Billing Essentials for Using a PA or NP in Orthopaedics

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In last month’s AAOS Now roundtable, “Making the Most of PAs and NPs,” Thomas F. Murray Jr, MD; Gail S. Chorney, MD; Anthony V. Petrosini, MD, and Kemuel Carey, MHS, PA-C, ATC, shared valuable insights on how to effectively use physician assistants (PA) and nurse practitioners (NP). This article covers essential billing research steps for groups who are new to using these providers, collectively described as nonphysician providers (NPPs).

Scope of practice
State scope of practice guidelines provide a foundation for the services NPPs can perform, whether in the office, ambulatory surgery center (ASC), or hospital setting. Scope of practice guidelines are set at the state level by legislative process; PA rules are typically enforced by the state’s medical board, while NP scope of practice rules are enforced by the state’s board of nursing.

The guidelines also describe physician supervision requirements and prescribing practices. Although some progress has been made toward greater regulatory consistency across states, hiring entities should not assume that all state rules are the same. Similarly, the regulations for PAs do not always match those for NPs, even within the same state. The American Academy of Physician Assistants (www.aapa.org) offers a database of state regulations for PAs; it is accessible at no charge to members, or for a fee to nonmembers.

Medicare billing rules
Medicare’s written guidelines are often used as a reference point for billing services provided by NPPs. Essential reference tools are Chapter 15 of the Medicare Benefit Policy Manual and Chapter 12 of the Medicare Claims Processing Manual. Key terms related to NPP billing under Medicare’s guidelines include the following:

Direct billing—Medicare offers direct credentialing to PAs and NPs, meaning that services they perform can be billed in their own names; payments are assigned to the practice employer. When a PA or NP performs and reports a service using the direct method, the practice is paid 85 percent of the Medicare Physician Fee Schedule (MPFS) allowable amount. The direct billing method offers the greatest degree of flexibility, because the NPP is not restricted from seeing
new patients or new problems; the standard for billing is whether the service meets state scope of practice and physician presence/supervisory requirements.

Assisting at surgery is an example of care that would always be reported direct by the NPP. Medicare instructs providers to designate that a PA or NP was the assistant by using the modifier AS with the surgical CPT code.

**Incident-to billing**—Incident-to is a billing concept that applies to various types of medical staff, but in particular to PAs and NPs. Under incident-to billing guidelines, the patient encounter must meet specific criteria, including the following:

- The services are an integral, although incidental, part of the provider’s professional service.
- The services are of a type commonly furnished in providers’ offices or clinics. (Incident-to billing does not apply in an ASC or hospital setting.)
- There must be a set plan of care. This is defined as a provider-initiated course of treatment “of which the service being performed by the NPP is an incidental part, and there must be subsequent services by the physician of a frequency that reflect continuing active participation in and management of the course of treatment.”
- The supervising physician must be physically present within the office where the incident-to service is provided (direct supervision). For example, if a PA or NP saw a new Medicare patient independently, that service could not be reported incident-to even if a physician was present in the office, because the plan of care had not been previously set. Alternately, if the PA or NP saw an established patient with an established problem, but no physician was in the office at that time, the service could not be reported incident-to because the physician presence rule was not met.

The advantage of incident-to reporting is that the practice is paid at 100 percent of the MPFS. Incident-to services are reported in the name of the supervising physician, not in the name of the NPP. In a group practice setting, the onsite supervising physician may not be the same physician who set the plan of care. However, the name of the onsite supervising physician must be reported on the claim, not the name of the physician who set the plan of care.

**Split/Shared billing**—Another policy that affects NPP billing for Medicare patients is that of split/shared evaluation and management (E&M) services. In a split/shared E&M service, the NPP and the physician both see the patient, either separately or together, but neither performs the entire service. Although this approach may be efficient for the physician, practices must be cautious about how such work is documented and billed.

In the office setting, when the physician and NPP perform an encounter together but neither performs the entire visit, Medicare’s incident-to guidelines take precedence over split/shared reporting. If incident-to criteria are met, including the patient’s or problem’s established status (ie, established patient with an established problem in which the PA or NP is carrying out the physician’s pre-determined plan of care), the encounter may be billed in the name of the
physician. If incident-to criteria are not met (ie, new or established patient with a new problem), the visit must be reported in the name of the PA or NP and is subject to the decreased reimbursement associated with direct billing. If the physician wishes to report such a visit in his or her own name, he or she must perform and document all components of the E&M service independently, which results in repeat work.

When a hospital E&M service is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E&M encounter with the patient, the service may be billed under either the physician’s or the NPP’s national provider identification number.

For example, if a PA or NP sees the hospital patient alone, and the physician also sees the patient that day, when each provider documents the services performed, the work can be combined and reported by the physician. If only the PA or NP sees the hospital patient, billing must be a direct service in the NPP’s name.

**Other payer billing rules**

Although Medicare policies are often used as blanket policy standards by physician practices and hospitals, organizations should ideally apply Medicare policies only to Medicare patients, and research both state-specific Medicaid guidelines and payer specific rules to see how they compare to Medicare’s policies. Key questions include the following:

- Does the payer independently credential PAs and/or NPs?
- Does the payer adhere to Medicare’s incident-to guidelines?
- If no to either question, what billing rules does the payer require for PAs and NPs?
- Should the group use any special modifiers to designate NPP performance?

**Explain the rules**

As the service providers, the NPPs are in the best position to indicate how their services correspond with the Medicare and other payer billing rules, and how they should be reported. Commonly this can be indicated via a paper or electronic charge capture document.

Charge capture and coding specialists will also need training, so they can help to ensure that the providers’ documentation appropriately adheres to the NPP billing rules for all contracted payers.

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