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Selection from: Billing For Nurse Practitioner Services -- Update 2007: Guidelines for NPs, Physicians, Employers, and Insurers

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Incident-to Billing

Billing an NP's Service Under a Physician's Provider Number

If an NP and a physician work together in an office to provide physician services, the services can be billed under the physician's provider number, to get the full physician fee, under the Medicare provision for "incident-to billing." However, certain rules must be followed when billing services under the incident-to provision. The rules are:

1. The services are an integral, although incidental, part of the physician's professional service.

2. The services are commonly rendered without charge or included in the physician's bill.

3. The services are of a type commonly furnished in physician's offices or clinics.

4. The services are furnished under the physician's direct personal supervision and are furnished by the physician or by an individual who is an employee or independent contractor of the physician. Direct supervision does not require the physician's presence in the same room, but the physician must be present in the same office suite and immediately available.

5. The physician must perform "the initial service and subsequent services of a frequency which reflect his or her active participation in the management of the

course of treatment."

6. The physician or other provider under whose name and number the bill is submitted must be the individual present in the office suite when the service is provided.

   The incident-to rules are stated in the *Medicare Benefit Policy Manual*, Chapter 15, Sections 60.1 to 60.3.

Incident-to Billing -- Appropriate Use

A physician evaluates a patient and diagnoses hypertension. The physician initiates treatment. The physician employs an NP. The NP conducts follow-up visits with the patient, monitoring and treating the hypertension over weeks, months, or years. The physician sees the patient every third visit, under a policy adopted by the practice. The NP's work may be billed under the physician's provider number, and the practice will receive 100% of the physician's fee schedule rate for the services performed by the NP.

Incident-to Billing -- Appropriate Use Unclear

If the scenario described above continued, but one day the hypertensive patient arrived for a follow-up visit with the NP and announced a new complaint of sinusitis, for example, it is not clear that incident-to billing would be appropriate. There are differing interpretations among clinicians and auditors of the phrase "the physician must perform the initial service," found in the "incident-to" rules. Some clinicians may interpret this rule to mean that only the first visit to the practice must be conducted by the physician. Others interpret "perform the initial service" to mean that when there is a new problem, the NP must either bill under his or her own number or refer the patient back to the physician.

The Centers for Medicare & Medicaid Services (CMS) has not defined "initial service." Neither has CMS clarified the phrase "subsequent services of a frequency which reflect [the physician's] active participation in the management of the course of treatment." "Active participation" may mean different things to different clinicians, auditors, and administrators. For example, active participation may mean chart review, or face-to-face visits, depending upon the reader's interpretation.

Incident-to Billing -- Illegal Use

A physician employs an NP to work in a satellite office. The physician is never present. Incident-to billing is inappropriate, as the requirements are not met. However, the NP's services may be billed under the NP's provider number, and Medicare will pay 85% of the physician rate for the services.

Billing Shared Visits

If an NP performs and documents physician services in a hospital (inpatient, outpatient, or emergency department) and a physician provides and documents any face-to-face portion of the evaluation/management encounter that day, the evaluation/management service may be billed under the physician's provider number. However, if there was *no face-to-face encounter* between the patient and the physician (even if the physician reviewed the medical record), then the service must be billed under the NP's provider number.[3]

It is fairly common for an NP to evaluate a hospitalized patient in the morning, with the physician who employs the NP following up later in the day with a face-to-face visit with the patient. In that case, either the physician or the NP may report the service.

CMS has adopted a similar approach when 2 physicians from the same practice see a hospitalized patient on the same day. According to the *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.5:

If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

These rules apply to Medicare only, unless other payers specifically adopt Medicare's rules. There is no law governing commercial payers on this matter.

The following is an example of appropriate shared billing:

- NP visits Patient A in the morning of the patient's second hospital day and performs a detailed examination and medical decision-making of high complexity. Later that day, a physician in the same practice visits Patient A and checks the patient's pupillary reaction. The NP's and physician's work is combined and the visit is billed as Level 3 subsequent hospital care, under the physician's provider number.

What *not* to do. The following billing practices are clearly inappropriate, under the rules on billing shared visits:

- Practice bills an NP's evaluation/management service to an emergency room patient under the provider number of a physician employed by the same practice without the physician ever having a face-to-face encounter with the patient.

- Private practice bills the work of an NP employed by the hospital.

What to do. Adopt one of these policies for patients covered by Medicare:

- Policy A: Bill any and all visits performed by an NP under the NP's provider number. If adopting this policy, a physician need not evaluate a patient daily, under Medicare's rules. However, a physician will need to be the "attending physician," who directs the care of the hospitalized patient, to conform with Medicare's conditions of participation regarding hospitals.

- Policy B: Bill an NP's services to hospitalized patients under the provider number of a physician in the practice if that physician has seen the patient, face to face, that day. The physician must document in the hospital record his/her face-to-face encounter. The CPT code billed may reflect both the NP's services and the physician's services.

Billing an Assistant's Services Under an NP's Provider Number

A medical practice may bill the services of a non-NP incident to an NP's services (ie, bill an assistant's services under an NP's provider number) if the rules for incident-to billing are followed. For example, if an NP sees a patient and orders an electrocardiogram (EKG), and an office technician performs the test, the NP may bill for the EKG as if the NP had performed it, under the incident-to billing provision.

More Payer Considerations

Services for Which a Physician Can Bill Medicare

Medicare operates 2 programs, Medicare Part A and Medicare Part B. Part A covers hospitalization, skilled nursing facility services, and some home health services. Part B covers physician services, outpatient hospital services, laboratory procedures, medical equipment, and some home health expenses.

NPs may bill Medicare Part B for services that would be physician services if performed by a physician, but that are performed by an NP. Medicare defines physician services as diagnosis, therapy, surgery consultation, and care plan oversight. Specifically, physician services are those that can be described by a Current Procedural Terminology (CPT) code[4] and an International Classification of Diseases, 9th revision (ICD-9) code.[5]

A service that does not meet Medicare's definition of a "physician service" will not be reimbursed. For example, health services that are within the realm of nursing but are not "physician services" are not covered under Medicare Part B. Furthermore, Medicare does not reimburse for all physician services. For example, yearly physical examinations and counseling for well patients are assumed by the general public to be physician services, but these services are not within Medicare's definition of covered services. For a list of noncovered services, contact the local Medicare Carrier.

Medicare Requirement for Collaboration

Federal law defines "collaboration" as "a process in which an NP works with a physician to deliver healthcare services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanism as defined by the law of the State in which the services are performed."[6] States vary in their requirements for collaboration between physician and NP. Check your own State Board of Nursing requirements.[7]

In 8 states, there is no requirement that an NP have a formal agreement with a physician or other healthcare provider promising collaboration or supervision. For example, Oregon law states: "The NP is responsible for recognizing limits of knowledge and experience, and for resolving situations beyond his/her NP expertise by consulting with or referring clients to other healthcare providers."[8] However, most states require NPs to have a collaborative agreement with a physician. And, while Medicare generally defers to state law requirements, federal law requires that an NP billing Medicare have a collaborative relationship with a physician. So, even in Oregon, an NP must establish a collaborative connection with a physician. For the law of each state on collaboration requirements, query the state board of nursing.[7]

Question 3:

Which one of the following scenarios is *not true*?

Your colleagues responded:

15% Under Medicare, a physician may bill for shared visits if an NP employed by the physician performs and documents evaluation/management services in a hospital (inpatient, outpatient, or emergency) department, and the physician has a face-to-face visit with the patient the same day.

12% Under Medicare, an NP may bill for services if the NP evaluates and manages a hospitalized patient.

72% Under Medicare, the NP may bill for "incident-to" services while under contract with a physician group, even if the physician is never present.

You answered:
Under Medicare, an NP may bill for services if the NP evaluates and manages a hospitalized patient.

This statement is true.

NP Services as Defined by Medicare

Medicare defers to states' laws authorizing the scope of practice of NPs (ie, the types of services an NP may perform under state law). Each state defines the scope of practice for NPs in its nurse practice act. For scope of practice, contact the state board of nursing.[7]

For example, Oregon law states: "The nurse practitioner is independently responsible and accountable for the continuous and comprehensive management of a broad range of health care, which may include:

- promotion and maintenance of health
- prevention of illness and disability
- assessment of clients, synthesis and analysis of data and application of nursing principles and therapeutic modalities
- management of health care during acute and chronic phases of illness
- admission of his/her clients to hospitals and long term care facilities and management of client care in these facilities
- counseling
- consultation and/or collaboration with other care providers and community resources
- referral to other health care providers and community resources
- management and coordination of care
- use of research skills
- diagnosis of health/illness status
- prescription and/or administration of therapeutic devices and measures including legend drugs and controlled substances...consistent with the definition of the practitioner's specialty category and scope of practice."[8]

Some states' laws are not as clear as Oregon's. Variation and vague language in state laws led the federal agency responsible for prosecuting Medicare fraud to complain that "most scopes of practice contain only a general statement about the responsibilities, educational requirements and a non-specific list of allowed duties and do not explicitly identify services that are complex or beyond their scope. Carriers voice concerns over non-physician practitioners performing such services as surgery and endoscopies. Further, when a service is not addressed in a scope, it cannot be assumed that a non-physician practitioner cannot provide that service."[9] Nevertheless, the CMS continues to defer to state laws on scope of practice.

Prohibition Against Dual Payments

Medicare requires that a practice or facility billing Medicare for NP services ascertain that "no other facility or provider has charged for the furnishing of services." If a hospital or nursing facility is being reimbursed under a cost report for an NP's salary, the hospital or facility should not be billing the NP's services separately. Additionally, physician practices and NPs must coordinate billing to avoid seeking duplicate payments.

Hospital may be reimbursed for NP's salary through Medicare, Part A. There is potential for billing NP services when a hospital employs an NP to provide a variety of medical services to inpatients. There also is potential for double billing. The hospital must make a choice about the method of seeking reimbursement from Medicare for the NP's services. If a hospital includes the NP's salary on the Medicare cost report (seeking payment under Medicare Part A) and if the hospital receives any reimbursement under that cost report, then the hospital may not bill the NP's services to Medicare under Medicare Part B (physician's services). On the other hand, if the NP's salary is not on the cost report, or the hospital receives no reimbursement from Medicare under the cost report, then the hospital may bill Medicare for the NP's services to patients as physician services under Medicare Part B, assuming no other provider has billed those services.

In the past several years, the Medicare payment system for hospitals has gradually changed from reimbursement for reasonable costs (as stated in annual cost reports) to prospective payment based on diagnostic related groups. As hospitals have diminished opportunity to recoup NP salaries under the cost reports, it becomes more important to bill NP services where possible under Part B.

Practice employs physicians and NPs. Potential for overlap of physician and NP services occurs when a medical practice employs an NP to evaluate, manage, and provide consultations on hospitalized patients. A physician employed by the practice may evaluate the same hospitalized patient as the NP on the same day and perform some of the same history, examination, and medical decision-making services. The practice may submit only 1 charge for those services. The practice may bill under either the physician's provider number or the NP's provider number.

Applying physician rules to billing NP services. The laws and guidelines applicable to physicians billing Medicare apply to NPs. Those rules include the following:

1. Services must be medically necessary;
2. Services must have been provided as billed, as supported by the medical record;
3. The clinician providing the service must have a Medicare provider number;
4. The entity seeking payment must submit a Centers for Medicare & Medicaid Services -- CMS 1500 form, appropriately completed;
5. The entity seeking payment must accept Medicare's rates;

6. Providers may not provide kickbacks for referrals*;

7. Services must be billed under the provider number of the clinician performing the service, unless incident-to or shared-visit rules are followed; and

8. Medicare will pay only certain parties.

(* It is illegal to solicit, pay, offer, or receive any remuneration, in cash or in kind, for the referral or to induce the referral of a patient, or for ordering, providing, recommending, or arranging for the provision of any service payable by federal healthcare programs. The federal antikickback rules apply to NPs.)

Reassignment: Medicare will pay only specified parties. An NP can reassign his or her right to receive Medicare payments to an employer or an entity with which the NP has an independent contract, under the following conditions:

- The entity doing the billing must be a Medicare provider.

- The NP and entity doing the billing must be parties to a contract that reassigns the right to be paid from the NP to the entity doing the billing.

- The entity receiving payment and the NP furnishing the services will be jointly and severally responsible for any Medicare overpayment to that entity.

- The NP furnishing the service shall have unrestricted access to claims submitted by an entity for services provided by that person.[10]

Note that the requirement that the NP have unrestricted access to claims submitted by the entity doing the billing is applicable only to independent contractors. At present, employed NPs do not have the right to unrestricted access to claims submitted by their employers.

Obtaining a provider number. NPs, like physicians, apply for Medicare provider status by filling out and submitting an individual application form CMS 855i. While awaiting action on the NP's provider application, the practice should hold bills until the provider number arrives, then fill in the number and submit. Beware that Medicare will pay batched and held bills only if the NP's application for provider number is accepted. There is at least one case of an NP who applied for Medicare provider status and, while awaiting approval, performed services for patients covered by Medicare. She performed a significant volume of services before Medicare notified the NP that she did not qualify for a provider number. All of the services the NP performed for the patients covered by Medicare went uncompensated.

Question 4:

Which of the following statements about dual payments is *false*?

Your colleagues responded:

7% Medicare requires that a practice or facility billing Medicare for NP services ascertain that "no other facility or provider has charged for the furnishing of services."

79% If a hospital or nursing facility is being reimbursed under a Medicare cost report for an NP's salary, the hospital or facility should be billing the NP's services separately.

12% Physician practices and NPs must coordinate billing to avoid seeking duplicate payments.

You answered:
If a hospital or nursing facility is being reimbursed under a Medicare cost report for an NP's salary, the hospital or facility should be billing the NP's services separately.

This is the correct answer; this statement is false. The hospital or facility should not be billing the NP's services. If a hospital includes the NP's salary on the Medicare cost report (seeking payment under Medicare Part A) and if the hospital receives any reimbursement under that cost report, then the hospital may not bill the NP's services to Medicare under Medicare Part B (physician's services).

More Billing Considerations: NP Services in Various Settings

Billing Home Visits Conducted by an NP

Because NPs are authorized by law to perform both nursing and physician services, it is important to keep the distinction clearly in mind when an NP provides a home visit. If an NP is performing a service billable to Medicare Part B as a physician service -- in general, a service described by a code found in CPT[4] made necessary by a diagnosis described by an ICD-9 code[5] -- to a patient in his or her home, the NP does not need a physician's order to perform the visit and could bill Medicare under the NP's provider number.

However, if an NP is providing nursing services -- billable under Medicare Part A -- the NP would need a physician's order for the home visit, the visit would need to be conducted through a home care agency enrolled as a Medicare provider, and the bill would be submitted by and paid to the agency under the prospective payment system.

Billing Nursing Home Visits Conducted by an NP

An NP may bill Medicare for physician services the NP performs in a nursing home with the following provisos:

1. An NP may not perform the initial comprehensive visit, unless the following requirements are met:

- The NP is performing that service for a patient in a nursing facility (as compared with a skilled nursing facility);
- The NP is not an employee of the nursing facility;
- State law permits an NP to perform this service;
- The service is within the scope of practice of an NP under state law;
- A physician has delegated this service to the NP; and
- The NP is working in collaboration with a physician.

2. If a patient admitted to a nursing facility or skilled nursing facility needs an evaluation and management visit for an illness or injury before a physician performs the initial comprehensive visit, an NP may perform that procedure and bill under the CPT codes for subsequent evaluation and management.

3. In a nursing facility, an NP may conduct all "required physician visits" (ie, a visit every 30 days for the first 90 days after admission, then once every 60 days) if the state authorizes NPs to do so, if a physician responsible for the visits delegates the visits to an NP, if the NP is not employed by the nursing facility, and if the NP is working in collaboration with a physician.

4. In a skilled nursing facility, an NP may alternate "required physician visits" with a physician.

5. An NP who is self-employed or who is employed by a nursing facility may conduct and bill for visits to evaluate and manage illnesses of patients in the nursing facility, as medically necessary. [11]

6. An NP may perform and bill consultations, if ordered by a clinician with the authority to order consultations.[12]

Note that state survey and certification requirements may exceed Medicare's billing requirements.

Billing Hospital Visits and Procedures Conducted by an NP

In recent years, hospitals and physician groups have been hiring NPs to take care of hospitalized patients, and programs that educate acute care NPs have proliferated. An NP may provide physician services to a hospitalized patient if the services are within the scope of practice of an NP under state law or if a physician delegates to the NP the authority to perform the services. See the section, "NP Services as Defined by Medicare."

Generally, evaluation and management of acute and chronic illnesses are within an NP's scope of practice under state law. States may also authorize NPs to perform diagnostic and therapeutic procedures. Where state law is silent or unclear, an NP may perform

procedures specifically delegated by a physician. For state law, contact the state board of nursing.[7]

NPs are not free to take over the care of hospitalized patients on their own, however, even in permissive states like Oregon. A physician must be involved in the process of care for hospitalized patients because, under federal law governing hospitals, a hospital must require that "every patient be under the care of a physician."

The general conditions for billing Medicare for physician services performed by NPs in hospitals are:

1. The services must be billed under the NP's provider number, unless the requirements for "shared visits" are met.

2. If an NP is an employee of a hospital and the NP's salary is included in the hospital cost report, and if the hospital receives reimbursement from Medicare under the cost report, then the services of that NP may not be billed to Medicare under Part B.

3. If the services an NP is providing are part of a surgical or maternity package, reimbursed under a global fee, and if a surgeon or obstetrician has billed the global fee, then the NP's services may not be billed, as the surgeon or obstetrician already has billed those services. However, when a service is reimbursed under a global fee, there are mechanisms for transferring care and for separating the components of the global fee, which would allow an NP's services to be billed.

Reimbursement Under Managed Care

The laws addressing Medicare and managed care do not specifically address NPs. Reimbursement from Medicare to an MCO and from an MCO to a physician or physician group is made under the terms of contracts -- between Medicare and MCO and between MCO and physician group. Generally, an MCO reimburses only those providers admitted to the organization's provider panel. Some managed care plans admit NPs to provider panels; others do not. Some managed care plans will pay for services rendered by NPs if delegated by a physician who is on the provider panel; others will not. See the section on "Commercial MCOs' Coverage of NP Services," below.

Medicaid Rules on Billing NP Services

Medicaid rules do not mimic Medicare rules. The Medicaid program is administered by the states, and state regulations vary regarding the billing of NP services. For example, federal law mandates that states reimburse family NPs and pediatric NPs for services provided to patients covered by Medicaid but does not mention adult NPs, geriatric NPs, or NPs with other specialties. States may elect to broaden federal law and reimburse adult NPs and geriatric NPs as well as pediatric and family NPs. Some states have elected to reimburse all types of NPs, and other states reimburse only pediatric NPs and family NPs.

Medicaid reimbursement is further complicated by the fact that many Medicaid recipients are enrolled in managed care plans. Managed care plans are subject to state laws but, in general, may make their own policies regarding reimbursement.

Billing NP Services Under Medicaid Fee-for-Service

An NP who has a Medicaid provider number may bill Medicaid on a fee-for-service basis for physician services provided to a patient covered by Medicaid if the patient is not enrolled in a managed care plan. In most states, Medicaid pays NPs 100% of the physician's fee. In some states, Medicaid reimburses NPs at a reduced rate. For details of each state's policies, contact the state Medicaid agency.

NP Reimbursement and Medicaid Managed Care Plans

If a patient is enrolled in a Medicaid managed care plan, the plan's policies and contracts will determine who may be reimbursed for physician services. In general, managed care plans reimburse only those providers admitted to the plan's provider panel. Medicaid MCO policies on empanelment of NPs vary and include:

1. Admitting NPs to provider panels; and
2. Declining to admit NPs to provider panels but allowing NPs to provide services for patients on a physician's panel.

A practice wishing to have an NP admitted to a managed care provider panel must query each managed care plan regarding its policies.

Billing Commercial Indemnity Insurers for NP Services

Indemnity insurers reimburse healthcare providers on a fee-for-service basis. Each company has its own policy regarding reimbursement of NP-provided services. The policies vary and include:

1. Payment at the same rate as physicians without requirement for admission to a provider panel;
2. Payment at a reduced rate;
3. Payment for NP-provided services when billed under a physician employer's name; and
4. Denial of payment for services provided by NPs.

Some states' laws require commercial indemnity insurers to reimburse NPs for physician services. Other states' laws are silent on the matter. Commercial insurers may adopt Medicare's rules and guidelines on billing NP services, or they may adopt completely

different policies. Each practice must query each insurer about the insurer's policies. Practice managers may find it useful to prepare grids that track the various insurers' policies.

Commercial MCOs' Coverage of NP Services

In general, MCOs reimburse only those providers admitted to the plans' provider panels. MCOs do not admit every physician to provider panels and may or may not admit NPs to provider panels. Commercial MCO policies on empanelment of NPs vary and include:

1. Admitting NPs to provider panels;

2. Declining to admit NPs to panels but allowing NPs to provide services for patients on a physician's panel; and

3. Declining to admit NPs to provider panels and permitting only those on provider panels to see patients.

Some MCO contracts allow a designated primary care provider (PCP) -- a provider admitted to an MCO's panel of providers -- to delegate to his or her employees the authority to provide services. Other contracts are silent on delegation. Some contracts may require that a designated PCP provide the patient services. If so, an MCO may consider it fraud for someone other than that PCP to provide physician services.

If an MCO will not credential a group's NPs, and if the contract between MCO and the practice is silent on the issue of PCP delegating the care of patients to an NP, and if the practice intends to offer care by NPs to an MCO's patients, then the practice should ask the MCO for written authorization, as part of the contract or as a separate communication, for NPs to provide services and receive reimbursement.

Businesses Contracting With NPs or Practices Directly

A business wanting an NP to provide health services to employees may contract with a practice or NP under whatever financial terms satisfy both parties. State law requirements for NP practice would need to be fulfilled.