



Easy-to-digest information for PAs in Gastroenterology and Hepatology



Diana McFarlane, MPAS, PA-C, GIPA President

Letter from the President

Hello, fellow GIPA members and potential members. We are proud to bring you our second edition of *GIPA Digest*. Our board continues to work on growing our membership base, reaching out to our current members, and expanding GIPA CME opportunities through our partners.

As you make plans for this year's AAPA conference in Atlanta, I hope you will join the GIPA board and fellow GIPA members at our annual reception. Each year we welcome our members for a brief reception where we mingle, discuss hot topics, and vote for our up-and-coming cast of board members. Note the details below. I hope you will join us!

Gastroenterology PAs Membership Reception

Sunday, May 30, 2010
5:30 PM—7:30 PM
Atlanta Marriott Marquis
International Ballroom 7

If you are a GIPA member, you may have already received your Call for Nominations notification. Each year we elect our board members to spend the following year (starting in July 2010) working together to represent the GIPA membership. We typically meet for a teleconference every quarter. We are excited to have new members this year and

welcome any of you to apply to participate on our board. Our board is often composed of seasoned board members and new GIPA members, which lends itself to a diverse, experienced, and bright group with new ideas. Please note that an active GIPA membership status is a requirement for board participation.

Do you have a particular expertise in the field of Hepatology? If so, we'd love to hear from you! As you may know, we partnered with Clinical Care Options (CCO) (<http://www.clinicaloptions.com/hepatitis.aspx>) to bring you up-to-date topics in Hepatology, especially as they relate to our work as Physician Assistants. CCO needs PA peer reviewers to participate in content review for their CME topics. Do you have a special area of interest or know-how in Hepatology? As a partner with CCO, GIPA can nominate you to the team. Just send your current CV and/or any questions you may have on this topic to GIPA@aapa.org.

In this publication, you'll find useful billing information, part one of a two-part update on hepatitis C treatment guidelines as defined by the American Association for the Study of Liver Diseases, more information on our teamwork with Clinical Care Options, and updated GIPA job information.

Sincerely,

Diana McFarlane, MPAS, PA-C
GIPA President

CPT Corner Saying Goodbye to Consults

An Opportunity for Physician Assistants

The elimination of consults in the inpatient setting

Last year the Centers for Medicare & Medicaid Services (CMS) announced that, effective January 1, 2010, they would no longer pay for CPT codes associated with consults. To compensate for the loss of the consult codes (99251–99255), CMS increased the reimbursement by an average of 6% for initial inpatient hospital visit codes (99221–99223). However, because of the overwhelming use of consultation codes in the inpatient environment, some practices may take a larger loss.

Why not consults?

As far back as 2000, Medicare recognized that the vast majority of consultations did not meet all elements required for a consultation. In 2006, the Office of Inspector General (OIG) for CMS issued a report that showed approximately 75% of consults did not have documentation to meet the requirements CMS had set forth for consults. In 2001 (the time period examined), OIG estimated that the overpayments exceeded \$1.1 billion. At the same time, Medicare recognized that with the increased documentation requirements for initial inpatient visits, the documentation was very similar to consults. (The main reason for the difference in reimbursement initially was documentation.) Because of this, Medicare announced in 2006 that they would no longer reimburse for consultation follow-up codes and, in 2009, announced that, beginning in 2010, they would no longer reimburse for inpatient consult codes.

The change for inpatient billing

With the elimination of consultations, CMS declared that all hospital encounters should be billed using the same CPT codes. For inpatient work, the initial encounter is billed using initial inpatient hospital visit (codes 99221–99223). For follow-up inpatient visits, codes 99231–99233 should be used.

(Continued)

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- News and Reviews
- Upcoming Events

Enclosures

- Career Connections
- New Member Application



(CPT Corner continued)

The importance of AI

One change Medicare made with the elimination of the consult code was to increase the payment for the primary admitting service. Recognizing that the admitting service had additional duties including coordination of care, CMS will reimburse this service at a higher rate. To designate the admitting service and capture the higher rate, the initial hospital visit must be coordinated as AI by the admitting service. On the other hand, if the admitting service does not code the visit as AI, CMS has announced that they will hold all payments until one service has designated their claim as the admitting service to avoid duplication.

Opportunity for PAs

While the revenue penalty for the elimination of consult codes may be severe, there exists an opportunity for practices that efficiently used PAs to regain some of this revenue. The opportunity exists around the differences between consults and initial hospital visits.

With consults, the practice had to choose between having the PA do the consult and receive reimbursement at 85% or having the physician do the consult and receiving full reimbursement. This choice came about with the 2006 decision by CMS not to allow shared visits for consults. With initial hospital visits, on the other hand, shared visits are explicitly allowed. This permits a practice to recapture an additional 15% in revenue by billing the initial hospital visit as a shared visit. As always, the rules for shared billing must be followed (direct face-to-face encounter by the physician, involvement in one E/M element, and documentation of the involvement).

The importance of proper billing

There are still a number of unanswered questions with the loss of consult codes. The primary question is whether private payors will follow suit. So far, the results have been mixed. Some insurance companies continue to pay for consults and some have followed CMS guidelines. In addition, the relationship between Medicare as a primary or secondary insurance has caused confusion if the other insurance has different policies concerning consults. It's vitally important that billing departments keep up-to-date as policies continue to change.

Overall, the loss of consult codes will result in revenue loss to a number of specialty groups. However, the judicious use of shared visits will allow practices that operate efficiently to recapture some of the revenue. Plus, the shared visit allows additional opportunities for PAs to provide expert services in the inpatient environment.

Resources:

MLN Matters® Number: MM6740 – CMS Guidance on Consults (last accessed on 3/26/10)

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf>

CMS Direction on Use of AI Modifier (last accessed on 3/22/10)

<http://www.cms.hhs.gov/apps/ama/license.asp?file=/HCPCSReleaseCodeSets/Downloads/10anweb.zip>

MGMA Practice Blog – Goodbye Medicare Consults (last accessed on 3/24/10)

<http://blog.mgma.com/blog/bid/28204/Goodbye-Medicare-consultation-codes-Your-practices-next-steps>

CMS OIG Report on Consultations 2001 (accessed 1/10/10)

<http://oig.hhs.gov/oei/reports/oei-09-02-00030.pdf>

Coding News Article on Elimination of Consultation Codes (accessed 2/25/10)

<http://codingnews.inhealthcare.com/provider-news/medicare-changes-to-2010-cpt-inpatient-consultation-codes>

News and Reviews

Update to the Diagnosis, Management, and Treatment of Hepatitis C

A review of the Guidelines of the American Association for the Study of Liver Diseases

by Michelle Barnett, GIPA Board Member 2009–2010

The American Association for the Study of Liver Diseases (AASLD) promotes preferable methods of approaching diagnostic, therapeutic, and preventative aspects of care through the development of practice guidelines. AASLD guidelines represent the official opinion of the Association, as reflected in the evidence-based reviews and recommendations of the individuals involved in developing the guidelines.

AASLD has revised the treatment guidelines for hepatitis C, due to the significant research and advances that have taken place in this field. Following is part one of a two-part series presenting a summary of these recommendations. The second part will be reviewed in our next newsletter.

According to the AASLD HCV treatment guidelines, HCV testing is recommended for these individuals:

- Persons who have injected illicit drugs in the recent and remote past, including those who injected only once and do not consider themselves to be drug users
- Persons with conditions associated with a high prevalence of HCV infection, including:
 - Persons with HIV infection
 - Persons with hemophilia who received clotting factor concentrates before 1987
 - Persons who were ever on hemodialysis
 - Persons with unexplained abnormal aminotransferase levels
- Prior recipients of transfusions or organ transplants, including:
 - Persons who were notified that they had received blood from a donor who later tested positive for HCV infection
 - Persons who received a transfusion of blood or blood products before July 1992
 - Persons who received an organ transplant before July 1992



Upcoming Events

AAPA Annual Conference
May 29–June 3
Atlanta, GA

Gastroenterology PAs Membership Reception
Sunday, May 30, 2010
5:30 PM – 7:30 PM
Atlanta Marriott Marquis
International Ballroom 7

Career Connections

See the enclosed insert for details on available opportunities in Richmond, VA, Boston, MA, and Seattle, WA.

- Children born to HCV-infected mothers
- Health care, emergency medical, and public safety workers after a needlestick injury or mucosal exposure to HCV-positive blood
- Current sexual partners of HCV-infected persons

Counseling to avoid transmission of HCV

- HCV-infected persons should be counseled to avoid sharing toothbrushes and dental or shaving equipment and be cautioned to cover any bleeding wound in order to keep their blood away from others
- Persons should be counseled to stop using illicit drugs. Those who continue to inject drugs should be counseled to avoid reusing or sharing syringes, needles, water, and cotton or other paraphernalia; to clean the injection site with a new alcohol swab; and to dispose safely of syringes and needles after one use
- HCV-infected persons should be counseled that the risk of sexual transmission is low and that the infection itself is not a reason to change sexual practices (i.e., those in long-term relationships need not start using barrier precautions and others should always practice "safer" sex)
- HCV-infected persons should be advised to not donate blood, body organs, other tissues, or semen

Management of adult patients with hepatitis C

- Regardless of the level of ALT, a liver biopsy should be done when the results will influence whether treatment is recommended, but a biopsy is not mandatory in order to initiate therapy
- A liver biopsy may be obtained to provide information on prognosis
- Regardless of the serum aminotransferase levels, the decision to initiate therapy with interferon and ribavirin should be individualized based on the severity of liver disease by liver biopsy, the potential of serious side effects, the likelihood of response, and the presence of comorbid conditions
- The treatment of choice is peginterferon plus ribavirin
- For patients for whom liver histology is available, treatment is indicated in those with more than portal fibrosis



- Treatment decisions should be individualized based on the severity of liver disease, the potential of serious side effects, the likelihood of treatment response, and the presence of comorbid conditions

Genotype-1 HCV Infection

- Treatment with peginterferon plus ribavirin should be planned for 48 weeks, using ribavirin doses of 1,000 mg for those ≤ 75 kg in weight and 1,200 mg for those >75 kg
- Quantitative serum HCV RNA should be performed at the initiation of, or shortly before, treatment and at week 12 of therapy
- Treatment may be discontinued in patients who do not achieve an EVR at 12 weeks, although the decision should be individualized according to the tolerability of therapy, severity of underlying liver disease, and demonstration of some degree of biochemical and/or virologic response
- Persons whose treatment continues through 48 weeks, and whose qualitative measurement of HCV RNA at that time is negative, should be retested for HCV RNA 24 weeks later to document an SVR

Genotype-2 or Genotype-3 HCV Infection

- Treatment with peginterferon plus ribavirin should be administered for 24 weeks, using a ribavirin dose of 800 mg
- Persons whose treatment continues for the full 24 weeks, and whose qualitative measurement of HCV RNA at that time is negative, should be retested for HCV RNA 24 weeks later to document an SVR

Management of pediatric patients with or exposed to hepatitis C

- Diagnosis and testing (including liver biopsy) of children suspected of having chronic HCV should proceed as with adults
- Because of the high rate of clearance of the HCV virus within the first year of life, and the level of anxiety that may be caused by an early positive test, routine testing for HCV RNA in infants born to HCV-infected mothers is not recommended. Testing with anti-HCV may be performed at 18 months or later. If an earlier diagnosis is desired, PCR for HCV RNA may be performed at or after the infant's first well child visit at 1–2 months
- Children aged 3–17 who are infected with hepatitis C and are considered appropriate candidates for treatment may receive therapy administered by those experienced in treating children
- Treatment of children under the age of 3 years is contraindicated

Watch for Part Two of our AASLD HCV guideline review in the next issue of this newsletter. We will examine management of patients with HCV and renal disease, HCV/HIV-coinfected patients, management of acute HCV, and HCV cirrhosis management.

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The Wave is Coming.



The number of people infected with
HCV for more than 20 years is about to peak.^{1,2}

Are you ready?

Visit www.vrtx.com to learn more about how Vertex is committed
to helping Physician Assistants change the future of HCV care.

References: 1. Armstrong GL, Alter MJ, McQuillan GM, Margolis HS. The past incidence of hepatitis C virus infection: implications for the future burden of chronic liver disease in the United States. *Hepatology*. 2000;31:777-782. 2. Davis GL, Albright JE, Cook SF, Rosenberg DM. Projecting future complications of chronic hepatitis C in the United States. *Liver Transpl*. 2003;9:331-338.

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www.vrtx.com



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Membership Application
GIPA membership year – July 1- June 30

Name: _____ Membership Type: _____
Company: _____ Home Address: _____
Address: _____
_____ Home Phone: _____
Work Phone: _____
Work Fax: _____
Preferred E-mail: _____

AAPA Member: Yes No AAPA Member Number: _____
NCCPA Certified: Yes No NCCPA Certificate Number: _____

My sub-specialty/areas of expertise are: _____
 My work setting is: _____
 Supervising Physician Name: _____

Please use this address for my membership mailings: Email (to conserve cost and paper) Home Work

May we share your contact information CME, employment, and product information? Yes No

Please check here if you do not want to be listed in the annual GIPA membership directory

Please check here if you would like to receive a complimentary membership to the American Association for the study of Liver Disease (please join AASLD and mail proof of payment to address above for reimbursement).

Membership Types and Dues

- Fellow Membership - \$30:** Physician Assistants who currently practice in the field of gastroenterology
- Sustaining Membership - \$30:** PAs, certified by the NCCPA, who have chosen not to practice in Gastroenterology and Hepatology, but who still wish to support GIPA.
- Physician Membership - \$30:** U.S. licensed physicians who wish to associate with and support the organization.
- Affiliate Membership - \$30:** are ineligible for the above categories and wish to associate with the organization. Their memberships must be approved by the Board of Directors.
- Student Membership - \$10:** Physician Assistant students who are currently enrolled in an ARC-approved PA program
Students are not eligible for membership to the Crohn's & Colitis Foundation

Payment Options

I would like to make an additional donation to support the efforts of GIPA. Amount: _____

Credit Card: VISA MasterCard American Express Check Enclosed

Card Number: _____ Expiration Date: _____

Name on Card: _____ Signature: _____ Date: _____

I am interested in serving GIPA as a volunteer

Fax: 703/684-1924
If paying by check, please make your check payable to: GIPA
Please mail to 950 N. Washington Street, Alexandria, VA 22314-1552

Mid-level provider Physician Assistant or Nurse Practitioner—Richmond, VA

Virginia Commonwealth University Health System in Richmond, VA, is seeking a mid-level provider (PA or NP) to join the Division of Gastroenterology to provide outpatient care of liver diseases including treatment of viral hepatitis and other liver disorders. Although GI experience is preferred, it is not required. Our 6-physician practice seeks to add a second mid-level provider with strong skills in clinical evaluation, communication, and patient education. Interested applicants are encouraged to apply online at www.vcuhealth.org. (4/20/2010)

Liver Oncology Nurse Practitioner/Physician Assistant—Boston, MA

Become a member of a dynamic multi-disciplinary team of physicians, PA/NPs, nurses, and social workers providing patients with the most advanced, state of the art care in a uniquely warm, patient-centered environment. In a dedicated outpatient clinic, the incumbent in this position will primarily care for liver oncology patients, although he/she may also care for patients with other oncologic diagnoses. The outpatient area is comprised of exam rooms which are adjacent to the infusion treatment area staffed with nurses committed to the care of patients with oncologic diagnoses. The nurse practitioner makes judgments relative to physical diagnosis and therapeutic management independently, using physician consultation where appropriate.

Job Description:

The nurse practitioner/physician assistant is a professional who cares for individuals, families, and/or populations of patients through implementation of the nursing process by using advanced competencies in history taking, physical examination, and interpretation of laboratory and related diagnostic tools. The nurse practitioner makes judgments relative to physical diagnosis and therapeutic management independently, using physician consultation where appropriate. The incumbent in this position will primarily care for liver oncology patients, although he/she may also care for patients with other oncologic diagnoses.

Qualifications:

License to practice as an advanced practice nurse/physician assistant in MA. MSN with ability to assume responsibility for delivery of care in the clinical setting. Valid DEA and MCS numbers for prescription-writing practices. Several years of Oncology or Hepatology experience required. (For more information, see careers at Beth Israel Deaconess Medical Center: <https://prod.fadvhms.com/bidmc/JobBoard/> and enter requisition #10-0454.)

GI Physician Assistant—Seattle, WA

The Gastroenterology Department at Virginia Mason Medical Center located in downtown Seattle, WA, is seeking a Physician Assistant. The GI Department is a world-renowned group of leaders in GI and advanced GI endoscopies. This truly is a great opportunity if you are looking for a career in Gastroenterology and Hepatology. Responsibilities include outpatient clinic visits, inpatient consultations, rounds, coordination of care, and communication with house staff and GI MDs. There may be an opportunity for procedure involvement as well. The candidate should have interest in seeing many types of GI/hepatology patients in both the hospital and clinic settings. The candidate will be working collaboratively with 19 GI physicians and Nonphysician Providers in this very busy and innovative group. Some hospital coverage shift options will be discussed as candidates are considered. If interested, please send your CV and cover letter to: patricia.wilbur@vmmc.org. (03/26/10)