Auditing Mid Level Providers

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Objectives & Agenda

- Who are Mid Level Providers
- Federal Regulations For Mid Level Providers
- State Regulations For Mid Level Providers
- What is their Scope of Practice For NP’s, CNS, & PA’s
- They are Credentialed to Perform What?
- CMS Documentation & Practice Setting Guidelines
- “Incident to” – Split/Shared Visits
- Documentation of “Incident to”
- Auditing NPP services
Who are Mid Level Providers

- Nurse Practitioners
- Physician Assistants
- Certified Nurse Specialists
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
Basic Overview Billing For NPP Services

- NPP or Non Physician Practitioner is frequently the term that you will see in the Federal and State Regulations when it comes to guidelines and regulations on the practice of NPP’s.
- The Balanced Budget Act of 1997 allowed NPs (CNM fall into this category), PAs and CNSs to billing Mcare directly for services within their “scope of practice”.
- Individual is to submit their claims under their own National Provider Identifier (NPI), they will be reimbursed according to separate fee schedule. Payment for the services of a PA is made only to the PA’s employer.
- Enrollment in Mcare uses the standard CMS-855 application.
Jan 1, 2003 NP’s applying for Mcare Provider numbers for the first time must meet the following requirements:

- Be a registered professional nurse who is authorized by the state in which services are furnished to practice as a NP in accordance with that state’s law.
- Be certified as an NP by a recognized national certifying body that has established standards for NPs.
- Possess a master’s degree in nursing.
- October 2015 must possess a Doctor of Nursing Practice degree or a Ph.D. in Nursing. If you graduated prior to 2015 you will be grandfathered in and have to meet the minimum requirements when you first applied to Mcare for a provider ID number.
Additional Detail

- Unless “grandfathered” must be certified by a CMS recognized national certifying body.
- Payments are made only under assignment. Direct payment can be made to the NP or the employer or contract or the NP.
- Coverage is available for services performed by an NP working in collaboration with a physician (MD or DO).
Collaboration

- Means a process whereby an NP works with one or more physicians (MD/DO) to deliver health care services with medical direction and appropriate supervision as required by the law of the state in which the services are furnished. In the absence of state law governing collaboration, collaboration must be evidenced by NPs documenting their scope of practice and indicating the relationships they have with physicians to deal with issues outside their scope of practice.

- There must be a written agreement between the collaborating physician and the NP for the services provided by the NP, and it must be made available to Medicare upon request. In Texas I have to have a copy at each one of my different practice sites. Must be signed by each physician who may be providing supervision or professional coverage for me, if I find something that is outside my scope of practice.

- The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient seen by the NP.
Clinical Nurse Specialists (CNS)

- Enrollment and education requirement are the same information as a Nurse Practitioner.
Covered Services for NP’s and CNS’s Under Part B of Medicare

- They are the type of services that are considered as physician’s services if furnished by a MD or DO.
- They are furnished in collaboration with an MD/DO as required by state law.
- They are performed by a person who meets the NP/CNS qualifications.
- The NP or CNS is legally authorized to perform the services in the state in which they are performed.
- They are not otherwise non-covered.
Examples Of Covered Services

- Physician examination
- Minor surgery
- Setting casts for simple fractures
- Interpreting X-rays and other activities that involve an independent evaluation or treatment of the patient’s condition
- If authorized under the scope of their state license, NPs/CNSs may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.
- What they are credentialed to perform by the Hospital Credentialing Committee.
Excluded Mcare Services (NP’s, CNS’s, & PA’s)

- These will be the same as they are for MD’s/DO’s.
- For example, routine foot care and routine physical checkups that are not “reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member”. Screening exams as outlined by Mcare are covered.
Reimbursement (NP’s & CNS’s)

- Payment may be made for ALL covered services furnished by the NP, CNS, PA in ALL settings permitted by state law.
- Must be filed and paid on an assigned basis.
- Reimbursement is 85 percent of the Mcare physician fee schedule.
- Services in an office setting may be reported as “incident to”.
- Services performed outside the office setting will required the NP, CNS, PA to obtain a Mcare NPI number.
The PA must be legally authorized to furnish services in the state in which he/she performs them and must meet the following conditions:

- Have graduated from a PA educational program that is accredited by the Accreditation Review Commission on Education for Physician Assistant; OR
- Have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants; AND
- Be licensed by the state to practice as a PA
Covered Services

- Coverage is limited to the services a PA is legally authorized to perform in accordance with state law.
- The services of a PA may be covered under Part B if the following requirements are met:
  - They are the types that are considered physician services if furnished by a MD or DO.
  - They are performed by a person who meets all of the PA qualifications.
  - The PA must be employed.
  - They are performed under the general supervision of an MD/DO.
  - They are not otherwise non-covered.
More on Covered Services

- Includes those services that traditionally have been reserved for physicians, such as physical examination, minor surgery, setting casts for simple fractures, interpreting X-rays and other activities that involve an independent evaluation or treatment of the patient’s condition.
- They are authorized under the scope of their state license, Pas may furnish services billed under all levels of CPT evaluation and management codes and diagnostic tests if furnished under the general supervision of a physician.
- What they are credentialed to do by the Hospital Credentialing Committee.
Employment Relationship

- Payment for services of a PA may be made only to the actual employer of the PA.
- PAs may not otherwise organize or incorporate and bill for their services directly to the Mcare program, including as a sole proprietorships or general partnerships.
- Leasing agencies and staffing companies do not qualify under the Mcare program as “providers of services” or suppliers of services/
Supervising Physician (PA)

- The State Board of Medical Examiners in most states requires that a PA have a supervising physician.
- The PA’s physician supervisor is primarily responsible for the overall direction and management of the PA’s professional activities and for assuring that the services provided are medically appropriate for the patient. However, if the physician supervisor is not physically present with the PA, he/she must be immediately available to the PA for consultation purposes by telephone or other effective, reliable means of communication.
- The supervising physician must be on record in each state with the State Board of Medical Examiners.
- If any services performed by personnel (PA) who do not meet the qualification outlined above cannot be reported as PA’s services. The services will be subject to recoupment action for any monies paid to an employer, all the services that did not meet the PA criteria.
Mcare will make payment for an assistant at surgery when the procedure is covered for an assistant and one of the following situations exists:

- The person reporting service is a physician; OR,
- The person bears the designation of PA, NP, nurse midwife, or CNS.

No other person can be paid. If the person who assists at surgery is a surgical, technician, a first surgical assistant, scrub nurse or bears any title other than those listed, the service is not payable and is not billable to the patient.
Reimbursement and Modifier Requirements

- For assistant at surgery services the physicians are approved at 16 percent of the surgical allowance, therefore, a PA, NP, and CNS would be approved at 85 percent of the amount and Mcare would pay 80 percent of that allowed amount. Reimbursement for these services can be paid directly to the NP, NM, or CNS.

- Modifiers
  - AS = PA, NP, NM, and CNS acting as assistant at surgery
  - 82 = Assistant surgeon at teaching hospital (when a qualified resident surgeon is not available).
An E&M visit can be shared/split between a physician and an NPP. 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 visit, the service MUST be billed under the NPP’s NPI, and payment will be made at the appropriate physician fee schedule payment.
Shared Visits – Hospital Inpatient, Outpatient Hospital, Emergency Department Settings

- There is no such thing as “incident to” in the inpatient hospital setting.
- The shared service concept does not apply to critical care services.
- When a hospital E&M service 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 physicians or NPP’s NPI number.
Hospital Shared Visit Documentation Requirements

- **Documentation must:**
  - Demonstrate that the physician personally saw the patient face to face and participated in the management of the patient.
  - Not be limited to a physician co-signature of the NPP’s note or additions to the NPP’s note.
  - Not a simply indication that the physician reviewed and/or discussed the case with the NPP. This is not a teaching physician attestation that they are looking for.

- **Coding for a shared visit may be based on the information recorded in the combined notes of the non-physician and the physician.**
More on Documentation

- If there was no face to face encounter between the patient and the physician (even if the physician reviewed the medical record), the service may only be billed under the NPP’s NPI.

- Again – the shared service concept does not apply to critical care services.

- Examples
  - If the NPP sees a hospital IP in the morning and the physician follows with a later face to face visit with the patient on the same day, the physician or the NPP may report the service.
  - In an office setting, the NPP performs a portion of an E&M and the physician completes the E&M service. If the “incident to” requirements are not met, the service must be reported using the NPP’s NPI number.
NPPs may provide services that are billed “incident to” a physician’s professional services.

There are specific rules, situations, and conditions that apply –

- For example, the services must be an integral, although incidental, part of the professional services and they must be performed under the physician’s direct supervision.
- While NPP’s can perform procedure without physician supervision, and have the service paid by Mcare as a NP/CNS/PA service.
- The same service may be covered as “incident to” the services of a physician, it must be performed under the direct supervision of the physician as an integral part of the physician’s personal in-office service.
More on “incident to”

- This means that there must have been a direct, personal and professional service furnished by the physician to initiate the course of treatment of which the service being performed by the NPP is an incidental part, and there must be subsequent services by the physician of a frequency that reflects his/her continuing active participation in and management of the course of treatment.

- Direct supervision means the physician must be physically present in the SAME office suite and be immediately available to render assistance if that become necessary. - Within Shouting Distance!
‘Incident to’ Services in Hospital Setting

- Services performed by NPP’s in an inpatient or outpatient hospital setting are not covered as “incident to” services. These must be billed under the NPP’s NPI number.
- They may meet the requirements of a “shared visit”.
- SNF/NF – any E&M reported with a SNF/NF place of service must be performed by the billing physician/NPP. Split/shared E&M visits cannot be reported in the SNF/NF settings.
The only NPPs who may bill E&M services (above level of 99211) under the “incident to” criteria are NPs, CNSs, Pas, and nurse midwives.

To ensure proper reimbursement according to the fee schedule, Mcare requires that documentation submitted to support billing “incident to” services must clearly link the services of the NPP to the services of the supervising physician.

For “incident to” services that are billed and undergoing medical review, documentation sent in response to the carrier’s request should clearly show the link.
Evidence of the Supervising Physician

- Evidence of the link may include:
  - Co-signature or legible identity and credentials of both the practitioner who provided the service and the supervising physician on documentation entries.
  - Some indication of the supervising physician’s involvement with the patient’s care. This indication could be satisfied by:
    - Notation of supervising physician’s involvement (the degree of which must be consistent with clinical circumstances of the care) within the text of the associated medical record entry. OR
    - Documentation from other dates of services (e.g., initial visits, etc.) other than those requested, establishing the link between the two providers.
  - Failure to provide such information may result in denial of the claim for lack of documentation from the billing provider.
Auditing NPPs

- May use the 1995 or the 1997 CMS Documentation Guidelines.
- Strong preference for the 1997 Documentation Guidelines.
- Because it tells the NPP what they actually need to document for the burden of illness that they are dealing with.
- Status of Chronic Conditions – excellent HPI method for Primary Care providers (MD and NPP). The status of at least three chronic or inactive conditions. (pg. 46, December 2010 Evaluation and Management Services Guide)
- Chief Complaint – this is not the reason for the appointment that is recorded in the scheduling system or the reason for the encounter recorded by MA or nurse.
- Physical Exam and MDM as per set of guidelines that you are using. If you do the chronic conditions you are locked into the 1997 physical examination documentation standards.
97 Multi System Content and Documentation Requirements

- **Problem Focused**  
  One to five elements identified by a bullet.

- **Expanded Problem**  
  At least six elements identified Focused by a bullet.

- **Detailed**  
  At least two element identified by a bullet from each of six areas/systems; OR at least twelve elements identified by a bullet in two or more areas/systems.

- **Comprehensive**  
  Perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of the nine areas/systems.

- **May use any of the 97 guidelines if in a specialty practice or patients complaint is better served with this set of physical exam guidelines.**
Risk of Significant Complications, Morbidity, and/or Mortality

- DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.
- The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one.
Table of Risk

- One of more chronic illnesses with mild exacerbation, progression, or side effects of treatment.
- Two or MORE stable chronic illnesses.
- One or MORE chronic illnesses with SEVERE exacerbation, progression, or side effects of treatment.
- Documentation is the Key
Examples

- Number One
- Number Two
- Number Three
- Number Four
Questions & Some Answers

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