

When Physicians Work with Non-Physician Practitioners: Compliance Risks of Collaborative Practices

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Brenden O'Neal, JD, CPC
Regional Compliance Officer
Intermountain Healthcare, UT

Objectives

- Review of collaborative practice models (what is collaborative practice?)
- Review of regulations and guidelines that govern collaborative practices
- Review common risk areas
- Strategies for identifying and resolving risk

What is a collaborative practice?

Non-Physician Practitioners

• According to Medicare:

Nurse practitioners, clinical nurse specialists, and physician assistants are health care providers who practice either in collaboration with or under the supervision of a physician. We refer to them as non-physician practitioners. States are responsible for licensing and for setting the scopes of practice for all three specialties. Services provided by them can be reimbursed by Medicare Part B.

Medicare Coverage of Non-Physician Practitioner Services - OEI-02-00-00290

• Certified Nurse-Midwife (CNM) also considered NPPs

Collaborative Practices

1. NPPs work independently, with supervision
 - Have their own schedule, see all of their own patients
 - Little to no physician involvement
2. NPPs see the same in-office patients as the physician
 - NPP may see patients independently, calling in the physician as needed
 - NPP may perform the initial part of the visit for all patients
3. NPPs assist with surgery, see post-op patients

Regulations and Guidelines Governing Collaborative Practices

Office vs. Hospital Visits

- Guidelines are different depending on location of the visit
- Office visits
 - Governed by CMS's "Incident-to" guidelines
- Hospital visits
 - Governed by CMS's "Shared Services" guidelines

Shared/Split Office Visits

- Medicare Claims Processing Manual - Ch. 12
SPLIT/SHARED E/M SERVICE Office/Clinic Setting
In the **office/clinic setting** when the physician performs the E/M service the service must be reported using the physician's UPIN/PIN. When an E/M service is a shared/split encounter between a physician and a non-physician 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. If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the NPP's UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

Incident-to

- Incident-to allows services to be performed by the NPP but billed out under the physician's provider number and paid at 100%, not 85% normally paid for NPP services
- Medicare Benefit Policy Manual (Internet Only Manual) Chapter 15, Section 60.1 – Incident To Physician's Professional Services (Rev. 1, 10-01-03) B3-2050.1
 - Incident to a physician's professional services means that the services are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.
- Chapter 15, Section 60.2
 - There must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the nonphysician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment.

Incident-to Takeaways

- Physician must perform initial visit and establish plan of care.
- NPP may see established patients under plan of care.
- If new problems arise, cannot be billed incident-to.
- A supervising physician must be present in same suite of offices (doesn't have to be supervising physician). Service is billed out under the in-office supervising physician, NOT the physician that established the plan of care.
- NPP must be a cost to the practice (employee, independent contractor).
- There must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment.
- Just because the claim is billed under the physician's name, does not mean the physician should be paid for that work.

Split/Shared Hospital Visits

- Medicare Claims Processing Manual Ch. 12 - 30.6.1

SPLIT/SHARED E/M SERVICE

Hospital Inpatient/Outpatient (On Campus or Off Campus)/Emergency Department Setting

When a hospital inpatient/hospital outpatient (on campus-outpatient hospital or off campus outpatient hospital) or emergency department E/M 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 physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.

Split/Shared Hospital Visits

- Medicare Claims Processing Manual Ch. 12 - 30.6.13

H. Split/Shared E/M Visit

A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where 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. The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to critical care services or procedures.

Hospital Shared Services Takeaways

- Applies to hospital visits (in patient, ER setting)
- Physician and NPP must be in same group practice
- NPP must be off the hospital cost report
- Physician must document their portion of face-to-face visit
- Level of service based on combined work
- If guidelines followed, may bill under physician's provider number

- Note: Consider whether the physician is paid based on production (Stark)

Global Periods

- MCPM Chapter 12 - 110.1 - Global Surgical Payments
When a PA furnishes services to a patient during a global surgical period, A/B MACs (B) shall determine the level of PA involvement in furnishing part of the surgeon's global surgical package consistent with their current practice for processing such claims. PA services furnished during a global surgical period shall be paid at 80 percent of the lesser of the actual charge or 85 percent of what a physician is paid under the Medicare Physician Fee Schedule. Billing requirements and adjudication of claims requirements for global surgeries are under chapter 12, sections 40.2 and 40.4 of the Medicare Claims Processing Manual, pub. 100-04.

Stark/Anti-kickback

- Key questions to ask:
 - Is the physician being paid for work the physician did not perform?
 - By collaborating with an NPP is the physician being compensated above fair market value for the work performed?

Common Risk Areas and Strategies for Resolving Collaborative Practice Risks

Risk: Physician billing for work of the NPP

- Examples:
 - Office visit:
 - NPP performs visit with physician, NPP documents visit, physician signs note and bills under physician's name.
 - Hospital visit:
 - NPP performs and documents visit, physician adds attestation and bills under physician's name. It is not clear that physician saw patient face-to-face and physician does not document physician's portion of E/M service.

Have the Physician Document the Encounter

- In the office setting, if not incident-to, service must be billed under NPP unless physician documents and bills for work that the physician performed.
 - Physician may borrow ROS and PSFH
- In the hospital setting, if shared services allowed, physician must document the physician's portion of the face-to-face E/M service. An attestation is not sufficient.

Risk: Inadequate documentation for shared services

- Physician must document face-to-face portion of the E/M
- Attestation used for residents NOT sufficient for shared services
- Bad examples:
 - "Agree with above as written by [the NPP]."
 - "I saw an evaluated the patient and agree with the plan as written by [the NPP]."
- Good example:
 - "I have seen and personally evaluated the patient. Patient states mild chest pain, no murmurs, rubs, or gallups. Will start razolazine and schedule catherization."

Risk: Physicians using NPPs as scribes

- The Joint Commission 2012 guidelines: "A scribe is an unlicensed person hired to enter information into the EHR or chart at the direction of a physician or practitioner (Licensed Independent Practitioner, Advanced Practice Registered Nurse or Physician Assistant)... scribe does not and may not act independently but can document the previously determined physician's or practitioner's dictation and/or activities."
- Is it a true scribe scenario?
 - Is the NPP acting independently and documenting work the NPP performs?

Risk: Physician uninvolved in the follow-up global care

- Physician performs the surgery and NPP sees patient for all follow-up care
- Harder to detect this practice as follow-up visits within the global period are not billed unless the patient is being treated for new issue or complication

Billing Appropriately for NPP Services

- Not all payers credential NPPs
- For payers that do not credential NPPs, bill the service out under the supervising physicians NPP provider number
- Example:
 - Medicare – bill under NP or PA's name
 - Medicaid – PAs bill under supervising physician, NPs bill under their own name
 - United Healthcare – PA and NP to bill under the supervising physician

Tips for Auditing Collaborative Practices

- Look at billing (if NPP billing is low, possible red flag)
- Look at documentation
 - Is NPP acting as a scribe? Is it a true scribe scenario?
 - Who is authoring the note? Check the EHR note history
 - Are shared services allowed?
 - NPP on cost report? Same group practice? Is physician paid based on production?
 - Sufficient documentation by physician?
- Look for sharing of services in the office setting (is incident-to met?)
- Are contracted physicians using the organization's NPPs?

Questions?

Thank you!

Brenden O'Neal, JD, CPC
brenden.oneal@imail.org
801-507-9507
