Nurse Practitioners and Physician Assistants: Emerging Compliance Issues for Hospitals

Carolyn Buppert

Nurse practitioners and physician assistants are performing physician services in hospitals, nursing facilities, clinics, and offices. These services include evaluation and management, consultations, and procedures such as placement of arterial catheter, intubation, chest tube insertion, lumbar puncture, and thoracentesis.[1]

Compliance professionals will want to be aware of emerging compliance issues involving nurse practitioners and physician assistants. These include:

- To avoid charges of inappropriate billing, follow Medicare's and Medicaid's billing requirements when the rendering clinician is a nurse practitioner or physician assistant and when clinical work is shared with physicians
- To steer clear of Stark and antikickback law violations, avoid allowing hospital-employed nurse practitioners and physician assistants to be utilized by self-employed physicians, and
- To avoid charges of fraud and drug trafficking, assure that prescribing clinicians follow state and CDC guidelines on prescribing opioids.

Billing and Stark/Antikickback Issues

Medicare and most other payers reimburse physician services performed by nurse practitioners and physician assistants. Medicare's rules require that:

- Only a credentialed nurse practitioner or a nurse practitioner's or physician assistant's employer may bill for the clinician's services.[2]
- Only one claim per patient per day per specialty will be paid.[3]
- Services of nurse practitioners and physician assistants, when "physician services," are billed as Part B physician services, using the relevant CPT codes.[4]
- Claims for physician services are billed under the name of the rendering provider, with two exceptions -- shared visits and incident-to services.[5]
- Medicare reimburses physician services provided by nurse practitioners and physician assistants at 85% of the Physician Fee Schedule rate.[6]

---

[1] 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

[2] 42 USC 1395l(r)(1), Medicare Transmittal 1734, December 13, 2001

[3] Medicare Claims Processing Manual, Ch. 12, §30.6.5

[4] Medicare Claims Processing Manual, Ch. 12 §30.6.1

[5] Medicare Claims Processing Manual, Ch. 12 §30.6.1

[6] 42 USC 1395l(a)(1)

- If following the rules on shared visits or incident-to, a physician may bill a nurse practitioner's or physician assistant's services under the physician's name, and get 100% of the physician fee schedule rate.[7]
- If billing shared visits and incident-to, the physician and nurse practitioner or physician assistant must be employed by the same entity.[8]
- A hospital may not give a referring physician more than $416 per year in non-monetary compensation.[9]

When a hospital hires nurse practitioners or physician assistants, only the hospital has the right to bill Medicare for those clinician's services. If a patient is under the care of a physician who is not employed by the hospital, and the hospital-employed nurse practitioner or physician assistant performs physician services for that patient, the question arises: Who can bill for what?

Consider these two scenarios:

Scenario 1: Hospital employs nurse practitioner. Hospital assigns the nurse practitioner to the neurosurgery. Neurosurgery patients are covered by and often referred by a Neurosurgery Group, an LLC. Nurse practitioner performs the pre-operative evaluation and most post-operative visits for Neurosurgery Group's patients. Neurosurgery Group bills Medicare a CPT code for each surgery, and Medicare reimburses a global fee.

Scenario 2: Hospital employs physician assistant. Hospital assigns the physician assistant to the cardiovascular service. Cardiovascular patients are covered by and often referred by Cardiology Group, an LLC. Each morning, a cardiologist from Cardiology Group and physician assistant divide up a list of patients currently on the cardiovascular service, and conduct "daily visits." Cardiovascular Group bills all of the visits, using CPT codes 99231 to 99233, under the cardiologist's name. Cardiologist writes "Agree" on the physician assistant's progress notes, and signs.

I. Who can bill for what?

The rendering provider or his employer has the right to bill the rendering provider's services. In these two scenarios the rendering provider is a hospital-employed nurse practitioner or physician assistant. The physician groups do not employ the rendering provider and therefore do not have the right to bill for the rendering clinician's services. In Scenario 1, the surgeon is billing the global fee, which includes reimbursement for the

---

[7] Medicare Claims Processing Manual, Ch. 12 §30.6.1

[8] Medicare Claims Processing Manual, Ch 12 §30.6.1

[9] 42 U.S.C.S. §1395nn and 42 C.F.R. §411.350 - 411.389 and Medicare, CPI-U updates at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/CPI-U_Updates.html

pre-operative exam and post-operative evaluation and management -- services being provided by the hospital-employed nurse practitioner.

A. Global fee

1. What global fee covers

Reimbursement under a global fee covers the pre-operative evaluation, the intraoperative service, and post-operative evaluation and management during the global period, which, for neurosurgery, is 90 days.[10]

Here is the breakdown, for CPT 61520 (excision of brain tumor), of the portion of the global fee paid by Medicare in 2019 in Baltimore that goes toward reimbursing the pre-operative, intra-operative, and post-operative evaluation and management services:

> Global fee, CPT 61520 = $4360.35
> Percentage attributed to pre-op evaluation = 11%
> Percentage attributed to intra-operative service = 76%
> Percentage attributable to post-operative service = 13%[11]

Therefore, if the surgeon in scenario 1 billed CPT 61520, the surgeon collected $1046.40 for pre-operative and post-operative evaluation and management provided by the hospital-employed nurse practitioner.

2. Splitting of global fee

Medicare allows for the global fee to be split, and that must be done formally in a process described by Medicare.[12] If a global fee is split, the surgeon is paid only for the services the surgeon performs, rather than the full global fee.

3. Compliance problems in Scenario #1

> a. Surgeon is not splitting the global fee, and is receiving reimbursement for services the surgeon did not perform.
>
> b. Hospital is providing Neurosurgery Group with non-monetary compensation in the form of nurse practitioner services, which value exceeds $416/year, in violation of the Stark Laws.[13]

---

[10] Medicare, MLN "Global Surgery Booklet" 2017, p. 4
[11] Medicare Physician Fee Schedule 2018
[12] Medicare, MLN "Global Surgery Booklet" 2017, p. 8-9
[13] 42 U.S.C.S. §1395nn and 42 C.F.R. §411.350 - 411.389 and Medicare, CPI-U updates at https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/CPI-U_Updates.html

c. Hospital is providing Neurosurgery Group with something of value in return for referrals, in violation of anti-kickback laws.[14]

4. Options for coming into compliance

a. Neurosurgery Group employs the nurse practitioner.

b. Neurosurgery Group leases the nurse practitioner from the hospital, at fair market value. Example lease provided as Exhibit A.

c. Neurosurgery Group employee/member personally performs his/her own pre-operative evaluation and post-operative evaluation and management service.

d. Hospital-employed nurse practitioner ceases to provide pre-op and post-operative services for Neurosurgery Group's patients.

e. Hospital refrains from hiring nurse practitioners and physician assistants and giving their services to physician groups.

f. Hospital develops and disseminates policy on use of hospital-employed nurse practitioners and physician assistants by physicians not employed by the hospital. Example policy provided as Exhibit B.

5. Case against physician

"After a five-week trial, [physician] was convicted on one count of conspiracy to defraud the United States, and nine counts of illegally soliciting or receiving benefits in return for referrals of patients covered under a federal health care program. Each count carries a maximum sentence of five years in prison and a $250,000 fine. Evidence at [physician's] trial revealed that he was one of Sacred Heart's most prolific sources of patient referrals. In exchange for his referrals, Sacred Heart provided [physician] with free labor in the form of physician assistants and nurse practitioners. The free labor was provided not only inside Sacred Heart but also in Chicago-area nursing homes where many of [physician's] patients resided. Sacred Heart allowed [physician] to bill Medicare and Medicaid for the services of the physician assistants and nurse practitioners as if he employed them himself."[15]

---

[14] 42 U.S.C. 1320a-7b(b)

[15] Justice Department News Release March 4, 2016 at https://www.justice.gov/usao-ndil/pr/oak-brook-doctor-convicted-kickback-scheme-sacred-heart-hospital

6. Case against hospital executive

> "[Physician], 60, of Chicago, conspired with other hospital executives to pay kickbacks and bribes to doctors to induce the referrals. The payoffs were disguised in a number of ways, including compensation for consulting work, instructional services and lease agreements, and through the provision of free professional staff."[16]

7. Additional cases

a. "[C]omplaint alleged that [physician] received payments in excess of fair market value (FMV) for clinical services provided at the Cancer Center based on receiving credit for work provided by other physicians and mid-level practitioners, and upcoding of E/M billings."[17]

b. "According to the settlement agreement, from January 1, 2006 through December 31, 2010, the salaries and benefits paid to FirstCare PAs and NPs were claimed on UMC cost reports filed with Medicare between 2006-2010. At the same times, University Emergency Medicine Associate (UEMA) physicians generally treated the FirstCare PAs and NPs as their own employees including, to various degrees, billing and collecting form Medicare for their professional services."[18]

B. Shared visits and incident-to billing

1. Payment rate

> a. Medicare pays for physician services provided by nurse practitioners and physician assistants at 85% of the Physician Fee Schedule Rate[19]
>
> b. If following incident-to rules or billing a shared visit, Medicare pays 100% of the Physician Fee Schedule rate[20]

---

[16] Justice Department News Release, July 31, 2015 at http://www.justice.gov/usao-ndil/pr/former-chief-operating-officer-sacred-heart-hospital-sentenced-21-months-prison

[17] Carter, KC and Fried, A. Georgia Health System and Medical Oncologist Settle Upcoding and Stark Allegations for Up to $35 Million, September 17, 2015, AHLA email alert and Justice Department News Release, September 4, 2015 at https://www.justice.gov/opa/pr/georgia-hospital-system-and-physician-pay-more-25-million-settle-alleged-false-claims-act-and

[18] U.S. Justice Department News Release, July 1, 2013 at Source: http://www.justice.gov/usao/kyw/news/2013/20130701-01.html

[19] 42 USC 1395l(a)(1)

[20] Medicare Claims Processing Manual, Ch. 12 §30.6.1

2. Default policy should be to bill under name of rendering provider

a. Medicare requires that visits and procedures be billed under the name of the rendering provider.

b. Exceptions are shared visits and incident-to billing.[21]

3. Shared visits - Applicable in hospital (POS 19, 21-23). May bill under physician's name if

a. Physician conducted and documented a face-to-face visit that day

b. Physician and nurse practitioner/physician assistant are employed by the same group

c. Service is evaluation and management.[22]

4. Incident-to billing - Applicable in office (POS 11). May bill under physician's name if

a. Physician is in the suite at the time of the visit

b. Physician and nurse practitioner or physician assistant are employed by the same entity

c. Physician has performed the “initial service.” Initial service is first visit to evaluate an episode of illness.

d. Physician remains involved in patient's care[23]

5. Compliance problems in Scenario #2

a. Cardiovascular Group is billing shared visits when they do not employ the physician assistant.

b. Writing "Agree" is not enough to document the physician's participation in the visit, under the rules on shared visits, even if the group employed the physician assistant.

6. Options for coming into compliance

---

[21] Medicare Claims Processing Manual, Ch. 12 §30.6.1
[22] Medicare Claims Processing Manual, Ch. 12 §30.6.1
[23] Medicare Claims Processing Manual, Ch. 12 §30.6.1

a. Hospital and physician practice adopt a policy that nurse practitioner and physician assistant services are billed under that provider's name by the provider's employer. Only when a physician employs the nurse practitioner or physician assistant and participates to the extent required by Medicare's rules on shared visit or incident-to billing rules may nurse practitioner's or physician assistant's services be billed under physician's name. Example policy is provided as Exhibit B.

b. In Scenario #2, Cardiovascular Group, not the hospital, employs the physician assistant. Then, the group would have the right to bill shared visits.

c. Cardiovascular Group leases, for fair market value, physician assistant from the hospital. Then, that group would have the right to bill for the physician assistant's services. An example lease is provided as Exhibit A.

d. Cardiologist personally performs and documents the history, exam, and medical decision-making and bills under the cardiologist's name.

7. Cases

a. "After it self-disclosed conduct to OIG, Mercer Osteopathic, Ltd. (Mercer), Ohio, agreed to pay $49,598.10 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Mercer improperly billed Medicare for patient visits under a physician's National Provider Identifier when the services had been rendered by a nurse practitioner and did not comply with Medicare's 'incident to' requirements."[24]

b. "After it self-disclosed conduct to the OIG, House Psychiatric Clinic, Inc. and [physician] (collectively House), California, agreed to pay $34,849.89 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that House billed Federal health care programs for items or services that were not provided as claimed and were false or fraudulent. Specifically, House: ...(2) submitted claims for services provided by a Nurse Practitioner as if those services were provided by Dr. House."[25]

c. "[Physician] and Metabolic Leader, LLC, PA (Metabolic Leader), Maine, agreed to pay $17,087.58 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that [physician] and his medical practice, Metabolic Leader, improperly

---

[24] Justice Department News Release December 22, 2014 at https://oig.hhs.gov/fraud/enforcement/cmp/psds.asp

[25] Justice Department News Release August 22, 2012 at https://oig.hhs.gov/fraud/enforcement/cmp/psds.asp

billed Medicare for: ...(3) services provided by nurse practitioners that were billed under [physician's] provider number when he was not in the office.[26]

d. "After he self-disclosed conduct to OIG, [physician], Illinois, agreed to pay $24,027.10 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that [physician] submitted claims to Medicare for incident-to services provided by nurse practitioners under his National Provider Identifier when the Medicare supervision requirements had not been met."[27]

e. "After it self-disclosed conduct to OIG, Gibson Community Hospital Association d/b/a Gibson Community Hospital, on behalf of itself and its wholly owned clinic (collectively, "GCH"), Illinois, agreed to pay $10,000 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that GCH submitted claims to Medicare for incident-to services provided by nurse practitioners under a physician's National Provider Identifier when Medicare supervision requirements had not been met."[28]

Following Prescribing Guidelines

I. Historical perspective

A. Old standard of care

In the 1990's and early 2000's, pharmaceutical companies and health care quality agencies told prescribing clinicians that they must attend to patients' pain, that assessment of pain was the 5th vital sign, that not to treat pain was unethical, that opioids were standard for treating pain, and that opioids were not addictive when used to treat pain.[29] Little was published by way of specific guidance.

B. New standard of care

Starting in 2014, the Centers for Disease Control (CDC), medical associations, and many state health departments published guidelines for clinicians who prescribe opioids for chronic, non-cancer pain. The drive to publish guidelines grew out of a recognition that

[26] Justice Department News Release July 25, 2012 at https://oig.hhs.gov/fraud/enforcement/cmp/cmp-ae.asp

[27] Justice Department News Release December 20, 2018 at https://oig.hhs.gov/fraud/enforcement/cmp/psds.asp

[28] Justice Department News Release December 20, 2018 at https://oig.hhs.gov/fraud/enforcement/cmp/psds.asp

[29]Quinones, S., Dreamland: The True Tale of America's Opiate Epidemic, New York: Bloomsbury Publishing, 2014

there is a national epidemic of opioid addiction, thought to be exacerbated by clinician willingness to prescribe opioids.

Law enforcement is now prosecuting clinicians who prescribe opioids inappropriately; that is, outside of guidelines. Often the prosecution is triggered by a patient overdose or a report that a clinician is over-prescribing opioids. Initially, guidelines focused on treatment of chronic, non-cancer pain. Now, the focus is turning to treatment of acute pain.

II. Treating acute pain

Compliance professionals should take the initiative in preparing clinicians for increased scrutiny of their prescribing practices. Hospitals should be taking a close look at their policies on prescribing opioids for acute pain. Recent presentations have stated that increased prescribing of opioids after surgery leads to increased opioid use, without an improvement in pain relief. Tolerance to opioids occurs sooner than previously thought – after a couple of days.[30]

A. Guidelines for treating acute pain

Some states have issued guidelines for treating acute pain. For example, in September 2019 Oregon released the following guidelines for treating acute pain, with the intent of reducing the supply of initial opioid prescriptions for the opioid-naïve patient:

- For most cases of acute pain, NSAIDs and acetaminophen are effective.
- In general, don't consider opioids to be first-line therapy for mild to moderate pain in patients with limited past exposure to opioids.

Follow these recommendations before any new opioid prescription:

- Avoid prescribing opioids without a direct patient-to-prescribing-clinician assessment
- Assess history of long-term opioid use and/or substance use disorder
- Check the Prescription Drug Monitoring Program
- Provide patient education regarding the risks of opioids
- Prescribe the lowest effective dose of short-acting opioids usually for a duration of **less than three days**; in cases of more severe acute pain, limit initial prescription to less than seven days.
- Do not prescribe opioids and benzodiazepines simultaneously unless there is a compelling justification

---

[30] National Academy of Medicine webinar, Best Practices in Opioid Tapering, July 22, 2019 at https://nam.edu/programs/action-collaborative-on-countering-the-u-s-opioid-epidemic/ [better link to be supplied later]

- Before providing a refill, re-assess the patient's pain, level of function, healing process and response to treatment. Explore other non-opioid treatment options. Do not prescribe a refill of opioids without a direct patient-to-prescribing clinician assessment[31]

B. Case against a nurse practitioner who over-prescribed for acute pain

> [A nurse practitioner] was prompted to surrender her license after the [nursing] board found she was grossly negligent and incompetent in her prescribing. In particular, she prescribed large quantities of oxycodone to a patient who was found dead in his home from an overdose one day after he filled her prescription.
>
> The 50-year-old male…had been admitted for spinal fusion therapy to the University of California San Francisco's Spine Clinic, where [the nurse practitioner] worked. At discharge…he was given prescriptions for 200 oxycodone/acetaminophen tablets for pain and an undetermined amount of clonazepam for anxiety. …[A] few days before KP's scheduled follow-up appointment, he called and spoke to [the nurse practitioner], who wrote him another prescription for 360 oxycodone/acetaminophen tablets….
>
> KP filled the prescription…and overdosed the next day. "A toxicology report showed that he had overdose levels of oxycodone and other drugs in his blood," the nursing board's decision and order stated.[32]

III. Treating chronic, non-cancer pain

A. Elements of current guidelines

Common elements of guidelines issued by states, medical societies, and the CDC for treating chronic, noncancer pain include:

1. Initial evaluation, prior to prescribing opioids. A clinician must:
    a. Affirm the patient's identity
    b. Perform a history and physical, urine screen, and diagnostic tests to ascertain a diagnosis calling for pain management
    c. Screen for risk of abuse, depression

---

[31]Brewster, M., Care Oregon Provider Updates: New opioid guidelines for acute pain, September 6, 2019 available at https://www.careoregon.org/providers/ProviderUpdates/2019/09/06/new-opioid-guidelines-for-acute-pain

[32] Clark, C. Four Nurse Practitioners Accused in California Death Certificate Project, *MedPage Today*, September 11, 2019 at https://www.medpagetoday.com/painmanagement/opioids/82082

d. Affirm that the patient is not pregnant, and has reliable birth control method
e. Obtain old records or speak with previous provider
f. Check the state prescription drug monitoring program to determine whether the patient is already on controlled drugs
g. Try, and document, trial of non-opioid therapy, and
h. Establish a diagnosis that justifies the need for an opioid.

2. Choice of medication
a. Refrain from prescribing benzodiazepines and opioids together.
b. Never prescribe sedative + muscle relaxer + opioid.
c. Don't use long-acting opioids for *acute* pain.
d. Avoid prescribing methadone, unless practicing in a methadone clinic

3. Written agreements
a. Develop, with the patient, a written treatment plan, with measurable goals (increase function, decrease pain)
b. Have the patient read and sign an agreement stating that the patient agrees:
- This is a trial (90 days, at most), and may be discontinued
- Will use only one provider and pharmacy for pain medications
- Drug testing will occur at the clinician's discretion; usually every 6 months
- He has been informed of risks (respiratory depression, addiction, etc.)
- Will safeguard medication
- Will keep pain diary and will log daily activity
- Will follow office's refill process, and give the clinician 72-hours' notice before needing a refill

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

5. Discontinue opioid therapy (via taper)
- When condition is resolved
- When side effects are intolerable
- When analgesia is ineffective after a trial
- When quality of life does not improve
- When functioning does not improve

- When the patient uses medication out of compliance with agreement

IV. Compliance activities

Compliance professionals should urge their organization to provide training on the guidelines for treating acute and chronic pain, conduct audits of clinician prescribing, and provide remedial training or discipline for clinicians who are not following the state's or specialty's guidelines.

V. Additional Resources:

1. Herzig, S. et al. Safe Opioid Prescribing for Acute Noncancer Pain in Hospitalized Adults: A Systematic Review of Existing Guidelines, *J. Hosp. Med*. 2018 April;13(4):256-262 at https://www.journalofhospitalmedicine.com/jhospmed/article/161929/hospital-medicine/safe-opioid-prescribing-acute-noncancer-pain-hospitalized

2. Franklin, G. (2014) Opioids for chronic non-cancer pain: A position paper of the American Academy of Neurology, *Neurology*, Vol. 83 No. 14, 1277-1284 at http://www.neurology.org/content/83/14/1277.full

3. Centers for Disease Control, CDC Guideline for Prescribing Opioids for Chronic Pain at https://www.cdc.gov/drugoverdose/prescribing/guideline.html

Exhibit A: Example lease

Lease agreement between hospital and private physician practice for services of hospital-employed clinician

AGREEMENT FOR SERVICES

This is an Employee Lease Agreement (hereinafter referred to as the "Agreement"), dated _____between [name of physician practice] (hereinafter referred to as "Physician Practice"), located at _____, and [name of hospital], its successors and assigns (hereinafter referred to as "the Hospital").

WHEREAS, Physician Practice and Hospital desire to enter into a lease arrangement whereby Physician Practice may utilize and bill for the services of specified clinicians employed by Hospital.

Accordingly, in consideration of the mutual covenants and agreements contained in this Agreement, the parties agree as follows:

1. Term.

A. This Agreement shall remain in force for the term of_____ (the "Initial Term"). Following the Initial Term, this Agreement shall remain in force from month to month until one party gives written notice to the other party as specified in Paragraph 18 below, at least seven (7) days prior to the expiration of any monthly extension of the Initial Term. Hospital may terminate this Agreement upon seven (7) days written notice should Physician Practice breach any of the provisions of this Agreement.

B. Hospital shall have the right to terminate this Agreement immediately in the event of non-payment or late payment by Physician Practice occurring at any time after the date of this Agreement.

2. Effective Date.

This Agreement shall become effective only when both parties have signed this document.

3. The Employees.

Hospital shall lease the employees listed on Exhibit A to Physician Practice for the percentage of full time equivalents and annual amounts specified. Hospital shall be fully responsible for notifying all leased employees that they are leased to Physician Practice, and shall notify Physician Practice no later than 48 hours after a change in employee status. Physician Practice shall notify Hospital no later than 48 hours after learning of a

change in status for any leased employee. Change in employee status includes, but is not limited to, a change in hours, licensing, certification, credentialing, provider status, insurance coverage, or a formal disciplinary action. No employees other than those listed in Exhibit A shall be leased to Physician Practice.

4. Services Provided To Physician Practice.

A. Hospital shall be fully responsible for payment of all payroll, payroll taxes, collection of taxes, unemployment insurance, and other administrative functions customarily performed by an Employer for its employees. Hospital shall, without regard to payments by Physician Practice, assume such responsibilities as are required by applicable federal Wage and Hour law for payment of wages to leased employees' until such employees are terminated from employment with Hospital. Hospital shall properly secure coverage for workers' compensation for employees covered under this Agreement and shall offer an optional Employee benefit package to qualifying employees.

B. Hospital shall credential and privilege leased employees in accordance with its bylaws and rules.

5. Reservation of Rights.

Hospital shall, after consultation with Physician Practice's managing director, member or partner:

A. Have the right and responsibility to reward, promote, reassign, evaluate and determine the wages, hours, terms and conditions of employment,

B. Have the right and responsibility to resolve and decide employee grievances and disputes,

C. Supervise and direct such employees in a reasonable manner consistent with the practices of similar businesses and enterprises, and

D. Retain employment of leased employees until termination of this Agreement.

E. Physician Practice shall retain such sufficient direction and control over the leased employees as is necessary to conduct the Physician Practice's business and without which the Physician Practice would be unable to conduct its business, provide safe patient care, discharge any fiduciary responsibility that it may have, or comply with any applicable licensure, regulatory, or statutory requirement of Physician Practice.

6. Licensing and Credentialing

A. It shall be the responsibility of Hospital to implement a credentialing program for the leased employees which meets the standard of care in the medical and/or nursing specialty of the employee's practice.

B. It shall be the responsibility of Physician Practice to comply with any state and federal requirements regarding collaboration or supervision of leased employees.

7. Safe Work Environment.

A. Physician Practice agrees that it will comply with all health and safety laws, right-to-know laws, regulations, ordinances, directives and rules imposed by controlling federal, state, and local government, and that it will immediately report all accidents and injuries to Hospital.

B. Hospital retains a right of direction and control over management of safety, risk and hazard control at the work-site or sites affecting its leased employees. Environmental factors, equipment, machinery and all other matters which affect employee health and safety shall be maintained in compliance with OSHA standards. Physician Practice represents that its working environment, equipment and machinery currently meet all OSHA standards and that they will be maintained in compliance with such standards for the duration of this Agreement.

8. Employee Benefits.

Hospital shall provide employees with benefits provided to Hospital employees.

9. Indemnification

A. Physician Practice agrees to indemnify, defend and hold harmless Hospital, its officers shareholders, non-leased employees, directors and agents from and against any and all losses, liabilities, expenses (including court costs and attorneys' fees) and claims for damage of any nature whatsoever, whether known or unknown as though expressly set forth and described herein, which Hospital may incur, suffer, become liable for, or which may be asserted or claimed against Hospital as a result of the actual or alleged acts, errors or omissions of Physician Practice, or any claims whatsoever arising out of actual or alleged violations of Wage and Hour laws, EEOC laws, tort law, The Family and Medical Leave Act, The American's with Disabilities Act, Title VII of the Civil Rights Act or the National Labor Relations Act by the Physician Practice or any leased employee.

B. Physician Practice agrees to indemnify, defend and hold harmless Hospital from real or asserted liability, including the cost of defense, connected with or resulting from the ownership custody, maintenance, use or operation of any of Physician Practice's machinery, facilities, equipment and/or automobiles whether leased, rented, borrowed or owned, which abilities are not covered by the insurance provided by Physician Practice,

or if covered, are in excess of the policy limits required pursuant to insurance hereinafter expressed.

C. Physician Practice agrees to indemnify, defend and hold Hospital harmless for any and all liabilities whatsoever arising out of Physician Practice's hiring of independent contractors and/or employees outside of this Agreement.

D. In the event that Hospital is required to defend against any claim to which Hospital reasonably believes it is entitled to indemnification under this Section, Physician Practice shall advance to Hospital any attorneys' fees and litigation expenses related to the defense of such action that have not yet been previously reimbursed by Physician Practice.

E. In the event that Hospital is required to defend against any claim or prosecute any claim occasioned by the breach or default in any provision of this Agreement to enforce the terms of this Agreement, Hospital shall be awarded all reasonable costs pertaining thereto, including reasonable attorneys' fees and costs in addition to any other relief to which Hospital may be entitled.

F. Physician Practice agrees that, notwithstanding any other provision of this Agreement, that access to any property, whether real, appurtenant, or personal, as well as the accommodation of said property to any person who may be handicapped or disabled, or perceived as being handicapped or disabled, over which real or personal property the Physician Practice has ownership, administration, maintenance or some other control, shall be the sole and exclusive responsibility of the Physician Practice. Physician Practice agrees to indemnify, hold harmless and defend Hospital, its officers, shareholders, non-leased employees, directors and agents, from any and all losses, liabilities, expenses (including court costs and attorneys' fees), and claims for damage of any nature, or other consequences of any sort out of the Physician Practice's obligations set forth herein.

10. Fees.

A. For services under this Agreement, Hospital shall be entitled to a fee as specified on Exhibit B attached to this Agreement. Exhibit B shall be signed by an authorized member of Physician Practice after it is filled in by Hospital's Representative. The signature by Physician Practice shall indicate Physician Practice's acceptance of the rates and classifications thereon. Upon acceptance by Hospital of the Agreement, a duly authorized representative (i.e. a corporate officer) shall sign Exhibit B indicating acceptance by Hospital of the rates and classifications. Both parties shall retain a copy of Exhibit B. Should Physician Practice require additional services not included in this Agreement, the fee for any such additional services shall be negotiated separately.

B. By signing, parties agree that the fees Physician Practice is paying hospital for leased employees' services have been evaluated for fair market value and are fair market value.

C. If, for any reason whatsoever, payment is not timely submitted to Hospital for its services in accordance with this Agreement, or the payment received is unable to be immediately negotiated, it will be considered a breach of contract and Hospital shall have the sole right to immediately terminate this Agreement and/or charge Physician Practice a special service fee of up to $____ per day. This special service fee shall be imposed to reimburse Hospital for all expenses incurred as a result of any Physician Practice's failure to timely meet financial obligations under this Agreement.

D. Should payment of any amounts due Hospital not be made when due, and should Hospital agree to continue to provide services to Physician Practice, Physician Practice shall pay a monthly service charge of one and one-half percent (1 1/2%) per month on the unpaid balance, however, in no event shall this amount exceed the lawful rate of interest.

11. Insurance.

A. Hospital shall furnish and keep in full force and effect at all times during the term of this Agreement, workers' compensation insurance covering all Hospital employees under the terms of this Agreement. Upon request, Hospital shall produce a Certificate of Insurance to be issued naming Physician Practice the certificate holder.

B. Both Hospital and Physician Practice, separately, shall furnish malpractice insurance which shall cover any and all acts, errors and/or omissions or employees. Physician Practice shall cause its insurance carrier to name Hospital as an additional named insured and issue a certificate of insurance to Hospital, allowing not less than thirty (30) days advance notice of cancellation or material changes. This insurance coverage shall have limits of liability of no less than $1,000,000. Hospital shall cause its insurance carrier to name Physician Practice as an additional named insured and issue a certificate of insurance to Physician Practice, allowing not less than thirty (30) days advance notice of cancellation or material changes. _____'s insurance shall be considered to be the primary policy.

C. Physician Practice shall secure and maintain General Liability Insurance coverage with Limits of Liability no less than $1,000,000 combined single limit. The policy shall also provide for the coverage of auto and non-owned auto. Physician Practice shall provide Hospital with a certificate of such insurance.

D. Physician Practice and Hospital agree to keep in full force and effect at all times during the term of this Agreement all insurance required under this Agreement.

12. Representation of Physician Practice.

Before the commencement of the Initial Term, Physician Practice shall warrant and represent to Hospital as follows:

A. That Physician Practice's Federal Employer Identification Number is _____.

B. That no separate agreements or arrangements exist that would obligate Hospital except as set forth herein.

13. Representation of Hospital.

Before the commencement of the Initial Term, Hospital shall warrant and represent to Physician Practice as follows:

A. That Hospital's Federal Employer Identification Number is _____.

B. That no separate agreements or arrangements exist that would obligate Physician Practice except as set forth herein.

14. Invalidity of a Provision.

If any provision of this Agreement or any portion thereof shall be held to be invalid, illegal, or unenforceable, the validity, legality or enforceability of the remainder of this Agreement shall not in any way be affected or impaired thereby.

15. No Waiver.

The failure by either Hospital or Physician Practice to insist upon strict performance of any of the provisions contained in this Agreement shall in no way constitute a waiver of any of its rights as set forth herein, at law or equity.

16. Termination.

This Agreement may be terminated by Hospital if, at any time, Physician Practice breaches any material term of this Agreement. Hospital may also terminate this Agreement if, at any time, Hospital, in its sole discretion, determines that a material adverse change has occurred in the financial condition, the business, or the business prospects of Physician Practice, or that Physician Practice is unable to pay its debts as they become due in the ordinary course of business. This Agreement may also be terminated, upon five days' notice by Hospital, in the event of any federal or state legislation, regulatory action, or judicial decision which, in the sole discretion of Hospital, materially adversely affects its ability to perform under this Agreement.

17. Venue and Jurisdiction.

Any action or counterclaim arising out of or related to this Agreement must be brought by Physician Practice only in _____ County, _____. Any action may be brought by Hospital in any jurisdiction where venue is proper. Physician Practice hereby irrevocably consents to be subject to the jurisdiction of the courts of _____ concerning any case or controversy arising out of or related to the Agreement.

18. Notices.

To be effective, any notice given under this Agreement must be in writing, shall be effective when received, and shall be delivered, by hand or by overnight delivery service, to the following addresses:

IF TO PHYSICIAN PRACTICE:

IF TO HOSPITAL:

or to such other address as either party may, in writing, from time to time, give notice to the other party.

19. Limitation of Damages.

In no event will Hospital be liable for any direct or consequential damages to Physician Practice as a result of a breach of this Agreement, nor for any loss of profits, business, or goodwill.

20. Waiver of Jury Trial.

Physician Practice hereby waives any right to a jury trial in any action against Hospital arising out of, or related to this Agreement.

21. Headings.

The headings in the Agreement are intended for convenience or reference and shall not affect its interpretation.

22. Amendments.

This Agreement constitutes the entire Agreement between the parties with regard to the subject matter and no other agreement, statement, promise or practice between the parties relating to the subject matter shall be binding on the parties. This Agreement may be changed pursuant to the terms hereof or by written amendment signed by both parties.

23. No Third Party Beneficiaries.

No rights of any third party are created by this Agreement and no person not a party to this Agreement may rely on any aspect of this Agreement notwithstanding any representation, written or oral, to the contrary.

24. Governing Law.

This Agreement shall be governed by and construed under the laws of _____, regardless of any choice of law provisions of any jurisdiction to the contrary.

25. Oral Representations.

Oral amendments to this Agreement are not allowed. No oral promise shall be enforceable. Agents and Sales Representatives of Hospital have no authority to alter or amend any provision of this Agreement. No promise by any Agent of Hospital is enforceable unless in writing, attached to this Agreement and approved by a authorized person.

AGREED TO:

For Hospital

By:

_____ _____

Title:

_____ _____

Date:

_____ _____

For Physician Practice:

By:

_____ _____

Title:

_____ _____

Date:

_____ _____

Exhibit B: Example Policy

Hospital Policy: Sharing of Physician Services Among Hospital-Employed Clinicians and Private Practice Physicians

SCOPE

This policy applies to all private practice physicians and hospital-employed clinicians, executives and administrators.

PURPOSE

This policy addresses shared physician services, when the clinicians performing the services are employed by separate entities. Sharing of patient care between private practice physicians and hospital-employed clinicians is regulated by federal rules on reimbursement and laws prohibiting rewards for referrals. For example, only one claim per specialty, per patient, per day may be submitted for an evaluation and management service. Only a clinician or the clinician's employer may bill Medicare for a physician service. Hospitals are prohibited from providing private practice physicians with non-monetary compensation in excess of $416 per year (2019, rate adjusted each year). Penalties for violation of these requirements are severe and can be levied against both a hospital and physician group.

This policy identifies which clinicians may perform and bill for services to patients admitted to the hospital. Through this policy, the hospital informs its employees and admitting physicians of the rules for complying with federal law, with the purpose of preventing violation of federal law.

STATEMENT OF POLICY

A shared service is a medically necessary encounter with a patient, where a physician and a qualified non-physician practitioner each personally perform a substantive portion of a procedure or evaluation and management visit. Hospital-employed clinicians may perform physician services only: 1) for patients admitted to the hospital by a physician employed by the hospital, 2) for patients of private practice physicians when the physician has leased, through written agreement, the non-physician practitioner from the hospital, or 3) when the private practice physician has agreed not to bill for the service, acknowledging that the hospital will bill the non-physician practitioner's services. Absent a lease agreement, only the hospital has the right to bill for physician services rendered by its employed clinicians.

Hospital-employed clinicians shall not perform services covered by a global fee billed by a private practice physician, absent a lease agreement between hospital and private

practice physician or a formal transfer of care from physician to hospital-employed clinician.

Private practice physicians may not utilize hospital-employed clinicians to perform evaluation and management services or the professional component of diagnostic procedures for the private practice physicians' patients, with two exceptions. The exceptions are: 1) When a private practice physician formally transfers a patient's care to a hospital-employed clinician. In that case, the private practice physician agrees not to bill for the services performed by the hospital-employed clinician, and agrees that the hospital has the right to submit claims for that care. 2) When a private practice physician leases from the hospital one or more hospital-employed clinicians, for fair market value, in which case a private physician may utilize the services of and bill for the services conducted by a leased employee.

Private practice physicians who admit to the hospital and hospital-employed clinicians must adhere to this policy. Any violations of this policy which become known to any hospital employee or private practice physician must be reported by the individual with knowledge to the hospital's compliance officer.

PROCEDURE

A. Discharge services (CPT 99238 and 99239)

The physician service "discharge service" as described by CPT 99238 and 99239 shall be conducted and documented by the attending physician of record. A private practice physician shall not direct a hospital-employed clinician to perform a discharge service, absent a lease agreement.

B. Technical procedures (Example: Cardiovascular stress test, CPT 78452-26 and CPT 93016)

The hospital may provide registered nurse-level supervision of diagnostic procedures, as allowed by Medicare rules and within the current standard of care, or, at the hospital's discretion, the hospital may provide a higher level of supervision. The hospital's goal shall be preservation of quality of care during the performance of tests. When a test is ordered by a private practice physician, the physician or his or her designate physician must be in the building and available during the test. The hospital may require the physical presence of the attending or consulting physician if the patient is assessed as high risk. If the hospital provides a hospital-employed clinician to supervise a test ordered by a private practice physician, and if the private practice physician is not present in the testing room during the test, the hospital, and not the private practice physician, will bill for the supervision aspect of the test. If a private practice physician provides in-room supervision and documentation of the supervision, the physician has the right to bill for supervising the test.

C. Evaluation and management

1. Admissions (CPT 99221 - 99223): A private practice physician who admits a patient shall provide a written admission history and physical in the patient's hospital record within 48 hours of admission, as required by Medicare Conditions of Participation. A hospital-employed clinician may perform the initial history and physical and plan of care for a patient admitted by a private practice physician, if medically necessary. In the case of admissions, and only in the case of admissions, Medicare allows more than one claim per patient per day. If a hospital-employed clinician performs an admission history and physical, the hospital will submit a claim for that service. The admitting physician shall submit his or her claim for the initial hospital visit with the modifier-AI. Each clinician's documentation must stand alone to justify the level of service billed by that clinician. That is, a private practice physician may not write "Agree" and thereby attempt to incorporate the note of a hospital-employed clinician into the private practice physician's documentation to achieve a level of service.

2. Subsequent hospital visits (CPT 99231-99233): Private practice physicians or their employees shall conduct their own daily visits with their patients and document such visits. In rare instances, a private practice physician may request that a hospital-employed clinician conduct a daily visit, and, in that case, the private practice physician shall not bill for a visit that day, and shall agree that the hospital will submit a bill for the daily visit that day.

3. Consultations (CPT 99221-99222 if billing Medicare and, in general, CPT 99251-99255 if billing commercial payers): A private practice physician may request a consultation from a hospital-employed clinician for a patient admitted by the private practice physician. In that case the private practice physician shall not bill a consultation or evaluation and management service that day, if the hospital-employed clinician and the private practice physician are in the same specialty. The hospital will bill consultations provided by its employed clinicians. Private practice physicians may not bill consultations provided by hospital-employed clinicians.

D. Surgical pre-operative and post-operative evaluation

1. Surgeons shall personally perform and document the pre-operative and post-operative services reimbursed under a global fee for surgery.

2. If a surgeon leases the services of a hospital-employed clinician from the hospital under a written lease agreement, the surgeon may utilize the services of that clinician to perform and document the pre-operative and post-operative evaluation and management service for a patient having surgery at the hospital.

DEFINITIONS

1. Hospital-employed clinicians means physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives and certified nurse anesthetists employed by [name of hospital] Hospital.

2. Private practice physicians means physicians who are not employed by [name of hospital] Hospital.

3. Transfer care means to shift responsibility for evaluation/management and also to shift the billing opportunity from transferor to transferee, through mutual agreement. This agreement may be in the form of a letter or an annotation in the hospital record which states "I am transferring the care of this patient to [name of clinician or department]."

4. Lease means a written agreement between hospital and private physician or group for specified services of a [name of hospital] clinician. The terms of a lease must specify the type, extent and duration of services. Compensation for such services must be at a fair market value. The agreement must be signed and dated by the parties, and must be updated on a regular basis to reflect changes in fair market value. Copies of lease agreements shall be maintained by the hospital's compliance officer and counsel.

5. Discharge service means final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, preparation of the discharge records, prescription of medications and referral forms.

6. Technical procedure means any procedure for which there is a professional component described by a Current Procedural Terminology (CPT) code.

7. Evaluation and management means performing a medical history, performing a physical examination, medical decision making, counseling, and coordination of care.

8. Consultation means a type of evaluation and management service provided by a clinician who performs physician services at the request of another clinician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem.

REFERENCES AND SOURCES OF EVIDENCE

1. Selection of Level of Evaluation and Management Service, Split/Shared E/M Service, *Medicare Claims Processing Manual*, Chapter 12, §30.6.1 (2018)

2. Novitas Solutions, "Evaluation & Management (E/M) Contractor Decisions: Split/Shared E/Ms," (2018) at https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?centerWidth=100%25&contentId=

00004983&leftWidth=0%25&rightWidth=0%25&showFooter=false&showHeader=false&_adf.ctrl-state=app9y91p6_34&_afrLoop=337389545471785#! (Accessed July 16, 2018)

3. Prohibition of reassignment of claims by suppliers, 42 CFR §424.80 (2009)

4. Centers for Medicare & Medicaid Services, MLN Matters Number: MM5794, Subsequent Hospital Visits and Hospital Discharge Day Management Services (Codes 99231 - 99239), updated July 12, 2013

5. American Medical Association, *Current Procedural Terminology*, 2018.

6. Exceptions to the referral prohibition related to compensation arrangements, 42 CFR § 411.357(k) and (m) (2011)

7. Social Security Act, Criminal Penalties for Acts Involving Federal Health Care Programs (Anti-Kickback Laws), 42 USC. §1320a-7b. (2011)

POLICY VIOLATION

Any Hospital employee who fails to abide by this policy may be subject to disciplinary action, up to and including termination.