Dollars and Sense: Calculating PA Productivity
MAPA 2012

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Disclaimer

• This presentation was current at the time it was submitted. It does not represent payment or legal advice.
• Medicare policy changes frequently, so be sure to keep current by going to www.cms.gov.
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Definitions

- **Enrollment**: The process of adding a provider’s credentials to the system.
- **Credentialed**: The process of assessing and confirming (verifying) the qualifications of a health care practitioner. It includes collecting and verifying information about a practitioner (such as licensing, certification, and education), assessing and interpreting the information, and making decisions about the practitioner.
Payers and Enrollment: Medicare

- Medicare enrolls PAs.
- Claims for services provided by PAs can be submitted using the PA’s NPI. Reimbursement is at 85% of the physician fee schedule.
- Claims also can be submitted under the physician’s NPI under Medicare’s “Incident-to” and Shared Visit provisions. Reimbursement is at 100% of the physician fee schedule. However, PAs are invisible on the claim.
Payers and Enrollment:

**Medicaid**

- Medicaid enrolls or identifies the PA on the claim in **28 states**.

- The remaining states’ policy (including Michigan) is to submit claims under the physician’s NPI. The PA is not identified on the claim and therefore is **invisible**.
Payers and Enrollment:

Private/Commercial Payers

• Private payers may promulgate their own rules.
• Many choose not to enroll PAs.
• Many instruct the practice to bill under the physician’s number.
• The PA, when not enrolled, is not identified on the claim/ invisible.
Direct Billing

• Medicare does not allow PAs to direct bill.
• Many states have laws prohibiting direct billing.
• While the claim/rendering provider is submitted under the PA’s NPI, payment is to the PA’s employer.
• Remittance advice (the check) therefore is not directed toward the PA, but to the employer, potentially rendering the PA invisible on the accounts receivable/collections side of the balance sheet.
Accounting

- Charges - what the practice charges for the encounter
- Collections - what the practice receives from the payer
- Claims data (billing data) is readily available in the practice management software system since almost everyone submits claims electronically.
Practice Management Software

• CPT Codes generate charges.
• CPT codes are kept in practice management software.
• CPT codes have a fixed “relative value unit”, also known as an RVU.
• RVUs are standardized, widely available, and a method to evaluate productivity.
RVU=Relative Value Units

• Can be found in the Physician Fee Schedule

• Three components:
  – Work
  – Practice expense (PE)
  – Malpractice
Office/Outpatient Visit: New Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>0.48</td>
</tr>
<tr>
<td>99202</td>
<td>0.93</td>
</tr>
<tr>
<td>99203</td>
<td>1.42</td>
</tr>
<tr>
<td>99204</td>
<td>2.43</td>
</tr>
<tr>
<td>99205</td>
<td>3.17</td>
</tr>
</tbody>
</table>
Office/Outpatient Visit: Established Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>0.18</td>
</tr>
<tr>
<td>99212</td>
<td>0.48</td>
</tr>
<tr>
<td>99213</td>
<td>0.97</td>
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<tr>
<td>99214</td>
<td>1.50</td>
</tr>
<tr>
<td>99215</td>
<td>2.11</td>
</tr>
</tbody>
</table>
Tracking Work RVUs

- A common approach to physician compensation.
- Difficult to apply to PAs for many reasons, including shared visits, incident-to, and lack of enrollment in some plans/invisibility
- Work is the same-no matter who provides it-thus, is an equitable way of determining production.
Productivity Pitfalls

• 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.
• Surgery: Global Visits (surgery) have ZERO RVU's, and are not billable.
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.
Production and Compensation

- One **MUST NOT** agree to a purely production based compensation package unless all work performed by the PA is attributed to the PA.
- Ancillary services generated by the PA should also be attributed to the PA, if attributed to other providers.
- 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”.
- Base salary should be negotiated that is fair.
- Production “bonus” is incentive to work harder.
Surgery/Global Work

• While not separately payable, insist on tracking “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 2012 ©AMA
For Consideration

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

• Assigned a random RVU of 1 to post-op global visits (similar to work of 99213)
• Used the appropriate E+M code RVU for the pre-op H+P to account for the work performed.
• PA’s work then “valued” and added to production data.
Global Surgical Package-Medicare

<table>
<thead>
<tr>
<th>Work Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRAOPERATIVE WORK</td>
<td>69%</td>
</tr>
<tr>
<td>POSTOPERATIVE WORK</td>
<td>21%</td>
</tr>
<tr>
<td>PRE-OP WORK</td>
<td>10%</td>
</tr>
</tbody>
</table>

Averaged percentages. Spine series of codes weighted slightly differently.
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.
Surgical Productivity

Example:

27447 Total Knee (payable at $1,769*)

Pre-op: $371.49
Intra-op: $1,220.61
Post-op: $176.90

*Final figure impacted by geographic index
Surgical Productivity

• If PA does pre-op exam and post-op rounding and office visits, $548.39 could be “credited/allocated” to PA.

• Billing records would show $1,769 being allocated to the surgeon.

• Separate payment of $240.58 officially credited to PA for the first assist (13.6% of surgeon’s fee)
PA Value

True measure of PA “value” might be

- first assist payment of $240.58 +

- share of global payment $548.39

Total = $788.97 per TKR
Work RVUs

• Total Knee Work RVU = 23.25

• Apply the same formula
  Pre-10% = 2.32
  Post-21% = 4.89
  Total = 7.21 per TKR for pre and post-op work

• Then, if you first assisted:
  (philosophical discussion on which number to use)
  16% = 3.72
  13.6% = 3.16
Medicare: Incident-to

• Strict guidelines, physician on-site.
• Billing is under the physician’s number if all guidelines are met.
• Payment will be attributed to the physician
• Ask that the billing office attribute the encounter to the PA to track productivity and RVUs.
Medicare: Shared Visits

• A great way to maximize reimbursement and efficiency.
• The physician still has to provide face-to-face, but minimal work is required and combined with the work of the PA. There are strict documentation guidelines!
• Practice management software should track the work of the PA, although the claim will not reflect the work.
Another Consideration

• “Value” the work of the PA 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....)
Do you know what you generate?
So, how am I doing?

There are some common metrics that practices can track 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.
Medical Group Management Association

• **Physician Compensation and Production Survey: 2011 Report Based on 2010 Data**
  • Practice Managers provide the data.
  • PA and NP data included.
  • Note the “n” is very low for most NPP categories.
  • Some regions have little or no data
  • Practice administrators rely heavily on this data.
# Productivity—Ambulatory Encounters

<table>
<thead>
<tr>
<th>PA – Primary Care</th>
<th>2,666</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA – Ortho</td>
<td>1,578</td>
</tr>
<tr>
<td>PA – Surgical</td>
<td>443</td>
</tr>
</tbody>
</table>

Median

### Work RVUs

CMS RBRVS Method (Median)

<table>
<thead>
<tr>
<th></th>
<th>PA-Primary Care</th>
<th>PA-Ortho</th>
<th>PA-Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3,243</td>
<td>3,082</td>
<td>1,324</td>
</tr>
</tbody>
</table>

**Sources:** MGMA Physician Compensation and Production Survey: 2011 Report Based on 2010 Data
MGMA Data Compensation
Salary—Median Income

<table>
<thead>
<tr>
<th>Profession</th>
<th>Median Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA-Primary Care</td>
<td>$92,767</td>
</tr>
<tr>
<td>PA-Orth.</td>
<td>$101,457</td>
</tr>
<tr>
<td>PA-Surgical</td>
<td>$93,447</td>
</tr>
</tbody>
</table>

### AAPA Census/Salary Data:
Salary by Specialty in the United States: Median Income

*Source: AAPA 2010 Salary Report*

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Median Income</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care:</strong></td>
<td></td>
</tr>
<tr>
<td>• Family Medicine</td>
<td>$84,000</td>
</tr>
<tr>
<td>• Family Med w/ Urgent Care</td>
<td>$89,000</td>
</tr>
<tr>
<td>• General Internal Medicine</td>
<td>$85,000</td>
</tr>
<tr>
<td>• General Pediatrics</td>
<td>$80,000</td>
</tr>
<tr>
<td><strong>Emergency Medicine</strong></td>
<td>$101,000</td>
</tr>
<tr>
<td><strong>Hospital Medicine</strong></td>
<td>$91,000</td>
</tr>
<tr>
<td><strong>Surgery:</strong></td>
<td></td>
</tr>
<tr>
<td>• “Other”</td>
<td>$95,000</td>
</tr>
<tr>
<td>• Cardiovascular/Cardiothoracic</td>
<td>$115,500</td>
</tr>
<tr>
<td>• Orthopaedics</td>
<td>$96,000</td>
</tr>
<tr>
<td>• Urology</td>
<td>$90,000</td>
</tr>
</tbody>
</table>
To understand value, we also need to understand costs…

- Physical Plant- “keeping the lights on”, exam space, computer terminals, phones
- Support Staff-medical assistant, biller/coders, transcription staff, receptionist
- Malpractice expense
- Evaluation of PA Cost-Salary, benefits, CME, vacation/sick time, licenses and fees
- Sharing overhead? What does that entail?
Talking Points

• PAs increase access to the practice. Same Day availability is great PR and customer service. No reason for new patients to wait 6 weeks.

• PAs can provide global visits, freeing up the physicians to see new patients, consults, and surgical candidate visits.

• PAs can facilitate communications with patients, the hospital, the community, and with office staff.
Talking Points

If the PA didn’t perform these services-
• global visits
• hospital rounds/notes/discharge summaries
• patient phone calls,
• calls from the VNA/physical therapy
• pharmacy phone calls
• insurance paper work/authorizations,

then the physician would have to.
Talking Point

• By virtue of performing these tasks, many of which are not billable or reimbursable, the PA enables the physician to see more new patients and consults, and perform more procedures, thus increasing revenue opportunities for the physician and the practice. That translates to value.

• “Lifestyle enhancement”
Talking Points

PA work can contribute to and qualify for incentive payments:

– PQRS
– E-Prescribing
– Meaningful Use/EHR
– Primary Care Incentive Program
Take Home

• Claims Data not sufficient information to adequately assess PA productivity.
• PAs, physicians, and administrative staff must recognize that some billing rules render the PA “invisible”, or that the work and revenue is mis-attributed.
• PAs must be able to articulate these points to illustrate their “value” to the practice.