

Physician Extenders: Know the Compliance Risks Surrounding Midlevel Practitioners

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Mid-Level Providers

- Mid-level providers include:
 - Nurse Practitioners;
 - Physician Assistants;
 - Certified Registered Nurse Anesthetists (CRNAs); and
 - Clinical nurse specialists (CNS).



Why is Compliance Important?

- Integrative care models and reimbursement changes are driving cost-efficient methods of care.
- There is a growing number of mid-level providers.
 - The number of PAs practicing continues to rise. There were 83,466 in 2010, and there are over 90,000 nationally-certified PAs in 2013.
 - In 2009, 49% of physicians were in practices having NPs, CNMs or PAs. (CDC NCHS Data Brief, No. 69, August 2011.)

Key Compliance Areas for Opportunity

- Scope of practice that may be delegated by physicians to mid-level providers
- Physician supervision/collaboration requirements
- Prescriptive authority
- Billing for mid-level provider services

Scope of Practice

Physician Delegation to Mid-Levels

- The services which can be delegated to a mid-level provider are largely determined by:
 1. The type of mid-level provider;
 2. State law;
 3. Setting of services provided;
 4. Medicare requirements; and
 5. Bylaws.

Hospital Scope of Practice Medicare COPs

- Patients may be admitted to a hospital by a “licensed practitioner permitted by the State to admit patients to a hospital.”
- Medicare patients admitted by a practitioner who is not an MD/DO must be under the care of an MD/DO.
- “In accordance with State law, including scope-of-practice laws, the medical staff may also include other categories of non-physician practitioners determined as eligible for appointment by the governing body.”

Setting Matters –Skilled v. Nursing Facility

- The requirements for mid-level providers vary with respect to the following depending upon whether the mid-level performs services in the nursing facility setting or the *skilled* nursing setting:
 - Initial comprehensive visits;
 - Monthly visits;
 - Medically necessary visits; and
 - Daily certifications/recertifications.

Medicare Home Health Scope of Practice

- A mid-level provider is authorized to conduct the face-to-face examination required to certify a patient for home health services.
- However, a physician must document that the mid-level provider completed the certification evaluation.

Medicare Hospice Scope of Practice

- A nurse practitioner may not provide the initial certification for hospice care.
- A hospice physician or hospice nurse practitioner may perform the requisite face-to-face encounter for recertification, but the recertification must be signed by the physician.

Physician Supervision

Physician Supervision Requirements

- Physician supervision requirements vary by mid-level provider type.
 - CMS requires that *physician assistants* be supervised by a physician.
 - Generally speaking, other mid-level providers can practice without physician supervision *if* allowed by state law. However, they must meet certain collaboration requirements.

Physician Collaboration Requirements

- Mid-level providers work with one or more physicians to deliver healthcare services within the scope of their professional expertise.
- Medical direction and appropriate supervision must be provided as required by state in which the services are furnished.
 - Collaboration or protocol agreements
 - Board approval
 - Number of PAs or NPs that a physician may supervise
 - Level of supervision
 - Physician review/audit of patient records
 - Location/distance requirements

Prescriptive Authority

Authority and Limitations

- Prescriptive authority varies by state and by type of mid-level provider.
- Factors and limitations to consider include:
 - Authority to prescribe/order medications
 - Authority to prescribe/order controlled substances
 - Protocol/ collaboration agreement requirements
 - Additional prescriptive authority agreement
 - Board approval
 - Physician supervision requirements

Georgia Mid-Level Provider Example

- Physicians may not improperly delegate activities that are not within the scope of the mid-level's practice.
- While Georgia law permits physicians to delegate certain activities to nurse practitioners (including writing prescriptions for certain controlled substances), there must be a nurse protocol agreement in place if the nurse practitioner has prescriptive authority.
 - "[A] physician may delegate to an advanced practice registered nurse in accordance with a nurse protocol agreement the authority to order drugs, medical devices, medical treatments, diagnostic studies, or, in life-threatening situations, radiographic imaging tests." *See* O.C.G.A. § 43-34-25.

Billing for Services

Payment for Services Provided By Mid-levels

- Medicare typically pays for mid-level services in one of three ways:
 1. Mid-levels may ***bill directly*** for their services under the physician fee schedule. In this case, mid-levels or their employers receive a percentage of the physician fee schedule payment.
 2. Services may be ***billed incident to*** physician services, in which case physicians bill for the services at 100 percent of the fee schedule payment, even though mid-levels provided the services.
 3. The services of mid-levels may be ***included in the payment bundle for services*** provided in hospitals and skilled nursing facilities.

Physician's Office or Clinic

- When an E/M service is a shared/split encounter between a physician and a midlevel provider, the service is considered to have been performed “incident to” if the requirements for “incident to” are met and the patient is an established patient.
- If “incident to” requirements are not met for the shared/split E/M service, the service must be billed under the non-physician practitioner's (NPP's) NPI.

Hospital

- When a hospital (inpatient, outpatient, 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 NPI.
- If there was no actual face-to-face encounter between the patient and the physician, the service may only be billed under the NPP's NPI.
- Thus, the setting matters.

FY 2013 OIG Work Plan

- **Physicians—Error Rate for Incident-To Services Performed by Nonphysicians**
 - OIG 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 . . . *OIG found that unqualified nonphysicians performed 21 percent of the services that physicians did not personally perform.* 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. They may also be vulnerable to overutilization and expose beneficiaries to care that does not meet professional standards of quality.

Enforcement

Enforcement Activity

- State licensure actions (physician and mid-level)
- Government contractors
 - Potential data mining of claims submitted under a physician's NPI for services provided by a mid-level provider
- OIG and other government agency investigations
- False Claims Act *qui tam* whistleblowers
- Department of Justice

Examples of Settlements

• Physician Settlements

- A SC physician and 3 clinics settled in 2012 for \$325,000 for allegedly submitting claims under the physician's NPI that were performed by mid-level providers. (FCA whistleblower)
- Caritas Carney Medical Group settled in 2008 for \$347,456 for allegedly billing under physician provider numbers for services at nursing homes provided by nurse practitioners.
- A MA physician and billing company settled for \$250,000 for billing for physician services performed by mid-level providers. (FCA whistleblower)
- OK orthopedic surgery and care providers agreed to pay \$3.5 million in 2009 for, among other allegations, charging for procedures not performed by a provider and charging for services without the required physician oversight. (FCA whistleblower)

Examples of Settlements

• Hospitals/Health Systems

- Kaiser agreed to pay \$1 million in 2005 for improper supervision because an employee was not licensed as a PA for failure to obtain a new PA certification.
- University of Louisville Hospital agreed to pay \$2,833,408.60 to settle FCA allegations. The hospital claimed salaries and benefits paid to UMC-employed PAs and NPs on its cost reports, but the physician group treated the PAs and NPs as their own employees.
- Trinity Health and St. Joseph Mercy Oakland Hospital paid \$205,000 to settle allegations that NPs, CNSs, and PAs provided services billed by physicians. (FCA case)

Additional Considerations

- Consider potential overpayment issues resulting from billing improperly billing for services provided by mid-level providers.
- Consider that improper delegation to mid-level providers can result in:
 - Liability for the employer;
 - Potential penalties under the mid-level’s license; and
 - Potential penalties under the physician’s license.
- Consider local contractor guidance.

Practical Applications

Where to Begin?

- Place mid-level provider issues on your organization's work plan.
- Understand the applicable state and federal authority governing mid-level providers for your organization.
 - For large multi-state organizations, consider developing a matrix capturing state licensure, Medicaid and Medicare requirements for each state.

Compliance Questions to Ask

- What services can the physician delegate to mid-level providers in the applicable setting?
 - Hospice, physician office, hospital, skilled nursing, nursing facility
- What prescriptive authority can be delegated?
- What are the physician supervision/collaboration requirements?
- How are the mid-level provider services billed?

Where to Begin?

- Inventory your midlevel providers.
 - Could be many kinds of physician relationships.
- Gather the facts.
 - Are the midlevel providers employed, subcontracted, etc.?
 - Who controls the midlevel providers?
 - What is their scope of work?
 - What collaboration agreements are in place?
 - What level of supervision is in place?
 - Who bills for their services?

Hospital Controls the Mid-level

- Clear identification of who supervises and is responsible for knowing the legal scope of work and managing the mid-level from an HR perspective.
 - What does the mid-level do?
 - Who do they do it for?

Hospital Controls the Mid-level

- Who supervises the professional activities of the mid-level?
 - Hospital employed physician or an independent physician?
 - Does this create fraud and abuse issues due to hospital arrangements with physicians?
 - Why is this physician supervising?
 - Is there separate compensation?

Practical Safeguards

- Require regular attestation that practitioner remains within their legally permissible scope of work and your organizational standards.
- Ensure each mid-level understands clearly who they report to and take instruction from.
 - No directions from individual physicians unless there is a specific supervision arrangement in place that is Stark compliant.
- Regular audit of physician supervision arrangement:
 - Record review
 - Time sheets
 - Is the documentation in line with practical knowledge of the physician's schedule and practice patterns (does it pass the "smell" test)?

Hospital Does Not Control Mid-Level

- Regular review to ensure that mid-level is within the legally allowed scope of work.
 - Bylaws are important
 - Will also need to address with the supervising/employing independent physician
- Regular process to assess quality of care
- Are protocols and supervision plans in line with license requirements, hospital policy, and maintained within the credentialing files?
 - Who audits compliance?

Hypothetical #1

- Greentown, GA has an independent, two physician orthopedic surgeon practice that employs one PA. The practice performs their surgeries at Green Memorial Hospital. The practice falls on hard times and Dr. A leaves Greentown for a robust recruitment deal in TN. Dr. B remains in the practice but cannot continue to support the salary of the PA. The PA has a great reputation and finds new employment at Green Memorial Hospital. Dr. B is thrilled and continues to use the PA at the hospital in the same way he always has. The PA rounds on Dr. B's patients post-surgery and Dr. B continues to bill for all of the post-operative care.

Hypothetical #1

- Issues?
 - Is there anything concerning about the hospital employing the PA when Dr. B is having financial trouble?
 - The facts would need to support the need for the PA at the hospital.
 - The PA needs to support the hospital and provide services that primarily benefit the hospital.
 - Can Dr. B continue to use the PA?
 - Can other physicians use the PA?

Hypothetical #2

- The hospital compliance line receives an anonymous call with a complaint about the practices of a NP. The NP works for an ENT that is close to retiring. The ENT is an independent practicing physician. The caller alleges that the NP is not being properly supervised and that the NP is writing orders that are not being reviewed and signed off by the physician. The caller alleges that the NP is forging the physician's signature. They also allege that the physician has not visited the hospital in months, and they suspect that no chart review is occurring.
- Two months after the call, there is a medication error.

Hypothetical #2

- Issues?
 - What was the response to the compliance call?
 - Who looks into the issue and who is the target of the investigation?
 - What are the potential implications for the hospital?
 - What responsibilities does the hospital have to report this issue to licensing boards?
 - What is the response to the potential patient harm?

QUESTIONS AND ANSWERS