



Society of Hospital Medicine Roundtable

Are NPs and PAs Right for Your Practice?

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Are PAs/NPs Right for Your Practice?

- Not an automatic “yes”
- Depends on:
 - Type of responsibilities/services to be accomplished
 - Attitudes of physicians
 - Level of respect offered/value perceived

Are NPs/PAs Right for Your Practice?

- Every health care professional needs to work at the highest level of their education & training
- If PAs/NPs are performing nursing services, the hospital/practice is overpaying
- NPs/PAs will be unhappy if their clinical skills are not appropriately utilized

What Are the Needs of the Practice?

- Discussion & agreement by physicians/ practice management/department leaders as to how PAs/NPs will be utilized
- Avoid creating a laundry list of responsibilities
- NPs/PAs are highly versatile and can fit many different practice styles

Overall Goals

- Maintain & improve patient care quality
- Help implement practice efficiencies
- Allow physicians to most effectively manage the most acutely ill patients
- Improve the work life of physicians

Common Understanding

- All members of the team, including nursing staff, should understand NP/PA roles and the delegated responsibility given to them by physicians
- Level of expected/desired supervision/collaboration should be clear
- Degree of oversight will likely decrease over time

New Versus Experienced

- New (recent graduate):
 - Lower starting salary
 - Can be trained in the style of the physician
 - Requires more mentoring (similar to a residency environment)

New Versus Experienced

- Experienced
 - Can hit the ground running
 - Busier practices will gain immediate productivity
 - If some physicians in the group are skeptical of the PA/NP concept, hiring an experienced person may be preferable

Differences Between PAs/NPs

- If you saw both in practice you might not be able to tell the difference
- PAs trained in the medical model (often in the same classes as medical students)
- NPs trained in the nursing model
- Matching clinical skills and personality traits

Legally – What Can They Do?

- PAs governed by the medical or PA board
- NPs governed by the nursing board
- Scope of practice:
 - State law, hospital by-laws/policies, Joint Commission policies, delegation by the physician, requirements by payers

Range of Responsibilities

- Histories & physicals
- Admitting patients on behalf of the physician (admit H&P)
- Conducting daily rounds
- Issuing orders for medications
- Writing discharge summaries (discharge day management)
- Evaluating changes in patient's condition

PA/NP Scope of Practice

- Must be within the physician's scope of practice
- Avoid lists, unless procedural lists are required by the hospital (e.g., lumbar puncture)
- Physician ultimately legally responsible for the PA's/NP's services

Scope of Practice

- Delineation of clinical privileges in important
- Outline in the medical staff by-laws
- By-laws should include a definition of NP/PA that is consistent with state law

Reimbursement & Payment Policy

- NPs/PAs:
 - must have a National Provider Identifier (NPI) number
 - must enroll in Medicare (same 855 form as physicians)
 - have access to the same CPT codes (within scope of practice laws)

Medicare Scope of Practice

PAs may perform (as allowed by state law):

- All E/M codes (including high levels)
- Consultations, critical care (time-based)
- Initial hospital admit & pre-surgical H&Ps
- All diagnostic tests/procedures

Supervision under Medicare

- Access to reliable electronic communication
- Personal presence of the physician is not required (except for “incident to” billing)
- Medicare will not override state law guidelines

Part A/Part B

- Medicare requires that medical and surgical services delivered by hospital-employed PAs (NPs & physicians) be billed under Medicare Part B (exception for administrative responsibilities).
- In the past, Medicare allowed hospital-employed PA salaries to be covered under Part A through the hospital's cost reports. That has changed.
[Medicare Claims Processing Manual, Chapter 12, Section 120.1]³

Medicare Hospital Billing

- PAs/NPs can deliver care with the service covered at 85% whether employed by the hospital or not
- No need for on-site physician presence under Medicare; electronic communication (telephone) meets supervision requirements (hospital bylaws/policies and state law must be followed)

Shared Visit Policy

- Ability to “combine” hospital services provided by the PA/NP and the physician to the same patient on the same calendar day (this is not “incident to” billing).
- Requires that the physician provide a face-to-face portion of the E/M service to the patient

[Medicare Transmittal 1776, October 25, 2002]

Shared Visit

- Applies to evaluation and management services, not procedures or critical care
- PA/NP and physician must be employed by the same entity (same hospital, same group practice, PA/NP employed by solo physician)

“Incident to” Billing

- Still allowed by Medicare [Medicare Carriers Manual; Transmittal 1764, Section 2050-2050.2 , Aug. 28, 2002] ⁵
- Allows an **office or clinic** provided service performed by the PA to be billed under the physician’s name (payment at 100%) (*not used in hospitals or nursing homes unless there is a separate physician office*)
- Terminology may have a different meaning when used by private payers

“Incident to” Billing

- Requires that the physician personally treat the patient for a particular medical condition presented, and provide the diagnosis and treatment plan
- PAs may provide subsequent (follow up) care for that same condition without the personal involvement of the physician
- Physician (or another physician in the group) must be physically present in the suite of offices when the PA delivers care

Credentialing & Payment

- Credentialing is not necessarily directly related to payment policy
- Credentialing and the issuance of provider numbers depend on the particular payer

Regulatory Issues

- Medicare Conditions of Participation
- Joint Commission rules/interpretative guidelines
- State scope of practice requirements
- Private payer and Medicaid regulations

Medicare Conditions of Participation for Hospitals

In order to receive Medicare or Medicaid payments, hospitals must certify that they have met the standards set forth in the Medicare Conditions of Participation (CoPs).

Medicare CoPs (continued)

The CoPs are found in the Code of Federal Regulations (CFR) Title 42, Section 482.

Each CoP regulation also has “interpretative guidelines” that are meant to guide surveyors; thus, these guidelines can be *de facto* regulations.

Credentialing

Joint Commission's standards require that hospitals credential and privilege NPs/PAs through the medical staff or by another "equivalent process"

[Standard HR 1.20, EP13 CAMH Refreshed Core, 1/2008]

Credentialing

- Queries to the National Practitioner Data bank and the Federation of State medical Boards should be conducted.
- Incidence of malpractice claims against NPs/PAs is low.

Chart Co-Signature

Generally, Medicare does not require chart co-signature

- Exceptions are discharge summaries; this requirement also applies to outpatients, including outpatient surgery and Emergency patients not admitted to the hospital [42CFR §482.24(c)(2)(vii)]
- Orders for respiratory care require co-signature
- PAs may perform/order these services, but a physician co-signature is required

Chart Co-Signature

Physician countersignature NO LONGER required by Medicare on pre-admission or surgical H+Ps as of 2/2008.

[42CFR §482.22(c)(5)(i)(ii)]

Teaching Hospital Rules

- Any restrictions on billing apply only to first assisting at surgery, not to other services delivered in the hospital
- Resident billing rules do not apply to PAs
- PAs are authorized to bill Medicare and most other payer programs, residents typically are not

[Medicare Carriers Manual Section 15106]

Productivity

- Billing software programs may allow the tracking of a health care professional's work/codes, even though that information will not be sent on to the third party payer (place for a rendering provider in addition to a billing provider)
- Virtually every service performed can be tracked by CPT code (often with the use of modifier codes) or relative value units (RVUs), even if the service is not submitted for billing purposes

Tracking Productivity

- Productivity includes services performed that are:
 - billed under PA's/NP's name
 - billed under the supervising physician
 - not separately billable (global/bundled services)

Productivity

- Productivity and reimbursement are distinctly separate
- Depending on utilization and payer billing requirements, PAs/NPs may not appear to bring in large amounts of revenue under their names
- PAs/NPs free up physicians to engage in other billable activities (new pt. visits, surgeries)

Productivity

- “Opportunity cost”
- If PA/NP didn’t perform the work, the physician would have.
- If PAs/NPs deliver non-billable services, the surgeon/physician is able to provide new, revenue generating services.

Resources

- http://www.aapa.org/images/stories/Advocacy-issue-briefs/hospitalc_p.pdf
- <http://www.aapa.org/images/stories/staff.pdf>
- <http://www.aapa.org/images/stories/housest aff.pdf>

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