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LEGISLATIVE NEWS

# Coverage and Reimbursement Issues for Nurse Practitioners

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Despite 30 years of providing cost-effective quality health care, nurse practitioners (NPs) still seem to be fighting the same battles in 1997 that they were fighting in the late 1960s. However, instead of battling a health care monopoly that only wants to permit a narrowly defined group of health care professionals to deliver health care, today's NPs are fighting a payment system that only wants to recognize a narrowly defined group of health care professionals for the delivery of health care.

How ironic that at the very time NPs and others are busting up the health care delivery monopoly, the payment system seeks to reimpose barriers that will restrict the ability of NPs to fulfill their health care mission. Rather than advocating for a change in the system, which is a long-term goal, this article seeks to help you understand the system so you can make it work to your advantage. Changing this system will require hard work and perseverance. Just as you had to work hard to overcome the biases and prejudices of the health care bureaucracy, so too will you have to overcome the biases and prejudices of the insurance bureaucracy.

For most NPs understanding the language and nuances of third-party reimbursement is like learning a second language. But by knowing the basics, you will find yourself in a better position to understand how you can make sure that the services you provide are covered by the third-party payer.

The fact that NPs have a variety of different mechanisms under which they are legally authorized to perform medical acts (i.e., Nurse Practice Acts with expansive Scopes of Practices that allow independent practice, Prescriptive Authority laws, requirements for MD collaboration or MD supervision) creates some unique situations that cannot always be addressed in an article on reimbursement. Because most NPs are in practices with a legal relationship with a physician, either collaboration or supervision, this article describes circumstances relevant to those situations.

It must also be noted that although it is important for NPs to have a working knowledge of reimbursement policy, it is not necessary that you become the office expert. Your practice should already have someone who is the office expert on reimbursement.

Most third-party payers, whether a health maintenance organization, preferred provider organization, fee-for-service, Medicare, or Medicaid, will recognize NPs as qualified providers of health care. However, the reimbursement policies and coverage policies may differ substantially. Differences will not only exist between how individual health plans treat NPs, but you will also find significant differences between how you are permitted to practice under state law and the criteria the plan may impose as a precondition for payment.

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Currently hundreds of health insurance companies are operating in the United States. In addition, many of these individual companies offer many different plans. Finally, many businesses have opted to discontinue the purchase of insurance and have chosen instead to "self-insure." Typically, these self-insured plans will hire an insurance company to administer the plan. Thus, although you may submit a bill to the local Blue Cross/Blue Shield plan, the payment policy may be determined by the plan sponsor, not Blue Cross/Blue Shield.

The first half of this article outlines some common principles of reimbursement and suggestions for how NPs can maximize payments for services they provide with respect to the private insurance market. The second half provides clarification of current Medicare policies that are affecting pediatric nurse practitioners (PNPs).

### Private Insurance

It is important to understand that an insurance policy is a contract between two parties: the insurance company and the plan's purchaser, usually the employer (either an individual or company). This contract specifies the terms and conditions under which certain payments will be made on behalf of the insured. You, as an NP, are not a party to this agreement and are therefore not bound by the terms and conditions of the agreement. This is the first problem.

Typically, a patient has an insurance policy that has rather specific language regarding the circumstances under which payment will be made for health care services. For example, the following language is typical of many insurance contracts.

> All treatments, services, and supplies must be covered expenses. To be considered covered expenses, these treatments, services and supplies:
>
> - must be medically necessary
> - must be performed, prescribed, or recommended by a doctor
> - will be limited to the usual and customary charge
> - must be referred to in this booklet.

Nowhere in this statement do you see the term nurse practitioner. Therefore one might reasonably conclude that if an NP had provided a service to a patient under this plan, it would not be covered by the plan. Although this conclusion may be reasonable, it is also often wrong.

There are two terms here that are important: "medically necessary" and "doctor." Under this plan the term "doctor" has a very specific meaning that would not include an NP. However, the term "medically necessary" is defined as follows:

> Any services and supplies provided for the diagnosis and treatment of a specific illness, injury or condition must be:
>
> - ordered by a doctor
> - required for treatment or management of a medical symptom to the patient
> - provided in accordance with approved and generally accepted medical and surgical practice.

In response to an inquiry, the insurance company that wrote this policy stated that if a practitioner was in a jurisdiction in which the practitioner worked with physician supervision, the insurer would presume that the service was ordered by the physician. Therefore under their interpretation the practice could legitimately bill for the services of the NP and expect payment for those services.

Another plan had language similar to the previously mentioned language, except that instead of the term "doctor," this plan used the term "physician." Again, one might logically conclude that NPs were not covered by this plan because of the explicit use of the term "physician." Again, on closer examination you would find that this is not correct.

In this plan the term *physician* is defined as a practitioner of the healing arts duly licensed or certified by the proper authorities of the jurisdiction in which he practices to render services within the scope of such license or certificate

Operating under the assumption that "physician" meant exclusively a doctor of medicine or osteopathy, the NP would have assumed that NP services were not covered. This would have resulted in lost payments.

How can you avoid losing out on payments to which you may be legitimately entitled? First, your office reimbursement expert should become as knowledgeable about the specific wording of health plans as possible. Second, if the insurance policy language is confusing, call the insurer and inquire as to their policy. It is absolutely critical, however, that you ask the proper question.

An NP working with physician supervision is formally acting as the agent for that physician. Therefore any medical act performed by that NP is generally deemed to be authorized by the supervising physician and is therefore covered by most health plans. Some may recognize this policy as being similar to Medicare's policy. However, as we know, insurance companies, as happened with Medicare, may choose to define supervision or collaboration more narrowly than is permissible under state law.

Two key points can be learned from these examples:

1. *Be sure your office fully investigates the language in the insurance policy. What is meant by the terms "doctor" and "physician"? You*

*might be surprised to learn that the language is not limited to MD or DO.*

2. *Does the policy stipulate the services must be medically necessary as a condition for payment? How does the policy define medically necessary? Again, you might be surprised to learn that the definition of this term is much broader than you had expected.*

Most insured individuals have been told by their insurance company that their policy will pay for medically necessary doctor's office visits. So when the patient shows up at the pediatrician's office with an insured child suffering from an earache, the patient assumes that the visit will be paid for by the insurance company. After all, this is a doctor's office, and the visit was medically necessary.

To the extent you better understand the nuances of payment policy, the better you will be able to serve the needs of your patients.

### Medicare's "Incident-To" Policy: Hospitals and Private Practices

NAPNAP has received several phone calls recently from NPs asking about Medicare's policy for "incident to" services delivered in hospitals and physicians' private practices. Some of the inquiries are the direct result of the federal government's ongoing audit of Medicare billing for physician services at teaching hospitals. In other instances the calls are the result of incorrect information being disseminated by billing consultants. In either case it is extremely important for the NP/PNP to know the law and the facts.

### Teaching Hospitals

To date, a number of teaching hospitals have been notified they will be audited by the Department of Health and Human Services Office of Inspector General (IG) under its Physicians At Teaching Hospitals (PATH) initiative. The auditing occurring in the teaching institutions has forced many NPs working in both the inpatient and outpatient areas to examine and learn billing practices, policies, laws, rules, and regulations. At this point it appears that many hospitals and physician practices are trying to apply the Medicare rules and regulations to all billings including Medicaid and private third-party payers, even though they may not legally be required to do so.

Specifically, the IG is applying evaluation and management documentation guidelines that went into effect in August 1995. In addition, the IG is demanding that teaching physicians be physically present when a resident is performing a procedure for the teaching physician to bill Medicare under Part B. The new teaching physician rules requiring physical presence became effective July 1996. Before July 1996 the billing of teaching physicians was governed by Intermediary Letter 372, which many are arguing was vague, confusing, and interpreted differently by different Medicare carriers.

The American Association of Medical Colleges, on behalf of the teaching hospitals and the academic medical community, has prepared a briefing paper on the matter with the hopes of working with the Department of Health and Human Services and the IG's office to alter the audit protocols. Although the academic community does not question the appropriateness of the IG audits of physicians' medicare billings, it would like the IG's approach to be "a fair and cooperative effort by the government and the nation's teaching physicians." Specifically, the American Association of Medical Colleges recommends:

- a countersignature by the teaching physician should be adequate documentation that the physician provided appropriate patient care services
- the Health Care Financing Administration's current documentation guidelines for evaluation and management services should not be used retroactively as an audit tool
- examples of overcoding of services discovered in an audit should be offset by examples of undercoding
- double and triple damages and threats of criminal prosecution of individual physicians cannot be justified as punishment under the audits.

It is quite possible that NPs will see these standards applied to them, even though the specific objective is the resident/supervising physician relationship. NAPNAP has learned that some hospitals are using the Medicare "incident to" standards to bill for services provided by NPs. Hospital-employed PNPs are strongly encouraged to review the "incident to" guidelines outlined in the following text. You should pay particular attention to the employment requirements that must be followed for a service to be billed as "incident to."

### Private Practices and Teaching Hospitals

We have also learned that physician practice consultants are providing inaccurate information and advising physician group practices including pediatric practices to follow the Medicare billing guidelines.

More specifically, a consultant incorrectly advised a pediatric practice that:

- The pediatrician must be on-site with the PNP at all times
- The physician must see all patients and sign all charts
- Stated that the practice could not bill for anything more than Level I or II Evaluation and Manage-

ment services provided by a nurse practitioner

PNPs should know that there is **nothing** in Medicare or federal law that limits the Current Procedural Terminology codes that a PNP can use. Thus it is important to know Medicare's "incident-to" billing policy.

Medicare incident-to services are services provided by an NP in a physician's office under the direct supervision of a physician. The "incident-to" policy would apply only in those circumstances where Medicare does not directly recognize or reimburse for the services the NP (i.e., rural areas and nursing homes) provided to Medicare beneficiaries. The following is taken from the Medicare Carriers Manual, updated as of October 1996.

**Section 2050.2 Services of Nonphysician Personnel Furnished Incident to Physician's Services.** In addition to coverage being available for the services of such nonphysician personnel as nurses, technicians, and therapists when furnished incident to the professional services of a physician (as discussed in 2050.1), a physician may also have the services of certain nonphysician practitioners covered as services incident to a physician's professional services. These nonphysician practitioners, who are being licensed by the states under various programs to assist or act in the place of the physician, include, for example, certified nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, and clinical nurse specialists. (See Sections 2150 through 2160 for coverage instructions for various allied health/nonphysician practitioner's services.)

Services performed by these nonphysician practitioners incident to a physician's professional services include not only services ordinarily rendered by a physician's office staff person (e.g., medical services such as taking blood pressures and temperatures, giving injections, and changing dressings) but also services ordinarily performed by the physician himself or herself such as minor surgery, setting casts or simple fractures, reading x-rays, and other activities that involve evaluation or treatment of a patient's condition. Nonetheless, in order for services of a nonphysician practitioner to be covered as incident to the services of a physician, the services must meet all of the requirements for coverage specified in Section 2050 through 2050.1. For example, the services must be an integral, although incidental, part of the physician's personal professional services, and they must be performed under the physician's direct personal supervision.

A nonphysician practitioner such as a physician assistant or a nurse practitioner may be licensed under state law to perform a specific medical procedure and may be able to perform the procedure without physician supervision and have the service separately covered and paid for by Medicare as a physician assistant's or nurse practitioner's service. However, in order to have that same service covered as incident to the services of a physician, it must be performed under the direct personal supervision of the physician as an integral part of the physician's personal in-office service. As explained in Section 2050.1, this does not mean that each occasion of an incidental service performed by a nonphysician practitioner must always be the occasion of a service actually rendered by the physician. It does mean that there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the nonphysician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects his or her continuing active participation in and management of the course of treatment. In addition, the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.

In addition to the previously mentioned requirements, a key requirement for a service to be considered "incident to" is that the individual performing the service must be an employee of the physician. The Carrier Manual states:

C. Employment.—To be considered an employee for purposes of this section, the nonphysician performing an incident to service may be a part-time, full-time, or leased employee of the supervising physician, physician group practice, or of the legal entity that employs the physician (hereafter referred to collectively as the physician or other entity) who provides direct personal supervision (as described below). A leased employee is a nonphysician working under a written employee leasing agreement which provides that:

- The nonphysician, although employed by the leasing company, provides services as the leased employee of the physician or other entity; and
- The physician or other entity exercises control over all actions taken by the leased employee with regard to the rendering of medical services to the same extent as the physician or other entity would exercise such control if the leased

employee were directly employed by the physician or other entity.

In order to satisfy the employment requirement the nonphysician (either leased or directly employed) must be considered an employee of the supervising physician or other entity under the common law test of an employer/employee relationship . . . (pp. 2-20).

### What You Can Do

PNPs/NPs need to know the federal and state laws, rules, and regulations that define their scope of practice and prescriptive authority. Also, it is important to know Medicare and Medicaid payment policy and your state's laws pertaining to private insurance practices.

Although in general PNPs do not see Medicare patients (except for disabled children who are eligible for Medicare), this does not mean that a pediatric practice is not affected by Medicare's payment rules. PNPs are advised to work with their physician colleagues and billing administrators, insurance plans, and employers to advise them on what PNPs can do or how they can practice in their state so that they are aware of the laws, rules, and regulations.

Finally, NAPNAP is working with members of Congress to introduce and enact legislation that would provide for direct reimbursement to NPs in all outpatient locations and settings. Such legislation was expected to be introduced in the House and Senate by March 1997. In addition, the President included, as part of his Fiscal Year 1998 Budget recommendations, a similar proposal.

We are hopeful that enactment of this Medicare legislation will help to alleviate some of the current billing practice confusion. It should also allow NPs to practice more fully by eliminating some of the more arcane and Byzantine billing practices. Because PNPs often feel the ripple effect created by Medicare's payment policies, it is expected that direct reimbursement will help.

We urge all PNPs to write their Representatives and Senators and ask them to support the NP Medicare direct reimbursement legislation. Enactment of such a law would be a step in the right direction.

## REFERENCE

Health Care Finance Administration. (1996, October). Claims process. In *Medicare Carriers Manual, part 3.* (Transmittal #1553).