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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Take Home Points

• Calculating PA Productivity requires in-depth knowledge of billing and reimbursement policy and claims methodology for the various payers.

• Many claims are submitted under the physician’s identification number (NPI), rendering the PA’s work invisible in the claims data.

• Unless a PA’s work (production) and financial contribution can be fully attributed to the PA, a production based compensation formula or bonus arrangement is not calculable.
Stakeholders (employers, health systems, policy makers) in the healthcare arena are constantly looking for methods (metric/formulas) to quantify the level and volume of professional work being delivered by health professionals.

For PAs there is often not a single method that fairly and accurately captures the full range of their contribution.

Productivity

As medicine and business are increasingly intertwined, PAs should be fully aware of how they are being “measured.”

New payment models will force all practices, hospitals and health systems to be more cost effective in their operations.

The Trend is Clear

The Rationale for Tracking PA Work

You can’t manage what you can’t measure.

You can’t count what you can’t see.
PA Value Is Beyond Reimbursement

• Financial contribution to the practice is important, but:
  • It's not just about the reimbursement
    - Quality of care remains a PA’s most important contribution
    - Patient satisfaction (less wait time, continuity of care, adherence to treatment/medication plans)
    - Physician quality of life (time off, reduced workload, decreased stress)

What Is Productivity?

• Measurement of clinical labor, professional work, intensity of services delivered, and risk of liability.
  • Productivity measures are less valid unless quality, the efficient use of resources, and patient satisfaction metrics are incorporated.

Medicare's Data Release

• April 9th CMS released billing information on 880,000 health professionals.
  • Contains Part B fee-for-service claims data for 2012.
  • Allows PAs to take a look at services billed under their name and NPI.
  • Will not show services performed by PA and billed under the physician.
Utilization Decisions Matter

• Unless PAs/NPs are empowered to deliver care to the top of their license it is difficult to maximize value.

• Organizational culture and exposure to best practice models impact utilization

Determining Value

Some areas are easier to measure than others:

• Clinical
• Teaching/mentoring other professionals
• Research
• Administrative

Issues that Traditionally Hinder Hospitals Billing for PAs

• General confusion
• Fear of making a mistake/fraud & audits
• Lack of clarity related to residents/fellow
• No clear payer contracting guidelines
• The Part B/Part A Medicare conundrum
• Services performed by PAs being “captured” by physicians
<table>
<thead>
<tr>
<th>Payers and Enrollment: Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicare enrolls PAs.</td>
</tr>
<tr>
<td>• Claims for services provided by PAs are submitted using the PA's NPI. Reimbursement is at 85% of the physician fee schedule.</td>
</tr>
<tr>
<td>• Claims also can be submitted under the physician’s NPI under Medicare’s “Incident-to” and Shared Visit provisions.</td>
</tr>
<tr>
<td>• Reimbursement is at 100% of the physician fee schedule. However, PAs are invisible on the claim.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payers and Enrollment: Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Oregon Medicaid enrolls or identifies the PA on the claim.</td>
</tr>
<tr>
<td>• In states where PAs are not enrolled, claims are submitted under the physician's NPI.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payers and Enrollment: Commercial Payers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Private payers may promulgate their own rules.</td>
</tr>
<tr>
<td>• Many choose not to enroll PAs. They DO however pay for services provided by PAs.</td>
</tr>
<tr>
<td>• Claim is submitted under the physician’s number. Note: This is NOT to be confused with Medicare’s “incident-to” billing!</td>
</tr>
<tr>
<td>• The PA, when not enrolled, is not identified on the claim/ invisible.</td>
</tr>
</tbody>
</table>
Payers and Enrollment:

**Commercial Payers**

- Many choose not to enroll PAs.
- Many do not discount; payment is at the physician rate.
- The entity billing must ascertain claims methodology and payment rate for each payer with whom they contract.

Example: Aetna

- Aetna enrolls PAs (since June 2010) except in Alaska, Kansas, Maine, Michigan and Missouri.
- Discounts PA services to 85%.
- Aetna’s policy manual states that it follows Medicare’s Incident-to policy, allowing for 100% reimbursement if all rules are met.
- It remains the responsibility of the practice to ascertain the payment policy and claims instructions for each payer with whom they contract.

Accounting

<table>
<thead>
<tr>
<th>Charges</th>
<th>Collections</th>
</tr>
</thead>
<tbody>
<tr>
<td>what the practice charges for the encounter</td>
<td>what the practice receives from the payer</td>
</tr>
</tbody>
</table>
Charges

- Are IRRELEVANT
- Fee schedules are set by payers
- Not indicative of production/revenue/profit
- Do not use as an indicator of “covering” your salary, unless you are in a cash-only practice with 100% collections.

Collections

- Accounts receivable can be considered when computing production or contribution however,
- MUST be assured FULL attribution to PA even when claims were submitted under physician’s NPI (shared, incident-to, commercial payers)

Practice Management Software

- CPT Codes generate charges.
- CPT codes are kept in practice management software.
- CPT codes also have a fixed “relative value unit”, also known as an RVU.
- RVU include a component to measure “work”
- RVUs are standardized, widely available, and a method to evaluate productivity.
There is no such thing as a “PA relative value unit.”

The work intensity and quality for delivering a service is the same whether delivered by a PA or a physician.

There may be a need to adjust compensation if a PA generates a similar number of RVUs compared to a physician.

RVU=
Relative Value Units

- Can be found in the Medicare Physician Fee Schedule
- Three components:
  - Work
  - Practice expense (PE)
  - Malpractice

Example: 99213
Office visit, established patient

- Work RVU=.97
- Practice Expense=1.07
- Malpractice= 0.07

Source: CMS Physician Fee Schedule
Accessed February 14, 2013
### Office/Outpatient Visit: New

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Work RVU</th>
<th>Price*</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>0.48</td>
<td>$43.35</td>
</tr>
<tr>
<td>99202</td>
<td>0.93</td>
<td>$74.51</td>
</tr>
<tr>
<td>99203</td>
<td>1.42</td>
<td>$108.18</td>
</tr>
<tr>
<td>99204</td>
<td>2.43</td>
<td>$166.22</td>
</tr>
<tr>
<td>99205</td>
<td>3.17</td>
<td>$207.06</td>
</tr>
</tbody>
</table>

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

### Office/Outpatient Visit: Established

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Work RVU</th>
<th>Price*</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>0.18</td>
<td>$20.06</td>
</tr>
<tr>
<td>99212</td>
<td>0.48</td>
<td>$43.70</td>
</tr>
<tr>
<td>99213</td>
<td>0.97</td>
<td>$73.08</td>
</tr>
<tr>
<td>99214</td>
<td>1.50</td>
<td>$107.83</td>
</tr>
<tr>
<td>99215</td>
<td>2.11</td>
<td>$144.37</td>
</tr>
</tbody>
</table>

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

### Production and Compensation

- There is no one production formula because of the many variables involved.
- There must be an understanding of billing procedures and payment rules.
- Practice must be able to capture and record the data for services provided by the PA; this often requires additional steps outside the claims process.
- Attribution must be MANDATORY
Compensation/Productivity Formulas

- Incident-to, shared visits and private payer claims methodologies render PAs “invisible” in the revenue cycle.
- Multiple “data” sources, but what data should be used?
- AAPA Salary Survey, Specialty PA Org surveys, MGMA, US Bureau of Labor & Statistics, Specialty Societies...
- Resource articles:
  - “Calculating PA Productivity” [link]
  - “RVU BASED PHYSICIAN COMPENSATION AND PRODUCTIVITY” [link]

A Word of Caution

- Physicians are increasingly being placed into production based compensation agreements or contracts, as they have become employees, rather than practice owners.
- PAs on production based compensation can be viewed as competing with, rather than contributing to, the physician’s bottom line.
- In some instances, the PA’s ability to seek supervision can be compromised.

Production and Compensation

- **DO NOT** agree to a purely production based compensation package unless all work performed by the PA is attributed to the PA.
- Base salary should be negotiated that is fair.
- Ancillary services generated by the PA should also be attributed to the PA.
- The PA **must** receive a copy of the data reports.
- Be aware that ANY change in the practice may directly affect the PA’s ability to “produce”.
- Production “bonus” is incentive to work harder.
Productivity Pitfalls/Attribution

- Global/Post-op Visits have ZERO RVUs.
- Shared Visit and Incident-to Visits are billed under the physician.
- Many payers do not enroll PAs so the claim is submitted under the physician’s NPI.
- Practice management software is often driven solely by claims.
- The PA’s work is not captured.

So, how am I doing?

- There are some common metrics out there that practices can track and are widely used to assess productivity.
- Most come from claims data. Some practice management software is able to capture encounters or work by provider outside of claims data.
- Many administrators use MGMA data, but there are other sources as well.
- Consider using multiple sources.

MGMA-ACMPE

- Practice Managers provide the data.
- PA and NP data included.

- Note the "n"=#practices reporting
  - Data for one specialty.
    - n2012=65
    - n2011=66
    - n2010=55
- Some regions, some specialties, have little or no data.
MGMA Data: Productivity - Ambulatory Encounters

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2012 Report</th>
<th>2013 Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA – Primary Care</td>
<td>2623</td>
<td>2763</td>
</tr>
<tr>
<td>PA – Ortho</td>
<td>1518</td>
<td>1409</td>
</tr>
<tr>
<td>PA – Surgical</td>
<td>489</td>
<td>391</td>
</tr>
</tbody>
</table>


MGMA Data: Work RVUs
CMS RBRVS Method (Median)

<table>
<thead>
<tr>
<th>PA-Primary Care</th>
<th>PA-Ortho</th>
<th>PA-Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>3,278</td>
<td>3,493</td>
</tr>
<tr>
<td>2011</td>
<td>3,243</td>
<td>3,082</td>
</tr>
<tr>
<td>2012</td>
<td>3,180</td>
<td>3,019</td>
</tr>
<tr>
<td>2013</td>
<td>3,323</td>
<td>2,899 (with variability by region)</td>
</tr>
</tbody>
</table>


Pitfalls with RVU and Encounter Data

• How was the PA used? Glorified nurse or full status as a PA?

• What patient care opportunities did the PA have?

• You can’t treat what you don’t see.
MGMA Data: Compensation

Salary—Median Income

<table>
<thead>
<tr>
<th>Specialty</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA-Primary Care</td>
<td>$92,767</td>
<td>$92,635</td>
<td>$96,834</td>
</tr>
<tr>
<td>PA-Ortho</td>
<td>$101,457</td>
<td>$106,157</td>
<td>$109,075</td>
</tr>
<tr>
<td>PA-Surgical</td>
<td>$93,447</td>
<td>$111,246</td>
<td>$100,674</td>
</tr>
</tbody>
</table>


2013 AAPA Salary Survey:
Total Compensation=Salary + bonus

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>$94,000</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>$105,000</td>
</tr>
<tr>
<td>General Surgery</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

Annual mean wage of physician assistants, by state, May 2013

Annual mean wage range: $60,000 - $69,999, $70,000 - $79,999, $80,000 - $89,999, $90,000 - $119,999.
### National Salary Report 2012
**ADVANCE for NPs & PAs Feb 2013**

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Full-time salary</td>
<td>$102,165</td>
<td>$94,870</td>
<td>$96,876</td>
</tr>
<tr>
<td>Average Part-time salary/Hourly</td>
<td>$55.16</td>
<td>$50.52</td>
<td>$51.11</td>
</tr>
</tbody>
</table>

2012 results: N=1,128 PA responses = 1.3 % of all PAs

### Society of Dermatology PAs

**TABLE 1. Dermatology PA annual income distribution (N = 153)**

<table>
<thead>
<tr>
<th>10%</th>
<th>25%</th>
<th>50%</th>
<th>75%</th>
<th>90%</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>$72,000</td>
<td>$85,000</td>
<td>$100,000</td>
<td>$100,000</td>
<td>$166,000</td>
<td>$133,491</td>
</tr>
</tbody>
</table>

**TABLE 2. Dermatology PA annual production distribution (N = 85)**

<table>
<thead>
<tr>
<th>10%</th>
<th>25%</th>
<th>50%</th>
<th>75%</th>
<th>90%</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>$300,000</td>
<td>$400,000</td>
<td>$500,000</td>
<td>$750,000</td>
<td>$925,000</td>
<td>$669,597</td>
</tr>
</tbody>
</table>


### MGMA Data: PA-Dermatology

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std Dev</th>
<th>25th %tile</th>
<th>Median</th>
<th>75th %tile</th>
<th>90th %tile</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>129,466</td>
<td>51,046</td>
<td>90.73 1</td>
<td>109,593</td>
<td>168,294</td>
<td>191,344</td>
</tr>
</tbody>
</table>

*n* = 17 practices

Unique Issues in Surgical Settings

Global Surgical Package

Surgery/Global Work

• While not separately payable, track “Global” visits by using the global visit code on the super-bill or in the EMR. 99024: “Postoperative follow-up visit included in global service.” CPT 2013 ©AMA

• The global visits performed by the PA would otherwise have to be performed by the physician.

• If the PA provided 300 post-op global visits per year, for example, theoretically 300 slots were then made available for the physician to see revenue generating visits.
Global Work

- 31% of the global payment is for work outside the OR.
- If the PA is doing the pre-op H&P, the post-op rounds, and the post-op office visits, then 31% of the global payment could, theoretically, be applied to the PA.
- Additionally, 31% of the Work RVU attributed to the procedure could be applied to the PA.

For Consideration

ACMPE Paper: “Physician Assistants in an Orthopaedic Practice: Changing from a Collections Based Compensation to RVU Based System” [Mike A. Timmerman, October 2007, American College of Medical Practice Executives]

1. Assigned a random RVU of 1 to post-op global visits,
2. Used the appropriate E+M code RVU for the pre-op H&P to account for the work performed.

RVUs added up quickly, demonstrating the PA’s contribution to the practice.

Surgical Productivity

Example:
27130 Total Hip (payable at $1,395*)
- Pre-op work (10%): $ 139.50
- Intra-op work (69%): $ 962.55
- Post-op work (21%): $ 292.95

*Final figure impacted by geographic index
Source: CMS Physician Fee Schedule
Accessed April 30, 2014
Surgical Productivity

• If PA does pre-op exam and post-op rounding and office visits, $432.05 could be “credited/allocated” to PA.

• Billing records would show $1395 being allocated to the surgeon.

• An additional separate payment of $189.72 can be officially credited to PA for the first assist (13.6% of surgeon’s fee)

PA Value/Contribution

True measure of PA “value” might be:

first assist payment of $189.72
work share of global payment $432.05

Total = $621.77 per THR

Work RVUs

Total Hip Work RVU= 20.72
Apply the same formula

Pre-10% = 2.07
Post-21% = 4.35
Total = 6.42 for pre and post-op work

Add in the 1st assist: watch the RVUs grow
Value Without Reimbursement?

• Just because a case is in the exclusion list and a first assist fee will not be paid, it does not mean that a PA should not assist the surgeon.

• A PA assisting in hand cases or scope cases can result in increased efficiency, resulting in the ability to do more cases in the same amount of block time. An extra case or two is far more reimbursement than that of an assist fee.

Determining Value

• Determine value by assessing the physician-PA team as a whole.

• Looking at the physician’s productivity, including work RVUs and accounts receivable before the PA and then after the PA (three or four quarters after orientation...)

• Claims Data, in most instances, not sufficient information to adequately assess PA productivity.

Determining Value

• PAs, physicians, and administrative staff must recognize that some billing rules render the PA "invisible", or that the work and revenue lacks proper attribution.

• PAs must be able to articulate these points to illustrate their “value” to the practice.
Value Beyond Dollars

If the PA didn’t perform these services-

- global visits
- hospital rounds/notes/discharge summaries
- patient phone calls,
- pharmacy phone calls
- paper work/authorizations,
  then the physician would have to

Resources/Contact Information

- AAPA Web site: www.aapa.org
  Click on Advocacy, then click on Reimbursement
- E-mail: michael@aapa.org

QUESTIONS?