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Tom Stevens,
CMC, CMIS, CMOM,
CCS-P, CPC

On the topic:
Proper Billing for Non-Physician Provider Services
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Proper Billing for Non-Physician Provider Services

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Overview

• Introduction
• “Incident To” Billing Criteria
• Auxiliary Personnel
• Setting of Service
• Therapy Services
• Differences between Nurse Practitioner and Physician Assistant
• Reimbursement Issues
• “Incident To” FAQs
Introduction

• Medicare provides reimbursement for non-physician provider services that are “incident to” a physician’s service. “Incident to” services are specific to Medicare billing and have defined guidelines that must be followed.

• When billing “incident to” services, a practice can be reimbursed 100% of the physician’s fee schedule. Failing to bill or billing incorrectly for “incident to” services could cost a practice thousands of dollars each year.

Introduction (continued)

• Medicaid carriers in most states often follow the rules set by Medicare for billing of these types of services, but not always.

• Other carriers may reimburse for non-physician practitioners differently, and it is imperative that you review your participation agreement with every contracted managed care company.

• However, like Medicaid carriers, Medicare often sets the standard for other carriers, therefore, making it important to understand Medicare guidelines even if your healthcare organization does not accept Medicare.

• State medical board and licensure laws should also be considered when billing for non-physician practitioners, as these can vary from state to state.
“Incident To” Billing Criteria

• Definition
• Requirements for “Incident To” Billing
• Direct Supervision
• Coverage Criteria
• Examples of Non-Physician Practitioners (NPP)

Incident To

• The physician personally furnishing the services or supervising the auxiliary personnel furnishing the services or supplies must have a relationship with the legal entity billing and receiving payment for the services or supplies.

• The “incident-to” services or supplies must represent an expense incurred by the physician or legal entity billing for the service or supplies.
• When a physician supervises auxiliary personnel who assist him or her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered “incident to” the physician’s service if there is a physician service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

• Services provided by auxiliary personnel in an institution such as a nursing home or convalescent home are especially problematic in determining if direct supervision exists.

• The availability of the physician by phone and the presence of the physician somewhere in the institution do not constitute direct supervision.
• Some state carriers will consider “incident to” in an institution to be met if the physician is in the same wing and on the same floor as the auxiliary personnel performing services other than E/M services.

• Medicare released a ruling in 2006 that “incident to” E/M services may not be performed throughout the facility but must be confined to a discrete part of the Skilled Nursing Facility or Nursing Facility as an office by the physician.

Auxiliary Personnel

• Auxiliary personnel constitutes any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician.

• The supervising physician may be an employee, leased employee, or independent contractor of the legal entity billing and receiving payment for the services or supplies.
Non-Physician Practitioners

In addition to coverage being available for the services of auxiliary personnel such as nurses, technicians and therapists when furnished “incident to” the professional services of a physician, a physician may also have the services of certain non-physician practitioners (NPP’s) covered as services “incident to” a physician’s professional services.

- NPPs include NPs, PAs, CNSs, certified nurse midwives, clinical psychologists, and clinical social workers.
- Services performed by these NPPs “incident to” a physician’s professional services include not only services ordinarily rendered by a physician’s office staff member such as blood pressures, temperatures, and administering injections, but also services ordinarily performed by the physician himself such as minor surgery, setting casts or simple fractures, reading x-rays, and other activities that involve evaluation or treatment of a patient’s condition.
Setting of Service

- “Incident to” a Physician Service in Clinic
- Departmentalized Clinics
- Hospital Setting
- Billing Requirements
- Shared/Split Visits is an Office or Clinic Setting
- Shared/Split Visits in a Hospital Inpatient, Outpatient, and Emergency Department Setting
- Shared/Split Visits in a Skilled and Non-Skilled Facility

“Incident To” Therapy Services

- Since 2005, Medicare has paid for physical therapy, occupational therapy and speech language pathologist services “incident to” the physician’s service.

- Medicare pays for therapy services performed by physical therapy assistants and occupational therapy assistants when performed under the supervision of a therapist.
• Therapy services appropriately billed “incident to” the physician service will meet the same requirements as therapy services that would be furnished by a physical therapist, occupational therapist or speech-language pathologist in any outpatient setting with one exception:

– when therapy services are performed “incident to” a physician/NPP service, the qualified personnel who perform the service do not need to have a license to therapy, unless it is required by the state. The qualified personnel must meet all other requirements except licensure.

Example

• If a physical therapist and a physical therapy assistant, or occupational therapist and occupational therapy assistant are both employed in a physician’s office, the services of the PTA, when supervised by the PT or the services of the OTA when supervised by the OT may be billed by the physician group as PT or OT services using the PTs or OTs provider number.

• If the PT or OT does not have their own provider number, Medicare will not pay for the service of the PTA or OTA as “incident to” the physician/NPP’s service.
Requirements For Therapy “Incident To”

- Therapy services must be covered and payable as outpatient rehabilitation service.

- Therapy services must be provided by or under the direct supervision of a physician/NPP who is legally authorized to practice therapy services by the state in which he or she performs such function or action.

- The services must be of a level of complexity that requires that they be performed by a therapist or under the direct supervision of the therapist, physician/NPP who is licensed to perform them. Services that do not require the performance or supervision of a therapist or physician/NPP will not be considered reasonable and necessary services even if performed or supervised by a therapist or physician/NPP.

Split/Shared Documentation

- A split/shared evaluation and management (E/M) visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified non-physician practitioner (NPP) each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service.

- A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service.
Split/Shared E/M Service
Office/Clinic Setting

- In the office/clinic setting when the physician performs the E/M service the service must be reported using the physician’s UPIN/PIN.

- When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed “incident to” if the requirements for “incident to” are met and the patient is an established patient.

- If “incident to” requirements are not met for the shared/split E/M service, the service must be billed under the NPP’s UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

Examples

1. If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.

2. In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the “incident to” requirements are not met, the service must be reported using the NPP’s UPIN/PIN.
• In the rare circumstance when a physician (or NPP) provides a service that does not reflect a CPT code description, the service must be reported as an unlisted service with CPT code 99499.

• A description of the service provided must accompany the claim. The carrier has the discretion to value the service when the service does not meet the full terms of a CPT code description (e.g., only a history is performed).

• The carrier also determines the payment based on the applicable percentage of the physician fee schedule depending on whether the claim is paid at the physician rate or the non-physician practitioner rate.
  – CPT modifier -52 (reduced services) must not be used with an evaluation and management service. Medicare does not recognize modifier -52 for this purpose.

Hospital Inpatient/Outpatient/Emergency Department Setting

• When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number.

• However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.
Differences Between Nurse Practitioner and Physician Assistant

• Education
• Scope of Practice
• Protocols

Education

• A nurse practitioner (NP) is a registered nurse (RN) with a master’s degree in nursing (although some older NPs are certificate prepared). Non-registered nurses cannot be nurse practitioners.

• NPs are licensed and governed by the Board of Nurse Examiners for the state they are practicing in and certified by various nursing specialty organizations. Note that nurses are under their own license, whereas physician assistants (PAs) are under a delegation agreement.
Education

• A physician assistant has an undergraduate or master’s degree from an approved PA program. It is possible for an RN or a licensed vocational nurse (LVN) to be a PA.

• These NPPs are licensed and governed by the State Board of Medical Examiners and also the State Board of Physician Assistant Examiners for the state of practice.

Scope of Practice

• Both nurse practitioners and physician assistants can perform physician services as defined by the scope of practice defined by their state laws.

• Each has limited prescriptive authority. These NPPs can perform services in all settings; i.e., inpatient, outpatient, SNF, nursing home or patient’s home.
Protocols

- Protocol requirements for nurse practitioners (NP) and physician assistants are different. Nurse Practitioners must have collaboration agreement with the physician with which they relate even if one is not required by their state laws.

- They must have written authorization to provide the medical aspect of patient care that are agreed upon and signed by the NP and the physician. These protocols must be reviewed and signed at least annually and maintained in the practice setting of the nurse practitioner.

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Protocols

- Protocols are defined to promote the exercise of professional judgment by the nurse practitioner based on their education and experience.

- Such protocols need not describe the exact steps that the nurse practitioner must take with respect to each specific condition, disease, or symptom and may state types or categories of drugs which may be prescribed rather than just life specific drugs.

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Protocols

- Each team of physicians and physician assistants are obligated to ensure that the PA's scope of practice is defined. The relationship of each of the members of the team must also be defined.

- The relationship of and access to the supervising physician must be spelled out. The team must ensure that the delegated medical tasks are appropriate for the level of the PA's competency. A process for evaluation of the PA's performance must also be established and described.

Reimbursement Issues

- Provider-Based Facility vs. Office-Based Facility
- Medicare Reimbursement
- Medicaid Reimbursement
- Private Carrier Reimbursement
Provider-Based Facility vs. Office-Based Facility

• Provider-based facility designation is determined by Medicare.

• Two bills are produced and billed to the patient or the appropriate source. The hospital facility will bill diagnosis-related groups (DRGs) for inpatient services and Ambulatory Payment Classifications (APCs) for outpatient services on the UB-04 form.

• The provider’s professional services are billed on the CMS 1500. Certain clinics are designated as provider-based facilities.

Office-Based Facility

• A facility will be considered an office-based facility if it does not meet the provider-based facility designation by Medicare.

• One bill is produced for the provider’s professional services and billed on the CMS 1500.
Medicare Reimbursement

- Nurse practitioners and physician assistants may apply and receive NPI numbers. In the provider-based facility they will bill for their services under their own provider numbers and entitled to 85% of the physician’s fee schedule. Documentation requirements are the same as those for physicians. ‘Incident to’ services are prohibited in a provider-based facility.

- In the office-based facility, a nurse practitioner or physician assistant may bill for their services either under their own provider number and be entitled to 85% of the physician fee schedule or bill ‘incident to’ and receive 100% of the physician fee schedule. ‘Incident to’ rules must be followed. NPs and PAs are not allowed to see new patients as the physician is required to perform the initial visit under the ‘incident to’ rules.

- Nurse practitioners and clinical nurse specialists may assign the right to payment to the employer, (this must be done for the employer to be able to receive reimbursement for their services), have independent contractor relationships when their services are billed under their own provider numbers, and even establish independent practice groups.

- Certified nurse midwives (CNMs) are at 100% of the physician fee schedule for OB pregnancy care. Everything else is at 85%. Certified registered nurse anesthetists (CRNAs) are at 92 % of the physician fee schedule.
Medicare Managed Care

• Under the statute and regulation for Medicare Managed Care, nurse practitioners may serve as PCPs on Medicare Managed Care Panels. They may also appeal claims in behalf of their patients. Non-discrimination language in the legislation prevents carriers from excluding nurse practitioners from provider panels and allows them to represent patients in appeals for rejected claims.

Source:

Medicare Reimbursement

• Physician assistants must comply with state laws about physician supervision and the protocol by which they collaborate with a physician.

• They cannot establish independent practice groups but they can have independent contractor relationships when their services are billed under their own provider numbers and payment is reassigned to their employer.
Medicaid Reimbursement

- In most states, nurse practitioners are allowed to bill under their own provider numbers and be entitled to 85% of the physician fee schedule or bill under the physician’s provider number and be entitled to 100% of the fee schedule.

- Physician Assistants are only allowed to bill under the physician’s provider number. Medicaid does not require physician supervision of the NP or PA in the clinic setting.

Private Carrier Reimbursement

- Some private carriers will cover medical services provided by NPs and PAs when they are ‘incident to’ services or services that are considered part of the surgical global.

- Other carriers may require the NPP to be credentialed and enrolled as a provider with that insurer.
Texas Medical Association:
Incident Billing Requirements

Medicare Option #2
All the following requirements must be met before an NPP may bill under the "incident to" provision:

• The NPP must be an employee of the physician.

• The initial visit (for that condition) must be performed by the physician. This does not mean that on each occasion of an incidental service performed by an NPP, that the patient must also see the physician.

• It does mean there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the services being performed by the NPP is an incidental part.

• There must be direct personal supervision by the physician as an integral part of the physician's personal in-office service.

• The physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.

• The physician has an active part in the ongoing care of the patient. Subsequent services by the physician must be of a frequency that reflects his/her continuing active participation in, and management of, the course of the treatment.
Frequently Asked Questions for “Incident To” Services

What types of services are considered eligible for “Incident To” reimbursement?

- The service must represent an expense to the physician. The service must be one that is commonly furnished in physicians' offices or clinics.
- The service must be commonly rendered without charge or included in the physician’s bill.
- The service must be rendered under the direct supervision of the physician and, the physician must evaluate and initiate the plan of care.
In a group practice setting, if a physician’s patient is scheduled for an office visit with a physician’s assistant who is a member of the practice while the physician is on vacation, how is the service billed?

- In clinical practices there are a number of physicians who are not “assigned” specific patients; but rather, see the patients of the practice. In these practices any one of the physicians may act as the supervising physician for any patient when seen by a physician’s assistant who is also a member of the practice. Of course, all of the other “incident to” guidelines must be met.
• The Medicare Carriers Manual 2050.3 covers “incident to” services in a clinic or group association (or group practice).

• This section states: “In highly organized clinics, particularly those that are departmentalized, direct personal physician supervision may be the responsibility of several physicians as opposed to an individual attending physician.”

Can I submit claims “Incident To” if my office is located in the hospital facility or on the hospital grounds?
Can I submit claims “Incident To” if my office is located in the hospital facility or on the hospital grounds?

- A physician’s office within a hospital facility must be confined to a separately identified part of the facility that is used solely as the physician’s office and cannot be construed to extend throughout the entire hospital facility.

- In addition, there must be a distinction between the physician’s office practice and the hospital.

The patient has a surgical procedure in the hospital and there is a global period. Can the registered nurse go to the inpatient hospital floor and see the patient, document a progress note and later the same day, the physician sees the patient and uses the nurse’s progress note to bill Medicare?
The patient has a surgical procedure in the hospital and there is a global period. Can the registered nurse go to the inpatient hospital floor and see the patient, document a progress note and later the same day, the physician sees the patient and uses the nurse’s progress note to bill Medicare?

- The physician can refer to the nurse’s documentation, but it is not acceptable to use his/her work when determining the level of service to bill by the physician. Remember “Incident To” does not apply in a facility setting.

If an NP is working under an independent contract with a physician, can the NP’s services be billed under the physician’s provider number to get 100% of the Physician Fee Schedule rate?
If an NP is working under an independent contract with a physician, can the NP's services be billed under the physician's provider number to get 100% of the Physician Fee Schedule rate?

- Yes. Under Medicare rules, if the other parts of the “Incident To” rules are followed (i.e., the physician is present in the suite and the physician has conducted the initial visit, which reflects his or her active participation in the management of the course of treatment.)

- CMS clearly stated in the Federal Register on November 1, 2001 that the employment relationship is irrelevant to “Incident-To” billing are Medicare’s rules.

- Other insurers may or may not require adherence to the incident-to rules when billing an NP’s work under a physician’s name.

- Physicians and practice managers wanting to submit bills under a physician’s provider number for services performed by an NO must read the policies of and contracts with each insurer and MCO with which the practice does business, and, if finding nothing to address the practice’s provider arrangement, query the payer, in writing, before assuming that all bills submitted under a physician’s name will be paid.
Is a physician required to be on-site or available within any specific time frame while an NP is working?

- The answer regarding physician presence depends upon the provider under whose name and number the visit will be billed, the state where the services are provided, and the insurer.

- **Example:** if billing Medicare under an NP's provider number, a physician need not be on-site, unless state law requires physician presence. However, if billing Medicare under a physician's provider number, that physician must be on-site, within the suite of offices where the NP is practicing.
• State law may require the presence of a physician or availability within a specific time frame. Insurers other than Medicare may or may not require physician presence.

• In general, insurers other than Medicare do not require physician presence.

• For state law requirements, query the state board of nursing.

Is a physician required to read and/or cosign an NP’s history and physical, progress note, or other documentation?
Is a physician required to read and/or cosign an NP’s history and physical, progress note, or other documentation?

• No, unless specifically required by state law. For a state’s requirements, query the state board of nursing.

I am a physician and I employ an NP. He/She takes the history and performs the physical examination, then we discuss the diagnosis and treatment plan, and she implements the plan. I cosign the chart. Will my signature suffice in getting reimbursement under my name?
I am a physician and I employ an NP. He/She takes the history and performs the physical examination, then we discuss the diagnosis and treatment plan, and she implements the plan. I cosign the chart. Will my signature suffice in getting reimbursement under my name?

- A physician’s co-signature is not useful in obtaining reimbursement. If billing Medicare under the incident-to rules, a physician must follow the incident-to rules, which say nothing about co-signature.

- For example, if an NP conducts a visit with a new patient, the practice must make a choice – bill the visit under the NP’s provider number or bill the visit under the physician’s provider number, and have the physician, not the NP, perform and document the portions of the evaluation relevant to the choice of procedure code.

- The physician’s signature or writing “agree” on an NP’s evaluation will not suffice for Medicare. Other insurers may have different rules, but no insurer pays extra if a physician cosigns an NP’s records.

Can services provided by NPs in a hospital outpatient, department or emergency department be billed to Medicare under a physician’s number?
Can services provided by NPs in a hospital outpatient, department or emergency department be billed to Medicare under a physician’s number?

- No. Incident-to billing is not allowed in a hospital. The services must be billed under the NP’s provider number, assuming no other provider has billed the service and the NP’s salary has not been reimbursed by Medicare under the hospital’s cost report.

I am a specialist physician, in solo practice. I want to engage an NP under an independent contract to provide hospital visits, an occasional home visit, an occasional nursing home visit, and see patients in my office on days when I am in the office and on some days when I am off. I want to bill all visits under my own provider number. I may have the NP do some in-office procedures, such as flexible sigmoidoscopy. Can I do this?
I am a specialist physician, in solo practice. I want to engage an NP under an independent contract to provide hospital visits, an occasional home visit, an occasional nursing home visit, and see patients in my office on days when I am in the office and on some days when I am off. I want to bill all visits under my own provider number. I may have the NP do some in-office procedures, such as flexible sigmoidoscopy. Can I do this?

- Yes, you can engage an NP as an independent contractor. Payments can come to you, under the term of your contract with the NP. However, to bill Medicare for the NP’s services, you will need to change your status with Medicare as a sole practitioner to that of a group practice.

- Under Medicare rules, NPs can perform nursing home visits, home visits, hospital visits, and office visits, and can perform such procedures as flexible sigmoidoscopy, as long as the scope of practice for an NP under state law authorizes diagnosis, treatment, and diagnostic procedures, or you delegate those functions to the NP under your collaborative agreement. You must bill the following procedures conducted by the NP to Medicare under the NP’s provider number.
  - Home visits
  - Nursing home visits (unless you rent space in a nursing home and are in that rented space at the time the NP sees patients in that space).
  - Office visits when you are not present in the office suite, and
  - Hospital visits.
Our hospital employs NPs who provide services to surgeon’s patients to improve the flow of admission and discharge. The NPs also perform some diagnostic procedures in the hospital, for the surgical service. Can the hospital bill for the NP’s services?

- The reassignment rules have implications on billing services provided in a setting where NPs and physicians practice together but have different employers.

**Example:**

An NP is employed by a hospital, and performs preoperative evaluations, postoperative visits, and discharge services for surgeons’ patients. The NP spends one afternoon a week in a surgeon’s office, seeing patients the NP had followed in the hospital, for the postoperative office visit. The surgeon is incorporated, and is an employee of his or her own corporation.
The hospital’s goal in hiring the NP is to improve the efficiency of admissions and discharges. The hospital is no longer getting any reimbursement from Medicare under its cost report, and the hospital wishes to bill the NP’s services to Medicare under Part B as physician services.

The Medicare billing issues are as follows:

– Who can bill for the NP’s preoperative evaluations, postoperative visits, and admission and discharge services to the surgeon’s patients?
– Who can bill for the NP’s visits conducted in the surgeon’s office?

The basic principles are as follows:

1. An NP’s services in a hospital must be billed under the NP’s own number.
2. Only one bill may be submitted for any given service to any given patient on any given day from the same provider, specialty, and practice.
3. Services must be billed under the provider number of the provider performing the service, unless billing incident to is appropriate and the rules are followed.
4. The global fee for surgery is billed by the surgeon and includes intensive care unit visits by the surgeon; preoperative visits; intra-operative services; and postoperative visits related to recovery from the surgery; pain management, complications, dressing changes, local incisional care, and removal of sutures and drains. The global fee does not include the initial surgical consultation, services of other physicians, visits unrelated to the surgical diagnosis, treatment for an underlying condition, diagnostic tests, clearly distinct surgical procedures, and treatment for a postoperative complication that requires a return to the operating room.

5. Under reassignment rules, Medicare will pay only the NP, or the NP’s employer, or the facility in which services are rendered if there is a contractual relationship between NP and facility.

An application of these rules to the facts given yields the following conclusions:

a. If this NP, rather than the surgeon, is performing some significant parts of the surgeon’s work for which the surgeon is seeking payment under the global fee, and the surgeon has not formally transferred the care to the NP, then the surgeon may be billing for services he or she did not render. If so, the surgeon is risking a charge of Medicare fraud. Furthermore, incident-to billing is not allowed in the hospital setting, so the NP’s services would be correctly billed under the NP’s own provider number. Because the surgeon does not employ the NP, payments for services submitted under the NPI’s provider number must be made to either the NP or the NP’s employer – the hospital.
b. If the surgeon is billing the NP’s visits to patients in his office under his own number, presumably under the incident-to rules, the payments for the NP’s work have to go to the NP’s employer, under the reassignment rules.

c. Finally, if the surgeon is billing and receiving payment for work done by the NP, then the hospital, as employer of the NP, is subsidizing the surgeon’s practice. Such a subsidy could be a kickback, which is illegal under federal law.

A series of contracts between surgeon, hospital, and NP could correct the legal problems inherent in this example, and enable the hospital to bill some of the NP’s services.

How can a practice convince a commercial managed care plan to admit NPs to provider panels?
How can a practice convince a commercial managed care plan to admit NPs to provider panels?

A practice may want managed care plans to admit its NPs to provider panels to:

- Avoid the possibility that a plan will decide it is contrary to the contract, or worse, fraudulent, to have an NP provide the care when a physician is listed as the provider;
- Increase the number of patients a practice can take on, if a plan limits the size of the provider panels;
- Create incentives for NPs to take responsibility for panels of patients and to increase the number of patients in a practice; and
- Align policies with current practice.

When attempting to get a managed care plan to change its policy and admit NPs to provider panels, use this checklist:

1. Ascertain whether state laws allows NPs to be managed care providers.
2. Identify the individual or individuals at the MCO who can make the decision to change company policy.
3. Ask for a meeting and present the case for empanelment of NPs.
4. In the meeting, ask what stands in the way of NPs being included on provider panels.
5. Address the barriers to empanelment with the provider panels.

6. Work with the appropriate individuals or committees to effect policy. The entity most likely to persuade an MCO to change its policy is a large employer that purchases health services through the MCO.

7. If policy does not change, follow up with the organization every six months, asking, “What stands in the way of NPs getting on provider panels?”

Can a mid-level provider (i.e., nurse practitioner, physician assistant, etc.) perform the wound procedure codes 97597 and 97598?
Can a mid-level provider (i.e., nurse practitioner, physician assistant, etc.) perform the wound procedure codes 97597 and 97598?

- A mid-level provider may perform these services.

Can a provider based clinic (PBC) using place of service (POS) code 22 bill under the incident to provisions for services provided by ancillary staff or mid-level providers?
Can a provider based clinic (PBC) using place of service (POS) code 22 bill under the “incident to” provisions for services provided by ancillary staff or mid-level provider?

- No. Services provided in a POS other than office (11) or home (12) do not meet the incident to guidelines as described in the CMC Internet-Only Manual.

- Services provided by mid-level providers (physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwife) may be billed to Medicare Part B under his/her provider number. Services provided by ancillary staff are not billed to Medicare Part B. Instead, the facility includes those charges in their bill submitted to Medicare.

- For those providers who have submitted charges and received payment under the MD/DO provider number for services provided by the mid-level providers should determine the difference in rates and refund Medicare.

How does time and evaluation and management (E/M) apply when the services are provided by a mid-level provider or by both a mid-level provider and the MD/DO as a shared/split visit?
How does time and evaluation and management (E/M) apply when the services are provided by a mid-level provider or by both a mid-level provider and the MD/DO as a shared/split visit?

- A MD/DO providing the service can use time to choose the procedure code. A mid-level providing the service can use time to choose the procedure code. Time cannot choose the procedure code when the service is a shared/split service between the MD/DO and mid-level provider.

- When using time to choose a level of procedure code, the counseling/coordination of care guidelines must be met. Part of this guideline is that the counseling/coordination of care is more than 50% of the face-to-face time spent with the physician. This is reflected in the CMS Internet-Only (IOM).

Can a clinic use and bill for a locum tenens mid-level provider while a mid-level provider is not present?
Can a clinic use and bill for a locum tenens mid-level provider while a mid-level provider is not present?

Locum tenens and reciprocal billing is only available for MD/DO. If you are hiring a temporary replacement for your mid-level provider you will need to enroll the new person with Medicare. You can find more information on the CMS website.

If a mid-level provider is the only clinician in an office and x-rays are performed by a technician, can the technical component of the x-ray be billed under the mid-level provider number?
If a mid-level provider is the only clinician in an office and x-rays are performed by a technician, can the technical component of the x-ray be billed under the mid-level provider number?

- No. Mid-level providers cannot supervise diagnostic tests. They can order a diagnostic test, they can perform the technical component acting as the technician, they can provide the professional component in performing the interpretation and report, but they cannot supervise a technician performing the service.
- In the example given, if the supervision requirements are met, the technical portion of the diagnostic test can be billed under the MD/DO.

What is a Non-Physician Practitioner (NPP) and how does the definition apply in the ED?
What is a Non-Physician Practitioner (NPP) and how does the definition apply in the ED?

- A NPP in the ED is defined by Medicare as either a nurse practitioner (NP) or a physician assistant (PA).

When an NPP and an emergency physician provide care to the same Medicare patient, how is the record evaluated to determine if the E/M service should be assigned to the NPP or the emergency physician?
When an NPP and an emergency physician provide care to the same Medicare patient, how is the record evaluated to determine if the E/M service should be assigned to the NPP or the emergency physician?

- When an ED E/M is shared between a physician and an NPP from the same group practice and the physician provides and documents say “face-to-face” portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s NPI number.

- However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by discussing the case with the NPP or reviewing the patient’s medical record) then the service may only be billed under the NPP’s NPI and payment will be made at 85% of the Medicare physician fee schedule.

What documentation is necessary for the emergency physician to indicate a shared E/M service?
What documentation is necessary for the emergency physician to indicate a shared E/M service?

- The medical record must clearly identify both the NPP and the emergency physician who shared in rendering the service. The emergency physician documentation should be linked to the NPP documentation of the shared service, and affirmatively state one or more elements of the encounter. This element may be an element of history physical examination, or medical decision-making.

- In a shared E/M situation, both parties must document the work they performed. A generic attestation of “I have seen and evaluated this patient and agree with the PA notes” or a notation of “seen and agreed” or “agree with above” would not qualify the service as a shared visit.

Can an NPP perform Critical Care?
Can an NPP perform Critical Care?

- Critical care services may be provided by qualified NPPs and reported for payment under the NPP’s National Provider Identifier (NPI) when the services meet the definition and requirements of critical care services.
- The provision of critical care services must be within the scope of practice and licensure requirements for the State in which the qualified NPP practices and provides the service(s).

Can the NPP Critical Care time and the emergency physician Critical Care time be added together and reported as a shared service?
Can the NPP Critical Care time and the emergency physician Critical Care time be added together and reported as a shared service?

- A critical care code for the specific time period (either 99291 or 99292) cannot be reported as a split/shared E/M service.
- Each critical care code shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified non-physician practitioner and shall not be representative of a combined service between a physician and a qualified NPP.

When a NPP performs an independent service must a doctor also sign the chart, or can the service be billed with only the NPP’s signature?
When a NPP performs an independent service must a doctor also sign the chart, or can the service be billed with only the NPP’s signature?

• The physician’s requirement to provide supervision of the NPP is governed by individual state licensing regulations and hospital medical staff policies and procedures.
• Additionally, different payers might interpret the definition of supervision differently.

Can the emergency physician bill for a procedure that is performed by an NPP on a Medicare patient?
Can the emergency physician bill for a procedure that is performed by an NPP on a Medicare patient?

- Procedures and interpretations performed by the NPP must be billed using the NPP’s NPI number. The shared service rules only apply to E/M services and “incident-to” does not apply in the ED.
- Any physician or non-physician practitioner (NPP) authorized to bill Medicare services will be paid by the carrier at the appropriate physician fee schedule amount based on the rendering NPI.

Can NPPs provide services to non-Medicare patients?
Can NPPs provide services to non-Medicare patients?

- Yes, but be sure to consider state regulations NPP scope of practice. For instance, in Ohio physician assistants could initiate treatment for new patients without directly consulting their supervising physician.

- In addition, Ohio law did not permit physician assistants to prescribe medications, but passed a bill giving nurse practitioners prescription privileges.

- In 2007, the law in Ohio was amended and the language prohibiting PA's from independently initiating treatment was removed. That same legislative change gave PA's prescribing (Sch. III-V). All 50 states now give PA's prescribing authority.

- Additionally, all states, including Washington, DC cover PAs under Medicaid fee-for-service or managed care plans. There are some variances to coverage, such as Missouri Medicaid. They do not cover PAs in the hospital setting.

- It is not unusual for the Medicaid office to ask that PAs submit bills under the name of the supervising physician. Some state Medicaid programs will limit procedure reimbursement when the state itself recognizes the procedure as within the NPP’s scope of service. Check with your state Medicaid carrier for specific policies and procedures. All 50 states now give PAs prescribing authority.
What is a modifier and how does it affect physician assistant or nurse practitioner billing?

Is a modifier needed for physician assistant or nurse practitioner billing?

- Modifiers are two character, either alpha or numeric codes that can be appended to CPT codes to “modify” the service.

- In the past, Medicare required modifiers such as “AN” or “AS” to identify services involving a physician extender.

- Medicare carriers have abandoned the use of modifiers for physician extenders and now require physician assistants and nurse practitioners to obtain and use NPIs to identify their services.
Can an NPP act as a scribe for the physician?

- Yes, but be careful. A scribe records the findings of a physician.
- If the NPP independently obtains the history and performs a physical exam, a third party payer might not consider this a scribe function but rather an independent service component by a healthcare provider, hence subject to the payer’s relevant payment policies.
To what extent, if any, will Medicare rules apply when NPPs treat patients who are in Medicare managed care plans?

General CMS rules should still apply, although you should check with the specific managed care plan to verify any policies in question.
What services are NPPs allowed to provide in the ED?

• Medicare will pay for ED E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP) and physician assistant (PA)).

• The services provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices.
Copy/Paste or Cloning

• Incorporating information that is not original to the author into a note also has the potential to jeopardize patient care and to expose providers and/or institutions to liability on several fronts.

• Risks include populating a note with outdated, conflicting, incomplete or inaccurate information that can result from many of the copy functions available in an EHR.

Copy/Paste or Cloning (Cont.)

• Example: The ability to default or autopopulate checkboxes (primarily in review of systems and physical exams) to “no” or “negative” upon starting a new note or closing a note may inadvertently include conflicting information in a single note. – i.e., a negative finding in the review of systems, but a positive chief complaint.
Copy/Paste or Cloning (Cont.)

Risks, continued:
• Inability to identify the original author in the EHR
• The original date of note creation may not be evident or may be difficult to locate
• Notes that are repetitive, inconsistent or identical. Such notes do not further the care of the patient and, over time, are likely to be ignored by care givers due to stagnant information
• Repetitive documentation may call into question the medical necessity of the care, thus triggering insurance payment denials, audits and/or investigations

Copy/Paste or Cloning (Cont.)

Risks, continued:
• Notes that are too long and contain irrelevant information. When a note is excessively long and cluttered with “canned” text, the important parts are likely lost to the reader. This increases the risk that pertinent, new and critical information is overlooked, or may not be read by other providers
• Misleading or false attribution of work performed by others into the current note.
WEB RESOURCES

- https://www.acep.org/Clinical---Practice-Management/Medicare-Mid-Level-Provider-FAQ/
- https://med.noridianmedicare.com/web/ebt/topics/incident-to-services
- http://www.novitas-solutions.com/webcenter/portal/MedicareJH/page/pagebyid?contentId=00004947&_adf.ctrl-state=1d5ypxay0a_4&_afrLoop=20957544637807f5f#!

Questions?

- Thank you for your attendance!
- Get your questions answered on PMI's Discussion Forum: http://www.pmimd.com/ pmiforum s/rules.asp