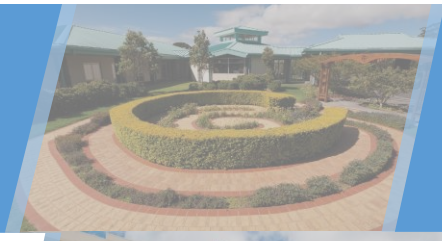

Advanced Practice Practitioners

Risks and Benefits in the Hospital Setting

THE QUEEN'S HEALTH SYSTEMS

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The Queen's Health Systems Family

-The Queen's Medical Center
  -Punchbowl
  -West Oahu
  -Hale Pulama Mau
-Molokai General Hospital
-North Hawaii Community Hospital
-Queen Emma Land Company
-Queen's Development Corporation
-Diagnostic Laboratory Services, Inc.
-CareResource Hawaii
-Hamamatsu/Queen's PET Imaging Center, LLC
-Queen's Clinically Integrated Physician Network, LLC
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-Queen's MSSP ACO, LLC
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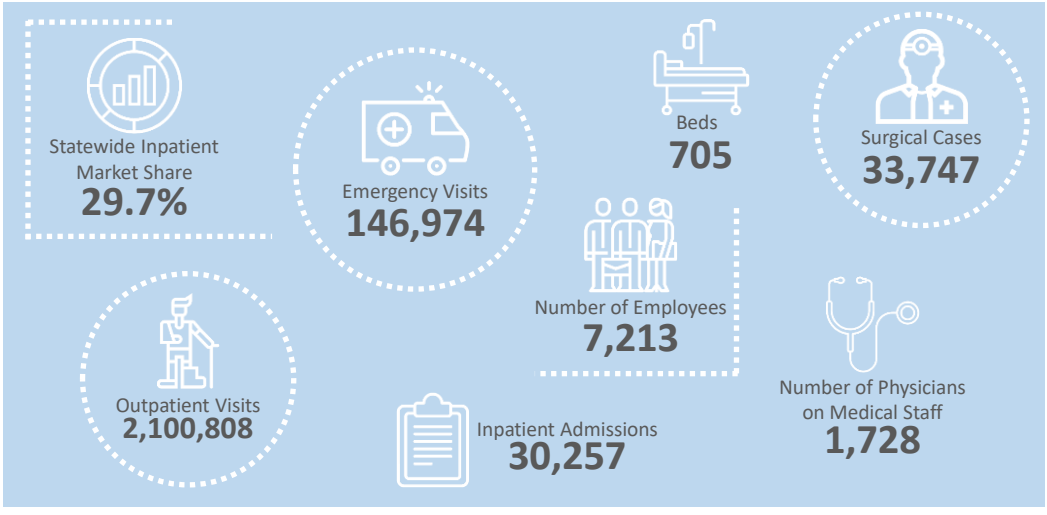
The Queen's Health Systems – FY019*

*Estimated



Today's Objective

To provide a brief overview of the risks and benefits of employing Advanced Practice Practitioners (APP) in the hospital setting

Agenda

- Who are APPs
- History of APPs as Hospital Employees
- Top Three Compliance Concerns
- Benefits
- Scenarios
- Wrap up
- Q&A

Who are APPs

Who are APPs

Advanced Practice Registered Nurse (APRN)

- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Nurse Midwife (CNM)

Physician Assistant (PA-C)

History of APPs as Hospital Employees

The Beginning

Hospitals originally employed APPs for specific reasons

APRNs were generally employed to smooth operations from admission to discharge, to shorten length of stay, provide continuity of medical care, and provide a liaison between nursing and medicine. APRNs were meant to provide complementary services to improve the quality of care.

PAs were generally employed to supplement house-staff (residents), and/or expand the capacity in specific specialties.

Things started to change

Later, opportunities to generate revenue were desired

The number of APRNs and PAs hired by hospital began to sharply increase, and the "expense" of these personnel was becoming noticeable.

State-granted scope of practice allowed these individuals to perform "medical level" services and insurers were allowing these types of providers to be reimbursed in certain instances.

This required attention to potential compliance risks and ensuring that processes were in place to mitigate these risks.

Top Three Compliance Concerns

Key Compliance Risks

1. Billing and documentation when APPs and physicians work as a team
2. Ensuring that employed APPs practice in a way that does not trigger a Stark Law or Anti-Kickback Statute (AKS) violation
3. Ensuring that only appropriate costs are included on the Medicare Cost Report

Compliance Risk #1

1. Billing and documentation when APPs and physicians work as a team

Compliance Risk #1

If the APP and the **non-employed** physician are both providing medical level of care billable service – APP is not billing but the **non-employed** physician is.

Compliance Risk #1

Keeping Compliant:

Use a screening form for APP positions in your organization, to assess why you are hiring and what the goals are?

Develop attestations by **non-employed** physicians to certify their understanding of the role of APRNs and PAs.

Compliance Risk #2

2 Ensuring that employed APPs practice in a way that does not trigger a Stark Law or Anti-Kickback Statute (AKS) violation

Compliance Risk #2

The Physician Self Referral Law (commonly known as the Stark Law) prohibits giving **non-employed** physicians non-monetary compensation beyond a nominal amount per year.

The nominal amount is $416 for calendar year 2019.

Compliance Risk #2

All physician non-monetary compensation should be tracked to ensure the allowed annual limit is not exceeded.

Compliance Risk #2

Exceeding the annual non-monetary compensation amount may trigger a Stark Law violation.

Penalties include financial settlement based on Medicare payments received for patients referred by that physician.

Compliance Risk #2

A type of non-monetary compensation would be for a hospital to provide the **non-employed** physician the benefit of using an APP to relieve the physician of work that he/she would bill for or is already being paid for as part of a global fee payment.

Compliance Risk #2

Example:

The APP performs pre-operative evaluations and post-operative E&M services in lieu of **non-employed** surgeons, when these are services for which the surgeons are being paid under a global fee. (i.e. the **non-employed** surgeons perform only cursory exams because they know the APP will "take over")

Compliance Risk #2

Keeping compliant:

The hospital may "lease" the use of the APP to the **non-employed** physician at fair market value.

Compliance Risk #3

3 Ensuring that only appropriate costs are included on the Medicare Cost Report

Compliance Risk #3

Medicare-certified institutional providers (such as hospitals) are required to submit an annual cost report which includes information on all facility costs and charges.

The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data.

Compliance Risk #3

Even in the era of the Prospective Payment System, the cost reports do matter.

The data for submitted cost reports feeds the Healthcare Provider Cost Reporting Information System (HCRIS), and is used for future rate setting, to analyze profitability, to make policy decisions, and to determine future reimbursement rates.

Compliance Risk #3

If the APP is performing a mix of "hospital" services (Medicare Part A or facility billing) and "physician-type" services (Medicare Part B or professional billing), the APP's time must be carefully accounted for in the Medicare Cost Report that is submitted annually.

Compliance Risk #3

"Hospital" services (referred to as Medicare Part A) are included on the Medicare Cost Report and reimbursed to the hospital through facility billing.

Compliance Risk #3

"Physician-type" services (referred to as Medicare Part B) are non-nursing clinical care services which are carved out of the Medicare Cost Report and reimbursed to the hospital through professional billing.

Compliance Risk #3

Keeping compliant:

If the APP is performing both types of services, the use of time studies or logs would be one way to ensure that only the cost of any "hospital" services performed are included on the Medicare Cost Report.

Benefits

Benefits

Physician Extenders:

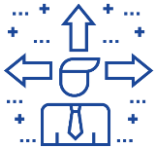
- APPs perform medical services in collaboration with **employed** physicians
  - Split/Shared Visits
  - Incident-to
  - Independently when physicians not available

Benefits

Non-patient care services:

- Quality Assurance
- Nurse education and higher level “nursing” duties
- Procurement and liaison to vendors

Scenarios



Appropriate APP Billing Scenario

APP functions as an assistant at surgery for allowable procedures when a qualified resident is not available (in an academic medical center).

How to bill:

- Bill under the APP's NPI
- Specific modifiers are needed
- Be sure to document per organizational policy

Assistant at Surgery Billing for APPs

Not all surgeries qualify for an assistant at surgery. Refer to the Medicare Physician Fee Schedule RVU table.

For non-physician assistant at surgery, use modifier -AS

Payment rate for non-physician assistant at surgery is 13.6% of the surgical reimbursement rate.

Appropriate APP Billing Scenario

For a billable hospital inpatient / outpatient / emergency department E&M (i.e. not part of a global fee) where both an **employed** physician and the APP document a face-to-face portion of the encounter. This is called a split-shared service.

How to bill:

- Can be billed under either the **employed** physician's or the APP's NPI
- The combined documentation determines the level of E&M that can be billed

Global Fee

Zero Day Post-operative Period

- No pre-operative period
- No post-operative period
- Visit on day of procedure is generally not payable as a separate service

10-day Post-operative Period

- No pre-operative period
- Visit on day of procedure is generally not payable as a separate service
- Total global period is 11 days. Count the day of the surgery and 10 days following the day of surgery

90-day Post-operative Period

- One day pre-operative included
- Day of the procedure is generally not payable as a separate service
- Total global period is 92 days. Count one day before the day of surgery, the day of surgery, and 90 days immediately following the day of surgery

Appropriate APP Billing Scenario

For a billable hospital inpatient / outpatient / emergency department E&M (i.e. not part of a global fee) where an APP documented the encounter and an **employed** physician reviews the record but does not provide or document any face-to-face activity.

How to bill:

- Must be billed under the APP's NPI

Medicare's Split/Shared Visit Policy

Medicare allows shared/split billing for a billable E&M (i.e. not part of a global fee) provided in a hospital location when both the physician and APP from the same group practice provide, document, and sign the work they each personally performed.

Both the physician and the NPP must have a documented face-to-face encounter with the patient on the same date of service. If the requirements are met, the services are billed under the physician's NPI.

The services are billed under the APP's NPI if the physician did not document a face-to-face encounter with the patient or other guidelines are not met.

Appropriate APP Billing Scenario

For a billable physician office location E&M (i.e. not part of a global fee) where an APP provides services incident-to a physician.

How to bill:

- If physician is in the office suite and available to provide "supervision," can bill either under this physician's NPI or the APP's NPI
- If there is no supervising physician in the office suite, must be billed under the APP's NPI

Incident to

"Incident to" services are those services furnished incident to a physician's professional services under an established plan of care, in a physician's office or in a patient's home and billed under the supervising physician's NPI as if they had been personally provided by the physician.

The physician must perform an initial service, establish the plan of care, and remain actively involved in the patient's care. The physician must be physically present in the same office suite in order to directly supervise the "incident to" services and to render assistance if needed.

Appropriate APP Billing Scenario

For a billable service provided by the APP independently without physician involvement (i.e. not part of a global fee).

How to bill:

- Bill under the APP's NPI

APP Billing Authority

Sections 4511 and 4512 of the Balanced Budget Act of 1997 (BBA) provide that payment for the professional services of these non-physician practitioners will be linked to the physician fee schedule.

Payment may be made for services furnished by APPs in all settings permitted by state law at an amount equal to 80 percent of the lesser of the actual charge or 85 percent of the physician fee schedule.

NOTE: Payment for a PA's services may only be made to the PA's employer. Under certain circumstances, a PA as an independent contractor qualifies as an "employment relationship" where payment is made to the employer.

Wrap-Up

Key Points to Remember

- Be careful when APPs are providing team care involving **non-employed** physicians.

Key Points to Remember

- Be careful when APPs are providing services incident-to an **employed** physician's plan of care.

Key Points to Remember

- Don't forget about scope of services being provided.

  Be sure that the APPs are always functioning under their scope of practice under state law and per their job description/medical staff credentialed privileges.

Q&As

Your turn to weigh in

A busy **non-employed** surgeon wants to be able to schedule more cases, which in turn would allow the hospital to capture more operating room revenue. Post-operative visits are paid to the surgeon as part of his/her global surgery fee.

In this case, is it OK for the hospital employed APP to perform and document post-operative visits, to free up the surgeon's time since the hospital will also benefit?

Your turn to weigh in

The APP and a **hospital-employed** physician both have a face-to-face encounter with a patient on the same day and write notes that, combined, contain documentation needed for billing an E&M service.

Can this claim be submitted under the physician's name?

Your turn to weigh in

The APP sees a patient and writes a note that contains the documentation needed for billing an E&M service. A **hospital-employed** physician does not see the patient but co-signs the note.

Can this claim be submitted under the physician's name?

Your turn to weigh in

A **non-employed** physician visits an inpatient and documents thoroughly and bills for the services provided. The APP provides additional service, similar in nature, but for hospital quality improvement purposes.

Is this considered a "Part A" service or a "Part B" service?

Your turn to weigh in

A **non-employed** physician visits an inpatient and documents thoroughly and bills for the services provided. The APP provides additional service, similar in nature, but for hospital quality improvement purposes.

Can a claim be submitted under the APP's NPI?

Ask us!

FEEDBACK?
QUESTIONS?

MAHALO!