

Who Is a Qualified Health Care Professional (QHP)? A Compliance Update on Using Extenders from CRNAs to PAs

Joette Derricks, CPC, CHC, CMPE, CSSGB, CLHC
Vice-President, Regulatory Affairs & Research
Anesthesia Business Consultants

Neda M. Ryan, Attorney, Clark Hill PLC

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Agenda

- ▶ Understanding AMA-CPT definition of a qualified health care professional (QHP) vs. clinical staff
- ▶ Examining varying "scope of practice" for QHP
- ▶ Discussing QHPs' credentialing and payer rules
- ▶ Reviewing Medicare "Incident to" billing requirements and reimbursement issues
- ▶ Exploring the impact place-of-services (POS)
- ▶ Investigating why QHPs are under RACs and other auditors scrutiny

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Who is a QHP?



- ▶ In 2013, the American Medical Association (AMA) established a definition for a Qualified Health Care Professional (QHP) in terms of which providers may report services:
 - 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."

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Who is a QHP?

- ▶ These professionals are distinct from "clinical staff". A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service; but who does not individually report that professional service.
 - Clinical staff are medical assistants, licensed practical nurse, etc.
 - Other policies may also affect who may report specific services
 - Inclusion or exclusion (in the AMA-CPT codebook) does not imply any health insurance coverage or reimbursement policy.

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Who is a QHP?

- ▶ Anesthesiologist Assistant (AA)
- ▶ Certified Nurse Mid-Wife (CNM)
- ▶ Certified Registered Nurse Anesthetist (CRNA)
- ▶ Clinical Nurse Specialist (CNS)
- ▶ Clinical Social Worker (CSW)
- ▶ Nurse Practitioner (NP)
- ▶ Physician Assistant (PA)
- ▶ Physical Therapist (PT)
- ▶ Others potential QHPs, Athletic Trainer, Dietitian

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Why the Growth in QHPs?

- ▶ Health Care Reform
 - The implementation of national health insurance coverage will reportedly result in about 32 million new insured.
 - According to a June 2012 article in the Los Angeles Times, the Association of American Medical Colleges has forecasted a shortage of 175,000 doctors by 2025.
 - The American Academy of Family Physicians estimates that 149,000 extra doctors will be needed by the year 2020.
 - US will need to increasingly rely on mid-level provider (QHPs) support to care for the newly insured.

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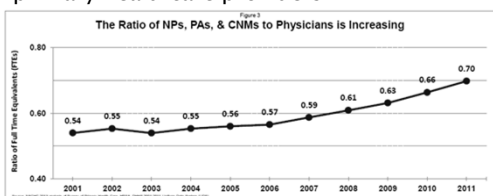
Why the Growth in QHPs?

- ▶ Numerous studies have found that when proper mechanisms are in place, QHPs can help to improve patient satisfaction, efficiencies and quality of care.
 - When appropriate supervising and collaborative measures are not in place, or policies and procedures are not followed, patient care can be negatively impacted and physician liability exposure can increase.

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Ratio of QHPs Increasing

- ▶ NPs, PAs and CNMs are often underutilized in primary care practices at a time when many communities face shortages of primary healthcare providers



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The Risk

- Risk for the facility
- Risk for the supervising practitioner (*e.g.*, the physician)
- Vicarious liability/ *respondeat superior*
- Expectations of the patient
- Negligent hiring/retention
- Negligent supervision

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What is a QHP's "Scope of Practice"?

- Dependent upon state law and regulations
- All 50 states recognize some QHPs
- PAs and NPs are allowed to practice in 50 states and DC
 - NPs may practice independently in 18 states and have limited or restricted practice privileges in Puerto Rico.
 - PAs must practice under physician supervision in 37 states, and have limited or restricted privileges in 13 states.
 - A PT can practice independently in all 50 states including DC, except Alabama may require a professional referral.

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What is a QHP's "Scope of Practice"?

- State rules can be complex, hard to find at times, change often and conflict with Federal rules and regulations, payer's coverage or hospital guidelines and bylaws
- Prescriptive authority is a prime example of the disparity in practice environments between the states and types of QHPs
 - Nurse Practitioners and Physician Assistants have prescriptive rights in all states, which are also regulated and may differ from state to state

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CRNAs

- ▶ The laws in most states permit CRNAs to work with physicians (such as surgeons) or other authorized healthcare professionals.
- ▶ CRNAs are qualified to make independent judgments regarding all aspects of anesthesia care, based on their education, licensure, and certification.
- ▶ Opt-out states
 - Medicare defers to states (17 states) relying on CRNAs to provide anesthesia care.

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CRNAs

- ▶ Payment can be made for medical or surgical services furnished by non-medically directed CRNAs if they are allowed to furnish these services under state law (however, payment may be difficult to get!).
 - These services may include the insertion of Swan-Ganz catheters, central venous pressure lines, pain management, emergency intubations, and the pre-anesthetic examination and evaluation of a patient who does not undergo surgery.

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Anesthesiologist Assistants (AAs)

- ▶ The AA develops and implements an anesthesia care plan in an assistant role/capacity.
- ▶ According to the Commission on Accreditation of Allied Health Education Programs (CAAHEP), the AA must work under the direction of an anesthesiologist.
- ▶ AA may not work under the direction of other physicians or healthcare professionals.

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Anesthesiologist Assistants (AAs)

- ▶ The anesthesiologist who is responsible for the AA is available to prescribe and direct particular therapeutic interventions in the operating room.
- ▶ Currently, eighteen (18) states and the District of Columbia authorize the practice of an AA through either a licensure or certification process.

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Other Types of QHPs

- ▶ Certified Nurse Mid-Wife (CNM)
 - Scope of practice includes a broad array of woman health services, including physical exams, prescribing medications, and assisting in child birth. The guiding principles of the practice of CPMs are to work with women to promote a healthy pregnancy.
 - CPMs are legally authorized to practice in 28 states
 - CPMs are not legally authorized to practice in 23 states
 - CNMs have achieved equitable reimbursement for their services under Medicare. As of January 1, 2011, the CNM reimbursement rate increased from 65% to 100% of the Medicare Part B fee schedule.

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Other Types of QHPs

- ▶ Clinical Social Worker (CSW)
 - A holistic approach, providing counseling and behavioral modification services.
 - Medicare covered services are those that the CSW is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services *are performed for the diagnosis and treatment of mental illnesses*. (ICD-9 codes 290.0-319, all-inclusive). Payment is at 75 percent of the physician fee schedule.
 - Medicare coverage in the office setting is billed directly to the Part B carrier.

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Other Types of QHPs

- ▶ Physical Therapist (PT)
- ▶ Certified Nutrition Specialist (CNS)
- ▶ Others potential QHPs,
 - Athletic Trainer, Dietitian
 - State rules and payer rules govern coverage and reimbursement.

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Nurse Practitioner (NP) (CNS)

- ▶ Evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications as permitted by law—under the exclusive licensure authority of the of the state board of nursing.
- ▶ A registered nurse with advanced training at a master's degree level with relevant experience and license to practice.
License: State regulations, Board of Nursing
- ▶ Collaboration: with physicians

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Physician Assistant (PA)

- ▶ A medical professional who must be nationally certified and state-licensed to practice medicine with the supervision of a physician.
 - Medicare pays for medical and surgical services provided by PAs in all settings at 85 percent of the physician's fee schedule. Physician supervision is not required when the service is being billed to Medicare under the PA's name.
 - Scope of practice is determined by the PA's education and experience. It includes ordering lab tests, evaluating medical history, diagnosing and treating medical conditions, prescribing medication as permitted by the law, assisting in surgery

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Role of the NPs/PAs

- ▶ Preoperative patient management
- ▶ Assistants at surgery PA and NPs (AS modifier required)
- ▶ ICU, critical care management
 - Start a-lines, chest tubes, read x-rays, lumbar punctures, run codes and help meet current patient outcomes and update the family daily
 - PLUS, have prescriptive authority
 - Most NPs work under collaboration agreement with an MD; may work independent in some states

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PayScale Website Reports

- ▶ Average pay for a Nurse Practitioner is \$81,085.00. They may earn anywhere between \$63,029.00 – \$107,842.00.
- ▶ Average pay for a Physician Assistant is \$81,682.00. They may earn anywhere between \$66,592.00 – \$113,988.
- ▶ Average pay for a CRNA is \$160,759.00. They may earn anywhere between \$114,325.00 and \$239,689 with 10 or more years experience.

Source: <http://www.payscale.com>

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Payor Credentialing

- ▶ The services provided by QHPs are typically covered by health care insurance carriers
- ▶ CMS has established Internet-based Provider Enrollment, Chain and Ownership System (PECOS) as an alternative to the paper (CMS-855) enrollment process.
 - Internet-based PECOS will allow physicians and non-physician practitioners to make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare, or check on status of a Medicare enrollment application via the Internet.

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Payor Credentialing

- ▶ The Council for Affordable Quality Healthcare, or CAQH, is a centralized “universal” source of data that commercial payers generally use for credentialing (www.caqh.org).
- ▶ Contact the specific payor you wish to be able to bill, and ask how to set up a contract. The payor will go to CAQH for your credentialing information and make a decision about whether or not they want to contract with you, and if so, the terms.

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“Incident to” vs. Direct Billing

- ▶ Direct Billing
 - Medicare and most other payers now credential NPs/PAs, and some other QHPs may apply for individual provider numbers for direct billing purposes. All covered services rendered may be billed using the NPPs direct provider number.
 - 85% of the MPFSDB amount for NP/PA/CNS.
 - 65% of the MPFSDB amount for CNM.
 - Other payers may pay at 85% or a different amount.

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“Incident to” vs. Direct Billing

- ▶ “Incident to” services are defined as those services that are furnished incident to physician professional services in the physician’s office (whether located in a separate office suite or within an institution) or in a patient’s home.
- ▶ These services are billed as Part B services to your carrier as if the physician personally provided them, and are paid under the physician fee schedule at 100%.

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“Incident to” vs. Direct Billing

- ▶ “Incident to” services are relevant to services supervised by QHP such as physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives.
- ▶ “Incident services” supervised by QHP are reimbursed at 85 percent of the physician fee schedule.

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“Incident to” vs. Direct Billing

- ▶ To qualify as “incident to” services a physician must personally perform an initial service and remain actively involved in the course of treatment.
 - You do not have to be physically present in the patient’s treatment room while these services are provided, but you must provide direct supervision. That is, you must be present in the office suite to render assistance if necessary.
 - The patient record should document the essential requirements for incident to service.

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Place of Service Issues

- ▶ Restrictions by State law and by payer coverage.
 - For example, CSWs only have direct reimbursement by Medicare for services performed in the office setting.
 - There is no “incident to” billing in the facility setting.
- ▶ Medicare physician fee schedule includes two payment amounts depending on whether a service is performed in a facility setting, such as an outpatient hospital department or ambulatory surgical center, or in a non-facility setting, such as a physician’s office.
 - The payments to physicians are higher when the services are performed in non-facility settings.

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Reviews/Audits Related to QHPs

- ▶ The list of issues in the 2014 OIG Work Plan includes “Physical therapists—High utilization of outpatient physical therapy services Billing and Payments.”
- ▶ Prior OIG work found that claims for therapy services provided by independent physical therapists were not reasonable or medically necessary or were not properly documented.
- ▶ Focused on independent therapists who have a high utilization rate for outpatient physical therapy services. Medicare will not pay for items or services that are not “reasonable and necessary.”

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Reviews/Audits Related to QHPs

- ▶ 2014 OIG Workplan: 5% of QHP or non-physician practitioners attributed to recovered or returned improper payments.
- <http://oig.hhs.gov/reports-and-publications/archives/workplan/2014/Work-Plan-2014.pdf>

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Reviews/Audits Related to QHPs

- ▶ The Office of Inspector General (OIG) released a report, “*Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services*” analyzing services that nonphysicians perform for which physicians bill Medicare.
 - The OIG found that, in January to March 2007, Medicare allowed \$12.6 million in unqualified nonphysician-rendered services (that is, roughly 14.5% of the nonphysician rendered services and roughly 7% of total billed services).

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Reviews/Audits Related to QHPs

- ▶ OIG issued in May 2012 a report on “*Coding Trends of Medicare Evaluation and Management Services*”
 - RAC Audits of E/M Services Set to Begin in 15 States to Target CPT Codes 99214, 99215 (9/18/2012)

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Reviews/Audits Related to QHPs

- ▶ 2013 OIG Work Plan
- ▶ “We 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. We will also assess Medicare’s ability to monitor services billed as “incident-to.”

<https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf>

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Thank you!!!!

Questions?????

Joette Derricks
joette.derricks@anesthesiallc.com
517.787.6440 ext. 4205

Neda M. Ryan
nryan@clarkhill.com
248.988.5884 (direct)

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