Hiring a Physicians’ Assistant or Nurse Practitioner?
What You Need to Know
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Executive Summary
- Provider Demand in Future
- What can a PA do?
- What can’t (shouldn’t) a PA do?
- “Incident-to” and “shared visit” billing
- Payment considerations
- Regulatory and other issues
- What about Nurse Practitioners?

Demand: The Short Story
- Eye care needs WILL increase as population ages
  - AMD
  - Cataract
  - Glaucoma
  - Diabetes
- PPACA increases number of insured
- New technology may actually create more care
  - Lucentis, Avastin, Eylea, Iluvien
  - OCT
  - Ophthalmic lasers

Ophthalmologist Trends
Source: DHHS Physician Supply and Demand Projections to 2020

US Population Growth
Physician Supply Projections

- Growth and aging of US population will cause a surge in demand for physician services
- Requirements for physicians will increase 21% – 22% from 2005 to 2020
- Requirements for ophthalmologists will increase 28% from 2005 to 2020

Source: DHHS Physician Supply and Demand Projections to 2020
http://bhpr.hrsa.gov/healthworkforce/reports/physiciansupplydemand/

What’s a PA?

- Just “Physician extenders” like techs?
  - NO - they are more!
- Licensed by the states
  - Actual scope of practice varies
- 86,700 PA’s in US
  - > 10K each in ER and Orthopedics (about 1 PA: 3 MD)
  - Much faster than average growth in jobs expected
- PA’s are part of a team, they “play well with others”

Source: American Academy of Physician Assistants (AAPA)

Physician Assistant

- 56% employed by multi specialty or solo physicians
- 37% primary care
- 64% female
- 80% salaried
- 41% include productivity or performance incentives

Source: 2008 AAPA Physician Assistant Census Report

“Six Key Elements” (Ideal) State PA Practice Acts

- "Licensure" as the regulatory term
- Full prescriptive authority
- Scope of practice determined at the practice level
- Adaptable supervision requirements
- Chart co-signature requirements determined at the practice
- # of PAs supervised determined at the practice level

1American Academy of Physician Assistants (AAPA)
https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=628

Physician Assistants in Eye Care

- Potential Eye Care Uses
  - Initial emergencies
  - Assistant surgeon (e.g., oculoplastic, etc.)
  - Minor procedures (e.g., IV injections, chalazions)
  - Intravenous injections (e.g., IVFA)
  - Chronic disease management
    - (e.g., diabetes, “interim” glaucoma checks)
  - Pre-op history and physical, Some post-op care
  - Orthoptist
  - Weekend call, triage, education
- Not generally regarded as competitive threat
PA Salary and Training

- Salary varies, but 2012 Median was $90,930/yr
- Education/Training:
  - Most common educational credential is Masters’
  - There are ~187 PA programs, average length 27 months
  - Average > 3500 hrs in direct patient contact
  - Pass a National exam
  - No “concentrated” classroom training on just eyes
  - Rarely are there mandated eye-specific clinical rotations except as electives

Source: Bureau of Labor Statistics, 2012 data (most recent)
American Academy of Physician Assistants

Training PA’s in Eye Care

- Variety of options
  - Consider “growing your own” (sending techs to PA school)
  - Expose PA students to ophthalmology
    - Volunteer as clinical rotation site
    - Offer to lecture at PA programs
  - Hire initially for H & P (part-time at first?), expand use
  - Does your subspecialty lend itself to surgical PA use?
    - Oculoplastics
    - Retina

Supervision of PA’s

- Supervising Provider determines limitations (Ideal)
- States generally limit how many PA’s can be supervised @ one time
- Chart co-signature (“countersignature”)
  - Some state laws have rigid requirements
  - Others allow supervising provider to decide

Source:

History and Physical Documentation

- Chart should show:
  - Reason for exam is to reassess the chronic condition in light of planned surgery
  - Use an Established Pt E/M code
  - “Comprehensive” level of service is unlikely
    - Outpatient EYE surgery is contemplated
    - If PA employed by CAH, use modifier GF
  - When PA is part of your group, bill under PA’s NPI and group TIN
    - Payment is to the group TIN

Other services by PA?

- NPP services generally payable when:
  - Services would be considered physician services
    - As defined by Payer
  - Performed by NPP
  - No other exclusion from coverage
  - Under supervision of physician
    - Watch state supervision rules
  - State PA laws allow the service

Source: AAPA, 2015
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 of the patient’s condition.

"Incident to" Services

"Incident to a physician’s professional services means that the services or supplies are furnished as an integral although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness."

"Incident to" Services

- Direct supervision
  - Physician is physically on-site when NPP care delivered
  - PA sees established patients
  - MD initiated course of treatment
  - MD continues to be involved in patient’s care
  - Claim filed under supervising physician
  - Reimbursement is at 100% of MPFS
    - HIGH SCRUTINY by MACs, OIG, Private payers

"Split/Shared" Service

- “... When an E/M service is a shared/split encounter between a physician and a [NPP] … the service is considered to have been performed “incident to” if the requirements for “incident to” are met and the patient is an established patient. If “incident to” requirements are not met … the service must be billed under the NPP’s [NPI] … payment will be made at the appropriate physician fee schedule payment.”
  - Do not apply to consultations (99241-99255), critical care (99291-99292), or procedures.

Non- “Incident to” Services

- General supervision
- Claim filed under PA (or NP) including PA/NP NPI #
- Must accept assignment
- Reimbursement is at 85% of MPFS (Physician rate)
- If the PA is functioning as assistant surgeon
  - If case qualifies for “Assistant” under MPFS indicator
  - Case is documented as medically necessary for assistant
  - Payment is 85% of 16% of MPFS
Credentialing

• TRICARE / Prime / Extra
  • Supervising physician must be a TRICARE provider

• Private payers
  • Not all separately credential PA’s (but most do)
  • May require billing under the supervising MD’s NPI
    • Watch this – still must meet “incident-to”
  • Coverage may vary by individual plan, service, & state

• Medicaid
  • Coverage for PA’s available in all 50 states
  • A minority of states do PA billing under the MD’s NPI
  • Some states have a “PA modifier”

Source: AAPA. Reimbursement Issues: Third-Party Reimbursement

Other concerns

• Supervision of Diagnostic Testing
  • Non-physician practitioners (incl. PA) cannot supervise diagnostic testing
  • PA’s can perform and be paid themselves for testing they do themselves
    • At their (non-physician) rate for professional (-26)
    • Technical (TC) portion is always paid at 100%
    • Multiple test reductions on TC still apply
  • Actual provider or another physician (MD/OD) must be present to count for “direct” or “personal” supervision of technical personnel

Source: AAPA

Other concerns

• Scribes for PA’s or NP’s?
  • They have a license, so they CAN place orders in MU2 for CPOE
  • As to using scribes, this is a poor use of a billing provider
  • If the PA or NP were the scribe¹:
    • “Shared visit” rules need to be carefully watched
    • If Shared visit is not met, the visit would need to be billed under the PA’s NPI unless “incident to” is separately met

¹Source: Scribe documentation rules, many MACs

Nurse Practitioners

• Have an independent license
• Have a scope of practice (varies by state)
• MD role with NP varies by state
  • Liability of physician depends on role the MD
• NP’s can:
  • Diagnose, treat and prescribe
• Masters Degree or more plus certification
• Employer relationship not required

Nurse Practitioner Qualifications

• Registered professional nurse authorized by the respective State in which services are furnished
• Certified as a NP by a national certifying body.
• Possess a master’s degree in nursing*

Source: MBPM, Chap 15 § 200

*If applying for Medicare for first time on or after 1/1/2003

Nurse Practitioner Coverage

The services of a NP may be covered under Part B, if all of the following requirements are met:
• They are the type that are considered physician’s services if furnished by a doctor of medicine or osteopathy (MD/DO);
• They are performed by a person who meets NP qualifications,
• The NP is legally authorized to perform the services in the state in which they are performed; and
  • They are performed in collaboration with an MD/DO;
  • They are not otherwise precluded from coverage because of one of the statutory exclusions.

Source: MBPM, Chapter 15, §200
Summary

• Aging US population
• May not be enough providers to meet demand
• Team-based approaches coming to the fore
• PA (as NPP) is one option to help
  • A number of regulatory issues
  • PA’s likely need some training in eye care
  • State laws, Scope of Practice
  • “Incident-to”
• NP’s are another (very good) option

Additional Assistance

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