Getting Paid for Mid-level Services

Chapter FastFACTS

1. All mid-level services are covered by both public and private third-party payers, but reimbursement rates may vary.

2. It’s important to confirm payment schedules with all payers to avoid audits.

3. Rates for visits to mid-level practitioners are sometimes reimbursed at a lower rate than physician visits.

4. An “incident to” visit is billed at the same rate as a physician visit.

5. The value of adding mid-level practitioners to your practice will likely increase given new models of reimbursement such as ACOs.

Whether mid-level practitioners will pay for themselves or even make money for your practice depends not only on how productive they are, but also on how your payers reimburse for mid-level services. Because reimbursement policies vary among payers and sometimes include differing billing requirements for PAs and NPs, it’s difficult to generalize. It's vital to check each payer's policy individually. “The consequences can be dire if you do it wrong,” Ms. Rathfon says. The last thing a practice wants is to spark an audit because of failure to master the details for billing a new service.

Ms. Capko notes that you should check on reimbursement policies before making a salary offer to a mid-level practitioner.
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to make sure the numbers will work for your practice. (See “What to Ask Your Payers.”) An accountant who specializes in healthcare can help you navigate the often-complex analysis, she says. This process works best if you’ve already thought about the volume of patients you expect the new mid-level practitioner to see each week, what types of patients he or she will see most often, and to what extent you or another physician in your practice will need to be on the premises to supervise.

All mid-level services will be covered by both public and private third-party payers, says Michael Powe, the AAPA’s vice president of reimbursement and professional advocacy. The question is whether those services are reimbursed at the same level as physician-provided services, or at a discount. Mr. Powe estimates that about 40% of payers offer discounted reimbursement for mid-level services. Payers may have differing requirements; for example, one may require specific circumstances under which the physician needs to review and sign off on the mid-level practitioner’s documentation, while another does not.

“Incident to” Services

Medicare and many other payers draw a distinction between services that are billed by a mid-level practitioner working independently and those billed “incident to” a physician visit. Independent visits—that is, those made to a mid-level practitioner but not to a physician—are reimbursed at a lower rate, often 85% of the normal rate for a physician visit. “Incident to” visits are billed at the same rate as a physician visit. If a physician is on the premises when the mid-level practitioner sees the patient, and is available for consulting, the physician may not actually have to see the patient for the visit to be billed “incident to,” although the physician may need to document the visit and the treatment plan, rather than having the mid-level practitioner do so. (See “Medicare’s Reimbursement for Mid-level Services” for more details on how Medicare defines “incident to.”)

Aetna, for example, changed its policy last year to conform to Medicare’s, and now pays mid-level practitioner visits at 85% of the contracted physician rates for covered professional services. Your practice will need to list the mid-level practitioner’s name in the servicing provider field when you submit claims for services
rendered by a mid-level practitioner. You may also bill mid-level services on an “incident-to” basis at 100% of the physician rate. Not all payers allow “incident-to” billing. For example, Blue Cross/Blue Shield of Rhode Island requires all mid-level practitioners to bill under their own provider number, and pays them a percentage of the physician’s rate as specified in its contract with the physician. Ask each of your payers about its “incident-to” rules when you ask how to bill for mid-level services.

In cases where the payer will grant 100% of your usual reimbursement for mid-level services billed as “incident to,” would
you ever want to bill that payer any other way? There are reasons you might, consultants say. “When my clients were first hiring mid-level [practitioners], they all billed ‘incident to,’” says consultant Mr. Hunt. “Then they saw they could be more effective if they got them credentialed with their own [national provider identification] numbers.”

Here’s why. Even though practices were taking a 15% hit (or sometimes more, depending on payer and contract) on each visit,

**Medicare’s Reimbursement for Mid-level Services**

While you must check with each of your payers about specifics for handling credentialing and billing for mid-level providers, many payers are likely to follow Medicare’s broad outlines. Here’s a partial list:

**For both PAs and NPs:**
- Services or supplies must be medically reasonable and necessary.
- Services are the type considered physician’s services if furnished by an MD or a DO.
- Services are not otherwise precluded due to a statutory exclusion.
- The NP or PA is legally authorized and qualified to furnish the services in the state where they are performed.

“Incident-to” services and supplies may be covered under the following circumstances:
- Must be an integral part of the patient’s normal course of treatment during which the physician has personally performed an initial service and remains actively involved in the course of treatment;
- Are commonly furnished without charge (i.e., included in the physician’s bill);
- Are an expense to the physician;
- Are commonly furnished in the physician’s office or clinic; and
- Must occur when the physician provides direct supervision—he or she is present in the office suite and immediately available if needed.

**For NPs only:**
- Services are performed in collaboration with a physician.
- An NP may be selected as a hospice beneficiary’s attending physician, but he or she cannot certify or recertify a terminal illness with a prognosis of six months or less.
Mr. Hunt says they found it simpler not to have to worry about whether a physician was physically present in the office for all the mid-level practitioner’s appointments. They also had more flexibility about where to use mid-level services: For example, some sent their mid-level practitioners to conduct hospital rounds, checking on patients and their treatments. Many payers, including Medicare, don’t allow “incident-to” billing of mid-level services for new patients or new treatment plans, but only

- An NP may bill the Medicare program either directly for services, using his or her NPI, or under an employer’s or contractor’s NPI.
- Claims for “incident-to” services must be submitted under the supervising physician’s NPI and identified on provider file by specialty code 50.
- Services are paid at 85% of Medicare’s physician fee schedule amount.

For PAs only:
- Services are performed by an individual who meets all of the PA qualifications.
- Services are performed under the general supervision of an MD or DO.
- The physician supervisor or designee need not be physically present when a service is being furnished unless state law or regulations require otherwise.
- The PA’s employer or contractor must bill under the PA’s NPI or may bill under a physician’s NPI if the physician in the group practice/employer has performed a visit that assesses the patient and establishes a plan of care.
- Claims for “incident-to” services must be submitted under the supervising physician’s NPI.
- The PA must be identified on provider file by specialty code 97.
- Payment may be made only to the PA’s employer or contractor.
- Services are paid at 80% of the lesser of these: the actual charge or 85% of the physician fee schedule amount.

Source: Medicare Information for Advanced Practice Nurses and Physician Assistants, published September 2010 by Centers for Medicare and Medicaid Services.
for seeing established patients with previously diagnosed problems. When Mr. Hunt’s clients examined all the ways they wanted to use mid-level practitioners, they decided that they were asking too much of their billing offices to ensure all “incident-to” rules were followed every time. Instead, mid-level practitioners bill their services under their own provider number.

“The optimal situation is to bill ‘incident to,’ because you make more money, but some money is better than no money,” says consultant Ms. Schechter. “If the physician isn’t in the office, but the nurse practitioner can see the patient for a follow-up visit and bill under her own number, the practice will make more.” When it comes to coding, don’t worry. Because mid-level practitioners provide (up to the limits of their licenses) the same services as physicians, they use the same procedure codes, Mr. Zetter says.

**Group Visits**

Because PAs and NPs are specifically trained to work closely with patients needing ongoing care, a practice can use them to expand its services to include group visits (sometimes called “shared medical appointments”), particularly for patients with diabetes, asthma, and other conditions that require patients to perform self-care and monitoring. The AAFP suggests group visits for the following categories of patients:

- Patients needing routine follow-up care
- Stable, chronically ill patients requiring total mind/body care
- Patients requiring more time with their physician
- Patients coming for frequent return visits

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Michael Powe
Vice President
Reimbursement and Professional Advocacy
American Academy of Physician Assistants

www.doctorsdigest.net
Patients presenting with extensive emotional, informational, or psychosocial needs

Patients presenting with concerns about their health, even without an immediate illness (the so-called “worried well”)

Group visits are not classes, but they include some component of personalized care. The AAFP has identified the following common formats:

- The cooperative healthcare clinic (CHCC), created for older patients requiring frequent, broad-spectrum care
- The disease-specific CHCC, a diagnostically exclusive group that aids patients with chronic disease management
- The drop-in group medical appointment, intended for established patients needing a more comprehensive approach to their follow-up care

The AAFP says group visits/shared medical appointments should include individual evaluation and management of each patient as well as counseling with the group as a whole, and thus should be billed using CPT codes for applicable evaluation and management (E/M) services. It’s essential to check with each of your payers on how such visits should be coded and billed, as there is wide variation.

Reimbursement in Team Practice

New models of reimbursement, such as the PCMH or ACOs, may increase the economic potential of adding mid-level practitioners to your practice. While the new models vary in their details, they are generally designed to reward value rather than volume of services provided; and they often share any savings between provider and payer. In that context, says Mr. Powe, the value of mid-level practitioners can only increase. “As organizations find ways to become more efficient and share risk along with the payers, it’s even more important to find efficiency,” he says. “PAs can provide that cost efficiency because they can provide so many services that a physician can provide, but at maybe half the salary.”