Compliance Challenges for Advanced Practice Providers

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Advanced Practice Provider Coding and Billing

- Definitions
  - Medicare Incident-to Split/Shared
- Other Payers
- Compliance Issues
- Other Thoughts
Advanced Practice Providers
Non-Physician Practitioners

- Nurse Practitioner (APN, APRN, CRNP, etc.)
- Clinical Nurse Specialist
- Certified Nurse Midwife
- Physician Assistant

Different rules for different insurers – Must pay attention to the patient’s insurance when deciding how to utilize these providers in your practice.

Medicare

Billing options
- NPP’s own provider number
- Incident-to physician’s service
- Shared visit

Nurse Practitioners must have Master’s or Doctorate in Nursing (or credentialed prior to 1/1/2003)

Nurse Practitioners can be paid directly, but PA payment must go to the employer.
APP’s Provider Number

- Any services allowed by the APP’s state scope of practice
- Reimbursed at 85% of the physician fee schedule
- 100% for nurse midwives, beginning 1/1/2011 – previously 65%

Incident-to

- "Incident-to" a Medicare term
- APP must be eligible
- Billed under the physician’s number
- Paid at 100% of the physician’s fee schedule
Incident-to Rules

Incident to a physician’s professional service
• Furnished in the physician’s office or clinic

Incident to a physician’s professional service
• An integral, though incidental part of the physician’s professional service
  – Following a plan of care established by the physician
  – Physician must perform initial service and be involved in subsequent services of a “frequency which reflect active participation and management”
  – Some MACs give more specific requirements – Cahaba, for example, requires cosignature

Incident to a physician’s professional service
• Under the physician’s direct supervision
  – Furnished by an individual who qualifies as an employee – either W-2 employee or contracted employee
Under the physician’s direct supervision

- In the office suite and immediately available
  - What constitutes an office suite?
  - How do you prove immediately available?
- Supervision can be provided by another physician in the group practice
  - Service billed under supervising physician
  - Ordering physician’s name and NPI entered in box 17

Employee of the Physician

- W-2 employee of the physician, group practice or legal entity that employs the physician
- 1099 contracted/leased employee
- Under the control of the physician
- Must represent an expense to the physician, group practice, or legal entity
Services
Incident-to an
APP

Services performed by auxiliary personnel supervised by APP and following plan of care established by APP.

Billed under the provider who ordered the service and who is supervising – the APP, not the collaborating physician

Incident-to Billing – CMS Final Rule 2016

Appears to be clarification rather than new regs
• Must be billed under supervising physician (the one who is actually in the office at the time of service)
• Provider cannot be excluded from any federal program
• Provider can’t have had Medicare enrollment revoked
• In compliance with state law
Shared Visits

Internet Only Manual section 30.6.1.B

“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.”

Shared Visit Documentation

Per Terrence Kay, Director of the Division of Practitioner and Ambulatory Care in the Center for Medicare Management, CMS –

“…any face-to-face portion of an E/M encounter (i.e., history, physical exam, or medical decision-making in whole or in part). A social salutation alone does not constitute a face-to-face portion or “physician work” of an E/M service.”
Documentation Examples

- A separate visit by the physician detailing some portion of the E&M service
- Notations within the APP’s note – adding to or verifying elements of the history or exam

Shared Services

- As long as there is evidence of a face-to-face service by both the MD and APP, the work is combined and billed under the MD – both must see the patient in the hospital setting
- Must be clear what portions of the service each performed
- “Seen and agree” not sufficient
- Expect to see documentation of physician repeating some portion of the examination or discussion with patient
- Some MACs audit for “substantive” involvement of physician
NOT Shared Visits

Procedures

Welcome to Medicare

Critical Care

Shared Visits in the Office

Must still meet incident-to guidelines

If visit dominated by and coded based on counseling and coordination of care, can combine NPP and physician time
Take care not to confuse shared visit rules with Teaching Physician guidelines!

Scribes

- CMS silent on scribes, other than that scribes do NOT have to sign the record
- Some MACs have policies on scribes
- “Human Dictaphone” – cannot add any observations of their own (other than ROS and PFSH as allowed by Documentation Guidelines)
- Must sign as “Scribed by --- for Dr. ---”
- Opinion: Suspicion of use of employee at the level of NPP as clerical staff
CIGNA on Scribes

- If a nurse or mid-level provider (PA, NP, CNS) acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note "written by xxxx, acting as scribe for Dr. yyy." Then, Dr. yyy should co-sign, indicating that the note accurately reflects work and decisions made by him/her. **Note: The scribe is functioning as a “living recorder,” recording in real time the actions and words of the physician as they are done. If this is done in any other way, it is inappropriate. This should be clearly documented as noted, by both the scribe and the physician. Failure to comply with these instructions may result in denial of claims.**

Scenarios for Medicare Patients

- Always bill under APP’s number
- Always bill under MD’s number
- Documentation for visit determines how to bill -
  - may vary from patient-to-patient, visit-to-visit
Limitation on Level of Service?

- Officially no limitation on level of service billed
- Some consultants consider higher levels of medical decision-making "what it means to be a physician"
- Some payers limit the levels of service payable to APPs

Other Payers

- Some allow billing under the MD regardless of incident-to guidelines or physician presence
- Some credential separately and allow independent billing
### Other Payers - Example

**Definition of “incident-to” is not the same as Medicare**
- Physician must also see the patient on the date of service
- Not specified which portions of the service each can perform
- Billed under the physician and paid at the physician fee schedule

### Other Payers - Example

For some payers, APPs can be credentialed and billed under their own NPI
- Payment may be based on patient’s contract benefits
- Only certain CPT codes (E&M codes and some minor surgery – some exclude hospital visits)
- Payment usually at 70-80% of physician fee schedule and may vary by CPT code
- Must be billed this way when the MD does not see the patient on the same date of service
Other Payers - Example

Alabama Medicaid
- In order to bill under the physician, he/she must also see the patient on DOS
- APPs can bill under their own numbers only for codes on the approved list
  - E&M codes paid at CRNP/PA fee schedule (but not hospital visits)
  - Laboratory codes paid at physician fee schedule
  - Injectables paid at physician fee schedule
- APPs can bill as assistant-at-surgery for certain codes (orthopedic codes)

Other Payers - Example

BCBS of Alabama –
- Visit must be billed under the provider who documents the History of Present Illness
Compliance Issues/Red Flags

- High number of visits billed under physician’s provider number
- Physician did not know he/she was “supervising physician”
- Patient dissatisfaction

Auditing Considerations - Medicare
Office Service – Need entire medical record - not just one DOS
- Are incident-to requirements met?
  - Established patient – established problem
  - Previous visit to establish plan to treat this problem
  - Visits by physician addressing this problem – does your MAC/payer establish frequency requirements?
  - Established patient – “minor” problem
  - If requirements met, and more than 50% of the visit is counseling, can combine MD and NPP time
- If requirements not met, must bill under APP’s own provider number
Auditing Considerations - Medicare

Hospital Service
 – Admission, Subsequent Visit or Discharge
   • Is there a face-to-face visit by the MD?
   • Combine documentation from both MD and APP to determine level of service
 – Consultation
   • Cannot combine documentation – must bill under either the MD or the NPP based on each individual’s documentation

Nursing Facility Service
 – Must bill under APP’s own number

Other Issues/Thoughts

Income distribution - for APP and supervising

Not just what income the APP brings in, but what this provider frees up the physician to do
Resources

- Nurse Practitioner Scope of Practice
  http://www.acnpweb.org/i4a/pages/index.cfm?pageid=3465
- American Academy of Physician Assistants
  http://www.aapa.org/
- Medicare Benefit Policy Manual, chapter 15, section 60 –
- Medicare Claims Processing Manual, chapter 12, section 30.6.1-

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