

Billing for services performed by nonphysician practitioners

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When surgeons find their workload is getting overwhelming, they sometimes consider adding another surgeon or a nonphysician practitioner (NPP), such as an advanced practice registered nurse (APRN) or physician assistant (PA), to their practices. The volume of surgical demand and the need for additional surgeons for on-call responsibilities are typically met by adding an additional surgeon to the group. Some surgical practices, however, determine that the volume of procedures they perform does not warrant adding another surgeon, and an APRN or PA could fulfill the necessary functions. Tasks that might be assigned to these individuals include preoperative evaluations, preoperative patient education, triage assessment, postoperative visits, and returning phone calls.

Once the group has decided to hire an NPP, the question is how to get paid for these services. Some of the services just mentioned are included in the global surgical package, meaning all fees are covered under one reimbursement package. In this case, when performing an economic analysis of how helpful it would be to hire an NPP, the group should consider whether freeing up surgeons to

complete other reimbursable work will offset the cost of adding an NPP. Practices want to know that they can generate revenue from hiring a mid-level provider, which leads them to ask: What are the billing rules for APRNs and PAs?

Typically, NPPs provide incident-to or shared services. Others may serve as assistants during operations. This column answers payment questions surgeons may have regarding each of these NPP services.

What are some of the general guidelines that Medicare and other payors apply toward reimbursement for NPP services?

Unfortunately, the rules vary by payor. Medicare has specific rules for reporting services provided by an NPP, but private insurers can set their own standards. Likewise, state Medicaid programs and managed Medicare and managed Medicaid plans may set their own rules.

For Medicare, a service that is provided by an NPP and reported to Medicare is reimbursed at 85 percent of the physician fee schedule when the NPP's national provider identification (NPI) number is used. Services that are reported incident-to a physician's services or as shared services are reported to Medicare under the physician's NPI and

are paid at 100 percent of the Medicare physician fee schedule.

What are incident-to services?

NPPs often render services that are incident-to procedures and care that the surgeon provides. Incident-to services are provided in the physician's office and billed as if the physician provided the care and using the physician's NPI. These services must be of the type that are usually provided in the office and must be integral to the plan of care. Staff members who provide the services must be an expense to the practice that employs the physician.

What are the incident-to billing rules?

Incident-to services are allowed in a nonhospital setting, such as the physician's office. Services typically provided in the office are designated by using place-of-service code 11 on the claim form. A surgical group that has joined a hospital is no longer billing with the "office" as the place of service, even though the practice may be in the same location it was in before joining the hospital. A surgical group in this position typically reports place-of-service code 22, signifying the outpatient department. Incident-to services for Medicare may only be

reported in the office, not in the outpatient department.

To bill for the NPP, the physician must have seen the patient first at a previous encounter and established the plan of care. Care provided to a new patient or an established patient with a new health care problem may never be billed as incident-to a physician service. If an NPP sees a new patient or assesses an established patient for a new problem, the practice should report that service under the NPP's provider number, not the physician's. Additionally the physician must be in the suite of offices when the services are performed and must stay involved with the patient's care.

According to Medicare rules, the services provided by the NPP must be within his or her scope of practice as mandated in the state where the practice is located. This model is used in billing for health care services provided to patients with chronic or ongoing conditions, such as wounds. The physician sees the patient at the initial visit, establishes the plan of care, and tells the patient to return to the office and see the APRN at the next visit. If the physician is in the office when the patient returns and the NPP is carrying out the plan of care, then the evaluation and management (E/M) service may be reported under the physician's NPI as if the physician had provided the service. If the physician is out of

the office, the service should be reported under the NPP's NPI.

What are shared services, and how do they differ from incident-to services?

Unlike incident-to services, shared services may be reported in the emergency department (ED), outpatient department, or inpatient department of the hospital. Shared services represent the model that many physicians would like to use everywhere in working with NPP practitioners. Shared services are E/M services that a physician and an NPP provide jointly.

What are the guidelines for shared services?

Both the physician and the NPP must provide a face-to-face service to the patient on the same calendar day and both must document their portion of the work. Typically the NPP's documentation is more detailed than that of the physician, but the physician should document the clinically relevant encounter with the patient and then tie his or her note to the NPP's. When these patient encounters occur on the same calendar day, the level of service is determined by combining elements in both notes to select the level of service. Remember, this applies to services provided in an inpatient setting, an outpatient department, or the

ED. If the physician practice is a provider-based clinic using the outpatient department as the location (22) to submit claims, shared services are permitted.

When should a practice bill patient care as a shared service?

This model is very useful for initial hospital services, ED visits, and consults. It allows the NPP to see and evaluate the patient first, take a detailed or comprehensive history, perform a thorough exam, and formulate a treatment plan. The physician then is able to do a more focused history and exam to confirm the assessment and plan.

Both clinicians must document their own participation in the care. If only the NPP sees the patient on that date, then report the service under the NPP's provider number, not under the physician's provider number.

Sometimes an APRN or a PA will assist with an operation. How do we bill in these instances?

Some surgical groups employ an APRN or PA to serve as an assistant at surgery, freeing up a surgeon to perform evaluations or surgical procedures. For a surgical practice to report and receive third-party reimbursement for the service, the NPP must be an expense to the practice. If the hospital employs the

NPP, and the NPP is not an expense to the practice, the practice may not report and be paid for those services.

Some hospitals employ NPPs to support their surgical groups. These NPPs are listed as an expense to the hospital on their Part A expense report. According to the Centers for Medicare & Medicaid Services' (CMS) *Medicare Benefit Policy Manual*, Chapter 15, Section 60.1:

For hospital patients and for [skilled nursing facility, or SNF] patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under §1861(s)(2) (A) of the Act. Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a Medicare intermediary. (See §80 concerning physician supervision of technicians performing diagnostic x-ray procedures in a physician's office.)

Surgical groups may bill for the services that their staff or contracted employees performed but may not report and be paid for services that the hospital's staff or contracted employees provide.

What about patients with commercial insurance?

In many markets, commercial insurers enroll and credential APRNs but not PAs. There is

no consistent national policy. States usually require that PAs have physician supervision, although that does not mean being physically in the same location when the PA provides services. A group must check with each payor about its policies for reporting APRN and PA services.

Two national insurers—Aetna and Anthem—have policies on NPPs. Aetna credentials both APRNs and PAs and follows Medicare rules for incident-to and shared services.

Anthem doesn't follow incident-to rules for any NPP who has been assigned an Anthem NPI number. In other words, if the NPP is enrolled in and credentialed by Anthem, services are to be reported under the NPP's NPI number. NPPs who are not enrolled and credentialed by Anthem are permitted to report their services incident-to the physician. Typically, APRNs are credentialed and report their services under their own provider numbers. PAs, however, are not enrolled or credentialed by Anthem and must report their services incident-to. Anthem does not follow all of Medicare's incident-to rules but notes these two policies on its website.

Pursuant to its incident-to policy, Anthem requires that the supervising provider be physically present in the office suite and immediately

available when necessary to provide assistance and direction throughout the E/M visit and/or rendered service. The supervising provider must stay involved and take an active part in the ongoing care of the patient. For details, go to http://www.anthem.com/provider/noapplication/f1/s0/t0/pw_e182215.pdf?refer=ahpprovider.

How will following these guidelines benefit my practice?

The lack of consistency and standardization among payors adds to the complexity and cost of employing NPPs; however, many practices find that the benefits outweigh the difficulties of learning and applying the billing rules. ♦

Editor's note

Accurate coding is the responsibility of the provider. This summary is only a resource to assist in the billing process.