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Effective and Profitable Use and Deployment of Ancillary Personnel

I was once amazed to hear a speaker, at a national meeting, stand before the audience and pronounce that cardiologists should hire PAs to "smooth out their work day." They may not make you any money and they may be expensive, but they will allow you to pace your day, eat lunch and get out of the hospital to see your family. **No way.** Hire, train, and take full advantage of these well-trained professionals to see more patients, make more money, and, OK, eat lunch.

Clearly, the myriad of rules that control the billing for cardiology services are unquestionably convoluted. For which test must a physician be present? All of it or part of it? Must the physician sign the chart if supervising a PA? How does that mesh with PA Protocols? Should I use Advance Practice Nurses (APRNs) or Physician's Assistants (PAs) or is it all just too much trouble if a physician cannot be there to supervise them all of the time?

You are smart people, and the rules are not that hard. However, there are two separate issues here. One issue is *should* you delegate at all; if so, what are the financial implications? The second issue is what can you do under the Medical billing rules.

Many physicians who have made the effort both to employ and train and to bill properly for services of ancillary personnel will tell you that their efforts have been rewarded. By providing a greater scope of services, to patients, to say nothing of greater availability, physicians experience greater patient compliance and more satisfied patients, as well as significant financial compensation for their efforts.

In conclusion, be aware of the interplay of these rules to ensure that supervised testing by your practice is properly billed. Understanding the finer points may require you to send your billing supervisor to receive education or training in the area.

Incident To Versus Personally Performed

You have a choice of how you are going to deploy your highly trained personnel. You can, as many physicians do, bill for your PAs as ancillary to your supervision, or you can bill for their services in their own names. If you are billing "incident to," you bill as if the physician rendered the service, but then you must meet the criteria for this type of billing. As subsequently addressed, the main criteria is that the service rendered actually be "incident to." In turn, this means that the physician supervising the services be immediately (in person) available; that if he is called out of the office, you are out of luck, and you fail the supervision principles, thus meaning that you cannot bill for your PA services as "incident to" your supervision.

On the other hand, if you bill for your PAs' services in their own names, you only receive eighty-five percent (85%) of the physician fee schedule rates. Now, however, your PAs can function *independently* of the physician schedules, meaning that the PA can staff the office, and your physicians can come and go on their own schedules.

Consider the following example:

You run a busy practice. You know that new patients (consults) are the economic lifeblood (literally) of your practice. But, even with the number of physicians you have, at any point in time at least one is off on vacation, and one is off post-call, at least one is in each of the hospitals doing procedures, rounding or seeing consults, two are in each of the satellites, and one is in the main office. In their "spare" time, some are reading echoes, some nuclear tests, and so on. That leaves only a few physicians actually available to see post ops and follow-ups and also to see work-ins. Now imagine you could use a PA to see the patient follow ups or work-ins. There are the economics:

Physician Schedule	Hypothetical Payment	PA Schedule	Hypothetical Payment
10 FU	\$80	10 FU	\$68
Work-in NP	\$120		
	\$920		\$680

From a patient satisfaction sense, as long as you are following protocols, and you adequately train your PAs, this type of scheduling is economically advantageous. While the practice earns only 85% of the physician fee schedule amounts, it also pays its PAs substantially less than 85% of its physician rates. And while this physician can always see the new patient (in the office, or in the ER as you work him in) **the important objective is that the patient is seen.**

Effectively Deploying Your Ancillary Personnel

Think for a moment about the logistics here. As a cardiologist seeing either a new (consult) or established patient, you cannot, without some diagnostic tools, visualize the heart. You cannot know the patient's clinical profiles. You can, initially, do little more than check the heart rate and pulse, maybe do an EKG and of course use your experience and training. These are, however, all services that the internist (or other referring physician) already checked (given his or her knowledge base), when sending the patient to you for a consult in the first place. So the primary consult is usually to take a sufficiently adequate history to determine your course of action in treatment, assuming the patient warrants further care. Assuming there is some necessity to continue to treat the patient either to determine or confirm a suspected problem.

Your next step is to determine which diagnostic test will yield the most efficient information. That can likely be reduced to some protocol on how to proceed. To some practices the history taking and physical status are too important to delegate to a PA. In some practices, it is so hard to arrange new patient work-ins that a PA may have to see follow ups to allow the practicing physicians to see new patients in-office visits at all. Do you (or your hospital) run clinics? Are they not run largely by non-physicians following protocols, supervised by physicians?

Ideally, you would have enough PAs to work with specific physicians, so they could know and "follow" a limited number of patients with physician. By working with one physician, the PA knows how the physicians want them worked up, what to look for, and so on. They are then available not only to extend the physician but to contribute materially to the work load and economics of the practice. They can see follow ups, work ins and so on, to keep the physicians productive and functioning at their highest talent/production level – serving really sick patients, interpreting tests, etc. Also consider staffing your facility with a PA to keep the physicians moving and coordinated in their cases, admissions, consults, rounds and so on, though in the setting you will have to determine how you want to bill more carefully. This also allows someone to be available for the physicians to be available to the family, coordinate the patient movement from the labs to the floors to home.

Working efficiently with PAs requires collaboration protocols, and those protocols vary widely from state to state. These protocols vary significantly from some states mandating that PAs can do whatever a physician (reasonably) tells them to do, to detailed regulations that form their own protocol. A well thought-out plan, also - most importantly - requires mentoring, training, and a commitment to continuing education and collaboration. As with any collaborative process, all those involved must agree on the expectations and the performance parameters. While PAs are often very well trained, they are not an "out of the box" commodity, and only the physician practice medicine. Any ancillary must learn about your practice and how to function within it, with your help. *Properly deployed*, however, they are very profitable both financially and practically.

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