Giving Credit Where Credit Is Due: Compensation Issues Arising From Physician-APP Collaboration

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Introduction

To improve access to care, hospitals and health systems are increasing the number of advanced practice providers (APPs) in their employed physician practices.[1] Often referred to as "physician extenders," APPs allow physicians to increase panel size by handling more 'routine' patient visits. These collaborative physician-APP practice arrangements, however, may raise concerns if the physician is compensated using a productivity methodology, such as a set compensation per work relative value unit (wRVU).

Depending upon the billing methodology used, a portion of an APP's clinical productivity may be attributed to a physician due to third-party billing conventions and limitations in the practical ability to isolate APP services on a real-time, encounter-level basis. The leveraged APP model may create a regulatory concern as physicians may be compensated based on wRVUs for services personally performed by the APP through the billing process. In this scenario, what began as an attempt to reduce expenses (by paying for an APP rather than a physician to provide services) ends up subjecting the hospital to greater expense, often with little or no supplemental revenue. This financial model is perhaps unsustainable, and potentially commercially unreasonable. That a payer (such as Medicare) permits a provider to bill for services furnished in whole or in part by an APP as if those services were rendered by the physician does not mean those services are deemed personally performed by the physician for purposes of compliance with the Stark Law Employment Exception.[2] Here lies our challenge: under a physician productivity-based compensation model, how should one account for services furnished under a collaborative physician-APP practice arrangement?

While recent clarifications to the Stark Law have highlighted this issue, CMS has not provided a definitive solution. In the following sections, we discuss the types of services furnished under collaborative physician-APP practice arrangements and propose three possible methods to properly account for these services in physician productivity-based compensation models. It is important to note that:

- APP supervision requirements vary by state and the type of service being performed. Readers are encouraged to familiarize themselves with the specific requirements applicable to their practice environment.

[1] For purposes of this article, APPs include but are not limited to nurse practitioners and physician assistants who are qualified health care professionals providing direct patient care and treatment while working either independently under applicable state scope of practice requirements or under the close supervision of a physician.

[2] 42 U.S.C. § 411.352 (2011). We note this discussion does not apply to group practice physicians as defined by the Stark Law (42 C.F.R. § 411.352). Further, a qualified health care attorney should be consulted for purposes of determining compliance with the Stark Law and other applicable regulations.

- Each payer maintains its own rules regarding APP reimbursement, and one must be familiar with these rules prior to submitting claims.
- Hospitals and health systems have latitude to address this issue, provided a chosen approach is appropriate, intentional, and leads to physician compensation that is fair market value and commercially reasonable.
- Nothing contained herein is intended to provide a legal, fair market value, or commercial reasonableness opinion to the reader.

Services Furnished Under Physician-APP Collaborative Practice Arrangements

There are four distinct ways in which governmental and commercial payers reimburse for services furnished by APPs. For the sake of brevity, we discuss the Medicare billing rules applicable to each in the following sections.

Independent Billing

APPs may provide clinical services within their scope of practice independently, without any direct physician involvement. Claims for these services are submitted under the APP's National Provider Identifier (NPI).[3] Traditional Medicare pays 85% of the applicable Medicare Physician Fee Schedule rate for services billed under an APP's NPI. These APP services will typically appear in an entity's billing information system as billed and rendered by the APP, and as such, any related wRVU productivity is attributed to the APP.

Incident-to Services and Billing

Medicare rules permit a physician to bill for services furnished by another individual as an integral, although incidental, part of the physician's ongoing care of a patient. The applicable regulations limit 'incident to' billing to services furnished in a non-facility setting (i.e., not a hospital or skilled nursing facility) for an established patient for an existing condition and require the billing physician to provide direct supervision, i.e., to be physically present in the same suite of offices immediately available to provide assistance. [4]

Although provided by the APP, incident-to services are billed under the supervising physician's NPI and reimbursed as if that physician had provided the service. If the payer-specific requirements for billing incident-to services are not met, the services must be submitted using the APP's NPI and are reimbursed at a lower rate (e.g., 85% of the applicable Medicare Physician Fee Schedule rate).

Incident-to services typically appear in the entity's billing information system as being billed by the physician but rendered by the APP. Importantly, if a hospital uses "billed by" data instead of "rendered by" data to calculate a physician's total wRVUs, the APP's incident-to services may be attributed to the physician.

[3] Billing and provider credentialing requirements for third-party payers may vary.
[4] See 42 CFR 410.26.

Split-Shared Services and Billing

When evaluation and management (E/M) services are performed jointly by a physician and an APP, a split-shared visit occurs. The concept of split-shared billing is only permitted in the hospital (i.e., inpatient or outpatient) or emergency department setting.[5] Further, split-shared billing is not permitted for all services; only a subset of E/M services can be billed in this manner. For example, critical care and nursing facility E/M services, as well as procedural services, cannot be billed as split-shared and must be billed using the rendering provider's NPI.[6]

If the physician and APP are in the same practice or work for the same employer, the provider who performs the substantive portion of the E/M encounter (defined as one of three key components [history, exam, or medical decision making] or more than half of the total time spent performing the visit) submits the claim under their NPI.[7] For Medicare, split-shared services are reimbursed at either 100% (for the physician) or 85% (for the APP) of the applicable Medicare Physician Fee Schedule rate, depending on who is the billing provider.

Without a separate tracking mechanism within the entity's billing information system to apportion the allocation of work between the physician and APP, split-shared services will typically appear in the entity's billing information system as billed and rendered by the billing provider. For the purposes of calculating compensation, this scenario increases the risk of wRVU credit misallocation.

Global Surgical Package Services and Billing

Medicare global surgical packages combine necessary professional services rendered before, during, and after a minor or major surgical procedure.[8] Stated another way, Medicare's payment for the surgical procedure includes the preoperative, intra-operative, and post-operative services performed by the surgeon, or by members of the same group and specialty, including APPs.

For example, a provider other than the operative surgeon (such as an APP) may furnish post-operative care (i.e., hospital rounding or in-office surgical follow-up visits after hospital discharge). In these cases, the total reimbursement amount for all providers may not exceed what would have been paid had a single physician provided all services, with specific defined exceptions.

Similar to split-shared services, global surgical package services typically appear in the entity's billing information system as being billed by and rendered by the physician who performs the procedure. In such case, work performed by the APP as part of the global service is attributed to the physician who is compensated based on those services under the productivity-based provisions of the physician's employment arrangement. While many industry experts predict an eventual elimination of global surgical periods altogether (and a shift toward separate billing for

[5] Medicare Claims Processing Manual Chapter 12, Section 30.6.
[6] Procedural services essentially include all professional services beyond E/M codes.
[7] At the time of this article, the 2023 Medicare Physician Fee Schedule Final Rule allows a one-year delay of the split-shared visits policy finalized in 2022. When implemented, the regulations will require time-based billing, whereby the provider with greater than 50% of the patient care time will be the billing and rendering provider on the claim.
[8] Minor or major procedures as defined by Centers for Medicare & Medicaid Services (CMS) guidelines.

post-operative care visits), for now, there is not a reliable billing mechanism to fully delineate instances in which an APP may provide portions of the global surgical package.[9]

Compliance Guidance Surrounding Personally Performed Services

The federal physician self-referral law, 42 U.S.C. 1395nn (commonly known as the Stark Law), prohibits a physician from making a referral to an entity with which the physician, or any member of the physician's immediate family, has a financial relationship, if the referral is for the furnishing of certain designated health services payable by Medicare, unless the financial relationship fits into an exception set forth in the Stark Law or its implementing regulations.

Many of the Stark Law exceptions require that compensation paid to a physician be fair market value and commercially reasonable and not determined in a manner that takes into account, directly or indirectly, the volume or value of any Medicare designated health services referral or other business generated by the physician. However, physician compensation may, in some cases, include a productivity bonus based on services *personally performed* by the physician. [10]

The Stark Law defines a personally performed service by identifying what it is not. A service is "not personally performed or provided by the referring physician if it is performed or provided by any other person, including, but not limited to, the referring physician's employees, independent contractors, or group practice members."[11] CMS has noted that incident to billing may be "conflating" Medicare billing conventions with physician self-referral policy.[12] "[C]oncerns arise when payment for items or services provided as the result of a physician's referrals or other business the physician generates, rather than the physician's own labor, is included in the calculation of compensation."[13] For this reason, without the consideration and analysis of a potential adjustment to the APP wRVUs attributed to the physician, or the related compensation per wRVU conversion factor under a productivity-based model, the physician may inadvertently be compensated for non-personally performed services, which may violate the Stark Law exception and result in compensation outside fair market value for services performed by someone else (i.e., an APP).

CMS clarified in its 2020 and 2021 revisions of the Stark Law that as part of a commercial reasonableness analysis, physician compensation should align with the actual services rendered by the physician. For example, a physician should not be credited productivity for services performed by the APP and receive productivity-based compensation, but instead it may be acceptable to compensate the physician for supervision of the APP as that provision of service is personally performed by the physician.[14] In addition to the level of supervision required for incident-to and split-shared billing, many states' licensure laws require an APP to practice under a physician's supervision. Hospital and health system employment contracts often require some level of supervision including, but not limited to, medical record review and best practice discussion and facilitation with the APP. If a hospital or health system intends to compensate a

[9] While there is a mechanism to track post-operative visits using Current Procedural Terminology (CPT® or CPT), a registered trademark of the American Medical Association, code 99024, use of this code is inconsistent.
[10] 42 C.F.R. § 411.352(i)(3).
[11] 42 C.F.R. § 411.351.
[12] 86 Fed. Reg. at 65,350.
[13] 86 Fed. Reg. at 65,346.
[14] See 85 Fed. Reg. 77,492 (Dec. 2, 2020); see also 86 Fed. Reg. 64,996, 65,343 (Nov. 19, 2021)

physician for APP supervision, it must define and document key principles and definitions surrounding APP supervision, to include how such supervision is personally performed by the physician.

Another regulatory perspective derives from the federal income tax laws specific to tax-exempt organizations. When an excess benefit transaction has occurred (such as when a physician employee, meeting the definition of a disqualified person, has received compensation in excess of fair market value), the Internal Revenue Service (IRS) may impose excise taxes on both the individuals receiving the improper benefit and on the organization's leaders who knowingly approved the transaction or arrangement.[15]

Previously, the IRS struggled with variable compensation arrangements (i.e., a compensation arrangement whereby the compensation is tied to the volume of services provided by the employee), with the concern that such arrangements could be used to remove earnings of an exempt entity away from its tax-exempt purpose. Over time, the IRS has become more accepting of variable compensation arrangements. However, variable compensation based on the work of someone other than the employee remains a potential issue. Accordingly, a healthcare entity should seek a legal review of the attribution or crediting of wRVUs generated by the APP to a physician in consideration of the Stark Law and IRS guidance, among other regulations.

Potential Compensation Methodology Solutions

In the absence of CMS directives or guidance, we have identified three potential methods to account for the value of work performed by an APP in a physician-APP collaborative practice arrangement and thus avoid compensating the physician for work not personally performed.

Methodology One – APP Reduction

Under this methodology, the net cost to the employer hospital or health system associated with the APP's employment is deducted from the physician's total compensation (with a credit for the amount of collections for services independently performed by the APP). The net cost of the APP considers APP personally performed professional collections, compensation, benefits, malpractice insurance, and an estimate of fully allocated overhead. For demonstration purposes, we have assumed a median level of costs and professional collections for the APP based upon various data sources for 2022 specific to a surgical nurse practitioner. [16] We have also assumed the physician produced wRVUs at approximately the 75th percentile, and the wRVU conversion factor approximates the median reported compensation per wRVU as reported by the same data sources specific to an orthopedic surgeon. As illustrated in the table, the physician's resulting compensation per wRVU is reduced by approximately $6 (i.e., the difference between Row B and Row K), or 8%.

[15] I.R.C. Section 4958.
[16] We utilized data from American Medical Group Association *Medical Group Compensation and Productivity Survey: 2022 Report Based on 2021 Data*, ECG Management Consultants *2022 National Physician and APP Compensation & Production Survey*, Medical Group Management Association (MGMA) *2022 DataDive Cost and Revenue Survey*, MGMA *2022 DataDive Provider Compensation Survey*, and SullivanCotter, Inc. *2022 Physician Compensation and Productivity Survey*.

Methodology One - APP Reduction

Description	Amount	Formula
Physician wRVUs[1]	12,200	A
Physician wRVU Conversion Factor	$75.00	B
Physician Productivity Compensation	$915,000	C=A*B
APP Compensation	$125,000	D
APP Benefits	$30,000	E
APP Malpractice Insurance Expense	$2,500	F
APP Allocated Overhead	$43,750	G=H*35%
Collections Related to APP for Personally-Performed Services	($125,000)	H
APP Net Cost	$76,250	I=SUM(D:H)
Adjusted Physician Productivity Compensation	$838,750	J=C-I
Resulting Compensation per wRVU	$68.75	K=J/A

[1] This amount includes wRVUs that may be attributable to the APP as well as the wRVUs for those services personally performed by the physician

APP Reduction is most like a physician in private practice, where the net costs of the APP are absorbed by the physician's practice collections. APP Reduction may be an easy to implement option because the information needed to complete this calculation (i.e., APP personally performed professional collections, compensation, benefits, malpractice insurance, and an estimate of fully allocated overhead) is generally available within an entity's information systems. In addition, APP Reduction may work best when there is a one-to-one relationship between the physician and APP since the allocation of APP revenue and expenses across multiple physicians may be difficult to estimate. Further, the APP Reduction model supports a care team approach by allowing an analysis of the care team compensation (i.e., physician and APP together).

With APP Reduction, the physician's compensation formula may begin with determining productivity-based compensation potentially inclusive of APP services, but by allocating the net cost of the APP to the physician, the resulting physician compensation represents an estimate of compensation for personally performed services. Further, by ensuring the physician bears the expense associated with the APP given the physician benefits from the use of the APP, the commercial reasonableness of the arrangement is further supported.

As with any physician compensation arrangement with a tax-exempt organization, consideration should be given to the provisions of private inurement, private benefit, and tax-exempt bond financing. To ensure a complete evaluation of the specific issues at hand, a tax-exempt healthcare entity should seek a formal legal review of the transaction.

Methodology Two - Physician wRVU Reduction

Under this method, the physician is paid a different rate for personally performed versus APP-attributed wRVUs, using the 15% differential between physician and APP reimbursement under the Medicare Physician Fee Schedule. This assumes the difference in reimbursement approximates the value of supervision of an APP by a physician. Services provided in collaboration with an APP and attributed to the physician would be compensated at 15% of the physician contractual compensation per wRVU, as the supervision or oversight of the service should not be compensated at the full compensation per wRVU amount. The remaining wRVUs

(i.e., those personally performed by the physician) are multiplied by the physician's unadjusted compensation per wRVU. The results of both calculations are then summed to determine the physician's total productivity-based compensation. As illustrated in the following table, the physician's resulting compensation per wRVU is reduced by approximately $6 (i.e., the difference between Row A and Row H), or 8%.

Methodology Two - Physician wRVU Reduction

Description	Amount	Formula
Physician Compensation per wRVU	$75.00	A
Reduction Factor for APP Usage	15%	B
Adjusted Physician Compensation per wRVU	$11.25	C=A*B
Total Physician wRVUs	12,200	D
Estimate of Physician wRVUs Split-Shared or Globally Billed (10%)	1,220	E
Personally Performed Physician wRVUs	10,980	F=D-E
Physician Productivity Compensation	$837,225	G=(E*C)+(F*A)
Resulting Compensation per wRVU	$68.63	H=G/D

Physician wRVU Reduction relies on an estimate of wRVUs which are personally performed by the APP and attributed to the physician. In the example, a 10% APP wRVU attribution was assumed (i.e., 10% of the physician's total wRVUs were attributed to the physician by the APP).[17] This estimate could be obtained through a detailed physician time study which may incorporate a review of patient records, review of physician and APP utilization files and schedules, physician and APP clinical shadowing, and/or management interviews. This analysis will be important, as no two physician practices are alike and may not utilize APPs in the same way.[18] Understandably, the data required to support Physician wRVU Reduction may be cumbersome to obtain initially but could allow an efficient update in subsequent years if a solid baseline is established in year one.

Methodology Three - Physician wRVU Reduction with or without Supervisory Stipend

Under this method, the physician's total wRVUs are reduced by a factor for estimated APP usage.[19] The adjusted wRVUs are then multiplied by an unadjusted compensation per wRVU amount. The physician also may or may not receive an annual APP supervision services stipend. In the following table, the physician's actual wRVUs of 12,200 are reduced by a factor of 10% as an estimate of APP usage. The physician's adjusted productivity compensation is the quotient of his or her adjusted wRVUs, or 10,980 wRVUs, and contractual compensation per wRVU, or $75. As illustrated in the table, the physician's resulting compensation per wRVU is reduced by approximately $7 (i.e., the difference between Row D and Row H), or 9%.

[17] The 10% APP wRVU attribution is for illustrative purposes only. In our experience, there is a wide range of appropriate attributions dependent upon specific facts and circumstances.
[18] However, a diligent review of several physician practices by specialty within the same entity may yield similarities that could help in the derivation of an estimate to be utilized across multiple physician practices.
[19] The estimated wRVUs attributed to the APP are determined by a physician time study, details of which are outlined under Methodology Two.

Methodology Three - Physician wRVU Reduction and Supervisory Stipend

Description	Amount	Formula
Physician wRVUs	12,200	A
Reduction Factor for APP Usage	10%	B
Adjusted wRVUs	10,980	C=A*(1-B)
Physician Compensation per wRVU	$75.00	D
Physician Productivity Compensation	$823,500	E=C*D
Add: APP Supervision Stipend	$10,000	F
Adjusted Physician Compensation	$833,500	G=E+F
Resulting Compensation per wRVU	$68.32	H=G/A

If a supervisory stipend is included, it should be supported by an agreement requiring the physician to perform specific duties, and corresponding stipends are intended to compensate the physician for the actual time spent with the APP, such as reviewing a percentage of the APP's charts and discussing these findings with the APP. Additional considerations regarding APP supervision stipends are highlighted in the sections to follow.

Sensitivity Testing of Methodologies One, Two, and Three

The three methodologies outlined above yield compensation results of $6 to $7 per wRVU less than the unadjusted compensation per wRVU factor, or an approximate 8% to 9% overall decline in physician compensation. To further test these results, we performed sensitivity testing with different (but not necessarily all encompassing) assumptions for primary care and procedural-type physicians. Specifically, we analyzed various scenarios using different levels of physician wRVU productivity and compensation per wRVU conversion factors and multiple APPs supervised (i.e., two or more APPs being supervised by one physician). The sensitivity testing yielded compensation per wRVU reductions of $3 to $7 for surgical specialties and $0 to $4 for primary care specialties across all three methodologies.

While performing the additional sensitivity testing, we observed that for physicians with a median level of productivity, the APP impact on physician productivity may not be significantly different than if the physician had no APP. Generally, a physician with a median level of productivity likely does not utilize an APP to the extent a physician with a high level of productivity would use an APP. Thus, the compensation of such a physician under a productivity-based model may also not be impacted as significantly.

We also reviewed the impact of multiple APPs on the three methodologies (i.e., when a physician utilized more than one APP in their practice). The key in this sensitivity test was the assumption that the physician's productivity level is finite. Essentially, a threshold exists at which the physician will reach capacity in terms of his or her wRVU productivity. At that point, the physician will be unable to provide additional clinical services without impacting the quality of patient care, even with the help of additional APPs. While the number of APPs supervised by a physician was impactful to the three methodologies, it was only modestly so, at a $1 to $3 additional reduction in compensation per wRVU.

Finally, we applied the resulting 8% approximate decline in compensation per wRVU per the study of the three methodologies demonstrated above to the median and 75th compensation per wRVU for all specialties, excluding hospital-based specialties, reported by MGMA in 2022 with a physician count of greater than 50. We found that the resulting average differential in compensation per wRVU was approximately $6 at the median and $7 at the 75th percentile across all specialties. These averages approximate with the range in the reduction of compensation per wRVU yielded by the three methodologies described herein (i.e., $4 to $7 for surgical specialties and $0 to $4 for primary care specialties).

Considerations from a Valuation and Commercial Reasonableness Perspective

As previously described, hospital-employed physicians are often paid using a productivity methodology, such as a set compensation per wRVU for each personally performed wRVU generated. These arrangements imply that if a particular service is not personally performed, the physician should not receive compensation for that service. Therefore, physician contracts should define a personally performed service or provide a mechanism by which wRVUs are adjusted for wRVUs (or a portion thereof) performed by someone else, so they do not inadvertently award compensation for wRVUs attributed to the physician, but which were not personally performed by the physician.

For physicians compensated under a productivity model, the inadvertent attribution of APP wRVUs may result in a higher level of wRVUs and a higher level of compensation. This higher level of compensation may not always be supportable under the premise of fair market value or commercial reasonableness. For example, in employment arrangements, hospitals pay the expense of employing an APP (i.e., salary, benefits, malpractice insurance, and associated overhead) for use by the physician, but will also pay additional compensation to the physician for increased productivity and possibly additional compensation for the supervision of the APP, thereby incurring additional expense beyond those originally anticipated (i.e., only the cost of the APP). In addition to potentially being commercially unreasonable, this financial model is perhaps unsustainable.

Additionally, when physicians are paid an APP supervision stipend and productivity statistics cannot be separated between rendering and billing provider, this potential duplication brings into question whether the physicians are being compensated twice for providing the same service, once in the form of an annual stipend for the supervision services and then again in the form of productivity-based compensation for services that, at least in part, may have been generated by the APP. While detailed analysis of the specific physician arrangement may indicate that total compensation is fair market value and commercially reasonable, the arguments for each individual component of compensation may not be supportable.

Other Considerations

Evolution of APP Supervision Compensation

Physician compensation for APP supervision continues to evolve. While a flat annual supervisory stipend continues to remain the most common method of compensation per data reported in 2022 by SullivanCotter, organizations are starting to increase reliance on other forms of compensation. For example, per SullivanCotter in 2018, of hospitals surveyed who provided physician compensation for APP supervision, 12% compensated the physician based on a percentage of APP incident-to wRVUs, while 5% relied on some other unspecified form of compensation that

was not an annual stipend or flat hourly rate.[20] However, per SullivanCotter in 2022, on average across all specialties, approximately 24% of hospitals compensated physicians based on a percentage of APP incident-to wRVUs and 19% relied on some other form of compensation.[21] Hospitals and health systems should continue to monitor the way APP supervision is compensated and ensure APP supervision compensation is fair market value.

Benchmark Data

Benchmark resources generally require parties reporting physician productivity data to ensure the data represents personally performed services only. However, in our experience and based on our understanding of the survey data requests, definitions, and data assimilation processes, analysts reviewing the data submitted by healthcare providers generally have few, if any, methods for vetting whether data submitted to the surveys truly represents personally performed physician services. Valuation appraisers and physician contracting specialists in healthcare organizations will continue to face issues regarding the nature of the underlying data within the benchmark data surveys, especially given the previous discussion about how productivity data is typically accumulated. This reality should be considered when implementing any of the aforementioned compensation methodologies.

Future Compensation Structures

Given the difficulty in identifying personally performed services using data generated through current billing conventions, organizations may seek compensation models not wholly reliant on wRVU productivity. This notion does not eliminate the need to measure physician productivity but may focus the measurement of productivity on metrics in addition to wRVUs, such as physician quality metrics, physician engagement metrics, patient outcome metrics, patient panel size, daily census, and patient visits, among others.

Conclusion

The reliance on APPs for increased clinical productivity and efficiency will likely continue into the foreseeable future. Unless CMS issues more formal guidance on this subject, health care organizations will be continually challenged with how to compensate physicians for personally performed services while also ensuring appropriate compensation for APP collaboration and supervision.

A review of the aforementioned methodologies may be helpful in accounting for the APP impact on physician productivity. Perhaps the most critical consideration for healthcare organizations is a legal review of the arrangement and methodology by which the physician is compensated for APP supervision and/or potentially credited with services performed by an APP. The compensation methodology ultimately utilized will depend on several factors including, but not limited to, the physician's level of APP usage, the physician's productivity level, the physician's

[20] SullivanCotter, Inc. (SullivanCotter) *2018 Physician Compensation and Productivity Survey Report*, Table 3.45 – Methods of Physician Compensation for APC Supervision.
[21] SullivanCotter *2022 Physician Compensation and Productivity Survey Report*, 8.6 – Methods of Physician Compensation for APP Supervision.

specialty, availability of data, and most importantly whether the methodology generates fair market value and commercially reasonable compensation.

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