Maximizing Utilization of PAs & NPs: Rules, Realities, and Reimbursement

Session Code: TU15

Date: Tuesday, September 20, 2016

Time: 2:30pm - 4:00pm

Total CE Credits: 1.5

Presenter(s): Tricia Marriott, PA-C, MPAS, MJ Health Law, CHC
Maximizing Utilization of PAs & NPs

Rules, Realities, and Reimbursement

Speaker

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www.chlm.org

Disclosure

Tricia Marriott is an employee of the AAPA. She has no other financial or industry disclosures to report.

She is also currently licensed in the State of Connecticut, NCCPA certified, and is employed part-time by the Yale Medical Group in the Department of Orthopaedics.
Disclaimer

This presentation is provided for informational purposes only and does not constitute legal or payment advice.

- The ultimate responsibility for statutory and regulatory compliance, as well as the proper submission of claims, rests entirely upon the provider of services.
- Medicare policy changes frequently, so be sure to keep current by going to www.cms.gov and to your Medicare Administrative Contractor’s website.
- The American Medical Association has copyright and trademark protection of CPT ®.

Myths & Misunderstandings

NPs and PAs are ‘mid-levels’, ‘physician extenders’, or “allied health”…

Fact

NPs and PAs are NPs and PAs¹
### NPs and PAs cannot see new Medicare patients

**Fact**

NPs and PAs CAN see new Medicare patients.¹

[When they do, the claim must be submitted under their own NPI, resulting in reimbursement at 85%.]

### Physicians must see every patient and/or be on site.

**Fact**

There is no Medicare rule that requires a physician to see every patient.²

³§190 Physician Assistant (PA) Services

“The physician supervisor (or physician designee) need not be physically present with the PA when a service is furnished to a patient, unless required by State law or regulations. The physician supervisor may be contacted by telephone, if necessary unless State law or regulations require otherwise.”

### The practice loses money on services provided by an NP/PA because Medicare only reimburses 85%.

**Fact**

Many organizations recoup NP/PA expenses and generate positive margin when PAs and NPs are utilized appropriately.
Myths

- PAs/NPs cannot see new patients
- Physician must be present in the office or clinic when a PA/NP sees patients.
- Physician must see every patient.
- A physician co-signature on a note means the claim may be submitted under the physician.
- Reimbursement for services provided by PAs/NPs "leaves 15% on the table".
- Commercial payers won’t pay.
- Patients won’t be happy: What about the “brand”?

What do Consumers want from Health Care?

Foundational Pillars
Foundation

PAs and NPs are not clinical support staff.

PAs and NPs provide professional services at a medical level of care that a physician would otherwise have to provide.

PA/NP Services

Defined by Medicare:

“They are the type that are considered physician’s services if furnished by a doctor of medicine or osteopathy (MD/DO).”5

PAs/NPs as Providers

What are the business implications?
What are the regulatory and compliance issues?
What are the cultural implications?

Situational analysis:

- What are we doing now?
- What needs to happen?
- How do we get it done?
**Interdependent Concepts**

**Credentialing & Privileging**

**Reimbursement & Billing Policy**

**Maximizing PA/NP Utilization**

**Regulatory Compliance and Scope of Practice**

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**PAs & NPs**

**RECOGNIZED BY MEDICARE PART B SINCE 1998**

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**Balanced Budget Act of 1997**

- Removed the restriction on settings and services furnished by PAs/NPs: payments allowed for services furnished by PAs/NPs in all settings.
- Effective for services furnished on or after January 1, 1998
- Prior to 1998, very little opportunity to bill for PAs/NPs other than via “incident-to” provision, and reimbursement rate in rural/healthcare provider shortage areas was 65%.
- Payment ... 85 percent of the physician fee schedule.
PAs/NPs are no longer clinical support staff:

No longer included in Medicare Part A Cost Report 1
42CFR Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services
§ 409.10 Included services.

(b) Inpatient hospital services does not include the following types of services:
(4) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.
(5) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

Medicare Benefit Policy Manual
§190: Physician Assistant Services

B. Covered Services
Coverage is limited to the services a PA is legally authorized to perform in accordance with State law or State regulatory mechanism provided by State law:
1. General: The services of a PA may be covered under Part B, if all of the following requirements are met:

2. Types of PA Services That May Be Covered
State law or regulation governing a PA’s scope of practice in the State in which the services are performed applies. Carriers should consider developing lists of covered services. Also, if 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 furnished under the general supervision of a physician.

PA/NP recognized by Medicare

• PAs and NPs are recognized as enrolled “non-physician providers”, “ordering/referring” providers, and “eligible providers” in the Medicare program.

• Must be enrolled in Medicare (PECOS) if ordering, referring and/or billing. (Rule in effect since January 1, 2014)

• Reimbursement for services provided by PAs and NPs are reimbursed at 85% of the physician fee schedule.

• There are provisions for 100%, such as the “Incident-to” provision in the office & Shared/Split Visits in the hospital setting; specific rules apply.
PAs/NPs can bill all levels of E/M: Medicare

“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.”

“NPs may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.”

CPT® Code Utilization

“A ‘physician or other qualified health care professional’ is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.”

“Throughout the CPT code set the use of terms such as ‘physician’, ‘qualified health care professional’, or ‘individual’ is not intended to indicate that other entities may not report the service.”

CPT ® 2016, Professional Edition, p. xii

PAs and NPs: One Difference Direct Billing/Payment

PAs

Medicare does allow PAs to submit claims under their own NPI.

Medicare does not allow PAs to direct bill/receive direct payment; while the claim is submitted under the PA’s NPI, the payment field is to the PA’s employer. 11-14

NPs

Nurse practitioners may direct bill under their NPI and receive direct payment from Medicare.12

• Nurse practitioners may reassign their payment to their employer.

• Most NPs reassign payment as a condition of their employment.
Supervision/Collaboration: Medicare

Medicare policy for supervision/collaboration essentially same for PAs and NPs; – Access to reliable electronic communication
– Personal presence of the physician is generally not required
– Medicare policies will not override state law guidelines or facility policies

NP Collaboration: Medicare

Medicare Benefit Policy Manual: Chapter 15 §200 Nurse Practitioner (NP) Services
D. Collaboration

Collaboration is a process in which 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 is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice.
Medicare: Supervision by an MD/DO

- Medicare Conditions of Payment require that PAs/NPs are supervised by a MD/DO.
- Medicare’s Conditions of Participation (CoP) for Hospitals require that each patient is under the care of an MD/DO.
- There are no provisions for any other type of physician under Medicare payment rules. (DPM, Chiropractor, DDS, etc.)
49 states and the District of Columbia enacted PA positive changes to their laws and regulations in 2015,...

...for a total of 201 law and regulation changes that improve PA practice.

These changes have the potential to positively impact 99% of America's 111,000 PAs...

...and more than 400 million patient encounters a year.

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Number of Key Elements Included in State PA Law

August 2016

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PA State Law Key Elements
PA State laws update

- Several state laws enacted provisions that include a patient-centered element. For more complete information on these provisions, please consult AAPA state-by-state summaries.
  1. Florida: The palliative care prescriber authority provision becomes effective 4/1/17.
  2. Kentucky: The chart co-signature legislation will become effective 9/8/16.
  3. New Jersey: PA Interim Practice Act passes into effect 8/1/16. Interim scope, adoptable
  4. North Carolina: Although part is effective only in the NCMQCA Medical Board, as stated in the FAQ resource, the information on this website, the electronic communication between the PA and the hospital primary representing physicians is to validate the procedures of quality improvement oversight as long as the spirit of Rule 15.0.A.
  5. Nevada: Minnesota state legislation will go into effect 8/1/16.

PA Profession Regulatory Changes

Recent Federal PA Laws and Regulations

- Allow PAs to order portable x-rays and local occult blood tests for Medicare patients.
- Clarify that PAs can write hospital admission orders and conduct H&Ps.
- Eliminate onsite supervision requirements for PAs working in RHCs.
- Allow PAs to order DME under TRICARE.
- Allow PAs to care for Medicare patients with complex, chronic conditions.
- Allow PAs to document face-to-face encounters for DME under Medicare.
- Allow RHCs to contract directly with PAs.
- Avoid a 21% immediate decrease in Medicare payments for PA and physician services; establish .5% increase for 5 years.
- Include PAs in new value-based incentive program (MIPS) under Medicare.
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NEW! Comprehensive Addiction and Recovery Act (CARA) of 2016 passed July 14, allowing PAs/NPs to be waived to prescribe buprenorphine.

NEW! Proposed Rule to eliminate “LIP” from “restraint” Medicare CoPs.

Nurse Practitioners

- Nurse practitioner laws and regulations are specific to each state. AAPA’s interactive map below provides reference and regulatory requirements, as well as practice environment details, for all 50 states and the District of Columbia. Nurse click on each state for details.

Example:
Ohio State Law/Regulations

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision/collaboration with physician required</td>
<td>✓ YES</td>
<td>✓ YES</td>
</tr>
<tr>
<td>Practice/Standard Care agreement required</td>
<td>✓ YES</td>
<td>✓ YES</td>
</tr>
<tr>
<td>Prescriptive Authority</td>
<td>✓ YES</td>
<td>✓ YES</td>
</tr>
<tr>
<td>Chart review determined at the practice level</td>
<td>✓ YES</td>
<td>✓ YES</td>
</tr>
<tr>
<td></td>
<td>✓ YES</td>
<td>Yes</td>
</tr>
<tr>
<td>Ratio limits</td>
<td>✓ YES</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>✓ (3:1 at any one time)</td>
<td></td>
</tr>
</tbody>
</table>

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PHYSICIAN CO-SIGNATURE

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Physician Co-signature

- Required by Medicare Condition of Payment (IPPS rule) for a hospital inpatient admission ORDER written by a NP/PA/resident.20
- Required by Medicare Condition of Participation for hospitals on discharge summaries.21
- The Medicare Condition of Participation for hospitals requirement that “there must be evidence in the chart” that the patient is under the care of an MD/DO has led many to require a co-signature on the Admission H&P.22
- Physician signature is required on Medicare home health certification and re-certification. While a PA/NP may perform and document the required face-to-face encounter, the “certification” requires a physician’s signature.23
- Physician “attestation statements” used in academic medical centers for teaching physician billing DO NOT apply to PAs and NPs.24

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PAYER ENROLLMENT & CREDENTIALING

Definitions

**Enrollment:** The process of adding a provider's credentials to the system.

**Credentialing:** The process of assessing and confirming (verifying) the qualifications of a health care practitioner. It includes collecting and verifying information about a practitioner (such as licensing, certification, and education), assessing and interpreting the information, and making decisions about the practitioner.

Payers and Enrollment

**Medicare**

Medicare enrolls PAs & NPs.25 (required since 2014)

Claims for services provided by PA/NP can be/are submitted using the PA/NP's NPI.

Reimbursement is at 85% of the physician fee schedule.
**Payers and Enrollment:**

**Medicaid**

- Medicaid programs in all states & DC pay for services provided by PAs and NPs.
- Medicaid enrolls or identifies the PA on the claim in 40 states; most states enroll NPs.
- 10 states and DC do not recognize PAs on the claim; claims are submitted under the physician.
- Some state Medicaid programs do not cover services provided in hospitals.
- Reimbursement rates vary widely.
  - CT 90% for PAs and NPs
  - TX 92% for PAs and NPs
  - VA 100% for PAs and 75% for NPs

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**Example-Illinois Medicaid: PAs**

**A-202.1 Charges**

**Exception:** A physician may submit a bill for services provided by a non-enrolled Advanced Practice Nurse (APN), a Physician Assistant (PA) or a Genetic Counselor, as long as such practice is in accordance with the policy outlined in this handbook or not in conflict with the following rules and regulations:

- Nurse Practice Act (225 ILCS 65)
- Physician Assistant Practice Act (225 ILCS 95)
- Genetic Counselor Licensing Act (225 ILCS 135)
- Department of Professional Regulations rules for administration of Physician Assistant Practice Act (68 Ill. Adm. Code 1350)

**Source:** Handbook for Practitioners Rendering Medical Services, p.21
[http://www2.illinois.gov/hfs/SiteCollectionDocuments/a200.pdf](http://www2.illinois.gov/hfs/SiteCollectionDocuments/a200.pdf)
### Example: Illinois Medicaid: APNs

“All Certified Nurse Practitioners (CNP) and Clinical Nurse Specialists (CNS), may enroll with the department. With the exception of psychiatric services (CPT code range 90801 through 90899), which must be rendered by a physician, all services rendered by an APN are reimbursed at 100 percent of the physician’s rate. In addition, APNs may enroll as a primary care provider under the Maternal and Child Health (MCH) program.”

http://www2.illinois.gov/hfs/SiteCollectionDocuments/a200.pdf

For enrollment information:
- Handbook for Practitioners Rendering Medical Services
- Section A-201.2 Advanced Practice Nurse Enrollment p.15
  http://www2.illinois.gov/Hfs/TaxCollectionDocuments/a200.pdf

### Payers and Enrollment

#### Commercial Payers

<table>
<thead>
<tr>
<th>Payer</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>- Private payers may promulgate their own rules.</td>
</tr>
<tr>
<td></td>
<td>- Many choose not to enroll PA/NPs. They DO however pay for services provided by PA/NPs.</td>
</tr>
<tr>
<td></td>
<td>- Claim is submitted under the physician’s number.</td>
</tr>
<tr>
<td></td>
<td>- Many do not discount; payment is at the physician rate.</td>
</tr>
<tr>
<td></td>
<td>- The organization billing must ascertain claims methodology and payment rate for each payer with whom they contract.</td>
</tr>
</tbody>
</table>

### Example: Aetna

- Aetna enrolls PAs & NPs (since June 2010) except in Alaska, Kansas, Maine, Michigan and Missouri.
- Discounts PA/NP services to 85%.
- Aetna’s policy manual states that it follows Medicare’s “Incident-to” policy, allowing for 100% reimbursement if all rules are met.
- It remains the responsibility of the practice to ascertain the payment policy and claims instructions for each payer with whom they contract.
Medicare Payment Policy: “Incident to Billing”

“Incident to” is a Medicare billing provision that allows reimbursement for services delivered by PAs/NPs at 100 percent of the physician fee schedule, provided that all “incident to” criteria are met.

“Incident to” billing only applies in a non-facility setting such as the physician’s office or physician’s clinic/POS 11.

DOES NOT apply in outpatient hospital clinic (provider based) or any facility setting such as inpatient hospital, skilled nursing facility/NF/IRF/LTCH, emergency department, and POS 22.
In the News:
Medicaid Billing under the physician NPI for services provided by NPs and PAs

From AHLA today:
Audit: Northgate, Asaker Overbilled MassHealth, Medicaid, CHIP For Services Provided By Nurse Practitioners, PAs.
The Springfield (MA) Republican (2/25, Berry) reports a state audit revealed Northgate Medical PC, of Springfield, Massachusetts, “substantially overbilled MassHealth for services that cost more than the actual services provided.” Over three years, the provider overbilled MassHealth for over $24,000 in doctor-provided services that were actually performed by nurse practitioners.” State Auditor Suzanne M. Bump said “both Northgate and Asaker received overpayments from MassHealth, the state’s combined Medicaid and Children’s Health Insurance Program, for services ostensibly provided by doctors” when in reality, “nurse practitioners or physicians’ assistants (sic) provided the services.”

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What’s Hot?

06-20-2016
After it self-disclosed conduct to OIG, Medical Plaza Family and Geriatric Physician, P.A. (Medical Plaza), North Carolina, agreed to pay $109,975.24 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Medical Plaza submitted claims to Medicare for payment under two physicians’ National Provider Identification numbers for incident-to services provided to patients at Medical Plaza when the services had been provided by Medical Plaza’s nurse practitioners.

06-17-2016
After it self-disclosed conduct to OIG, Radiology Alliance, PC (Radiology Alliance), Tennessee, agreed to pay $355,461.34 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Radiology Alliance submitted claims to Federal health care programs that were false or fraudulent in the following ways: (1) services were performed by two radiology practitioner assistants that were supervised by Radiology Alliance’s physicians as if they were personally provided by the physicians; (2) in certain instances Radiology Alliance billed for nursing practitioner and physician assistant services using the supervising physician’s billing number at the supervising physician’s billing rate; and (2) billed for the insertion of peripherally inserted central catheter lines by hospital nurses and radiology technicians that were supervised by Radiology Alliance’s physicians as if those services were directly provided by the physicians.

https://oig.hhs.gov/fraud/enforcement/cmp/psds.asp

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Medicare “Incident-to” Rules

- The physician must have **personally** treated the patient on his or her **initial** visit for the particular medical problem and established the diagnosis and treatment plan. (This is not a shared visit.)
- A physician (does not need to be the same physician) is within the suite of offices when the PA/NP renders the service upon the patient’s return for follow-up for the same problem.

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Medicare “Incident-to” Rules

- The physician must have **some ongoing participation in the patient’s care**.
- This must be reflected in the medical record somehow, in the event of an audit.
- If all requirements are met, encounter can be billed under physician’s NPI for 100% reimbursement.
- **If ALL are not met, bill under the PA/NP’s NPI; reimbursement will be at 85%.**

*Be sure to check you MAC websites for guidance!!!*
What about the 15% left on the table?!

Office/Outpatient Visit: Established Patient

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Work RVU</th>
<th>Non-facility Price* Physician</th>
<th>Non-facility Price* PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>0.97</td>
<td>$73.40</td>
<td>$62.39</td>
</tr>
</tbody>
</table>

15% = $11.01

Source: CMS Physician Fee Schedule
Accessed March 15, 2016
*National Payment Amount: actual payment amount will vary by geographic index
NP/PAs are paid approximately 1/2 to 1/3 the salary of their physician counterpart. (This is a broad generalization, but supported by MGMA data.)

The profit/contribution margin is higher when the NP/PA provides the service, even at the 85% reimbursement rate.

### Same Service Provided

<table>
<thead>
<tr>
<th>Physician: Family Medicine</th>
<th>NP/PA: Family Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Salary $215,306* ($104/hr)</td>
<td>Median Salary $95,118/$96,026* ($46/hr)</td>
</tr>
<tr>
<td>The service/office visit is reimbursed at 100% for $100.</td>
<td>The same service is reimbursed at 85% for $85.</td>
</tr>
<tr>
<td>First visit of the day: profit $4.</td>
<td>First visit of the day: profit $39.</td>
</tr>
</tbody>
</table>

*©2015 MGMA. Data extracted from MGMA DataDive™

### Another View: Family Medicine

Assumptions:
- 15 minute appointment slots = 4 visits per hour = 28 visits/day
- 8 hour days

<table>
<thead>
<tr>
<th></th>
<th>Physician</th>
<th>NP/PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receipts providing same level of service</td>
<td>$2,800 ($100 x 28 visits)</td>
<td>$2,380 ($85 x 28 visits)</td>
</tr>
<tr>
<td>Wage per day ($104/hour x 8 hours)</td>
<td>$632</td>
<td>$368 ($46/hour x 8 hours)</td>
</tr>
<tr>
<td>Contribution margin</td>
<td>$1,968</td>
<td><strong>$2012</strong></td>
</tr>
</tbody>
</table>
**Contribution Margin**

**Same E/M Service Provided**

<table>
<thead>
<tr>
<th>Physician: General Orthopaedics</th>
<th>PA: Orthopaedics</th>
</tr>
</thead>
</table>
| Median Compensation $568,319*  
$273/hr | Median Compensation $106,716* $51/hr |
| The service/office visit is reimbursed at 100% for $100. | The same service is reimbursed at 85% for $85. |
| First visit of the day:  
- $173; occurs 1st visit every hour if same service provided. | First visit of the day:  
- Profit $34. |

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**Contribution Margin**

**Another View: General Orthopaedics**

Assumptions:
- 15 minute appointment slots = 4 visits/hour = 28 visits/day
- 8 hour days

<table>
<thead>
<tr>
<th>Physician</th>
<th>NP/PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receipts providing same level of service</td>
<td>Compensation per day</td>
</tr>
<tr>
<td>$2,800 ($100 x 28 visits)</td>
<td>$2,380 ($85 x 28 visits)</td>
</tr>
<tr>
<td>$2,184 ($273/hour x 8 hours)</td>
<td>$408 ($49/hour x 8 hours)</td>
</tr>
</tbody>
</table>

**Hospital Medicine**

**Hospitalist Physician**

Salary $263,511* ($114/hr)

The admission H&P (99221) is reimbursed at 100% for $102.

First encounter of the day:  
profit -$12.

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**PA/NP Hospital Medicine**

Salary $95,763/102,960* ($48/hr) averaged

The same service is reimbursed at 85% for $87.

First encounter of the day:  
profit $39.
MEDICARE PAYMENT POLICY: HOSPITAL SHARED VISITS

Split/Shared Visit to Hospital

- Can be billed for a new patient, admission, or subsequent hospital visit; the service performed was an evaluation and management (E/M) service, not a procedure nor a critical care service.
- PA/NP and physician must be employed by same entity (same hospital, same medical group).
- Physician must perform some element of history, exam, medical decision making and document on same calendar day.
- If physician documentation not adequate, bill under PA/NP’s NPI.

“Unacceptable” Shared Visit Documentation

- “I have personally seen and examined the patient independently, reviewed the PA/NP’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.
Shared Visit-Office

In the office/clinic, a shared visit only applies to an established patient. A new patient visit may not be performed as a shared visit under Medicare rules, and must be billed under the PA/NP’s NPI.

“When an E/M service is a shared/split encounter between a physician and a nonphysician practitioner (NP, PA, CNS or CNM), 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.” 31

Shared visits /schedules in the office are inefficient and poor utilization of PAs and NPs!

Consequences
Just Ahead

TEAM DEPLOYMENT DECISIONS

What are we doing now?

Evaluate current roles, responsibilities and costs associated with current team players. Opportunities? Challenges?

Good
Bad
SURVEY/ ACCREDITATION CONSIDERATIONS

Hot Topics
Reported from the Field

- Restraints and Seclusion
- EMTALA\textsuperscript{22}
  - Medical Screening Exam
  - Certification of False Labor
  - On-Call Coverage
  - Transfers
- Conscious Sedation
- FPPE/OPPE
Questions?

Contact: Tricia Marriott

http://www.chlm.org/contact-us/

Endnotes

1. The clarity and transparency in practice and in services so they say no defined roles and scope makes calling people who they are, as defined by licensure important. In California the acronym “APP” was just passed into law as “advanced practice pharmacists.” In many cases, there is a need to understand the specific clinical role.

2. California Section 378, Sec. 20-94a. Licensure as advanced practice registered nurse. (d) A person who has received a license pursuant to this section shall be known as an “Advanced Practice Registered Nurse” and no other person shall assume such title or use the letters or figures which indicate that the person using the same is a licensed advanced practice registered nurse.


**IPPS Rule January 30, 2014 “Additional Clarification of Guidance”**

 CMS does not require these practitioners be employed by an MD/DO. However, CMS regulations do require that Medicare and Medicaid patients admitted by licensed practitioners (e.g., nurse practitioners, midwives, etc), as allowed by the State, to admit patients to a hospital, and personnel such as nurse practitioners and MD/DO assistants to the extent recognized under State law or a State's regulatory mechanism. Whether delegated or non-delegated, we would expect the person who writes the discharge summary to authenticate, date, and time their entry and additionally, for delegated personnel such as nurse practitioners and MD/DO assistants to the extent recognized under State law or a State's regulatory mechanism. The outcome of the treatment, procedures, or surgery; the outcome of the treatment, procedures, or surgery; the potential of the treatment, progeny, or severity. The potential of the treatment, progeny, or severity. Evidence of being under the care of an MD/DO must be in the patient's medical record. In accordance with hospital policy, and 42 CFR part 482.12(c)(1)(i) the MD/DO may delegate writing the discharge summary to other qualified health care providers such as nurse practitioners and MD/DO assistants to the extent recognized under State law or a State's regulatory mechanism. Evidence of being under the care of an MD/DO must be in the patient's medical record.

**Endnotes**

* IPAJ (Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)*

§ 482.12(c)(2) (continued) If a Medicare patient is admitted by a practitioner not specified in paragraph(c)(1) of this section, that patient is under the care of an MD/DO.

**Guidance/Guidance/Transmittals/downloads/R178CP.pdf**

• Provisions for follow-up care for an outpatient surgery patient or an emergency department patient who can not be admitted or transferred to another hospital.

*for: Medicare (KY and Ohio) : First Coast (Florida) WPS, Noridian, Home Health:

**Guidance/Guidance/Manuals/downloads/clm104c12.pdf**

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**Guidance/Guidance/Manuale/downloads/medenroll_orderreferprov_factsheet_ICN906223.pdf**

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