Nurse Practitioners and Physician Assistants: Emerging Compliance Issues for Hospitals

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To be covered today

- Billing requirements when the rendering clinician is a nurse practitioner or physician assistant and when clinical work is shared with physicians
- Stark/anti-kickback considerations when hospitals allow their employed nurse practitioners and physician assistants to be utilized by self-employed physicians
- New guidelines on prescribing opioids

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Procedures NPs and PAs perform in hospitals

- Daily medical evaluation/management
- Placement of arterial catheter
- Intubation
- Chest tube insertion and removal
- Lumbar Puncture
- Thoracentesis
- Placement of pulmonary artery catheter
- Bone marrow biopsy
- Bronchoscopy
  - Jalloh, F, et al. Credentialing and Privileging of Acute Care Nurse Practitioners to Do Invasive Procedures: A Statewide Survey, Am J Crit Care, July 2016 vol. 25 no. 4 357-361

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Scenario 1

- Hospital employs NP; assigns him to neurosurgery
- Neurosurgery patients are covered by and often referred by Neurosurgery Group, LLC
- NP performs pre-operative evaluation and most post-operative visits for Group's patients
- Group bills Medicare CPT code for the global fee for each surgery

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Scenario 2

- Hospital employs PA; assigns to cardiovascular
- Cardiovascular patients are covered by and often referred by Cardiology Group, LLC
- Each morning, cardiologist from Cardiology Group and PA divide up patients currently on the cardiovascular service, and conduct "daily visits"
- Group bills, using CPT 99231 - 99233, under the cardiologist's name. Cardiologist writes "Agree" on the PA's progress notes, and signs

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Rules applicable to scenarios

- Services of NPs and PAs, when "physician services," are billed to Medicare under Part B, using the relevant CPT codes
- Medicare reimburses physician services provided by NPs and PAs at 85% of the Physician Fee Schedule rate
- Claims for physician services must be billed under the name of the rendering provider
  - Two exceptions: Shared visits and incident-to services

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Rules applicable to scenarios

- If following Medicare's rules on shared visits or incident-to, a physician may bill a NP's or PA's services under a physician's name, and get 100% of the physician fee schedule rate
  - Rule details provided in handout

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Rules applicable to scenarios

- If billing shared visits or incident-to, the MD and NP/PA must be employed by the same entity
- Only the NP or the employer may be reimbursed for the NP or PA's services
- Medicare will pay only one claim per patient per day per specialty
- A hospital may not give a referring physician more than $416 per year in non-monetary compensation

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Compliance problems in scenario 1

1. Neurosurgical Group is billing global fee for surgery

Global fee includes payment for pre-operative evaluation, the surgery, post-operative evaluation, and management and removal of drains

NP is performing pre-op evaluation and post-op management

Only the NP's employer has the right to bill for the NP's services

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Compliance problems in scenario 1

2. Hospital is providing Neurosurgical Group with NPs

Stark Laws limit non-monetary compensation from hospital to private practice physician to $416/year (2019)

Anti-kickback laws prohibit giving or receiving anything of value in return for referrals

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Example: CPT 61520, excision brain tumor

Physicians Fee Schedule:

- Global fee $4360.35 (Maryland, 2019)
- Attributable to pre-op 11%
- Intra-op 76%
- Post-op 13%
- Portion of global fee reimbursing pre- and post-op evaluation/management $1046.40

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Compliance problems in scenario 2

1. Only the NP or the NP or PA's employer has the right to bill Medicare for the NP/PA's services

   Cardiovascular Group does not employ the NP

   Writing "agree" and signing the NP's documentation does not grant the right to bill
   Being the NP's "collaborator" does not grant the right to bill
   Beware of the physician who says the NP or PA is "scribing"

   To bill the daily visit, cardiologist would need to re-perform and re-document the history, exam and medical decision making

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Compliance problems with scenario 2

2. Stark Laws limit non-monetary compensation to $416/year (2019)

Medicare reimburses daily evaluation and management visits at $40 - 105 per visit, depending upon complexity of the visit

Anti-kickback laws prohibit giving or receiving anything of value in return for referrals

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Compliant options

- Group employs the NP or PA
- Group leases, at fair market value, the NP or PA from hospital
  - Example lease provided in handout as Exhibit A
- Group MD personally performs his/her own pre-operative evaluation and post-operative evaluation and management service
- Absent a lease, hospital-employed NP or PA ceases to provide pre-op and post-operative services or daily visits for Group's patients

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Compliant options

- Hospital refrains from allowing self-employed physicians to utilize hospital employees as if the physicians were the employer
- Hospital develops and disseminates policy on use of hospital-employed NPs and PA by MDs not employed by the hospital
  - Example policy provided as Exhibit B

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Consequences of failure to comply

- Triple damages; return of tainted collections
- Criminal prosecution of physicians and hospital executives
  - Examples provided in handout

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Strategic Compliance Program Initiatives

- Examples of great communication that led to detection of compliance issues, resolution and corrective action
- Stories from the front line!
- Do you train your compliance team and leaders what you learned from investigations? What do you do to mitigate risk?
- Review your coding audit practices. What tools do you have? Can you drill down and delve deeper to identify risk? Examples from a risk-based auditing tool. Providers identified as high producers who work with Advance Practice Providers may not be following the incident-to and split shared visits in the hospital.

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Effective compliance education for providers

- Is your compliance program education reaching hospital staff, hospital employed providers, medical groups employed by the healthcare system, and community providers?
- How do you know if your education is effective? Knowledge Surveys: Formal and informal examples
- Who delivers your education? How is it delivered? What works in your organization? Get a seat at the leadership meetings!! What is your governance model? Examples of what may be effective for your organization

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Risk of inappropriate prescribing

- Patient harm
- Fraud
- Criminal prosecution: Drug trafficking
- Civil liability: Negligence

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Case of fraud, related to prescribing

Nurse practitioner sentenced to 78 months for unlawful dispensing of opioids and health care fraud

- Defrauded Medicare and Medicaid by writing Lidocaine, Modafinil, and Diclofenac Sodium without medical purpose
- Ordered to pay restitution of $3.7M

https://www.justice.gov/usao-nv/pr/nurse-practitioner-sentenced-over-six-years-prison-unlawful-dispensing-opioids-and-health

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Until 3 years ago, there were few guidelines on prescribing opioids for pain

- American Academy of Pain Medicine was one of few sources (2009)
- OH issued opioid prescribing guidelines 2013
- OK issued guidelines 2014
- CA Board of Medicine issued guidelines 2014
- NC Medical Board expanded its guidelines 2014
- CO issued policy 2014
- TN issued policy 2014
- American Academy of Neurology issued position paper 2014
- CDC Guidelines 2016

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Common elements in guidelines for treating chronic, non-cancer pain

- Initial evaluation
  - Affirm patient's identity
  - History, physical, urine screen, diagnostic tests to ascertain diagnosis, screen for risk of abuse, depression
  - Affirm not pregnant, has reliable birth control method
  - Obtain old records or speak with previous provider
  - Check with state prescription drug monitoring program
  - Try, and document, trial of non-opioid
  - Establish a diagnosis that justifies the need for an opioid

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Common elements in guidelines

- Choice of medication
  - Don't use benzodiazepines and opioids together
    - Never prescribe sedative + muscle relaxer + opioid
  - Don't use long-acting opioids for acute pain
  - Avoid prescribing methadone, unless you are a methadone clinic

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Guideline elements

- Written agreements with patients
  - Develop and document treatment plan, with measurable goals (increase function, decrease pain)
  - Patient agrees
    - This is a trial (90 days, at most) , may be discontinued
    - Agrees to use only one provider and pharmacy for pain meds
    - Agrees to drug testing
    - Agrees has been informed of risks (respiratory depression, etc.)
    - Agrees to safeguard medication
    - Agrees to keep pain diary, log daily activities
    - Agrees to refill process

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Guideline elements

- Monitoring, with visit #2 and on
  - 5 A's
    - Analgesia
    - Activity (function, overall quality of life)
    - Adverse events
    - Aberrant behavior
    - Affect
  - Urine testing at least twice/year
  - If greater than 80 morphine milligram equivalents/day, seek pain management consultation

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Guideline elements

- Discontinue opioid therapy (via taper)
  - When condition is resolved
  - Intolerable side effects
  - Ineffective analgesia after trial
  - Quality of life does not improve
  - Functioning deteriorates
  - Aberrant medication use
- Taper – Generally, 10% dose reduction/week over 6-8 weeks
  - Taper should be individualized

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Guidelines for treating acute pain

- For most, NSAIDs and acetaminophen are effective
- Opioids should not be first-line therapy for mild to moderate pain in patients with limited past exposure to opioids

Before writing a new opioid prescription:

- Face-to-face assessment
- Assess history of long-term opioid use, substance use disorder
- Check Prescription Drug Monitoring Program
- Patient education regarding risks
- Prescribe lowest effective dose, usually for **less than 3 days**
- No opioids and benzodiazepines simultaneously
- Before refill, re-assess pain, function, healing process, and response to treatment[ro9/09/06/new-opioid-guidelines-for-acute-pain]

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Case

- Patient admitted for spinal fusion
- At discharge, nurse practitioner prescribed 200 oxycodone/acetaminophen tablets for pain plus anxiety med
- A few days before his follow-up appointment, patient called and spoke to the nurse practitioner and she wrote him another prescription for 360 oxycodone/acetaminophen tablets
- He filled the prescription and overdosed the next day
  - Clark, C. Four Nurse Practitioners Accused in California Death Certificate Project, *MedPage Today*, September 11, 2019 https://www.medpagetoday.com/painmanagement/opioids/82082

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Opioid initiatives

Audit:

1. Prescriptions of all controlled substances prescribed for chronic pain patients
2. Whether providers have entered into controlled substance agreements with patients and
3. Performed urine test annually

- CMO and Compliance Team review reports
- CMO determines if intervention is needed based on prescribing data, urine test results* and other factors
- Compliance team follows up with providers regarding patient/provider agreements and that provider is performing urine testing

* Did urine tests show no controlled substances were present? Who is taking the drugs?

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Opioid education

- Organization Policy/Guidance
- CDC Guidelines
- Your State Resources – e.g. Florida Department of Health Educational Pamphlet – Post to your Compliance Website and/or distribute to hospital and medical group providers and operations leaders
- Get your CMO involved in education: CMO message to providers – What is your governance model? Deliver education at those meetings

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