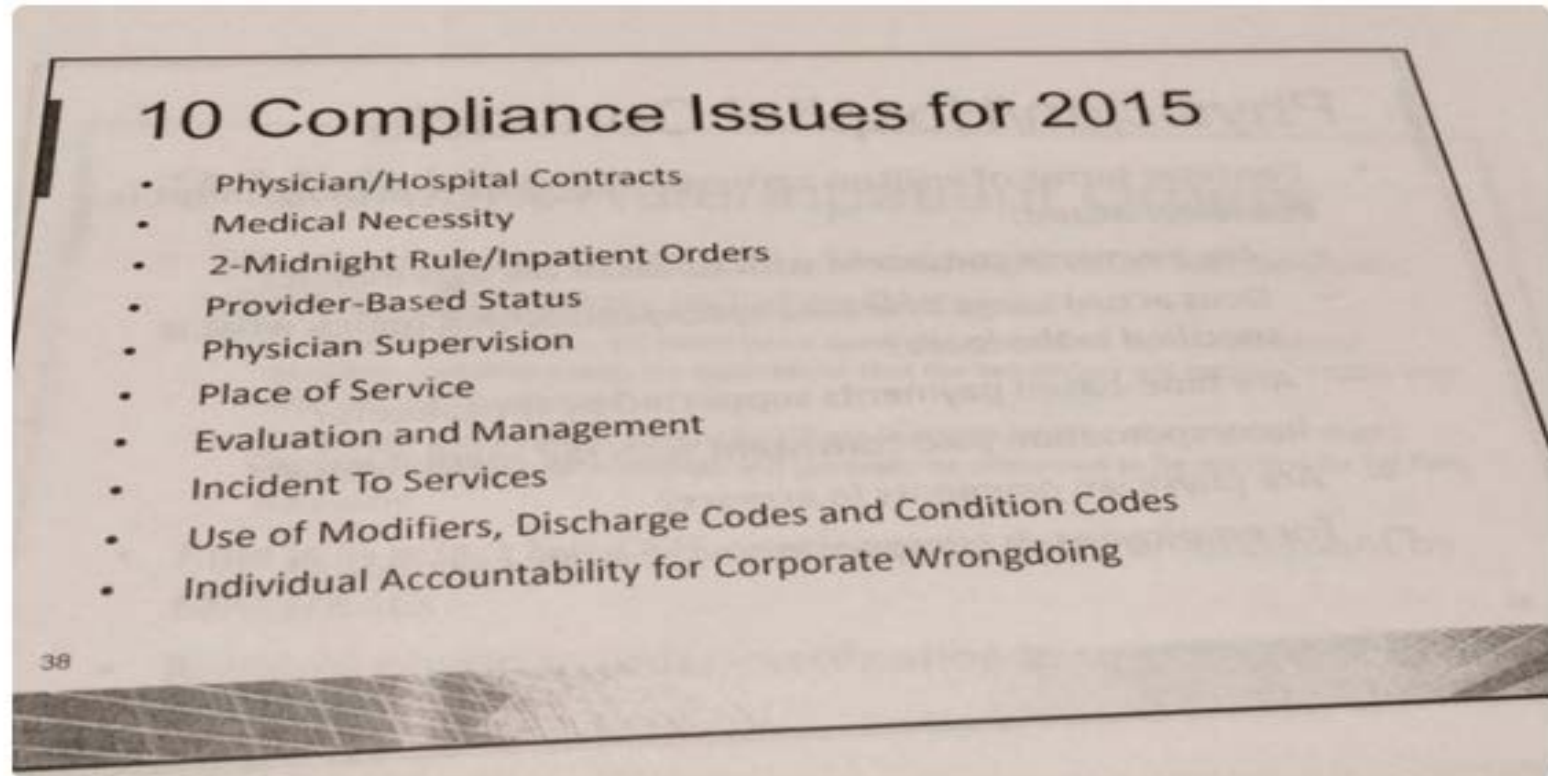


**AHLA**  
@healthlawyers



Following

#ahla15



# JUNE 2016

6-24-16

After it self-disclosed conduct to OIG, Planned Parenthood Health System, Inc. (Planned Parenthood), incorporated in North Carolina, agreed to pay \$1,572,752.80 for potentially violating the Civil Monetary Penalties Law. Planned Parenthood submitted claims to Medicaid programs in North Carolina, South Carolina, Virginia and West Virginia that included the following billing errors: (1) services billed under a provider number different than the medical professional who provided the service and (2) billed for services of non-physician practitioners who were not properly enrolled in their state Medicaid program.

06-20-2016

After it self-disclosed conduct to OIG, Medical Plaza Family and Geriatric Physician, P.A. (Medical Plaza), North Carolina, agreed to pay \$109,975.24 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Medical Plaza submitted claims to Medicare for payment under two physicians' National Provider Identification numbers for incident-to services provided to patients at Medical Plaza when the services had been provided by Medical Plaza's nurse practitioners.

06-17-2016

After it self-disclosed conduct to OIG, Radiology Alliance, PC (Radiology Alliance), Tennessee, agreed to pay \$355,461.34 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Radiology Alliance submitted claims to Federal health care programs that were false or fraudulent in the following ways: (1) services were performed by two radiology practitioner assistants that were supervised by Radiology Alliance's physicians as if they were personally provided by the physicians; (2) in certain instances Radiology Alliance billed for nursing practitioner and physician assistant services using the supervising physician's billing number at the supervising physician's billing rate; and (2) billed for the insertion of peripherally inserted central catheter lines by hospital nurses and radiology technicians that were supervised by Radiology Alliance's physicians as if those services were directly provided by the physicians.

# 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**

# Initial Hospital Care (Admission H&P)

**15% = \$20.73**

CPT Code	Work RVU	Non-facility Price* Physician	Non-facility Price* PA/NP
99222	2.61	\$138.20	\$117.47

Source: CMS Physician Fee Schedule  
Accessed March 25, 2016

\*National Payment Amount: actual practice amount will vary by geographic index

# Subsequent Hospital Care


**15%= \$10.90**

CPT Code	Work RVU	Non-facility Price* Physician	Non-facility Price* PA/NP
99232	1.39	\$72.68	\$61.78

Source: CMS Physician Fee Schedule  
Accessed March 25, 2016

\*National Payment Amount: actual practice amount will vary by geographic index


# 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**

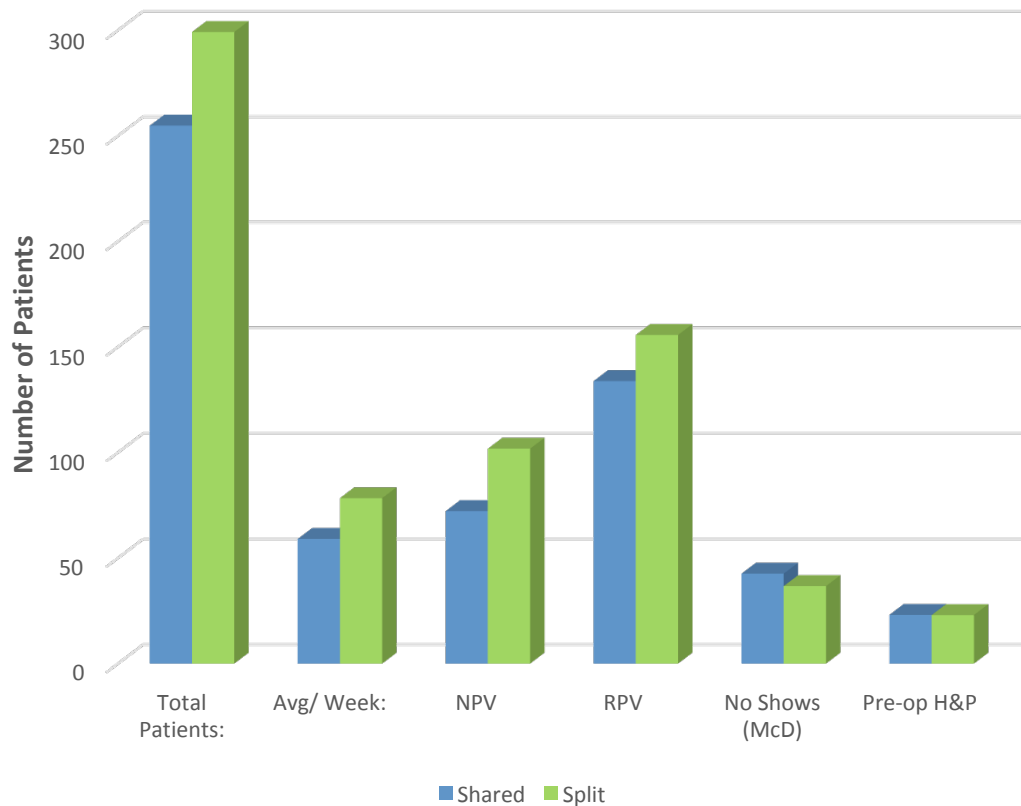
**Eric D. Olson, PhD**

# 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

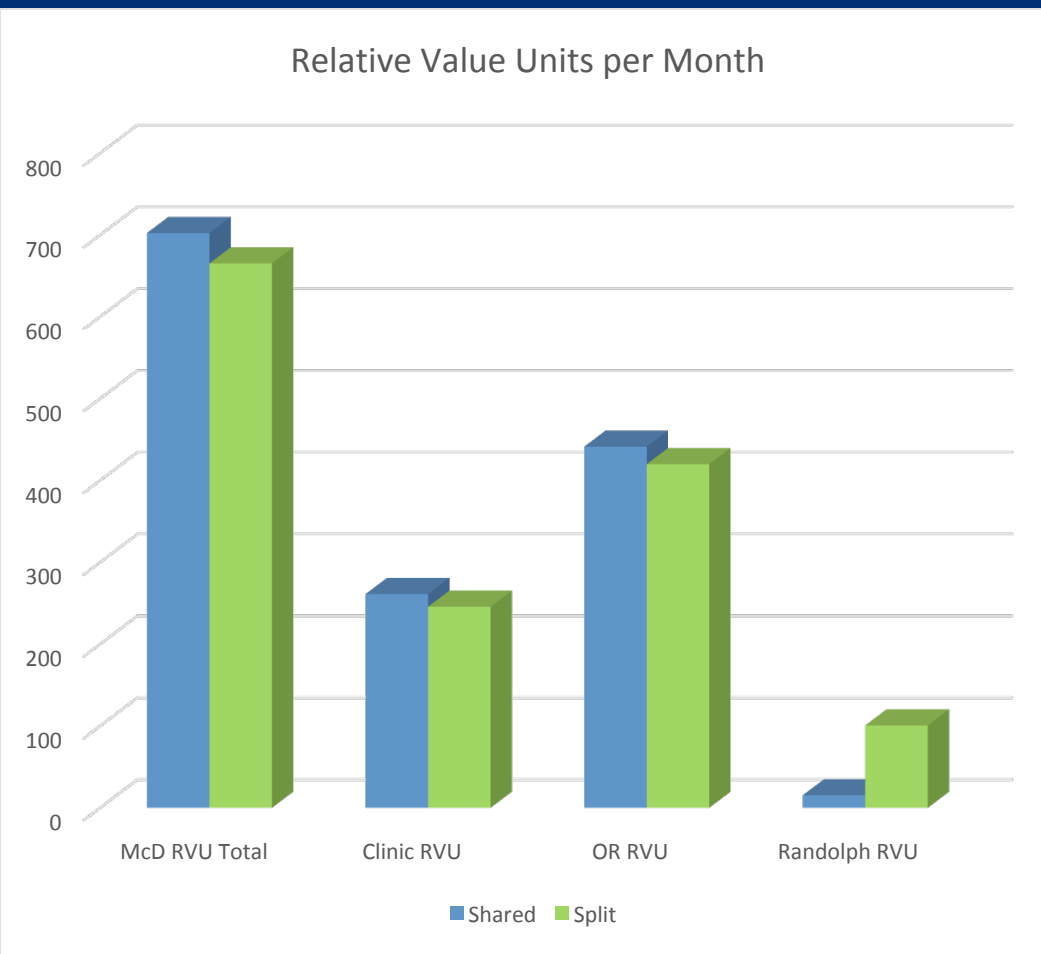
# 6 Month Results of Pilot Study







Comparison of Shared and Split Clinics



- 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

**15%=\$11.01**

CPT Code	Work RVU	Non-facility Price* Physician	Non-facility Price* PA/NP
99213	0.97	\$73.40	\$62.39

Source: CMS Physician Fee Schedule  
Accessed March 25, 2016

\*National Payment Amount: actual practice amount will vary by geographic index

# Office/Outpatient Visit: New Patient

**15%= \$16.33**

CPT Code	Work RVU	Non-facility Price* Physician	Non-facility Price* PA/NP
99203	1.42	\$108.85	\$92.52

Source: CMS Physician Fee Schedule  
Accessed March 25, 2016

\*National Payment Amount: actual practice amount will vary by geographic index

# Procedures

**15%= \$9.18**

CPT Code	Work RVU	Non-facility Price* Physician	Non-facility Price* PA/NP
20610 (Asp/inj joint)  [Note: #1 procedure performed by PAs and NPs according to Medicare data]	0.79	\$61.23	\$ 52.05

Source: CMS Physician Fee Schedule

Accessed March 25, 2016

\*National Payment Amount: actual practice amount will vary by geographic index

# Post-op Global Visit

CPT Code	Work RVU	Non-facility Price* Physician	Non-facility Price* PA/NP
99024	0	\$ 0	\$0

Source: CMS Physician Fee Schedule

Accessed March 25, 2016

\*National Payment Amount: actual practice amount will vary by geographic index



# Academic Medical Center Considerations



# 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 re-think approach to work flow 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

By Dani Kass

Law360, New York (August 11, 2016, 1:44 PM ET) -- An [Advocate Health Care](#) teaching hospital allowed surgeons to bill Medicare and Medicaid for surgeries performed with assistant surgeons and physician assistants when qualified residents were available to help, in violation of the False Claims Act, according to a whistleblower suit in Illinois federal court.

Former medical resident Luay Ailabouni, in a suit unsealed Monday, said teaching hospitals must use qualified residents when they're available for surgeries with Medicare and Medicaid patients, but are allowed to enter a modifier, 82, when billing for surgeries during which no residents could help. He alleged the surgeons from Cardiothoracic & Vascular Surgery Associates, practicing at Advocate Christ Hospital and Medical Center, would use that modifier even when it wasn't appropriate.

<http://www.law360.com/articles/827368/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%**



## Physician Fee Schedule Search

### Search Results [1 Record(s)]

#### Selected Criteria:

Year: 2016 HCPCS: 27130  
Type of Info.: All Modifier: All Modifiers  
HCPCS Criteria: Single HCPCS Code  
MAC Option: National Payment Amount

#### Single HCPCS Code

Code	Description
27130	Total hip arthroplasty

GLOBAL



090

PRE

OP



0.10

INTRA

OP



0.69

POST

OP



0.21

# 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.

*<http://www.cms.gov/manuals/downloads/clm104c12.pdf>*

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
- \*Evans, L ; Pre-op H&P: often required, usually not separately billable, MGMA Connexion, July 2010, p.11-12



# Medicare Transmittal Pre-op H&P

## 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...**”

August 2001

Source: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1719B3.pdf>

# 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**





# Billing In-Office X-Ray and Interpretation



# 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.**

Source: Medicare Claims Processing Manual, §20.1.

“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](http://www.aaos.org/news/aaosnow/feb09/managing1.asp)*

Mary LeGrand, RN, MA, CCS-P CPC, and Margi Maley, BSN, MS <http://www.aaos.org/news/aaosnow/feb09/managing1.asp>



# 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.





**Jurisdiction K**  
*Part B Providers*  
**NGSMedicare News**

## **Nonphysician Practitioners Billing for Surgical Procedures**

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 splint/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>

## Coding for closed treatments of fractures

By: Mary LeGrand, RN, MA, CCS-P, CPC Margaret Maley, BSN, MS Robert H. Haralson III, MD, MBA M. Bradford Henley, MD, MBA Matthew Twetten, MA

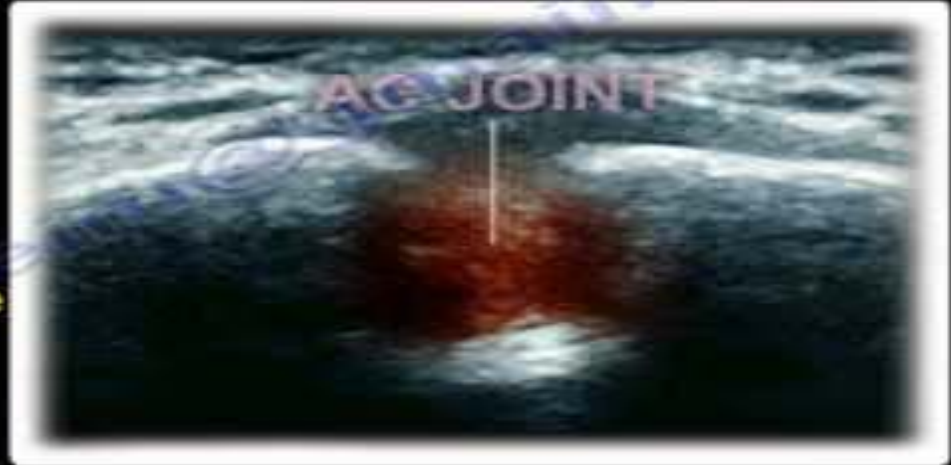
By Mary LeGrand, RN, MA, CCS-P, CPC; Margaret Maley, BSN, MS; Robert H. Haralson III, MD, MBA; M. Bradford Henley, MD, MBA; Matthew Twetten, MA

Coding for closed treatment of fractures is controversial; this article provides suggestions on how to code for this form of treatment. Closed treatments are either with or without manipulation. An orthopaedic surgeon has the following two ways of coding closed treatment of a fracture under Current Procedural Terminology (CPT):

The AAOS position is that the orthopaedist must have the option of coding these services either way to enable the treating surgeon to address the specific situation and to meet the physician's contractual obligations with payors.

- 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.)

# AC Joint Injection Blind or Ultrasound Guided ULTRASOUND GUIDED INJECTION



Move the probe to identify the acromion, clavicle, and the AC joint.



Injections with Ultrasound Guidance: 20611

# New codes for injections with ultrasound guidance published in

## NEW AND REVISED INJECTION CODES

Descriptor	Work RVUs	Non-Facility RVUs
Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes); without ultrasound guidance	0.66	1.35
with ultrasound guidance, with permanent recording and reporting	0.89	2.02
Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	0.68	1.41
with ultrasound guidance, with permanent recording and reporting	1.00	2.22
Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	0.79	1.70
with ultrasound guidance, with permanent recording and reporting	1.10	2.55

; ● = New code; ⊙ = Moderate sedation

# 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





The Boston Globe

# CLASH IN THE NAME OF CARE



AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality: Highest Standards, Better Outcomes*

## Statements on Principles

Revised April 12, 2016

### Concurrent or Simultaneous Operations

Concurrent or simultaneous operations occur when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time. The critical or key components of an operation are determined by the primary attending surgeon. A primary attending surgeon's involvement in concurrent or simultaneous surgeries on two different patients in two different rooms is not appropriate.

**SunSentinel**

The state claims Paley successfully took out the rod then handed the boy off to physician assistant to prep the child for the insertion of a device, about the size of a paper clip and shaped like an 8, commonly used to treat an abnormality.

Paley meanwhile "rotated to a different operating suite" to tend to another patient, the complaint states.



# Emerging False Claims Liability

## UPMC Inks \$2.5M Deal To Settle Neurosurgery FCA Claims

By Dani Kass

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 whistleblowers' 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...

[www.law360.com/health/articles/822064?nl\\_pk=7d5303c1-cde3-44ac-88cd-9f53823e57dd&utm\\_source=newsletter&utm\\_medium=email&utm\\_campaign=health](http://www.law360.com/health/articles/822064?nl_pk=7d5303c1-cde3-44ac-88cd-9f53823e57dd&utm_source=newsletter&utm_medium=email&utm_campaign=health)

<http://www.post-gazette.com/business/healthcare-business/2016/07/27/Justice-Dept-says-UPMC-agrees-to-pay-2-5M-for-false-billing-claims/stories/201607270198>

<http://www.healthcarefinancenews.com/news/university-pittsburgh-medical-center-pays-25-million-resolve-whistleblower-allegations>

# Department of Justice Press Release


[HOME](#)[ABOUT](#)[NEWS](#)[MEET THE U.S. ATTORNEY](#)[DIVISIONS](#)[PROGRAMS](#)

[U.S. Attorneys](#) » [Western District of Pennsylvania](#) » [News](#)

**Department of Justice**

U.S. Attorney's Office

Western District of Pennsylvania

SHARE 

FOR IMMEDIATE RELEASE

Wednesday, July 27, 2016

## **False Claims Act Violation by UPMC Resolved for \$2.5 Million**

PITTSBURGH – The University of Pittsburgh Medical Center, together with the University of Pittsburgh Physicians, UPMC Community Medicine, Inc., and Tri-State Neurosurgical Associates-UPMC, Inc. (“UPMC”) have agreed to pay the United States \$2,520,429 to settle False Claims Act allegations, United States Attorney David J. Hickton announced today.

# Thank You

Dan Coll

[danieljohnncoll@gmail.com](mailto:danieljohnncoll@gmail.com)

Dennis Gregory

[dennis.c.gregory@gmail.com](mailto:dennis.c.gregory@gmail.com)

