Learning Objectives

- Compare and contrast productivity and value
- Describe the relative value unit (RVU) and how it is used to measure productivity
- Identify situations where the value of the APRN and the PA may be hidden
- Apply knowledge of billing toward playing an active role in the practice's business operations
- Implement strategies to demonstrate one's value to the practice
Outline

- Productivity vs. value
- Core measures of productivity
- Core measures of value
- The unique value that APRNs and PAs can provide in oncology
- Medicare and documentation issues that influence reimbursement
- Physician involvement in care

Increasing DEMAND

- Demand for cancer care visits will grow by 48% by 2020
- Number of Americans 65 and older will double by 2030
- It is estimated that there will be more than 19 million cancer survivors in the next 10 years
- Health-care reform will bring additional consumers/patients into the market

We Are NEEDED

- PAs and APRNs are recognized members of the oncology team and continue to play a larger role in cancer care
- The increased hiring and rising salaries demonstrate our crucial role
- Physicians embrace the roles of PAs and APRNs as part of the oncology team
Some REALITY

- Still need more clarity to the roles and value of the advanced practitioner (AP) in oncology
- Terms such as return on investment, productivity, and value proposition may appear too business-like in a specialty where compassion is key, but it still matters
- All health-care entities must be sensitive to cost and how to create greater economic efficiencies

Changing Health-Care Landscape

- The line separating payers from insurers is blurred
- The employment of healthcare professionals by hospitals and health-care systems is growing
- Nontraditional companies are interested in entering the health-care space (e.g., Walmart)

Has there been a change in the way you provide care and do business in the health-care system in the past 5 years?

A. No change: I still practice the same way
B. Little change: a few changes in my practice
C. Moderate change: a number of changes in my practice
D. Large change: my practice is almost completely different
Declining Solo Physician Practices

- Hospitals are buying and merging
- Small physician group practices in urban markets are selling or engaging in contractual relationships with health-care systems
- Hospitals have seen a 32% increase in physician employment over past 10 years

Reimbursement Has Refocused

- Bundled or episodic payments
- Value-based purchasing
- Readmission reduction
- Risk plays a key role
- Outcomes are as important as interventions
- These realities for coordinated care are tailor made for APs

Productivity & Value

- Productivity: Measure of financial/work product contribution (individual or group)
  - Clinical services
  - Billing data
  - Professional activity
  - Intensity of work
- Value: Measure of the perceived benefit despite cost
  - Quality
  - Efficient use of resources
  - Patient satisfaction
  - Nonbillable services that are crucial to patient care/the practice
Common Measures for “Productivity”

- Patient volume
- Gross billing
- Net billing
- Relative value units (RVUs)

Definitions

- **Cost center:** A business unit/employee that generates a cost or expenditure through work efforts
- **Revenue center:** A business unit/employee that generates income through work efforts
- **Gross billing:** The total amount billed to payers for all of the work done by a provider prior to any deductions or discounts
- **Incident to:** Patient care by APRN/PA that follows the plan of care created by MD without deviation; CMS allows billing APRN/PA at the same rate as MD if criteria are met

Definitions (cont)

- **Net revenue:** The final amount received from Gross Billing once deductions and discounts are applied
- **Patient volume:** The number of patients seen in any given unit of time by individual providers or by the practice without regard to type of care or complexity of care
- **RVU:** A numerical unit in health care that tries to standardize the amount of work required to provide a specific task
- **Shared visit:** A patient encounter in which MD and AP share the responsibility for care
  - Both provide unique work efforts and document
  - CMS allows MD and AP work to be combined into 1 charge
Why Track Productivity?

- Method to compare clinicians to their peers
- Is AP a “cost center” or “revenue center”?
- Helps determine when additional clinical staff is needed
- Aids in determinations of compensation

Does your practice track your productivity?

A. I have no idea
B. Maybe, but I am not engaged in that
C. Yes, but I don’t have any required level of productivity
D. Yes, and I am required to meet certain goals
E. Yes, I have goals, I am engaged, and my compensation is impacted by my productivity

Shortcomings of “Productivity” Measures

- You can only treat the patients assigned to you
- Shared patient encounters with physicians are difficult to track and assign a value
- Data are only as good as the system used to collect information and analyze it
- AP activity can be hidden and hard to assign a numerical value
Why Do CPT Codes Matter?

- Every clinical activity has a CPT code
- CPT codes help determine billing
- Every CPT code has a fixed RVU = how your “work” gets measured
  - Time it takes to perform the service
  - Technical skill to perform the service
  - Mental effort and judgment
  - Liability risk of treatment

Why Do CPT Codes Matter?

For any given clinical activity there is an RVU that is created by combining 3 factors:

Demystifying the RVU

- Work effort
  - Time
  - Skill
  - Expertise
  - Intensity
- Practice expense
  - Rent
  - Supplies
  - Staff
  - Equipment
- Malpractice expense
  - Professional liability insurance

Example of CPT & RVU

- Hypertensive patient comes in for a routine visit with no new problems
  - CPT Code = 99213 (office visit, established patient)
  - RVU = 0.97
- Practice sums your RVUs each month to measure your “productivity”
Important to Remember About RVUs

- One factor to determine compensation (bonuses)
- Work is the same no matter who provides the care
- RVUs are standardized, not based on the provider type

Global Period for Surgical Services

- **Pre-Operative**
  - Activity
    - Prep
    - Scheduling
  - RVU
    - The RVU for this care is 0
  - Charges
    - All of the costs for the surgical procedure is included in the surgical payment
  - Time Period
    - The day of surgery

- **Surgery**
  - Activity
    - All of the surgical services are included in the surgical procedure
  - RVU
    - The RVU for this care is 0
  - Charges
    - All of the charges for the surgical procedure are included in the surgical payment
  - Time Period
    - The day of surgery

- **Post-Operative**
  - Activity
    - Post-operative management and supervision
  - RVU
    - The RVU for this care is 0
  - Charges
    - All of the post-operative management is included in the surgical payment
  - Time Period
    - The days after the day of surgery depending on the type of surgical procedure

RVU Pitfalls

- Global visits related to surgery have “0” RVUs
- Shared visits and “incident-to” are billed under the physician (you are hidden)
- Some payers do not enroll APs, and the claim is billed under the physician (you are hidden)
- In capitated systems your patient panel size may be more relevant than RVUs
Medicare
- Enrolls APRNs and PAs
- Claims for services are submitted under the AP’s NPI and reimbursed at 85% of the physician fee schedule
- Claims for shared visits and “incident-to” are billed under the physician’s NPI and reimbursed at 100% of the physician fee schedule (you are INVISIBLE on the claim)

Medicaid
- Enrollment of APRNs and PAs varies by states
- Reimbursement of APRNs and PAs varies by states
- If the APRN or PA is not enrolled in that state, then claims are filed under the physician’s NPI (you are INVISIBLE on the claim)

Value Added Activity
- A great deal of work related to patient care is not measured, listed as a CPT or counted in RVUs
- APRNs and PAs provide large amounts of work that are not counted toward “Productivity” but are crucial to patient care

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Value Added Activity

- Administrative projects
- Chemotherapy teaching
- Clarification of orders for pharmacy/hospital staff
- Clinical research
- Coordination of care
- Dietary counseling
- FMLA, disability, insurance, paperwork
- Global visits for preoperative and postoperative care
- Hospital rounds/notes/discharge summary
- Patient education
- Symptom management via telephone
- Triage

APRN and PA Contributions

- Increase access to the practice
- Decrease patient wait times for appointments
- In surgical practices, can provide the global visits thus freeing physicians to see new patients and consults
- Facilitate communication with patients
- Coordination of care with hospitals, other providers, and office staff
- All care and clinical activity provided by an APRN or PA would have to be done by a physician

Does your employer recognize your value beyond RVUs?

A. I have no idea
B. They only care about RVUs
C. Somewhat; they recognize activity that is important but not billable
D. Yes, it is clear that there is a great deal of value in both billable and nonbillable activity
Documentation: Why It Matters

- Communication with other health-care professionals
- Creates a history of the management and progress of the patient
- Enables quality review programs
- Protection against liability and support reimbursement claims made to payers

Documentation Suggestions

- Be brief: This is not creative writing
- Be clear: Why is the patient here?
- Be precise: Describe the details that support your diagnosis and treatment plan
- EHR
  - Be cautious of cloned records
  - Be cautious of cutting and pasting
  - Can promote efficiency

Documentation Realities

- Old rule: “If it isn’t written in the chart, it didn’t happen”
- New rule: “Even if written in the chart, will not be reimbursed if not medically necessary”
Shift to ICD-10

- ICD-9 ~13,000 code sets vs. ICD-10 ~68,000 code sets
- ICD-10 in 2015?
- Specificity
  - Laterality: Left, right, anatomical pairs
  - Anatomy: Upper outer breast, transverse colon
  - Episode of care: Initial, subsequent, sequelae
  - Etiology: Pneumonia due to *E. coli*
  - Acuity: Chronic, acute, severe

Hospital Billing: Part A and Part B

- Medicare requires that medical and surgical services delivered by hospital-employed MDs, APRNs, and PAs be billed under Medicare Part B (exception for administrative responsibilities)
- In the past, Medicare allowed hospital-employed AP salaries to be covered under Part A through the hospital’s cost reports. That has changed.

Medicare Hospital Billing

- Whether employed by the hospital or not, APs are covered by Medicare
- No need for on-site physician presence under Medicare; electronic communication meets supervision requirements (hospital by-laws/policies and state law must be followed)
Shared Visits

- Can "combine" services provided in a hospital by the AP and MD to same patient on same day
- Requires that the MD provide a face-to-face portion of the E/M service to the patient
- Applies to evaluation and management services, not procedures or critical care
- AP and physician must be employed by the same entity

Required Documentation for Shared Visit

- Clear note (can be brief) detailing the physician's professional service
- Need a clear distinction between the AP's work and the physician's work
- The physician needs to document something besides "seen and agreed"

What the Heck Is “Incident to”?*

- Often misunderstood, can lead to fraud allegations
- Service performed by the AP in an office or clinic can be billed under the MD at 100% reimbursement
- Not used in hospitals or nursing homes unless service is delivered in a private physician office
- Terms and rules may have a different meaning when used by private payers
"Incident to" Billing

- Requires that the physician personally treat the patient for a particular medical condition and provide the diagnosis and treatment plan
- APs may provide subsequent (follow-up) care for same condition without the personal involvement of the physician
- Any MD in practice group must be physically present in the suite of offices when the AP delivers care

How is your work billed?

A. I have no idea
B. I bill everything under my own NPI
C. I bill everything "incident to"
D. I bill everything as a shared visit
E. I have a combination of billing depending on physician involvement or location of care

"Incident to" Billing: New Problems

- Not for new problems or conditions
  - AP has option to treat and bill at 85%
- Can AP treat patient on first visit, have MD see patient second visit to establish "incident to" billing? NO!
- Can AP order test, have patient return when results are available for MD treatment (initial visit)? YES!
Physician Involvement and Billing

- Physician greeting the patient, sticking their head in the room, co-signing chart, or discussing the patient’s care in the hallway does not allow 100% billing under the physician
- Physician needs to actually see the patient, evaluate the patient, and document what they did

Regulatory Policies/Entities That Impact Practice

- Medicare Conditions of Participation
- Joint Commission
- State Scope of Practice Statutes
- Statutes outside of AP practice statutes (insurance, radiography, behavioral health)
- State Medicaid Policy
- State Workers’ Compensation plan policies

Generally, Medicare Does Not Require Chart Co-Signature

- Exception: Discharge summaries from hospital, outpatient surgery, or the ED not admitted
  - APs may perform, but MD co-signature required (time frame not specified, see state law)
- Physician countersignature no longer required by Medicare on H&Ps (admit or preop) as of February 2008
Teaching Hospitals

- Billing restrictions only to surgical first assist
  - AP billing for first assist; restrictions only for hospitals with approved, accredited surgical specialty program
  - Billing modifier must indicate trainee was not available
- APs can bill Medicare; other payers, MD residents cannot

A Word About Compensation

- You need a copy of the “productivity” reports
- Negotiate a fair base salary
- Production “bonus” is an incentive to work harder
- Be cautious about purely production-based compensation (your work can be hidden)
- All AP services should be attributed to them
- Remember that value added activity counts

Action List

- Take an active role in practice business operations
- Get to know the coders and office managers
- Seek feedback on ways to improve your clinical documentation to support your billing
- Politics plays a role in productivity measurement and compensation
- Discuss your role and advocate for your contribution to the practice
Action List (cont)

- Demonstrate your value by sharing call schedules, hospital duties, and coverage for time off
- Ask to see the monthly productivity reports and be prepared to discuss them
- Keep a log of all the non-billable, non-RVU-generating work you do that brings value
- Ask the practice to review physician productivity before you joined the practice and compare it to after you joined the practice

Conclusion

- Understand the language of productivity
  - CPTs, RVUs, charges, revenue
- Understand the politics of productivity
  - Whose work is being measured, and why?
- Know the law, rules, and regulations
  - What is required, and how do I comply?
- Clearly identify what you bring to the table
- Your work increases revenue and value for the practice