Mid-Level Providers: What You Need to Know to Use Them Successfully in Your Practice

Presented by

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The following program is founded upon the principles of coding, documentation and regulatory compliance as interpreted by the presenter. Even though the presenter has made every effort to produce reliable content, attendees are encouraged to verify the information prior to implementing changes within their practice. The presenter has no conflicts of interest to report at this time.
Slides and Information

Please be aware that these slides are basic information about Mid Level billing. We will discuss specific RHC issues during our session.

Not all slides will be discussed in detail during the presentation. Some of them are informational.

If you have a question just ask…
Ms Reed prefers an interactive presentation and will try to address questions as they occur unless we become short on time.

Thank you in advance for your consideration of others by not talking among yourselves.

Also at this time please mute your phones and pagers.
Why are we here?

- Audits are continuing to discover abusive patterns of incident-to billing that are costing CMS millions of dollars.
- Rules have changed significantly in the past few years with regard to what is considered incident-to.
- More payors are allowing credentialing of mid-level providers.
Incident-to Definitions of note

• An integral, although incidental, part of the physician’s professional service.
• Commonly rendered without charge or included in the physician’s bill.
• Of a type that are commonly furnished in a physician office or clinic.
• Furnished by the physician or by auxiliary personnel under the physician’s direct supervision.
Simpler way to interpret

In follow up to.....
Weighing the Risks vs. Benefits

- **Risks**
  - Misunderstanding of rules
  - Documentation not supportive
  - Confusion with shared services
  - Mixing supervision requirements of other payers
  - Using the wrong kind of billing in the wrong place
Weighing the Risks vs. Benefits

- **Benefits**
  - Continuum of care/Patient satisfaction
  - Reimbursed 100% of physician fee schedule
  - Physician face-to-face not required
  - Allows physicians to see other more complex cases
I-2 Checklist

- Employed staff providing service
- Established patient
- Physician initiated treatment plan and remains active
- Subsequent visits follow plan with no changes
- Supervision requirements met
I-2 Checklist

✔ No new problems addressed

✔ POS 11

✔ Documentation present

✔ Initiating physician (ordering) name reported box 17 of the 1500 claim form
Who is a non-physician practitioner (NPP)?

- Advanced Registered Nurse Practitioner
- Physician Assistant
- Clinical Nurse Specialist
- Certified registered nurse anesthetist
- Nurse midwife
The central principle underlying physician supervision of NPPs is that the physician retains ultimate responsibility of the patient care rendered when so required by state law. In these cases, physician supervision means that the NPP performs only medical acts and procedures that have been specifically authorized by the supervising physician.

*American Academy of Family Physicians, Nurse Practitioner Information Kit*
State Supervision Requirements

- It is the responsibility of the supervising physician to direct and review the work, records, and practice of the NPP on a continuous basis to ensure that appropriate directions are given and understood and that appropriate treatment is rendered consistent with applicable state law.

   American Academy of Family Physicians,
   Nurse Practitioner Information Kit
Collaborating Agreement

- Varies from state to state. Typically expect the following elements:
  - Scope of NPP’s practice
  - Protocol for consultation w/ the collaborating as well as medical record review
  - Covering physician when collaborating is absent
  - Resolution for disagreement
  - Parties involved in the agreement
  - Update and review the agreement frequently
State Scope of Practice

- **Scope of Practice** is a terminology used by national and state/provincial licensing boards for various professions that defines the procedures, actions, and processes that are permitted for the licensed individual. The scope of practice is limited to that which the law allows for specific education and experience, and specific demonstrated competency. Each jurisdiction has laws, licensing bodies, and regulations that describe requirements for education and training, and define scope of practice.
Medicare Enrollment

- Non-physician practitioners must have their OWN number
Do they carry specialty designation?

- CPT differs in concept from Medicare enrollment

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Code</th>
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<tbody>
<tr>
<td>Nurse practitioner</td>
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<td>Physician Assistant</td>
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<td>Family Practice</td>
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<td>Infectious disease</td>
<td>44</td>
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<td>Vascular surgery</td>
<td>77</td>
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</table>
Specialty Designation

- Does this affect new patient visit coding?
- Initial hospital service coding?
- Concurrent care hospital care between NPP’s?
Billable Services

- Evaluation and management
- Injections
- Therapies
- Minor surgeries
- Fracture care

*Must stay within scope of practice above are a few examples. What other services are provided in your practice?*
Q: must a supervising physician be physical present when flu shots, EKGs, labs, x-ray are performed in the office in order to be billed as incident-to?

A: these services have their own statutory benefit categories and are subject to the rules applicable to their specific category. They are not incident-to services and the incident to rules do not apply.

Important to note; NPP’s cannot supervise x-rays. Therefore, only their interpretation can be billed. The technical component is billed under the physician.
Employment Relationship

- The person providing the service must be an employee of the physician or physician’s group. (W-2)

- Contract labor is acceptable. (1099)
Hospital Employee

- It is becoming a common practice for many hospitals to employ a mid-levels to assist on the units. These providers often help physicians on their rounds to streamline the process and to aid in quality care of the patients.

- Please note that a provider can not split/share a visit with a mid-level that is employed by the hospital unless they are also employed under the same TIN.
Initial Visit for Follow-up to be incident too.

- Physician must provide initial visit/treatment plan
- Document RTC recommendation to see mid-level
- Mid-level must follow the written plan of the physician
- Physician must remain active in the participation of the care of the patient
Incident-to visits

- **New patients** do not qualify for I-2 billing
- Subsequent visits follow the initial treatment plan
- Does not involve a new complaint (including change in medications per WPS medical director)
  - How else do you define?
- Billing (supervising) physician must be on site for direct supervision
  - *Does not have to be initiating physician*
Stop! Do not bill as incident-to:

- Initial Preventive Physical Exam (IPPE) aka “Welcome to Medicare"
- Initial Annual wellness visit
- Subsequent annual wellness visit

They carry their own benefit category
Incident-to visits

- Incident-to billing applicable to office setting only (place of service 11)
- Documentation to support I-2 billing must be present
  - Locate initial treatment plan?
  - Follow plan with no changes, additions, or tests
  - Able to provide evidence of direct supervision
- How do you communicate to the billing office?
02/01/13 – Patient sees physician for diagnosis of overactive bladder. Started on Mirabegron. Told to return to the clinic in four weeks for recheck w/ NPP

03/01/13 – Patient returns. Improved symptoms, no new complaints. Tx plan: continue w/ meds as prescribed

New complaint
Adjust/change medication
Order diagnostics
Can a nurse bill services under a NPP?

Yes. A nurse is able to provide a service incident to the NPP when the situation meets all requirements. If the nurse performs an E/M, use 99211.

Be sure you have verified any state regulation that might apply.
Is there any restriction on the level of E/M codes allowed under the incident to or shared/split guidelines?

There is no restriction on the level of service as long as the situation meets the requirements and the person providing the services can legally perform the services. You must be able to verify the documentation of both parties.
Something to Ponder again...

- Data mining-
  - If billing incident-to significantly increases the physician’s claims to a payer, what does that look like to the payer?
Average Daily Visits to Medicare

- Dr. Green: 14 visits
- Dr. Brown: 17 visits
- Dr. Black: 57 visits
How else are 1-2 violations identified?

- Patient complaint (phone call; “I never saw Dr. ___”)
- Disgruntled employee
- Comparative Billing Reports (CBR)
“Section 410.32(b) of the Code of Federal Regulations (CFR) requires that diagnostic tests covered under §1861(s)(3) of the Act and payable under the physician fee schedule, with certain exceptions listed in the regulation, have to be performed under the supervision of an individual meeting the definition of a physician (§1861(r) of the Act) to be considered reasonable and necessary and, therefore, covered under Medicare.”
X-rays – how do you bill?

In the office setting, POS 11, split the bill for those services such as an x-ray that only requires general physician supervision

NPP’s claim
- 99214
- 71020-26

Physician’s claim
- 71020-TC
Take A Deep Breath
Medicare Shared Visits

- Applied to services in which both the physician and the NPP both see the patient and perform substantial portions of the visit
- Not applicable to the office setting
  - Except..... When incident-to is met

- Remember; New patients never qualify as incident-to
Weighing the Risks vs. Benefits

- **Benefits**
  - Provides comprehensive services in the appropriate settings
  - Frees up the physician for other complex cases
  - Reimbursed at 100% of physician fee schedule
  - Shared documentation
Shared Service Checklist

- Employed staff participating in the care
- Appropriate setting
- Physician face-to-face
- Documentation present by billing physician
- Signed by both providers
Shared service

- Both physician and NPP are employed by same entity

- Physician **face-to-face** is clearly documented.

- Be sure you do not have any payor regulations that might be a problem.
Shared service

- Not applicable in the SNF (CMS IOM 100-4, ch 15, 30.6.13.h)
- Common place of service:
  - OP hospital
  - Inpatient
  - ER
Documentation

• CMS IOM, Publication 100-04, ch 12, sect 30.6.13.h

…the physician and a qualified NPP each personally perform a **substantive** portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves *all or some* portion of the history, exam or medical decision making **key components** of an E/M service.”

Documentation

WPS Medicare – unacceptable documentation;

- I have personally seen and examined the patient independently, reviewed the PA's Hx, exam and MDM and agree with the assessment and plan as written" signed by the physician
- "Patient seen" signed by the physician
- "Seen and examined" signed by the physician
- "Seen and examined and agree with above (or agree with plan)" signed by the physician
- "As above" signed by the physician
- Documentation by the NPP stating "The patient was seen and examined by myself and Dr. X., who agrees with the plan" with a co-sign of the note by Dr. X
- No comment at all by the physician, or only a physician signature at the end of the note
1. If the NPP sees a hospital inpatient 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.

2. Amount of documentation by both parties determines who should bill
2. In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the “incident-to” requirements are met, the physician reports the service. If the “incident to” requirements are not met, the service must be reported using the NPP’s number.
Unlike other E/M services where a split/shared service is allowed the critical care service reported shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified non-physician practitioner and shall not be representative of a combined service between a physician and a qualified NPP.
Time Based Codes

- Providers and mid-levels can not split/share any code that is time based.
- Prolonged care is a good example of this.

What other codes in your speciality are time based?
If in doubt....

- Take the more conservative route! Bill under the NPP’s personal provider number
Medicaid Programs

- Check with specific state Medicaid programs on-
  - Acceptance of Incident-to billing
  - Acceptance of Shared Service billing
Other Plans

- Commercial plans; each create their own policies
- Some adopt CMS policy
- Will they credential the NPP?
- Most have their own defined supervision requirements
  - On site?
  - By phone?
  - Co-signature requirements?
Incident-to billing (recap)

1. Employed staff providing service
2. Established patient
3. Physician initiated treatment plan and remains active
4. Subsequent visits follow plan
5. Supervision requirements met
6. No new problems addressed
7. POS 11
8. Documentation present
9. Initiating physician (ordering) name reported box 17 of the 1500 claim form
Shared Services (recap)

1. Employed staff participating in the care
2. Appropriate setting
3. Physician **face-to-face**
4. Documentation present by billing physician
5. Signed by both providers
Quiz

• For incident-to billing the physician must see the patient at intervals that would be considered “actively involved in the patient’s treatment”.
  • True or False?
Quiz

For shared services billing in the hospital setting, which is the most accurate statement?

- The NPP is employed by the physician
- The NPP is employed by the hospital
- The NPP is not employed, just waiting to get their license reinstated after that one awkward incident last year….
- Part of a training program
Best Practices...

- Know the distinctions between payers
  - Supervision
  - Documentation
- Perform self audits
- Create written policies
- Keep informed!
- Know any state regulations that apply to your practice.
Thank you!

QUESTIONS

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