# **Notes from the AAPA STAR Network conference call – October 17, 2019**

# **THE PHYSICIAN FEE SCHEDULE PROPOSED RULE – AAPA Staff and John Bishop**

Medicare Proposes to Alter PA-Physician Relationship

* Medicare proposes to change its PA supervision policy to be in alignment with state law (collaboration, participating physician, …)
* What was formerly general supervision will, if finalized, defer to individual state law
* 22 states currently have language other than supervision to describe PA-physician relationship
* Parity with NP Medicare policy
* Culmination of a year-long advocacy effort by AAPA
* AAPA looking to adjust CMS proposed language that “In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA’s approach to working with physicians in furnishing their services.”
* AAPA suggested: “a PA should document at the practice the relationship that they have with physicians to deal with issues outside their scope of practice.”
* Mixed reactions from physician organizations

**PFS Hospice Section: Key Takeaways**

* CMS provided interpretation of what an attending physician does, and it’s more restrictive than previously thought
* CMS is modifying regulatory language to permit PAs who are attending physicians, and not employed by the hospice, to prescribe medications for hospice patients that are unrelated to the patient’s terminal illness
* As a result of conditions placed upon PAs for prescribing, PAs who work for a hospice cannot prescribe for hospice patients (physicians and NPs can) and cannot be selected to act in the role of an attending physician if the patient has not chosen one (physicians and NPs can).
* Statutory restrictions, such as certifying terminal illness and conducting the face-to-face encounter prior to recertification, continue

**PA Preceptors and PA Student Contribution**

* PA students’ work can be used in the medical record of PAs, NP and physicians for Medicare billing purposes similar to the work performed by medical students.
* PAs can be preceptors (not teaching physicians) similar to physicians and use the work of students in the medical record for billing purposes.
* Expanded ability to use the work of other health professionals in the medical record.

**New Proposed Documentation Changes**

* For new and established outpatient codes
	+ Maintain separate codes/payment rates for 99202-99215
	+ Elimination of level one new outpatient 99201
* # of elements of History and Exam no longer contribute to determination of code (medically appropriate documentation still needed)
* Coding based on level of Medical Decision Making or Total Time spent on encounter
* Time changing from F2F and counselling/coordination of care to total time spent on the day of encounter

<https://www.govinfo.gov/contnet/pkg/FR-2019-08-14/pdf/2019-16041.pdf>

**\*\*\*New Proposed Documentation Changes**

* Changes have not taken effect and not likely until January 1, 2021
* Only effects 99201-99215 (no change to inpatient or other codes)
* May require changes to EHRs, workflows, facility policies, etc.
* Commercial payers may/may not change documentation & coding policies

**Updates to the Quality Payment Program (QPP)**

* Measured increase in performance, data completeness and participation thresholds, as well as adjustments to category weights
* Continued participation flexibility for PAs and NPs under the promoting interoperability category
* A new way to participate in MIPS: MIPS Value Pathways (MVPs)

**Updates to the QPP: MVPs**

* Starting in 2021
* A health professional or group selects a pathway, structured around a specialty or condition, then submits unified administrative claims-based population health and care coordination measures + measures that reflect activities one would perform under the chosen specialty/condition
* Meant to increase comparability

**PATIENTS OVER PAPERWORK RFI – Trevor Simon**

**Patients Over Paperwork: CMS initiative to reduce policy barriers to efficient provision of care**

* **Regulatory Examples**
	+ State flexibility re: supervision, student documentation, LIP
	+ Hospice restriction
	+ Co-signature requirements at admission and discharge
	+ Supervision of diagnostic tests
* **Legislative Examples**
	+ “Incident to” billing
	+ Ordering DME under Medicaid
	+ Home Health
	+ Direct payment
	+ Ordering diabetic shoes

**PATIENTS OVER PAPERWORK CHANGES: LIP & PSYCHIATRIC HOSPITAL PROGRESS NOTES**

 **Sondra M. DePalma, DHSc, PA-C, DFAAPA**

* **Licensed Independent Practitioner (LIP)**
	+ An individual authorized to provide care and services without direction or supervision
	+ CMS changed term “Licensed Independent Practitioner” to “Licensed Practitioner”
	+ § 482.13(e)(5) “use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law”
* **For PAs to order restraint and seclusion as of December 2019, the following criteria must be met:**
	+ **Allowed by accreditation standards**
	+ **Consistent with hospital bylaws and policies**
	+ **Included as part of a PAs scope of practice, practice agreement and granted privileges**
	+ **Consistent with State laws and regulations.**
* **Psychiatric Hospital Progress Notes**
	+ CoP § 482.61 and CMS Manual required that progress notes be recorded by an allopathic or osteopathic doctor
	+ CMS is clarifying the scope of authority for non-physician practitioners to document progress notes of patients receiving services in psychiatric hospitals
	+ Social Security Act and CoP § 482.60 require that inpatient psychiatric services are provided under the supervision of a physician.

**HOSPITAL OPPS PROPOSED RULE** – Trevor Simon

* Efforts to increase price transparency
	+ CMS proposed requirements for posting gross and payer-specific costs for services online (one list of all services and one list of “shoppable” services
* Level of supervision for outpatient therapeutic services
	+ CMS proposed to change required level of supervision for hospital outpatient therapeutic services provided by hospitals and CAHs from “direct” to “general”
* No need to comment on site neutrality as struck down by courts

**MEETING WITH CMS – MICHAEL POWE**

* **AAPA Meets with CMS on “Incident to” billing**
	+ AAPA is working to increase PA recognition and ensure appropriate attribution of services delivered by PAs
	+ “Incident to” billing hides the PAs’ patient care productivity and impact under the physician
	+ September 20th CMS meeting was to talk about ways to identify PAs in the system (elimination of “incident to”, use of current Medicare 1500 claim form to capture PAs even when “incident to” billing occurs).
	+ Discussions will continue with CMS’ Office of Standards and Quality
* **Executive Order signed by the President on October 3rd**
	+ Asking HHS within one year to propose policies that would:
		- Eliminate Medicare burdensome regulations and licensure requirements that are more restrictive than state or federal requirements
		- Ensure appropriate reimbursement for the time health professionals spend with patients
		- Ensure that items and services provided by clinicians, including physicians, physician assistants, and nurse practitioners, are appropriately reimbursed in accordance with the work performed rather than the clinician’s occupation.