Correctly Charging NPP Services

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In the face of continually declining reimbursements and rising expenses, physicians are exploring all options to maximize revenue. The use of non-physician practitioners (NPPs), such as nurse practitioners (NP, ARNP, APN) and/or physician assistants (PA), may be a way to obtain full physician reimbursement under the Medicare "incident-to" formula. However, many providers are unaware of pitfalls in the documentation and coding required to ensure compliance with these guidelines.

Non-physician practitioners are professionals licensed by a State under various health programs to assist physicians or act in place of physicians. While many types of NPPs provide healthcare services today, this column focuses on services performed by nurse practitioners and physician assistants, which also may be referred to as midlevel providers. According to CGS Medicare in a January 2012 webpage notice:[1]

"If you are in charge of billing for non-physician practitioners in your office group, you may be billing erroneously."

The 2013 Office of Inspector General's (OIG) Work Plan includes a concern relating to the error rate for incident-to services performed by non-physician practitioners. According to the OIG:[2]

"We will review physician billing for 'incident-to' services to determine whether payment for such services had a higher error rate than that for non-incident-to services. We will also assess Medicare's ability to monitor services billed as 'incident-to.'

Medicare Part B pays for certain services billed by physicians that are performed by non-physicians incident-to a physician office visit. Incident-to services are a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. Incident-to services may also be overused and expose beneficiaries to care that does not meet professional standards of quality."

Hospitals and practices encounter few problems when billing for qualified NPPs in their own name and NPI number, but there are specific guidelines that must be met when the NPP performs services that are billed in the name of the supervising physician. The following is a list of recommended steps to ensure compliance when submitting charges for services performed by midlevel providers, but billed in the name of the supervising physician. CGS Medicare also provides the following information:[1]

"AdvanceMed is tasked with data mining to identify aberrant, and potentially fraudulent, billing patterns. Analysis has found an increase in the number of providers whose data demonstrates the physician is working up to, or more than 24 hours per day. After investigation by AdvanceMed, and many hours of physician and/or their office staff time, it was determined the issue was incorrect billing of NPP services under the physician [provider number]."

Key to reporting services performed by midlevel providers is the recognition that these practitioners are not resident physicians; a different set of billing rules exist for these midlevel providers.

Step 1. Qualified NPP

The OIG published a June 2001 report that states:[3]

"…when a service is not addressed in a scope, it cannot be assumed that a non-physician practitioner cannot provide that service. Scopes, as well as Medicare, call for collaboration with a physician. This may have the effect of either limiting or expanding the services that are allowed."

According to the Medicare Payment Advisory Commission (MedPAC), the collaboration agreement is a written contract that provides specific guidelines for the services to be performed by the NPP—both independently and under the direct supervision of a physician.[4] The Centers for Medicare & Medicaid Services (CMS) also states that it would expect an NPP performing a service to have all the qualifications needed to successfully complete, supervise, or interpret the procedure, therapy, or diagnostic test. Therefore, the cancer center should maintain information on the midlevel provider's education, training, and experience to support the independent provision of services.

The OIG recommended that CMS establish a modifier to identify services performed by a midlevel provider incident-to and billed in the name and identification number of the physician; to date CMS has declined to pursue the application of an incident-to modifier.

Step 2. State Guidelines & Scope of Practice

Each state has regulations regarding the scope of practice and level of supervision

required for each type of practitioner. Most NPPs know the scope of practice in their own state, but cancer center administration should also be familiar with these regulations to know which services can be performed by the midlevel practitioner.[5]

In addition, the American Medical Association (AMA) states:[6]

"Many physicians employing mid-level health care professionals, such as nurse practitioners and physician assistants, are unaware that their state might have mandatory filing requirements for the supervising physician or the mid-levels. Failure to comply with those requirements could result in monetary fines, license revocation and suspension, and/or criminal charges, depending on the state in which you practice."

This AMA article highlights contracting, paperwork, and related requirements for physicians who employ non-physician practitioners and ends with a recommendation that a physician consult with legal counsel to determine the relevant state filing requirements prior to hiring a midlevel provider.[6]

AMA adds a caveat that "some states require a physician to audit a percentage of the charts" for services performed by a midlevel provider.[7]

Step 3. Insurance Payer

The next step is to determine the patient's insurance coverage for services performed by a non-physician practitioner. While Medicare includes an incident-to policy in its guidelines, many managed care and traditional indemnity plans do not recognize the incident-to reporting convention for midlevel providers. For those payers who do not accept incident-to billing, the midlevel provider must be fully credentialed with the payer and all services provided must be reported in the name and identification number of the NPP. For example, Aetna published an update on billing for non-physician practitioners that said:[8]

"Beginning with June 1, 2010 dates of service, Aetna will pay midlevel practitioners at 85 percent of the contracted rates for covered professional services (consistent with the Centers for Medicare & Medicaid Services payment policy).

This policy applies to nurse practitioners, physician assistants, certified nurse midwives, and registered nurses. As of June 1, you will need to list the midlevel practitioner's name in the servicing provider field when you submit claims for services rendered by a midlevel practitioner."

In addition, some Medicaid contractors require providers to append a modifier to the HCPCS or CPT® procedure code when the service was performed by a PA or NP. For example, California Medi-Cal requires the following modifiers:

- U7: Used by Medi-Cal to denote Physician Assistant services billed in the name of the supervising physician
- SA: Nurse Practitioner rendering services in collaboration with a physician.

Physicians should obtain a provider number for each midlevel provider they employ. Not all services will meet incident-to criteria, and if an audit detects that services were billed in error in the name of the physician, the entire payment can be considered an overpayment. However, if midlevel providers have their own provider numbers, the physician could argue that the overpayment is limited to 15 percent of the payment received, since Medicare should have allowed 85 percent of the physician fee schedule for a service performed by the midlevel provider.

Step 4. Site of Service

To meet the incident-to requirements, the services must be of a type commonly furnished in a physician's office or clinic. While professional services may be provided by an NPP in a hospital or other institutional setting, these services would either be reported in the NPP's name and provider number, or considered to be part of the hospital's service, with the exception of encounters that meet the "shared visit" definition for Medicare patients.

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Step 5. Established Medical Condition

The physician must perform the initial patient evaluation and management service and develop the plan of care to initiate the course of treatment. As a result, new patient visits and consultations are never incident-to and cannot be reported as shared visits for Medicare patients. A written treatment plan results from the physician's initial patient encounter that provides orders and direction for the NPP and other practice employees to perform future services incident-to the physician's initial evaluation.

If the non-physician practitioner is providing follow-up care for an established medical condition (initially evaluated by the physician), but the patient reports *any new medical problem*, the physician must participate in the evaluation of the new problem in order for the service to be reported in the name of the physician. This participation must include separate physician documentation in the medical record for the treatment of a new medical condition, including a visit note and update to the care plan. If the NPP provides evaluation and treatment of a new medical condition (i.e., a condition not previously evaluated by the physician), then the services are reported in the name of the NPP.

Step 6. Active Involvement

According to CMS, the treating physician must not only perform the initial patient visit service, but also provide subsequent services at a frequency that reflects his or her continued active participation in and management of the course of treatment. When the physician is involved with a particular service, his or her contribution to the care must be personally documented by the physician. The extent of physician involvement should reflect the patient's condition, increasing with the instability and uncertainty of the situation.

While there are no national CMS guidelines regarding the frequency of these subsequent services that the physician must perform, some local Medicare contractors have published policies that detail the need for the treating physician to personally perform a patient encounter within specified time frames.

Step 7. Direct Supervision

The billing physician must provide direct supervision for all incident-to services. Direct supervision means the physician is present in the office suite and immediately available to provide assistance or direction to the non-physician practitioner. The supervising physician must be within the same entity to be considered immediately available. For example, if the patient is being seen in the clinic and the supervising physician is located in the adjoining hospital, the physician is not considered to be in the office suite.

With respect to completion of the professional CMS1500 claim form, there may be instances when the physician who performed the initial service and ordered the service that is subsequently performed by auxiliary personnel is not the same physician who is supervising the incident-to service. In this situation, the supervising physician must be identified on both the paper and electronic claim forms. In other words, the physician supervising the service should be reported on the claim form, even if this is a different physician than the provider of record for the individual patient.[9]

If there is not a physician in the office at the time the service is provided, the service must be billed under the NPP's provider number. According to the American Academy of Family Physicians (AAFP):[10]

"Independently contracting physicians who reassign their right to payment to a group practice can also supervise non-physician providers' services as the on-premises supervisor. However, hiring a moonlighting resident or other type of physician to do nothing more than supervise non-physician providers will not meet the standard; he or she must also be treating patients."

And make certain that direct supervision is documented! This documentation can be accomplished using sign in/out forms, card swipe for attendance, or another method, but in the event that proof of supervision is required, the cancer center should have a method to confirm that the direct supervision requirement was met at all times while patients were treated.

Step 8. Significant or Substantive Service

While services incidental to the physician service may be performed by ancillary personnel and reported as incident-to, if the service or procedure performed is a significant or substantive service, it must be reported in the name of the individual who personally performed the service. For example, if the midlevel provider performs a bone marrow aspiration and/or biopsy, the service is reported in the name of the NPP, regardless of whether or not the physician is in the office suite.

Step 9. Shared Visits

A split or shared service is an encounter during which a physician and an NPP each personally perform a portion of an Evaluation and Management (E/M) visit. According to CMS:[11]

"…a split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient in which both the physician and a qualified NPP (who must be in the same group practice or be employed by the same employer) personally perform a substantive portion of the 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 (all key components of an E/M service).

The split/shared E/M visit applies only to selected E/M visits and settings (hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non-

facility clinic visits, and prolonged visits associated with these E/M codes)."

If there was no face-to-face encounter between the patient and the physician (e.g., if the physician only participated in the service by reviewing and/or signing the patient's medical record), then the service may only be billed in the name of the NPP. Physicians must have a verifiable and significant face-to-face encounter with the patient on the same day as the visit by the NPP, and separately document their portion of the encounter, to bill the shared visit in their name.

For example, physicians would document the extent of history, examination, and medical decision making they personally performed and NPPs would separately document the elements of the patient encounter they performed. While both dictations may be combined to determine the visit level for a Medicare patient, a reviewer must be able to clearly identify the extent of the service performed by the physician and the extent of the service performed by the NPP. The non-physician practitioner cannot dictate a single note that includes services performed by both the physician and midlevel provider, and the physician cannot simply countersign the NPP's note.

Step 10. To Scribe or Not to Scribe?

"Scribing," defined by CMS as "entering data in the record," is another issue that creates confusion when documenting incident-to services.[10] While non-physician practitioners can perform the duties of a scribe, this means that they do not personally perform any clinical services for the patient; instead, the scribe writes down or electronically captures the services performed by the physician as if they were a human transcription machine. According to an article published by the American Health Information Management Association (AHIMA):[12]

"A scribe's core responsibility is to capture accurate and detailed documentation (handwritten, electronic, or otherwise) of the encounter in a timely manner. Scribes are not permitted to make independent decisions or translations while capturing or entering information into the health record or EHR beyond what is directed by the provider."

Therefore, if the non-physician practitioner performs any part of the patient encounter, he is not functioning as a scribe.

Closing Thoughts

Remember that non-physician practitioners are not resident physicians and follow a separate set of billing rules. For example, while the attending physician can have the resident physician dictate the patient encounter and add an attestation of physician presence, that is not the case with midlevel providers. When the NPP and physician share a patient encounter, each must separately dictate or otherwise document the services performed for the patient.

There is also a difference between Medicare and commercial payer credentialing and payment guidelines for non-physician practitioners. According to one managed care insurer, the purpose of a non-physician practitioner credentials review is to ensure that NPPs possess the practice experience, licenses, certifications, liability coverage, education, and professional qualifications necessary to provide a level of care consistent with professionally recognized standards.

According to an article published by AAFP:[10]

"Since the positive financial implications from using nonphysician providers can be significant and the penalties for using them the wrong way can be dire, you should ensure that everyone in your practice understands how to bill and be reimbursed for incident-to services." OI

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