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

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MJ Health Law, CHC

Disclaimer

• This presentation was current at the time it was submitted. It does not represent payment or legal advice.

• Medicare policy changes frequently, so be sure to keep current by going to www.cms.gov.

• Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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Interdependent Concepts

 Credentialing & Privileging PAs/NPs

 Reimbursement & Billing Policy

 Maximizing PA/NP Utilization

 Regulatory Compliance and Scope of Practice

5th “Dimension”-Unspoken Organizational Culture & Perceptions

• Prior experience of physicians: generational and training experiences.
• Preconceived notions of support staff and management.
• Lack understanding of how the roles have evolved and what the possibilities might be for change.
• Culture can completely derail even the best of business plans.
• Myths and misconceptions.
• The word “supervision”.

FOUNDATIONAL PILLAR
PA/NP Services as Defined by Medicare

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


Myths & Misperceptions

Myths

• PAs/NPs cannot see new patients
• Physician must be in the office when PA/NP sees patients.
• Physician must see every patient.
• A physician co-signature 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”?
PAs & NPs

RECOGNIZED AS “PROVIDERS” BY
MEDICARE
SINCE 1998

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.
- Payment … 85 percent of the physician fee schedule.
- Allows payment to a PA/NP as an independent contractor to qualify as an employment relationship.
- 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%.

PAs and NPs are NOT hospital clinical support staff: Medicare Part A Cost Report

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.
PA Direct Billing/Payment

- 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.

- Note that payment is not in any way associated with having supervised/collaborated. Employment is the determining factor.

Medicare Manual Citations

- Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services §190 - Physician Assistant (PA) Services (Rev. 1, 10-01-03)

  D. Employment Relationship

  Payment for the services of a PA may be made only to the actual qualified employer of the PA that is eligible to enroll in the Medicare program under existing Medicare provider/supplier categories.


- Medicare Program Integrity Manual, Pub 100-08, Chapter 10, §2.4.11

  Payment for the PA’s services may only be made to the PA’s employer, not to the PA himself/herself. In other words, the PA cannot individually enroll in Medicare and receive direct payment for his or her services. This also means that the PA does not reassign his or her benefits to the employer, since the employer must receive direct payment anyway. The PA’s employer can be either an individual or an organization.

NP Direct Billing/Payment

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

• Nurse practitioners may reassign their payment to their employer.

• Most NPs reassign as a condition of their employment.

PAAs can bill all levels of E/M: Medicare

Medicare Benefit Policy Manual: Chapter 15, §190 Physician Assistant (PA) Services states:

“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 can bill all levels of E/M Medicare

Medicare Benefit Policy Manual: Chapter 15, §200 Nurse Practitioner (NP) Services states:

“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

“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 ® 2015, Professional Edition p. xii

“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.”

CPT ® 2015, Professional Edition p. xii

SUPERVISION/ COLLABORATION

Supervision/Collaboration under 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
PA Supervision

Medicare Benefit Policy Manual: Chapter 15, §190 Physician Assistant (PA) Services states:

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

NP Collaboration

Medicare Benefit Policy Manual: Chapter 15, §200 Nurse Practitioner (NP) Services states:

“The collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.”

NP Collaboration: Medicare

Medicare Benefit Policy Manual: Chapter 15, §200 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: New Patients/New Problems

• PAs/NPs may provide evaluation and management services to new patients and established patients with new problems in the Medicare program.

• When they do, the encounter should be billed under the PA/NP’s NPI for Medicare; reimbursement will be at 85% of the physician rate.

What about the “15% left on the table”?

MYTH

What about the 15% left on the table?!
Let's Compare

Physician Salary/Compensation

PA/NP Salary/Compensation
Provider Salaries

• PA/NPs are paid approximately 1/3\textsuperscript{rd} to 1/4\textsuperscript{th} the salary of their physician counterpart.
  (This is a broad generalization, but supported by MGMA data.)

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

Math: Same Service Provided

<table>
<thead>
<tr>
<th>Physician</th>
<th>PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary $300,000 ($144/hr)</td>
<td>Salary $100,00 ($48/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: still $44 in the RED. Recurs first visit every hour thereafter.</td>
<td>First visit of the day: profit $36.</td>
</tr>
</tbody>
</table>

Another View

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

<table>
<thead>
<tr>
<th>Receipts providing same level of service</th>
<th>Physician</th>
<th>PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>($100 x 28 visits)</td>
<td>$2800</td>
<td>$280</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wage per day</th>
<th>Physician</th>
<th>PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>($144/hour x 8 hours)</td>
<td>$1152</td>
<td>$384</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contribution Margin</th>
<th>Physician</th>
<th>PA/NP</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1648</td>
<td>$1996</td>
<td></td>
</tr>
</tbody>
</table>
Business Considerations

- Contribution margin: Revenue minus expenses
- What is the total expense to the practice when you utilize your human capital as you currently do?
- Opportunity cost: Is there a better (higher value) alternative use of that resource?

**TDABC Step 2: Calculate the Capacity Cost Rate for each type of personnel and resource**

- Costs: All the costs (salary, fringe benefits, occupancy, support resources) associated with having that person (or piece of equipment) available to treat patients
- Capacity: The capacity (time) that each resource (personnel, equipment) has available for treating and caring for patients
  - Number of days person shows up, available for clinical work multiplied by...
  - Number of minutes available per day for patient-related work (net of breaks, meetings, training, education, etc.)
- Capacity Cost Rate ($/minute) = Resource Cost / Resource Capacity

**Capacity Cost Rates ($/minute) for clinical and staff people**
Trend Analysis

Mintz Levin Health Care Qui Tam Update: Recent Developments & Unsealed Cases - September 2015

Subject matter of claims:
- A number of cases involved claims that the defendants billed for products or services that were not actually provided, engaged in upcoding, or billed for services of non-physician providers under physicians' names.


“We bill everything under the physician…”

MEDICARE PAYMENT POLICY: “INCIDENT TO”
“Incident to Billing”: What’s the Big Deal?

- “Incident to” is a Medicare office billing provision that allows reimbursement for services delivered by PAs/NPs at 100% of the physician fee schedule, provided that all “incident to” criteria are met.
- The “extra 15%” reimbursement appears enticing.
- “Incident to” Part B billing only applies in the office or clinic. Does not apply in a facility (hospital inpatient or outpatient) setting.

MEDICARE PAYMENT POLICY: HOSPITAL SHARED VISITS

100% Reimbursement: Split/Shared Visit -Hospital

- Can be billed for a new patient, admission, subsequent hospital visit, observation services, and ED visits.
- The service performed was an evaluation and management (E/M) service; does not apply to a procedure or a critical care service.
- PA/NP and physician must be employed by same entity (same medical group).
- Physician must perform some element of history, exam, medical decision making and document* on the 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'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

Source: Medicare Contractor guidance.

Initial Hospital Care
(Admission H&P)

<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>99221</td>
<td>1.92</td>
<td>$102.09</td>
<td>$86.78</td>
</tr>
<tr>
<td>99222</td>
<td>2.61</td>
<td>$138.63</td>
<td>$117.84</td>
</tr>
<tr>
<td>99223</td>
<td>3.86</td>
<td>$204.19</td>
<td>$173.56</td>
</tr>
</tbody>
</table>

Source: CMS Physician Fee Schedule
Accessed April 2, 2015
*National Payment Amount: actual practice amount will vary by geographic index

Subsequent Hospital Care

<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>99231</td>
<td>0.76</td>
<td>$39.41</td>
<td>$33.50</td>
</tr>
<tr>
<td>99232</td>
<td>1.39</td>
<td>$72.36</td>
<td>$61.51</td>
</tr>
<tr>
<td>99233</td>
<td>2.00</td>
<td>$104.24</td>
<td>$88.60</td>
</tr>
</tbody>
</table>

Source: CMS Physician Fee Schedule
Accessed April 2, 2015
*National Payment Amount: actual practice amount will vary by geographic index
Math: Same Service Provided

Inpatient Services

Physician  
- Salary $300,000 ($144/hr)
- The admission H&P (99221) is reimbursed at 100% for $102.
- First visit of the day: still $42 in the RED. Recurs first visit every hour thereafter.

PA/NP  
- Salary $100,000 ($48/hr)
- The same service is reimbursed at 85% for $87.
- First visit of the day: profit $39.

Shared Visit Math: 99221 Admission

Physician plus physician performing Admission H&P:
Physician Salary $144/hr + PA/NP Salary $48/hr = $192/hour salary cost
Reimbursement for 99221 at the physician rate when shared visit rules are met: $102
$90 loss if service takes the physician and the PA/NP an hour.

If physician performs the Admission H&P:
$144/hr salary cost, $102 reimbursement
$32 loss if service takes an hour

PA/NP performs Admission H&P:
$48/hr
$87 reimbursement
$39 contribution margin if service takes an hour.

PA/NP Performs Service with Physician spending 15 minutes
Physician salary cost is $36 (15 minutes) + PA/NP $48 (1 hour)=$84 salary cost
Reimbursement = $102
Contribution margin= $18

Shared Visit Math: 99222 Admission

Physician plus physician performing Admission H&P:
Physician Salary $144/hr + PA/NP Salary $48/hr = $192/hour salary cost
Reimbursement for 99222 at the physician rate when shared visit rules are met: $139
$53 loss if service takes the physician and the PA/NP an hour.

If physician performs the Admission H&P:
$144/hr salary cost, $139 reimbursement
$5 loss if service takes an hour

PA/NP performs Admission H&P:
$48/hr
$118 reimbursement
$70 contribution margin if service takes an hour.

PA/NP Performs Service with Physician spending 15 minutes
Physician salary cost is $36 (15 minutes) + PA/NP $48 (1 hour)=$84 salary cost
Reimbursement = $139
Contribution margin= $55
Shared Visit Math: 99232 Subsequent Hospital Care

PA/NP plus physician performing Subsequent Hospital Care:
Physician Salary $144/hr + PA/NP Salary $48/hr = $192/hour salary cost divided by 4= $48 for 15 minutes spent each.
Reimbursement for 99232 at the physician rate when shared visit rules are met= $72
$24 contribution margin if it takes the physician and the PA/NP 15 minutes each.

If physician performs the Subsequent Hospital Care
$144/hr salary cost divided by 4= $36 for 15 minutes spent
$72 reimbursement
$36 contribution margin if service takes 15 minutes

PA/NP performs Subsequent Hospital Care
$48/hr divided by 4= $12 for 15 minutes
$61 reimbursement
$49 contribution margin if service takes 15 minutes.

Business Considerations

• Are the physicians "wasting" their time trying to re-see all of the patients? When the PA/NP performed the admission H&P, there was already a positive contribution margin. Should the physician forego seeing an additional admission or critical care service in order to get that "extra 15%" on the service provided by the PA/NP?

• Could they be seeing additional patients, increasing the patient volume?

• EFFICIENCY is the required for Shared Visits to be profitable. Minimize the time spent by the physician. Documentation requirements must be met. Physicians need to be educated on what those requirements are.

UNINTENDED CONSEQUENCES OF FEWER SHARED VISITS
Production Based Compensation

- Physician compensation formula will likely be negatively impacted when they no longer get "credit" for RVUs generated by the PA/NP.
- The formula/benchmarks, developed on former RVU assumptions, may need to be adjusted!
- RVU production based compensation can cause friction amongst providers, setting up competition rather than collaboration, eroding the team model.
- Removing the physician's ability to "capture" the RVUs can be significantly disruptive.
- Medicare compliance is not optional.

CONSULTATIONS & SHARED VISITS

Joint Commission

MS.03.01.03: The management and coordination of each patient's care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

Relevant Elements of Performance:

4. The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a doctor of medicine or osteopathy, or other licensed independent practitioners, is required.

5. Consultation is obtained for the circumstances defined by the organized medical staff.

"Definition of LIP from the Joint Commission Hospital Accreditation Manual Glossary includes the following:

"When standards reference the term "licensed independent practitioner," this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care personnel (for example, physician assistants [PAs] and advanced practice registered nurses [APRNs]) to the extent authorized by state law or a state's regulatory mechanism or federal guidelines and organizational policy."
Consultations

Consultation policy is therefore typically located in the Medical Staff Bylaws or Rules and Regulations.

1. Are PAs and NPs specifically included?
2. Are Consultations specified in privileges?

Services formerly known as Consultations

Medicare eliminated the use of CONSULTATION codes in 2010.

Services performed as a result of a request from another provider (formerly billed with Consultation Codes) are now billed with Initial Hospital Care/Subsequent Hospital Care codes in the hospital setting.

Consultation Services-Medicare Manual

Medicare Claims Processing Manual, Chapter 12
§30.6.10 - Consultation Services

Consultation Services versus Other Evaluation and Management (E/M) Visits

Effective January 1, 2010, the consultation codes are no longer recognized for Medicare Part B payment. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. In the inpatient hospital setting and the nursing facility setting, physicians (and qualified nonphysician practitioners where permitted) may bill the most appropriate initial hospital care code (99221-99223), subsequent hospital care code (99231 and 99232), initial nursing facility care code (99304-99306), or subsequent nursing facility care code (99307-99310) that reflects the services the physician or practitioner furnished. All physicians and qualified nonphysician practitioners shall follow the E/M documentation guidelines for all E/M services. These rules are applicable for Medicare secondary payer claims as well as for claims in which Medicare is the primary payer.

Available at:
“Consultations” as Shared Visits?

When the consultation codes were eliminated from Medicare, so too were the Medicare rules for consultations which specifically did not allow for shared visit billing.

In the absence of rules for Consultations Services (because they no longer are recognized by Medicare), we must refer to the Shared Visit Rules, which do not mention consultations at all.

They do exclude critical care services and procedures and services provided in an SNF/NF.


Consultations and Shared Visits

The work of what used to be called a consultation is now:
“E&M service resulting from a request by another provider to see a patient on a consultative basis.”

National Government Services, Medicare Contractor for New England, NY and North Central Region posted the following FAQ on August 20, 2015:

Can a physician and NPP perform a split/shared consultative visit?

Answer: In the inpatient setting, a physician and NPP can perform a shared/split visit for the E&M service resulting from a request by another provider to see a patient on a consultative basis. As always, both providers need to fully document the details of their segments of the visit. In the outpatient setting, incident-to criteria would need to be met in order to share a consultative visit.

Available at: National Government Services - Policy Education Topics, Frequently Asked Evaluation and Management questions

OBSERVATION SERVICES
Order Observation Services
Outpatient Order

- "Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests.

Source: Medicare Benefit Policy Manual, Chapter 6: Hospital Services Covered Under Part B, §20.6 Outpatient Observation Services

- PAs and NPs can order outpatient services, including Observation services, as long as they have been granted the privileges by the facility to do so.

MLN Matters ® MM5791: Payment for Hospital Observation Services (Codes 99217 - 99220) and Observation or Inpatient Care Services (Including Admission and Discharge Services - Codes 99234 - 99236)

Provider Types Affected
Physicians and qualified non-physician practitioners (NPPs), submitting claims to Medicare Administrative Contractors (H/B MACs) and carriers for hospital observation services provided to Medicare beneficiaries during a hospital visit.

Available at: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5791.pdf]

Observation services have their own set of CPT ® codes and rules.

- Physicians and qualified NPPs should report Initial Observation Care using a code from CPT code range 99218 – 99220 when the observation care is less than 8 hours on the same calendar date.
- Physicians and qualified NPPs should not report an Observation Care Discharge Service (CPT code 99217) when the observation care is less than 8 hours on the same calendar date.
- Physicians and qualified NPPs should report Initial Observation Care using a code from CPT code range 99218 – 99220 and an Observation Care Discharge Service (CPT code 99217) when the patient is admitted for observation care and discharged on a different calendar date.
- Physicians and qualified NPPs should report Observation or Inpatient Care Service (Including Admission and Discharge Service) using a code from CPT code range 99234 – 99236 when the patient is admitted for observation care for a minimum of 8 hours but less than 24 hours and discharged on the same calendar date.
- Physicians and qualified NPPs should not report Observation Care Discharge Service (CPT code 99217) when the observation care is a minimum of 8 hours and less than 24 hours and the patient is discharged on the same calendar date.
Observation Services can be shared

“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.”

• Source: Novitas Solutions Article
  “E&M-Service-Specific Coding Instructions: Billing of Shared/Split Evaluation and Management Services”
  http://www.novitasolutions.com/webcenter/faces/oracle/webcenter/page/scopedMD/sad60252a_657_4c5d_9350_ca405e36e159/Page133.jsp?contentId=00081589&_adf-state=xoe07k801_4&_afrLoop=1429278184772484

Critical Care Services: Medicare Definition

“A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient’s condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition.”

...and

“Critical care services must be medically necessary and reasonable. Services provided that do not meet critical care services or services provided for a patient who is not critically ill or injured in accordance with the above definitions and criteria but who happens to be in a critical care, intensive care, or other specialized care unit should be reported using another appropriate E/M code (e.g., subsequent hospital care, CPT codes 99231-99233).”

Medicare Claims Processing Manual Chapter 12, §30.6.12
Critical Care Services have their own set of CPT® codes and rules.

From Noridian:

Q9. If a person is in a coma, is the care provided considered critical care?
A9. No, not based on this alone and not based on patient condition alone. Critical care is provided for a "critical illness or injury (which) acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition." See the discussion that includes this quotation in CPT under "Critical Care Services." Both the patient's condition and the services being provided must meet critical care criteria.

Q11. Is it correct that any critical care time a non-physician practitioner (NPP) performs has to be billed by the NPP?
A11. Physicians and NPPs critical care time cannot be aggregated. Each provider type must bill and document separately the time spent performing critical care. NPPs from the same group, providing services of a single specialty may aggregate their critical care time for a day and bill under one of the NPP’s NPI.


Critical Care Services Cannot be Shared

Q13. Can you explain split/share E/M billing?
A13. When a hospital E/M (inpatient/hospital, outpatient or emergency department) is shared between a physician and an NPP from the same group practice, and the physician provides and documents the provision of any face-to-face portion of the E/M with the patient; the service may be billed under either the physician’s or the NPP’s number. The visit is combined and each provider documents his or her portion. However, if there was no documented face-to-face service between the patient and the physician, then the service is only billed under the NPP. Critical care may not be billed as a split/shared service.


Critical Care Services Resources


AMA CPT® Professional 2015, Critical Care Service Codes


Medicare references:


Hospital Admission Order & Certification

- The (IPPS) rule for 2014, released August 2013, appeared to restrict the authority of PAs, NPs & residents to provide admission services, specifically the admission order.

- A major purpose of the IPPS rule was to assist hospitals in defining the appropriate use of hospital admission versus observation status, thereby helping more Medicare beneficiaries become eligible for nursing home care after a minimum three-day hospital inpatient stay.

- Part of the so-called “2-Midnight Rule”.

- The IPPS rule is a Medicare Condition of Payment for facility payment under Part A.

Hospital Inpatient Admission Order and Certification

INTRO: “As a condition of payment for hospital inpatient services under Medicare Part A, section 1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis. The order to admit as an inpatient (‘practitioner order’) is a critical element of the physician certification, and is therefore also required for hospital inpatient coverage and payment under Part A. The physician certification, which includes the practitioner order, is considered along with other documentation in the medical record as evidence that hospital inpatient service(s) were reasonable and necessary. When a physician signs the certification, they are certifying that inpatient hospital services were reasonable and necessary.”

January 30, 2014
CMS “Additional” Certification
A. Physician Certification

For physician certification of inpatient services of hospitals other than inpatient psychiatric facilities:

1. Content: The physician certification includes the following information:

   Authentication of the practitioner order:
   The physician certifies that the inpatient services were ordered in accordance with the Medicare regulations governing the order. This includes certification that hospital inpatient services are reasonable and necessary and in the case of services not specified as inpatient-only under 42 CFR 419.22(n), that they are appropriately provided as inpatient services in accordance with the 2-midnight benchmark. The requirement to authenticate the practitioner order may be met by the signature or countersignature of the inpatient admission order by the certifying physician.


   3. Authorization to sign the certification:

   The certification or recertification may be signed only by one of the following:
   (1) A physician who is a doctor of medicine or osteopathy.
   (2) A dentist in the circumstances specified in 42 CFR 424.13(d).
   (3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under state law.

   Certifications and re-certifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital’s medical staff. And, in the specific case of a non-physician non-dentist admitting practitioner who is licensed by the state and has been granted privileges by the facility, a physician member of the hospital staff (such as a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement that specifically contains all of the content elements discussed above.

   Take Home

   • PA/NP/residents can write the hospital admission order.
   • PA/NP/residents can personally perform and document the admission H+P.
   • PA/NP/resident documentation can contribute to the “medical necessity” content requirements for the “certification”
   • A counter-signature is required on the inpatient admission order by the certifying physician.
Admission Order & Certification

- CMS 1599-F: IPPS Rules August 19, 2013 (see Section C. Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A) at http://www.asahq.org/Administration/rules/hipps/2013/med0313-rulebook.pdf

Update: 2015 OPPS Final Rule

FEDERAL REGISTER

Vol. 79    Monday, No. 217  November 10, 2014


CMS Admission Order Requirements

January 1, 2015

- The existing requirement for the inpatient admission order to be signed by a physician before discharge remains unchanged in acute care hospitals. This has caused some organizations to implement a HARD STOP on discharge orders if the admission order has not been signed.
- Medicare relaxed the time frame for CAH co-signature in the FY 2015 IPPS/LTCH rules published in the Federal Register August 2014, with counter-signature required prior to the submission of the claim, as opposed to prior to the patient discharge.
- No subsequent “guidance” has been published since the last clarification from CMS published January 2014; therefore, a physician co-signature for orders written by a PA/NP or resident is still required.

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**Physician Certification Requirement**
January 1, 2015

- The requirement for a separate written certification at the time of inpatient admission has been **ELIMINATED**.
  - The documentation of medical necessity in the medical record is still required in order for a hospital to be paid for inpatient services.

- Physicians are no longer expected to predict how long patients will be in the hospital.

- A requirement for physician certification for prolonged inpatient stays of 20 days or more is also included in the rule.

**STATE MEDICAID**

- All state Medicaid programs pay for services provided by PAs/NPs.
- Many states do not enroll, although that is changing rapidly since PPACA (Section 6401)
- For those states that do not enroll, the claim is submitted under an enrolled physician’s NPI.
- Most do not require a physician’s presence on site.
- A few will not pay for services provided in a hospital. Some won’t cover first assisting.
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

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/MedicalProvider/MedicaidReimbursement/Pages/IndividualPractitioner.aspx

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

The billing methodology must be clearly ascertained by every individual practice for every individual payer with whom they contract.

- Enrollment does not necessarily equate with payment.
- Many do not follow Medicare rules (such as Incident-to or Shared Visits)
- Many do not use the –AS modifier for first assisting
- Many do not discount services provided by PAs/NPs.
- Must not assume.