Top 10 Most Frequently Asked Questions About NP Billing and Reimbursement

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Incident-to Billing

Question 1: If an NP is working under an independent contract with a physician, can the NP's services be billed under the physician's provider number, to get 100% of the Physician Fee Schedule rate?

Answer: Yes, under Medicare rules, if the other parts of the "incident-to" rules are followed (ie, the physician is present in the suite, the physician has conducted the initial visit, and the physician remains an active participant in the management of the patient).

The CMS clearly stated in the Federal Register on November 1, 2001, that the employment relationship is irrelevant to "incident-to billing," as long as the reassignment rules are followed. The rules on incident-to billing are Medicare's rules. Other insurers may or may not require adherence to the incident-to rules when billing an NP's work under a physician's name.

Physicians and practice managers wanting to submit bills under a physician's provider number for services performed by an NP must read the policies of and contracts with each insurer and MCO with which the practice does business and, if nothing to address the practice's provider arrangement, query the payer, in writing, before assuming that all bills submitted under a physician's name will be paid.

Physician Presence While an NP Is Seeing Patients

Question 2: Is a physician required to be on site or available within any specific time frame while an NP is working?

Answer: The answer regarding physician presence depends upon the provider under whose name and number the visit will be billed, the state where the services are provided, and the insurer. For example, if billing Medicare under an NP's provider number, a physician need not be on site unless state law requires physician presence. However, if
billing Medicare under a physician's provider number, that physician must be on site, within the suite of offices where the NP is practicing.

State law may require the presence of a physician or availability within a specific time frame. Insurers other than Medicare may or may not require physician presence. In general, insurers other than Medicare do not require physician presence. For state law requirements, query the state board of nursing. [7]

**Physician Cosignature**

**Question 3:** Is a physician required to read and/or cosign an NP's history and physical, progress note, or other documentation?

**Answer:** No, unless specifically required by state law. For a state's requirements, query the state board of nursing. [7]

**Question 4:** I am a physician and I employ an NP. She takes the history and performs the physical examination, then we discuss the diagnosis and treatment plan, and she implements the plan. I cosign the chart. Will my signature suffice in getting reimbursement under my name?

**Answer:** A physician's cosignature is not useful in obtaining reimbursement. If billing Medicare under the incident-to rules, a physician must follow the incident-to rules, which say nothing about cosignature. For example, if an NP conducts a visit with a new patient, the practice must make a choice -- bill the visit under the NP's provider number or bill the visit under the physician's provider number and have the physician, not the NP, perform and document the portions of the evaluation relevant to the choice of procedure code. The physician's signature or writing "agree" on an NP's evaluation will not suffice for Medicare. Other insurers may have different rules, but no insurer pays extra if a physician cosigns an NP's records.

**Billing Under Physician Provider Number vs NP Provider Number**

**Question 5:** Can services provided by NPs in a hospital outpatient department or emergency department be billed to Medicare under a physician's provider number?

**Answer:** Yes, if the rules on shared visits are followed.

**Question 6:** I am a specialist physician, in solo practice. I want to engage an NP under an independent contract to provide hospital visits, an occasional home visit, an occasional nursing home visit, and see patients in my office on days when I am in the office and on some days when I am off. I want to bill all visits under my own provider number. I may have the NP do some in-office procedures, such as flexible sigmoidoscopy. Can I do this?

**Answer:** Yes, you can engage an NP as an independent contractor. Payments can come to you, under the terms of your contract with the NP. However, to bill Medicare for the NP's
services, you will need to change your status with Medicare as a sole practitioner to that of a group practice. This change requires completing form number CMS855b.

Under Medicare rules, NPs can perform nursing home visits, home visits, hospital visits, and office visits and can perform such procedures as flexible sigmoidoscopy, as long as the scope of practice for an NP under state law authorizes diagnosis, treatment, and diagnostic procedures, or you delegate those functions to the NP under your collaborative or delegation agreement. You must bill the following procedures conducted by the NP to Medicare under the NP's provider number:

- Home visits;
- Nursing home visits (unless you rent space in a nursing home and are in that rented space at the time the NP sees patients in that space);
- Office visits when you are not present in the office suite; and
- Hospital visits, when the requirement for billing shared visits cannot be met.

On those days that you are present in the office suite at the time the NP is working, you may bill office visits conducted by the NP under your own provider number, if you have conducted the initial service and if you remain involved in the care of the patient. As for Medicaid, you would bill the NP's work under his or her provider number. As for other insurers -- commercial indemnity insurers and commercial MCOs -- you will need to ascertain the policies of each of these insurers regarding reimbursement of your contractor's services.

**Question 7:** Our hospital employs NPs who provide services to surgeons' patients to improve the flow of admission and discharge. The NPs also perform some diagnostic procedures in the hospital, for the surgical service. Can the hospital bill for the NPs' services?

**Answer:** The answer is complicated. Medicare's rules on reassignment, shared visits, global fees, and billing NP services in general have implications on this scenario. The factual questions that need to be answered before a legal opinion can be given are:

1. What services is the NP providing (ie, preoperative evaluation, postoperative visits, and/or discharge services for surgeons' patients)?
2. Is the surgeon billing for the services the NP is providing?
3. What surgeries or procedures are involved?
4. If the NP is performing postoperative visits, are the visits related to the surgery or to another medical problem?
5. Is the NP performing all services in the hospital, or is the NP performing some services in the surgeon's office?

6. Is the surgeon employed by the hospital or his or her own corporation?

7. Does the hospital receive any reimbursement from Medicare under its cost report? How about Medicaid?

8. Has the surgeon leased the NP from the hospital?

9. Does the surgeon have a contract with the NP under which the NP reassigned his or her billings to the surgeon?

10. Who is the payer?

The legal issues are as follows:

1. Whether Medicare's or Medicaid's rules apply;

2. Whether the hospital can bill, under Medicare's rules on reassignment, for the NP's services;

3. Whether the hospital would be billing for a service that has already been billed or paid;

4. Whether the NP's services should be billed under the NP's provider number or whether Medicare's requirements on shared visits can be met;

5. Whether the NP has a provider number with the payer; and

6. Whether a global fee applies to the surgery, and, if so, whether the services the NP is performing are included under the global fee or are separately billable.

The basic principles are as follows:

1. If the payer is Medicare, services must be billed under the provider number of the provider performing the service, unless the requirements for billing incident-to or shared visits are met.

2. Only 1 bill will be paid for any given service to any given patient on any given day.

3. The global fee for surgery is billed by the surgeon and includes intensive care unit visits by the surgeon; preoperative visits; intraoperative services; and postoperative visits related to recovery from the surgery, pain management, complications, dressing changes, local incisional care, and removal of sutures and drains. The global fee does not include the initial surgical consultation, services of other physicians, visits unrelated to the surgical diagnosis, treatment for an
underlying condition, diagnostic tests, clearly distinct surgical procedures, and treatment for a postoperative complication that requires a return to the operating room.

4. Under the reassignment rules, Medicare will pay the NP, the NP's employer, or an entity that has a contract with the NP, provided that the NP has reassigned his or her billing rights to that entity and the entity meets certain program integrity requirements.

An application of these rules to the facts given yields the following conclusions:

1. If the NP, rather than the surgeon, is performing some significant parts of the surgeon's work for which the surgeon is seeking payment under the global fee, and the surgeon has not formally transferred the care to the NP, then the surgeon may be billing for services he or she did not render. If so, the surgeon is risking a charge of Medicare fraud.

2. Assuming the surgeon is not employed by the hospital, the hospital cannot bill for services performed by the NP for which the surgeon is being paid under a global fee.

3. If a private practice surgeon is billing and receiving payment for work done by an NP employed by the hospital, then the hospital, as employer of the NP, is subsidizing the surgeon's practice. Such a subsidy could be a kickback, which is illegal under federal law.

4. Physician services unrelated to the surgery that are performed by the NP and that are not billed by another clinician could be billed by the NP's employer (the hospital). For example, if a patient has heart surgery and, on the second postoperative day, develops otitis media, which is treated by the hospital's NP, the hospital could bill for evaluation and management of the otitis. The NP's services, if billable, would be billed under the NP's provider number.

5. Procedures that are physician services and that are performed by an NP and not billed by another clinician could be billed by the NP's employer, using the NP's provider number.

A series of contracts between surgeon, hospital, and NP could correct the legal problems inherent in this example and enable either the hospital or the surgeon to bill some of the NP's services.

**Business Relationships and Business Form**

**Question 8:** Which type of business relationship -- employer/employee, independent contractor, or equity shareholder -- between an NP and physician is best for the NP? For the physician?
**Answer:** One arrangement is not inherently better than another for either physician or NP. The most appropriate and satisfying business structure and employment relationship will depend upon the individuals and the specifics of the practice. Practices should consult an experienced attorney, describe the facts and the business objectives, and obtain an advice letter on how the relationships should be structured and which form the business should adopt.

**Question 9:** Do NPs and physicians ever do business as partners, shareholders of a professional corporation, or members of a limited liability company? Is that legal?

**Answer:** Partnership is becoming less common for all professionals because partnership, as a choice of business structure, has drawbacks. (For example, each partner is personally responsible for the debts and liabilities of the other partners.) The most common business forms for professionals are professional corporations, professional associations, and limited liability companies. Many attorneys now recommend that professionals form a limited liability company, which has some similarities to a partnership, without the drawbacks. NPs and physicians have formed limited liability companies. In some states, professionals holding differing classes of licenses cannot join together to own professional corporations. In other states, professionals with different licenses can form only 1 type of company; for example, they may form a limited liability company but not a professional corporation. NPs and physicians wanting to share equity should seek the advice of a local attorney who specializes in business and healthcare law.

**Gaining Admission to Managed Care Provider Panels**

**Question 10:** How can a practice convince a commercial managed care plan to admit NPs to provider panels?

**Answer:** A practice may want managed care plans to admit its NPs to provider panels to:

1. Avoid the possibility that a plan will decide it is contrary to the contract, or worse, fraudulent, to have an NP provide the care when a physician is listed as the provider;

2. Increase the number of patients a practice can take on, if a plan limits the size of provider panels;

3. Create incentives for NPs to take responsibility for panels of patients and to increase the number of patients in a practice; and

4. Align policies with current practice.

When attempting to get a managed care plan to change its policy and admit NPs to provider panels, use this check list:

1. Ascertain whether state law allows NPs to be managed care providers.
2. Identify the individual or individuals at the MCO who can make the decision to change company policy.

3. Ask for a meeting and present the case for empanelment of NPs.

4. In the meeting, ask what stands in the way of NPs getting on provider panels.

5. Address the barriers to empanelment with the provider panels.

6. Work with the appropriate individuals or committees to effect policy change. The entity most likely to persuade an MCO to change its policy is a large employer that purchases health services through the MCO.

7. If policy does not change, follow up with the organization every 6 months, asking "What stands in the way of NPs getting on provider panels?"

**Conclusion: Why the Law on NPs Is So Complicated**

There are several explanations for the complicated and varied law on NPs:

1. The federal government frequently defers to state law regarding NPs. Some states' law on NPs was enacted in the 1970s. Other states' law on NPs is brand new. Each of the 50 states has its own brand of legislators, governor, lobbyists, medical associations, and nursing associations that influence legal language and process.

2. The wide array of patient needs, providers, and payers in today's healthcare industry makes for continually evolving delivery systems and practice arrangements. Providers find that their specific situation is not addressed in the rules and frequently call upon the government to issue new rules to address questions that arise. Rules proliferate.

3. Much of federal law, such as the law governing hospitals and nursing homes, was enacted when NPs were not as prevalent or well known as they are today. The word "physician" was used traditionally throughout the United States Code, as, until 40 years ago, no other professional performed medical services. So, to authorize NPs to perform some physician services, each section of the code and regulations has to be changed to broaden the language from "physician" to "physician and other authorized provider" or to "physician, nurse practitioner, clinical nurse specialist, and physician assistant." Such changes take time to draft, disseminate, and discuss and do not come about unless there is a proponent for change and unless the proponent is more persuasive than any opponents to change.