Medicare payment policies for advanced practice registered nurses (APRNs) and physician assistants (PAs)

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Overview

- Background on advanced practice registered nurses (APRNs) and physician assistants (PAs)
- Billing trends
- Prevalence of “incident to” billing
- Potential policy options
- Discussion
Definition of APRNs and PAs

- **APRNs**
  - Four types of APRNs: nurse practitioners (NPs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs), and certified nurse midwives (CNMs)
  - Registered nurse and complete additional training (most commonly a master’s degree)
  - Licensed to practice in a state

- **PAs**
  - Graduate of a PA educational program (including clinical rotations)
  - Licensed to practice in a state
Scope of practice

- States determine the activities that APRNs and PAs can perform
- Supervision/collaboration requirements vary by state and category of APRN
- Overall, states have substantially increased the authority and/or independence of APRNs and PAs over time
Evidence of NP and PA cost and quality outcomes

- Conclusions based on review of existing literature, which has some limitations
- NPs/PAs appear to provide care comparable to physicians in terms of clinical quality and patient experience (for services they provide in common)
- NPs/PAs’ effects on costs and utilization:
  - Lower costs for the providers that employ them
  - Payer costs - literature is limited, mixed
    - Lower per-service payment rates (in some cases)
    - Referring/ordering patterns may be higher/lower
    - NP/PAs may alter downstream costs (e.g., hospitalizations)
APRN and PA specialties

- The specialty information on APRNs and PAs is limited and not uniform
- Point-in-time estimates
  - NPs: Around half work in primary care
  - PAs: 27 percent work in primary care
- Medicare classifies all NPs as one specialty and all PAs as one specialty
Medicare coverage and payment policies for APRNs and PAs

- **Coverage**
  - Medicare generally covers all medically necessary APRN and PA services provided in accordance with state law
  - Medicare imposes some restrictions on ordering/certifying certain services (e.g., home health)

- **Payment**
  - Bill under own NPI = 85% of fee schedule
  - Bill under physician NPI = 100% of fee schedule
    - Practice referred to as “incident to” billing

NPI: National Provider Identifier
Direct and “incident to” billing in Medicare

In the following circumstances, NPs must bill directly:
- Hospital settings
- New patients
- New problem for an existing patient

Billing type
- Billed directly
- Billed “incident to” physician services

Provider ID
- NP’s own ID
- Physician’s ID

Physician supervision?
- General collaboration (or state law)
- Direct supervision (physician present in suite)

Payment
- 85% of the fee schedule amount
- 100% of the fee schedule amount
Medicare FFS allowed charges for APRNs and PAs increased rapidly from 2010-2016

<table>
<thead>
<tr>
<th>Practitioner type</th>
<th>Total allowed charges billed, 2010 (in millions)</th>
<th>Total allowed charges billed, 2016 (in millions)</th>
<th>Percent growth, 2010-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse practitioner</td>
<td>$1,249</td>
<td>$3,217</td>
<td>158%</td>
</tr>
<tr>
<td>Physician assistant</td>
<td>916</td>
<td>2,001</td>
<td>118</td>
</tr>
<tr>
<td>Certified registered nurse anesthetist</td>
<td>869</td>
<td>1,162</td>
<td>34</td>
</tr>
<tr>
<td>Clinical nurse specialist</td>
<td>54</td>
<td>71</td>
<td>31</td>
</tr>
<tr>
<td>Certified nurse midwife</td>
<td>2</td>
<td>5</td>
<td>216</td>
</tr>
<tr>
<td>Total</td>
<td>3,090</td>
<td>6,456</td>
<td>109</td>
</tr>
</tbody>
</table>


Notes: Numbers rounded. Percentages based on unrounded numbers. Numbers exclude "incident to" billing.

Data are preliminary and subject to change
Number of E&M office visits billed by APRNs and PAs grew rapidly from 2010 to 2016

<table>
<thead>
<tr>
<th>Practitioner type</th>
<th>Number of visits, 2010 (in millions)</th>
<th>Number of visits, 2016 (in millions)</th>
<th>Percent change, 2010-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>APRN or PA</td>
<td>11</td>
<td>28</td>
<td>149%</td>
</tr>
<tr>
<td>Primary care physician</td>
<td>97</td>
<td>84</td>
<td>-13</td>
</tr>
<tr>
<td>Specialist</td>
<td>133</td>
<td>143</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>241</td>
<td>255</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: MedPAC analysis of the Physician/Supplier Procedure Summary file; HCPCS codes 99201-99205 and 99211-99215.

Note: The primary care physician category includes internal medicine, family medicine, pediatric medicine, and geriatric medicine. The specialist category is defined as not being a primary care physician, APRN, or PA. APRN/PA numbers exclude “incident to” billing.

Data are preliminary and subject to change
Prevalence of “incident to” billing by NPs and PAs

- “Incident to” billing obscures the number of services furnished by NPs and PAs
- Rapidly expanding supply of NPs and PAs suggests “incident to” rules could apply to increasing number of Medicare services
- Research on prevalence of “incident to” billing is limited
- We conducted analyses to estimate the share of E&M services billed “incident to”
### Share of E&M office visits billed by NPs in physician offices and HOPDs, 2016

<table>
<thead>
<tr>
<th></th>
<th>New patients</th>
<th>Established patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New patient: &quot;incident to&quot; billing</td>
<td>4%</td>
<td>14%</td>
</tr>
<tr>
<td>Established patient: &quot;incident to&quot; billing</td>
<td>not allowed</td>
<td>allowed in physician office, not in HOPDs</td>
</tr>
</tbody>
</table>

- **New patients**: 4% (Physician office) vs. 14% (HOPD)
- **Established patients**: Not allowed in HOPDs

**Source**: MedPAC analysis of Carrier SAF.

**Note**: Percentages displayed are weighted averages of HCPCS codes 99201-99205 (new patients) and 99211-99215 (established patients). HOPD (hospital outpatient department).

Data are preliminary and subject to change.
Prevalence of “incident to” billing by NPs and PAs

- We conclude that:
  - ~40 percent of E&M office visits NPs’ performed for established patients in physician offices likely billed “incident to” in 2016; and
  - ~30 percent of such visits performed by PAs’ likely billed “incident to” in 2016

- This means that ~5 percent of all E&M office visits billed by physicians were likely performed by an NP or PA in 2016
Policy option 1: Eliminate “incident to” billing for APRNs and PAs

- APRNs and PAs would be required to bill Medicare FFS under their own NPI

- Potential implications:
  - Reduce Medicare and beneficiary expenditures
  - Improve fee schedule valuations
  - Enhance program integrity
  - Improve comparisons of care furnished by physicians and APRNs/PAs
Policy option 2: Improving Medicare’s specialty designations for APRNs and PAs

- APRNs and PAs could be required to:
  - Indicate field of practice (e.g., primary care)
  - Update information regularly

- Policy would help Medicare identify primary care clinicians
Commission discussion

- Clarifying questions
- Requests for additional information or analyses
- Discussion of potential policy options
  - Eliminate “incident to” billing for APRNs and PAs
  - Improving Medicare’s specialty designations for APRNs and PAs