RhAPP

RHEUMATOLOGY ADVANCED PRACTICE PROVIDERS

RHAPP NATIONAL CONFERENCE

SEPTEMBER 8-10, 2022

Professional Development Workshop

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- There are no relevant financial relationships to disclose: as this is a non-clinical session.

Professional Development Objectives

1.History- How did we get here?

2. Practice Models

3. Billing and Coding

Productivity/ Relative Value Units

4. Recognizing Value

Rheumatology Workforce Shortage

2030

Current number of Rheumatology providers will decline by 25%

2040

The number of adults in the United States diagnosed with arthritis will increase by 49%

Demand for patient care is projected to exceed the number of available rheumatologists by > 100%

Advanced practice providers will play an increasingly crucial role in providing care to Rheumatology patients and filling in the workforce gap

Miloslavsky EM, Bolster MB. Addressing the rheumatology workforce shortage: A multifaceted approach. Semin Arthritis Rheum. 2020 Aug;50(4):791-796. doi: 10.1016/j.semarthrit.2020.05.009. Epub 2020 May 25. PMID: 32540672; PMCID: PMC7255118.
The ACR Launches Initiative to Tackle Workforce Shortage - The Rheumatologist (the-rheumatologist.org)

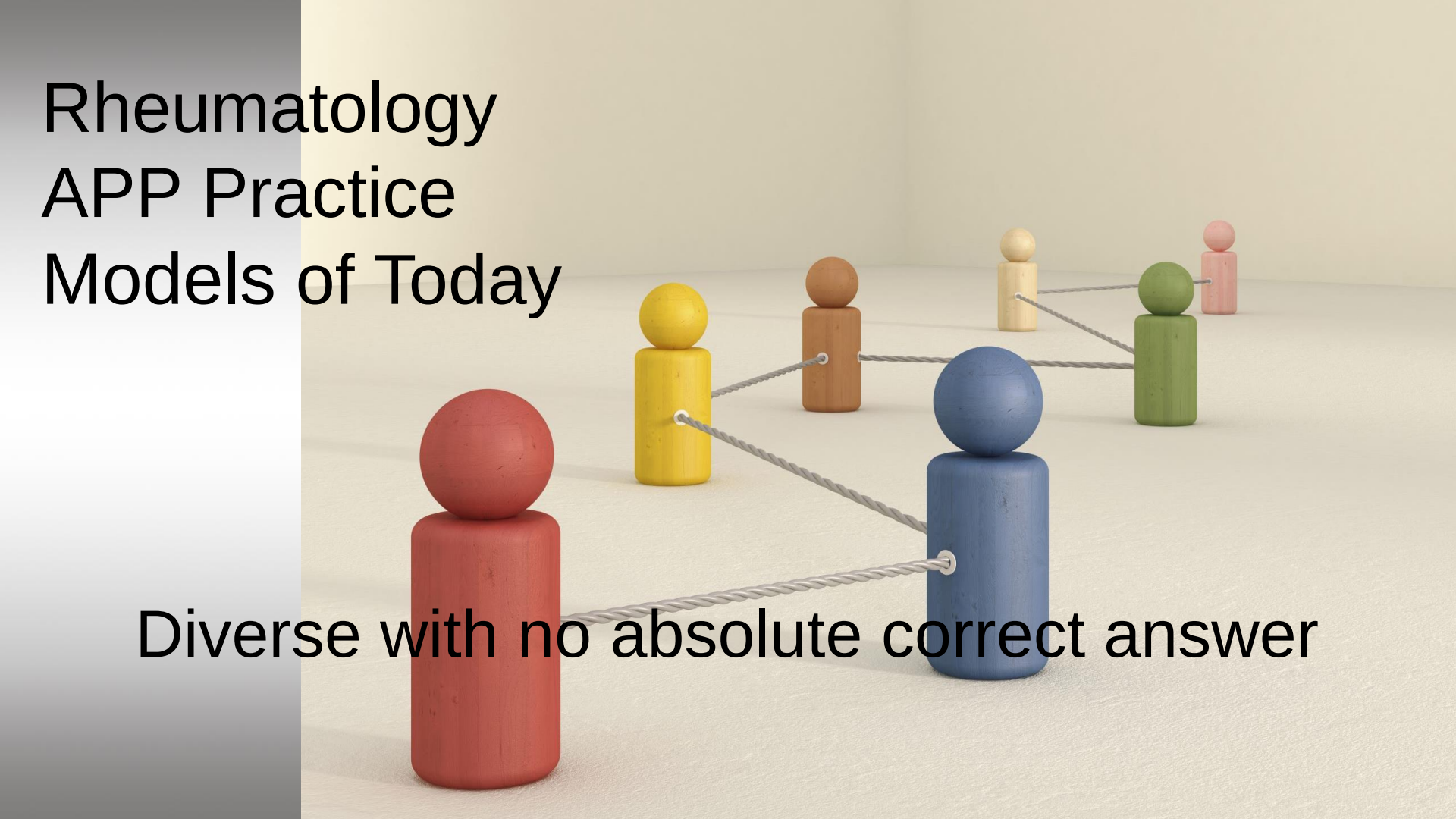
Increased consumer access to healthcare

1920–1971

1965- Present

Focus on reducing out of control healthcare costs

Rheumatology APP Practice Models of Today



Diverse with no absolute correct answer

Rheumatology APP Practice Models

Independent Model

APP practices independently from rheumatologist – Doesn't share panel

APP evaluates and manages new and follow up visits.

New patients are triaged and distributed appropriately between MD/DO and APPs.

Patients per day will vary according to the practice expectations.

New patients 60 minutes / Return patients 30 minutes

New patients 40 minutes / Return patients 20 minutes

Sample Schedule – Independent Model

8AM NEW
9AM RETURN
9:30AM RETURN
10AM NEW
11AM RETURN
11:30AM RETURN
12PM BREAK
1PM RETURN
1:30PM RETURN
2PM RETURN
2:30PM RETURN
3PM RETURN
3:30PM RETURN
4PM RETURN
4:30PM RETURN

Independent Model

The Pros & Cons

Pros

- APP is functioning at the top of scope and independently
- Opportunity to establish long-term relationships with patients as sole provider

Cons

- Steep and risky learning curve
- Diseases are complex and burden of care can often be overwhelming

Rheumatology APP Practice Models

Collaborative Model

Shared panel:

APP works with rheumatologist/s

Alternating Model:

Patients alternate visits between APP and physician. Some practices prefer to have all initial new patient visits with physicians and then follow-up with APP.

Bullpen/Tandem Model:

Physician will see each patient (as needed) at the end of APP visit to formulate assessment/plan.

Sample Schedule – Collaborative Model

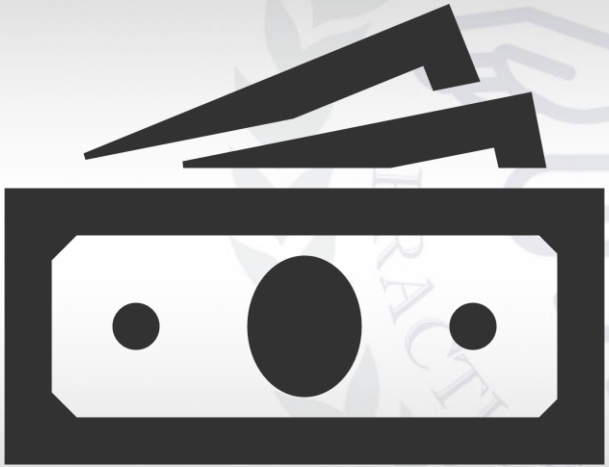
APP	Physician
8am RETURN	8am NEW
8:30am RETURN	
9am RETURN	9:00am RETURN
9:30am RETURN	9:30 am RETURN
10am RETURN	10:00 am NEW
10:30am RETURN	
Collaboration	
11:30am RETURN	11:30 am RETURN

Collaborative Model

The Pros & Cons

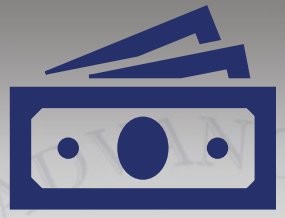
Pros	Cons
• Encourages lifelong learning with a physician mentor. • Creates a shared burden of care and reduces risk of burnout while increasing patient satisfaction • Collaboration can lead to expanded patient access	• Risk of putting a ceiling on APP's scope. • Is the autonomy in changing treatment plans? • Delegation to manage busy work i.e. inbox • Could undermine patient trust in APP ("I want to see the doctor!") • Challenging to work with multiple rheumatologists with varying style

Independent vs. Collaborative



Billing 101

Or . . . Should you code up…or code down



Billing 101

Accurate billing is an integral part of the APP practice

Billing and RVUs are often the most tangible (and monitored!) component in determining an APP's value

What is the value in non-billable work?

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

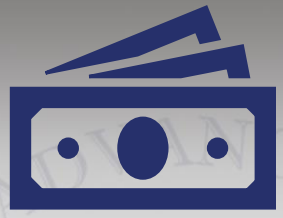
Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

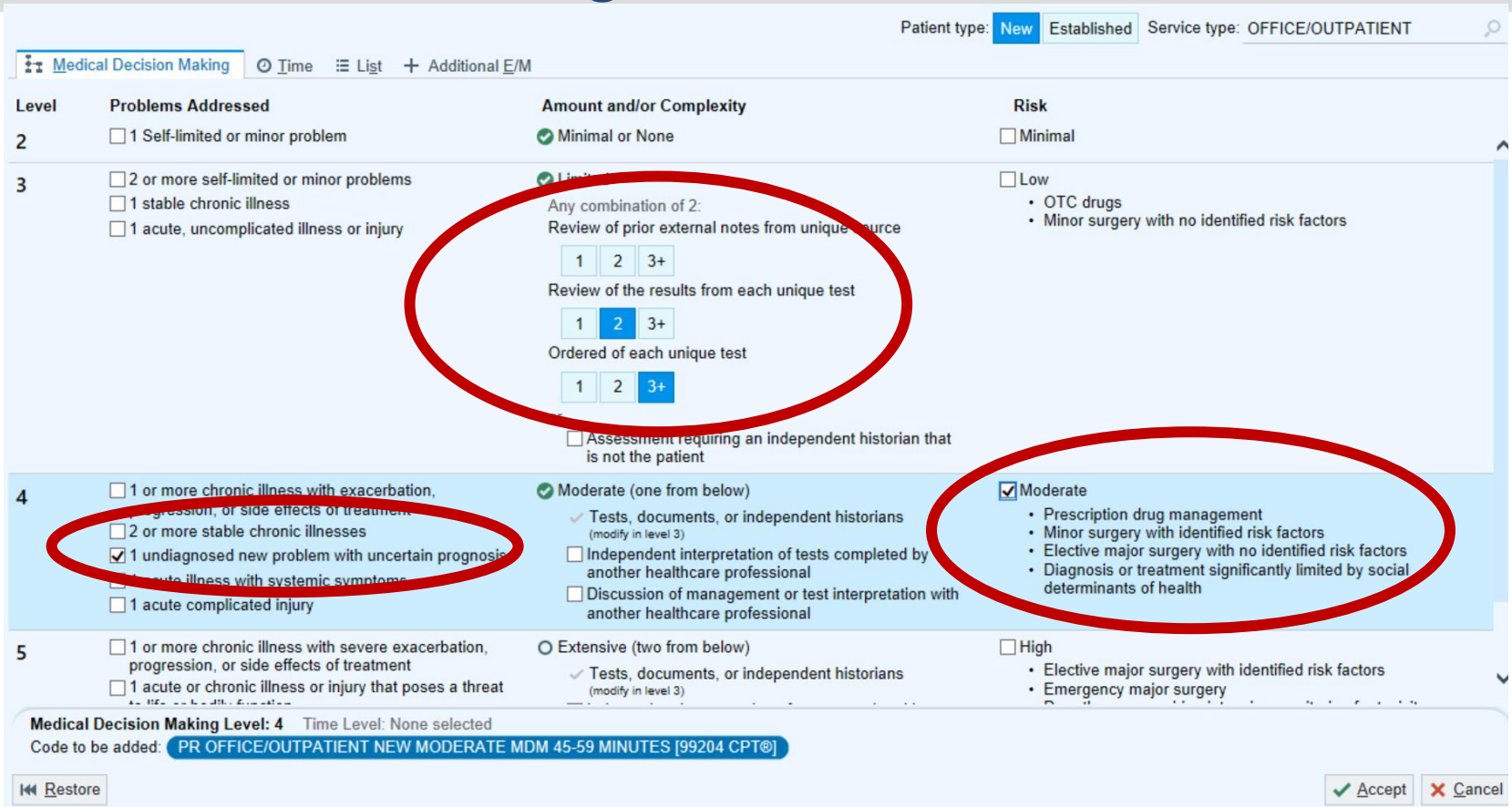
99205
99215
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis



Billing 101

Level 4 & 5
New Patient Visits

Medical Decision Making (MDM) New Patient Billing – Level 4



New patient billing 99204 – MDM

Assessment/Plan: **One undiagnosed new problem with uncertain prognosis**

1. Possible SpA: Patient presents with long-standing history of possible Crohns plus low back associated with AM stiffness. X-rays from 2020 show bilateral sacroiliitis. Presentation suspicious for spondyloarthropathy **Review of the results from each unique test**

Plan:
- Check labs: CBC, CMP, HLA-B27, RF, CCP ab, Quantiferon, **Ordered of each unique test**
- MR sacrum
- Return to clinic for physical exam and to review data

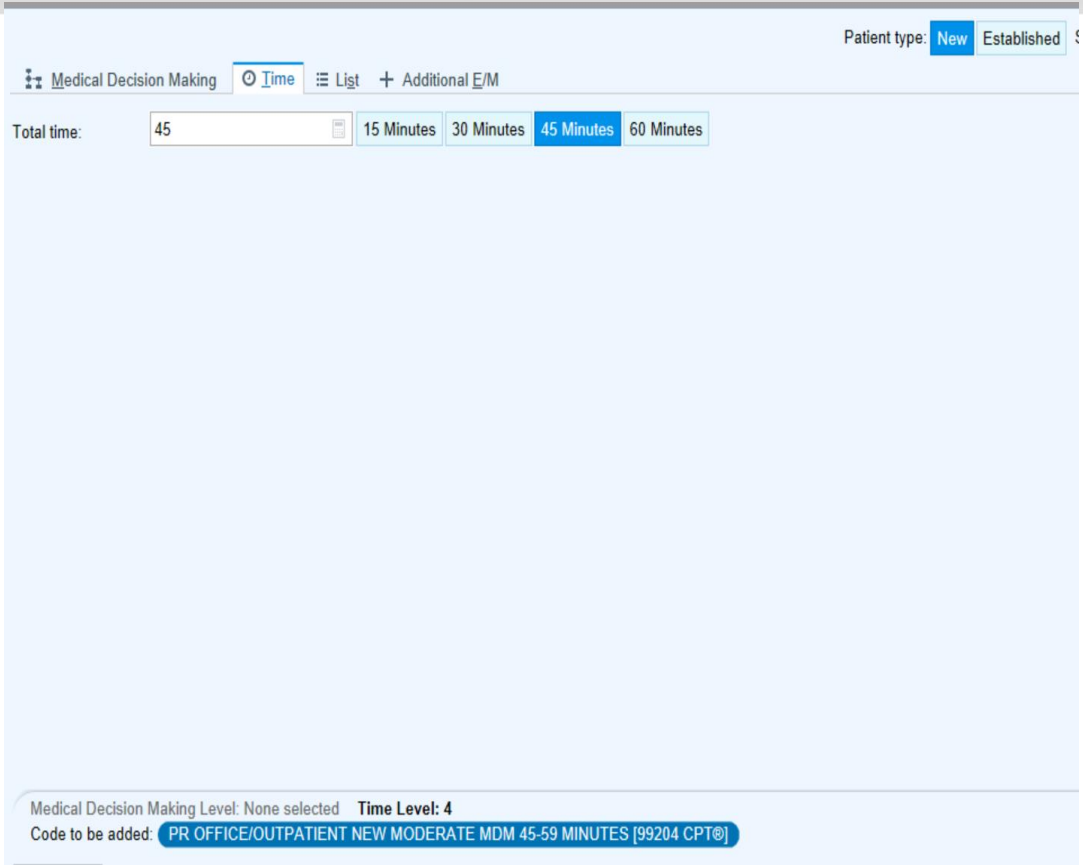
2. Crohn's: Per Temple GI notes, sy**Review of prior external notes from unique source**n GI in November.

Patient is in agreement with plan.

Follow-up in 4-6 weeks or sooner if necessary. The patient knows to call if they have any questions or if symptoms change or worsen.

99204

Time Based New Patient Billing – Level 4



New patient billing 99205 – Time based

Assessment/Plan:

1. PROBABLE EGPA: Eosinophilic granulomatosis with polyangiitis (EGPA) is a good working diagnosis with manifestations that have included adult-onset asthma, sinus disease, pulmonary infiltrates, possible neuropathy, hypereosinophilia, and possible inflammatory eye disease. Since starting benralizumab, she has been able to taper off prednisone and her asthma has been stable. We recommend that she continue on benralizumab as this seems to be effective in controlling her disease.

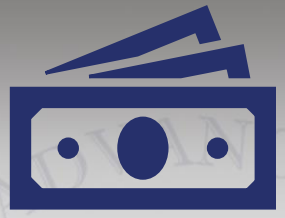
2. Peripheral Neuropathy: She presents today with new/worsening peripheral neuropathy in her hands. We will refer her to [redacted] for further evaluation to determine if she has active neuropathy secondary to vasculitis. If she has evidence of active neuropathy, we may need to start her on a steroid-sparing agent.

3. Empty Sellae with history of pituitary tumors: She has new findings on her brain imaging that require additional work-up. This is likely not related to her diagnosis of vasculitis, although pituitary gland involvement has been reported in granulomatosis with polyangiitis (GPA).
Refer to [redacted]

4. Dry Eyes: Refer to [redacted]

5. Possible history of uveitis: She has a reported history of inflammatory eye disease, but based on the notes that are available it is not clear if she has uveitis or other inflammation conditions. We will refer to Dr. [redacted] in Ophthalmology.

>60 minutes spent on the visit including charting, face to face time and plan.



Billing 101

Level 4 & 5 Established Patient Visits

Established patient billing 99214 – MDM

Assessment and Plan:

RA: Stable/Continue Remicade 400mg every 6 week, methotrexate 7.5mg weekly and folic acid daily
Responding well to current treatment plan. No change in treatment plan. Patient understands that treatment is long term and if patient fails to continue regimen , the disease has propensity to flare. Discussed with patient nature of, general treatment goals. Patient understands implications of un or undertreated disease. Patient understands need for regular Rheumatology follow-up, and agrees to report any new symptoms or flares to rheumatology provider.

OA: Stable. Continue OTC NSAID or analgesic .
Patient is taking OTC analgesics PRN for pain. Encouraged exercise. Some OTC supplements can be beneficial including Omega fatty acids along with tumeric, and glucosamine and chondroitin.

High Risk Medication:
Basic labs Monitored (CBC,CMP and ESR): ordered Labs routinely ordered due to high risk medication use- Monitored for cytopenias, liver toxicity, renal dysfunction and disease activity.
Hepatitis panel negative 2014 This will be checked every 5 years based on patients risk or at time of biologic drug change.
Chest x-ray satisfactory 2000 No evidence of cardiopulmonary disease
TB test negative 2/2022. This will be checked yearly as long as the patient remains on a biologic. Patient is at risk for exposure in geographical area and the biologic immunosuppressant has the potential to activate latent TB

Established patient billing 99215 – MDM

RA: Flaring with a CDAI>20. St… weekly. D/C hydroxychloroquine due to retinal toxicity.

Severe exacerbation → treatment change

Osteoporosis: Recent DEXA indicated a T-score of -3.0 which progressed from 2022. Start authorization for Prolia. Risks ar… discussed and educational material was giv… ontinues to take OTC vitamin D and either takes OTC calcium or better yet consumes calcium through food intake. Patient u… e importance of weight bearing activity. Recommended daily values: Calcium 1000 mg daily, Vitamin D 2000 IUs daily

Worsening DEXA score→ treatment change

High Risk Medication:

Basic labs Monitored (CBC,CMP and ESR): ordered Labs routinely ordered due to high risk medication use- dysfunction and disease act…

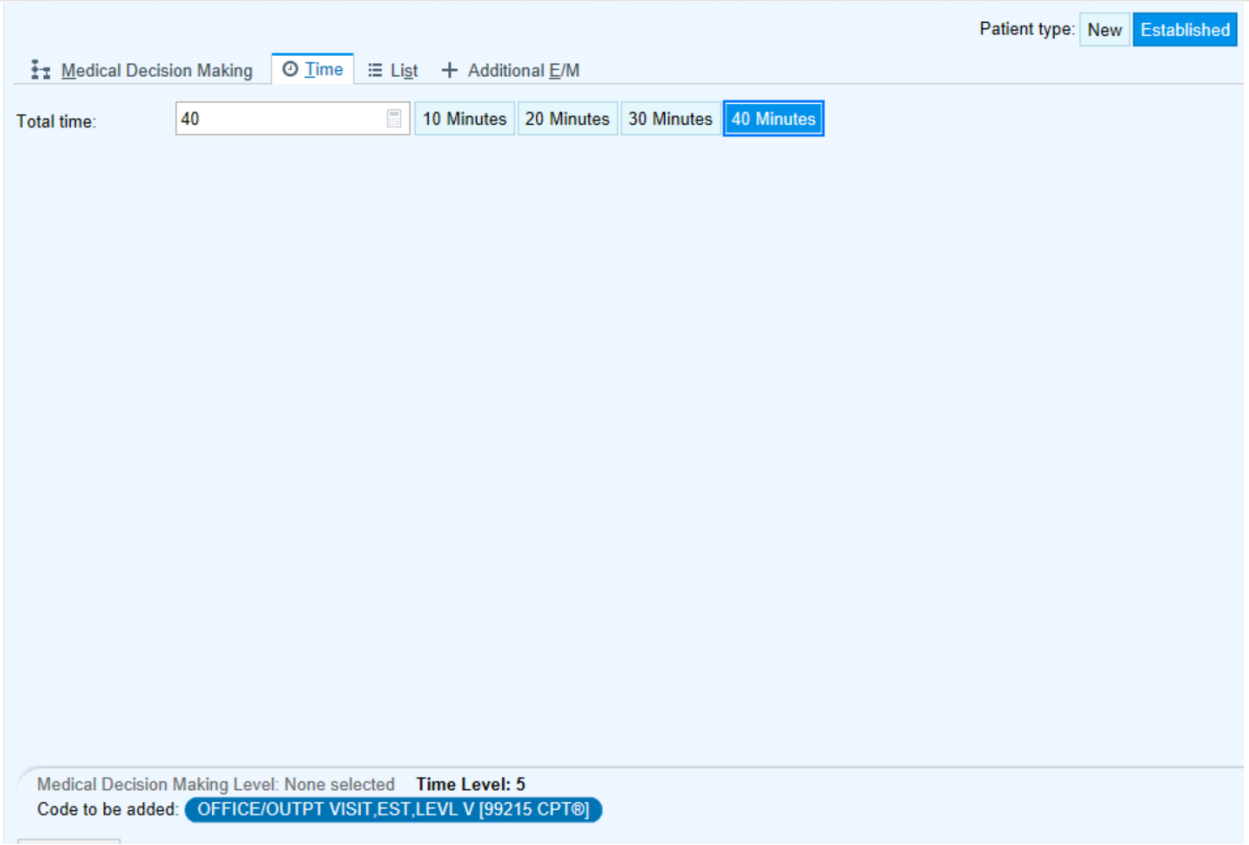
Risk of complications: Plaquenil toxicities / Methotrexate lab monitoring

Hepatitis panel negative 2014 This will be checked every 5 years based on patients risk or at time of biologic drug change.

Chest x-ray satisfactory 2000 No evidence of cardiopulmonary disease

TB test negative 2/2022

Time Based Established Patient Billing – Level 5



How can this work impact your compensation?

	CPT Code	Year	
		wRVU 2022	wRVU 2021
New	99202	0.93	0.93
	99203	1.60	1.42
	99204	2.60	2.43
	99205	3.50	3.27
Established	99211	0.18	0.18
	99212	0.70	0.48
	99213	**1.30**	**0.97**
	99214	**1.92**	**1.5**
	99215	**2.80**	**2.11**

Base Salary : 100k
$100,000/$30 = 3,333 wRVU needed

Consider:
16 Follow-ups/day 5 days a week= 80pt/wk
49 weeks a year (removed PTO/holidays)
49(80)= 3,920 FU per year

80% 99214= 3,136 FU
20% 99213= 784 FU

3136 FU x **1.5wRVU (level4)**= 4704wRVU

784 x **0.97wRVU (level 3)** = 760.48wRVU

Total wRVU= 5464.48
Less Base (3,333RVU)= 2131.48 rvu

2131.48 rvu x $30 = $63,944.40

Total compensation: $163,944.40

CPT	wRVU (2021)	Compensation $30 per wRVU
99202	0.93	$27.90
99203	1.42	$42.60
99204	2.43	$72.9
99205	3.27	$98.1
99211	0.18	$5.40
99212	0.48	$14.40
99213	**0.97**	$29.1
99214	**1.5**	$45
99215	**2.11**	$63.30

What is your value?

Value = Non-Billable Work

Operations

- Workflow development– Access and wait time improvement
- Rheumatology is a “high touch specialty”. Can you help your organization meet benchmarks to meet their value-based metrics?

Learn something or Teach someone

- Train- How do you prove your competency beyond CMEs?
- Take students/ Educate nursing and ancillary staff/ Seek speaking opportunities
- Participate in Committee and Organizations
- Add a modality- vaccines, DEXA, punch biopsy
- Add a degree or certification.

Lets hear it!

What is your experience?

How can you make changes in your practice?

What value do you bring?

References

Battafarano DF, Ditmyer M, Bolster MB, et al. 2015 American College of Rheumatology workforce study: Supply and demand projections of adult rheumatology workforce, 2015-2030. *Arthritis Care Res*. 2018;70(4):617–626.

Correll CK, Ditmyer MM, Mehta J, et al. 2015 American College of Rheumatology workforce study and demand projections of pediatric rheumatology workforce, 2015–2030. *Arthritis Care Res.* 2022;74(3):340–348

Miloslavsky EM, Bolster MB. Addressing the rheumatology workforce shortage: A multifaceted approach. Semin Arthritis Rheum. 2020 Aug;50(4):791-796. doi: 10.1016/j.semarthrit.2020.05.009. Epub 2020 May 25. PMID: 32540672; PMCID: PMC7255118.