Maximizing Value Out of PA's and NP's in Surgery Practices

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Acknowledgements

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- I specifically wish to acknowledge all of her groundwork and continued work with AAPA and AAOS.

Practice Information

- I am a Physician Assistant, practicing in North Lake Tahoe. I have practiced for 15+ years, with experience in private practice and community and academic trauma centers.
- I am an employee of Tahoe Forest Hospital District in Truckee, California as a Physician Assistant in Orthopedics and clinical Director of Orthopedics and Sports Medicine.
- I have no conflicts to disclose for this topic.

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.
- Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with **the provider** of services.
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At the conclusion of this session the participant will be able to:

- Review what is a Physician Assistant, PA
- Ways you can use a PA in your practice.
- Employment models and PAs in Academic and Private practice.

What is a Physician Assistant?

- Physician Assistant profession started in 1965 at Duke University modeled on World War II accelerated physician training.
- Education averages 24-27 months of didactic and clinical training with the majority of programs offering a Masters degree.
- Physician Assistants work within a Physician led healthcare team.
- 110,000+ PAs are nationally certified and practice in 50 states plus the District of Columbia. 60+ PAs work in U.S. territories of Guam and the Commonwealth of the Northern Mariana Islands.
- Also PA Programs exist in Canada, Netherlands, South Africa, and Ghana.
- US PAs are licensed by states, nationally certified, re-certify every six years with 100 hours of CME minimum every two years to maintain certification. Certification is transitioning to re-certify every 10 years with similar 100 hours of CME but additional components of self-assessment (SA) and performance improvement (PI) CME's.

What are the best ways to use a PA in your practice?

- PAs practice medicine with supervision by physicians. As members of the healthcare team, PAs provide a broad range of medical services **that otherwise would be provided by physicians**. (Source: AAPA)
- "*PAs may furnish services billed under **all levels** of CPT evaluation and management codes, and diagnostic tests if furnished under the general supervision of a physician.*"

  http://www.cms.gov/manuals/Downloads/bp102c15.pdf
- NOT ALL payers enroll, but virtually all payers cover services provided by PAs. PAs can provide reimbursable services in your office or clinic, the emergency room, the operating room, and inpatient floor care. Insurers will reimburse differently but pay up to 100% of physician fees for PA services.

Office or Clinic Practice PAs

- Run urgent care/fresh fracture clinics
- Also can be the provider for Fragility Fracture Program- In/Outpatient
- Most efficient model:
  - PA has own clinic schedule and space with staff. PA sees patients on their own with a physician available for questions in person or electronically.
- Less efficient:
  - Shared patient visit with the PA and the doctor, for the majority of patient visits.
- Least Efficient (Truly Inefficient):
  - The doctor to sees every patient of the Physician Assistant.
- That said, in my experience PAs who meet patients throughout the whole process preoperatively/emergently, operatively, then follow up on the floor or in the clinic are much better accepted an integrated part of the patient's care team and have high patient satisfaction scores with lower liability.
- Recent Beckers Hospital Review Article
  - "Want higher HCAHPS scores? Physician assistants may be key"
    - http://www.beckershospitalreview.com/quality/want-higher-hcahps-scores-physician-assistants-may-be-key.html

Emergency Room Triage and Evaluation

- Reviewing studies, ordering appropriate additional studies, properly immobilizing, and ultimately filtering patients who need acute care, versus patients who can have delayed or urgent outpatient care, or just routine outpatient follow-up.
- Published review at my facility using Physician Assistants at a community surgeon staffed orthopedic trauma program.
  - Diminished times for patients in the emergency room by 3+ hours
  - Shortened time to the operating room by 6 hours
  - Diminished lengths of stays by ½ day
  - Improved core measures compliance

Impact of Hospital-Employed Physician Assistants on a Level II Community-Based Orthopaedic Trauma System:Althausen, Peter L.; Shannon, Steven; Owens, Brianne; Coll, Daniel; Cvitash, Michael; Lu, Minggen; O'Mara, T; Bray, T. J.:Journal of Orthopaedic Trauma. 27(4):e87-e91, April 2013.

Operating Room Utilization

- Physician Assistant retrieves and posts preoperative studies, reviews the operating room setup including appropriate imaging equipment and its position for the procedure.
- Physician assistant then assists with patient transfer, positioning for procedure, assist with prep, draping, intraoperative first assisting, wound closure, dressing, splinting, and removal of patient from operating room table while protecting surgical repair.

Inpatient Care By The Physician Assistant

- The inpatient abilities of the Physician Assistant are directly related to the hospital bylaws and facilitated or restricted by them.
- Postop orders by the PA. Follow patients and assures core measures, mobilization, and postop planning starting from the PACU. PAs also can play a large role of patient recovery expectations and understanding.
- PA will communicate with the floor nurse, physical therapy, occupational therapy, case coordination, and discharge planning. Early postop, the PA will be able to identify the needs for durable medical equipment, and discharge prescriptions.
- On discharge the PA can complete the orders, prescriptions, and discharge summary.

Post-Operative/Follow-up Care

- PA can see patients to assess postoperative wounds, refill prescriptions, complete work/school notifications, and order physical and occupational therapy.
- PA can again participate in patient education to facilitate the patient's understanding of the plan of care, normal postop recovery. And return work.
- Physician assistant can apply postoperative medical equipment and splints and charges as provider applied if indicated.
- Last, physician can still drop in and make patient contact if needed to satisfy patient, but physician time is more protected and efficient by the PA doing the majority of the visit. Track RVUs/quantification to PAs for Postop Visits as they free Surgeon to see new patients and the practice handles more patients and has shorter wait times for appointments.

Employment models. Physician Assistant privately or hospital employed?

- Many models around the country using PAs as house-staff, hospital employed but supervised by private or hospital employed physicians.
- There also models where the on call physician has their own PA and the hospital has an additional Hospital Employed PA to support the emergency and inpatient services.
- At my facility, physician assistants work with the on call Orthopaedic Panel Members. There are many models of funding positions privately or hospital employed.
- PA must **NOT** be included in the hospital Medicare A Cost report.
- Services provided by non-employee PAs, should not be billed for by private physicians. CMS has recently considered this Stark "incentivization" and successfully enforced their interpretation.
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Academic Settings

- PAs can and are being integrated into resident teams.
  https://www.acgme.org/acgmeweb/Portals/0/PDFs/DH_Definitions.pdf
- Teaching/Resident billing rules DO NOT apply to PAs; physician attestations are irrelevant to billing for PAs, except for the required attestation for first assistant billing when "no qualified resident" available.
- PAs must NOT be assigned as "resident" in the EMR. There are compliance and billing implications; teaching attending attestations should NOT be appended.
- No PA billing restrictions Outside OR- Clinic, ER, Floor, Procedures etc.

PAs can First Assist in the teaching hospital operating room and bill if:

- No qualified resident available: this can be because they are in required training sessions (Grand Rounds) or off-duty for sleep or required to be in clinic
- Physician NEVER uses the residents
- Trauma Surgery

PA/NP: Physician Salaries

- PAs/NPs are paid approximately 1/3rd to 1/4th the salary of their physician counterpart. (a broad generalization, but estimate supported by MGMA data.)
- This is about math.
- The **profit margin is higher** when the PA or NP provides the service, even at 85% reimbursement.

Take Home Points

- Calculating PA Productivity requires in-depth knowledge of billing and reimbursement policy and claims methodology for the various payers. Many resources exist.
- Many claims are submitted under the physician's identification number (NPI), rendering the PA's work invisible in the claims data from practice and payers.
- Unless a PA's work (production) and financial contribution can be fully attributed to the PA, a production based compensation formula is not calculable and should not be negotiated/used.

- For copies of of my lecture or for follow-up questions.
- Please send an email to danieljohncoll@gmail.com

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Thank you