

# Office of University Compliance



**SAINT LOUIS  
UNIVERSITY**  
— EST. 1818 —

Non-Physician Practitioner (NPP)

Nurse Practitioners and Physician Assistants

Saint Louis University Compliance Auditor: Mickey Coriell, CPC, CPMA 12/2018

# What is a Non-Physician Practitioner (NPP)

- ▶ Physician Assistant (PA)
- ▶ Advanced Practice Registered Nurse (APRN)
  - ▶ Nurse Practitioner (NP)
  - ▶ Clinical Nurse Specialist (CNS)
  - ▶ Nurse Midwives (CNM)
- ▶ Clinical Psychologists
- ▶ Clinical Social Workers
- ▶ Physical and Occupational Therapist
- ▶ Speech Pathologists
- ▶ Optometrist

# What is a Non-Physician Practitioner (NPP)

- ▶ Physician Assistant (PA)
- ▶ Advanced Practice Registered Nurse (APRN)
  - ▶ Advanced Nurse Practitioner (ANP)
  - ▶ Certified Nurse Midwife (CNM)
  - ▶ Clinical Nurse Specialist (CNS)
  - ▶ Pediatric Nurse Practitioner (PNP)
  - ▶ Family Nurse Practitioner (FNP)

APRN's and PA's are also identified as “other qualified healthcare professional” in the CPT manual for ability to provide and bill services.

# State of Missouri Requirements

Applicable Regardless of Payer

# Missouri Scope of Practice

NP and PA

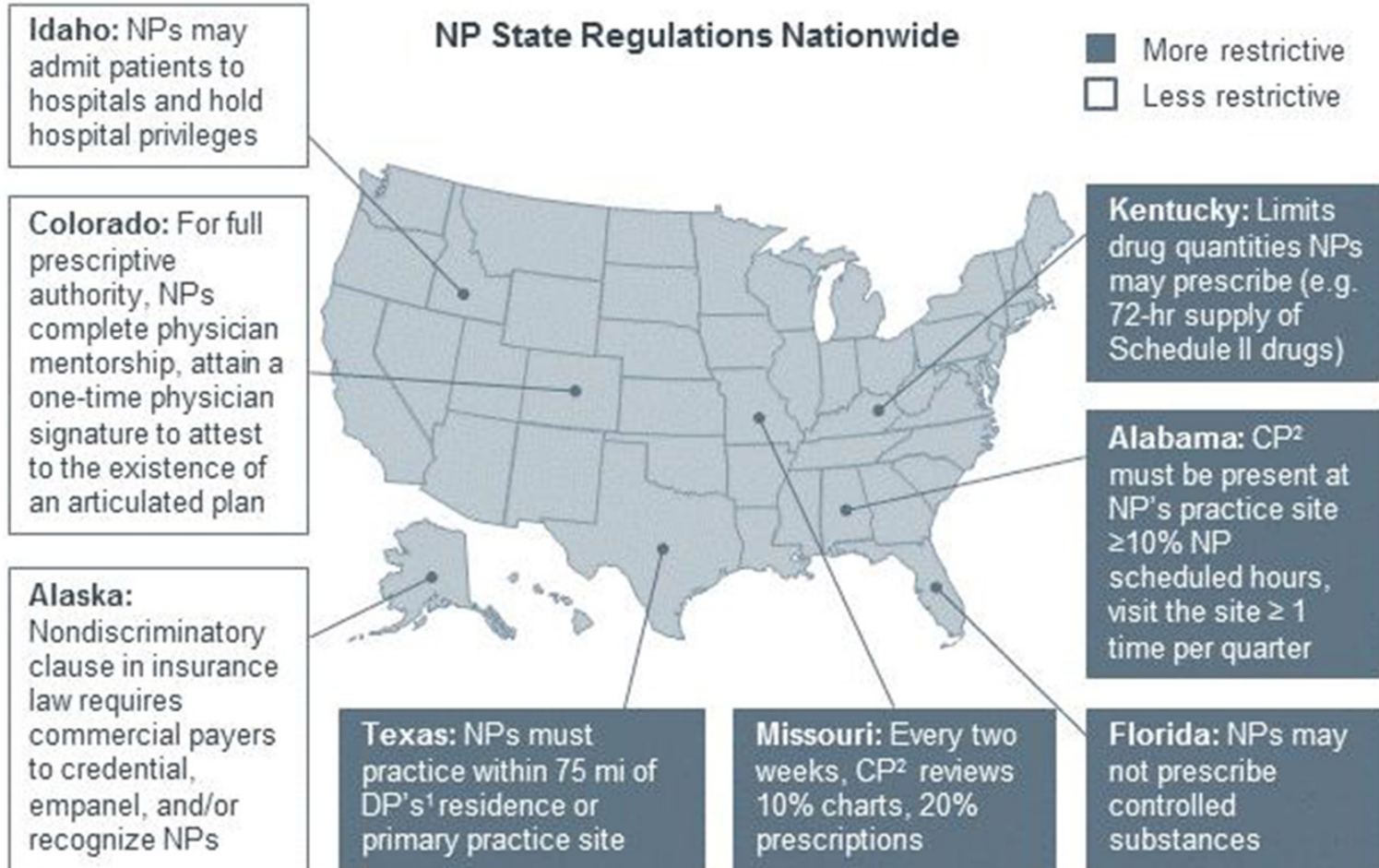
# According to MONA



MONA is currently working on removing the “scope-of-practice” barriers for Advanced Practice Nurses.

Nurses, and all NPP’s, should be able to practice to the full extent of their education and training.

# NP State Regulations Nationwide



1) Delegating physician  
2) Collaborating physician

# NP Supervision

- NP must work at the same site as the new collaborating physician for a period of 1 month, and the collaborating MD must be continually present.
- After the first month, the NP must practice within a 30 mile radius of the collaborating physician in a non-HPSA and within a 50 mile radius of the collaborating physician in a HPSA-designated area.



# NP Supervision

- The collaborating physician must be present onsite with the NP at least once every 2 weeks to “review the NP's services” and that process is not defined.
- The collaborating physician must sign at least 10% of the NP's charts overall, including at least 20% of charts in which the patient was prescribed controlled substances.
- Charts must be submitted to the MD for review at least once every 2 weeks.
- The collaborating MD must be available to the NP at all times (by phone.) If the collaborating MD is unavailable, a designated substitute must be named and available for consultation.

# NP Scope of Practice

- Any patient that does not have a “acute self-limited or well-defined condition” or is provided on-going care for other patient conditions must be seen and re-examined by an MD within 2 weeks of the NPP visit and this must be documented in the medical record.
  - Applicable to an NP that “diagnoses and initiates treatment for an acutely or chronically ill or injured patient.”)
    - No guidance on what is “acute well-defined” verse “acutely or chronically ill...”
    - If the NP identifies a new diagnosis for an established patient, the patient will need to be seen by the Collaborating Physician within two weeks.
    - The physician must evaluate and determine, or approve, the course of treatment for the “acutely or chronically ill...” patient that the NPP diagnosed and initiated treatment for.

# NP Scope of Practice

- NP has no restrictions on procedures or services they can perform as long as they have the skills, education and training, and are competent to perform services.
- NP are now allowed to sign death certificates IF the institution allows.
- Allowed to sign handicap parking permits.

# PA Supervision

- Appropriate supervision shall require the supervising physician to be working within the same facility as the physician assistant for at least four hours within one calendar day for every fourteen days during which the physician assistant provides patient care.

# PA Supervision

- The supervising physician must be immediately available in person, or via telecommunication, during the time the PA is providing care.
- No physician shall serve as supervising physician for more than 3 full-time equivalent licensed PA's. (Does not apply to PA agreements of hospital employees providing inpatient care service in hospitals.)

# Collaborative Agreement

- Written agreement required to be in place for all NP and PA services.

The regulatory definition of “collaboration” is defined at 42 CFR 410.75 (c):

Collaboration is a process in which a NPP works with one or more physicians to deliver health care services within the scope of the practitioner’s expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by the law of the State in which the services are performed.

# Collaborative Agreement - Functions

- Responsibilities/functions of NPP & physician:
  - Evaluation & Management
  - Prescribing (categories & conditions agreed upon)
  - Procedures (i.e., wound debridement, surgery, IVs, lacerations, EKG, GT replacement, etc.)
  - Diagnostics
  - Emergency Care
  - Referrals
  - Physician Back-up, Vacation Coverage



# Group Practice Agreement

- Can our group practice submit one protocol agreement that includes all the NPP's and all the physicians in our practice?
- No.
  - A collaborative agreement is a written document mutually agreed upon and signed by a collaborating physician and a NPP.
  - Each NPP in the practice must have his/her own protocol agreement with his/her collaborating physician that is submitted to the Medical Board.
  - The other physicians in the practice can be named as designated physicians in the agreement.



# Group Practice Agreement

- **Are there a maximum number of physicians that can be listed on a collaborative agreement?**
  - There can be only one (1) collaborating physician on an agreement. However, there is no limit to the number of designated physicians on an agreement. The number will depend on your particular practice and the physician availability for consultation.
- **Does the delegating physician have to work at the same physical practice location as the NPP?**
  - No. The delegating physician should be available for immediate consultation with the NPP, in person or by electronic means.

# Group Practice Agreement

- The collaborating physician, or any other physician designated in the collaborative practice arrangement as a designated physician, shall review the required percent of the group in accordance with Missouri laws.
- The collaborating physician (or other designated physician) must be immediately available for consultation. If the collaborating physician or designee is unavailable (vacation, on-leave, etc.) patient services cannot be provided by the NPP.

# Documentation Coding and Billing Your Services

# Billing Options For NPPs

- Shared/Split (S/S) SLUCare does not bill split/shared services. All services should be billed under the Nurse Practitioner or Non Physician Providers own NPI # in all places-of-service

# Billing Under Your NPI

- Does not require physician participation in the service
- Restricted only by state law
- Diagnostic Tests
  - May order PT, OT and ST studies
  - Certify and re-certify plans of treatment and perform consultations
- Assistant at Surgery (modifier AS)

# Billing Under Your NPI

Paid at 85% of the fee schedule

# SLUCare Billing

SLUCare no longer allows Incident-To billing or Split/Shared billing.

The SLUCare physician's compensation plan is heavily dependent on RVU's. They can not take credit for RVU's when the work for these RVU's is being done by another provider.

# General Documentation Principles

Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services (Centers for Medicare and Medicaid Services).

*“If it isn’t documented,  
it hasn’t been done”*



# General Documentation Principles

- The documentation of each patient encounter should include pertinent information:
  - Reason for the encounter (Chief Complaint) and relevant history, physical examination findings, and prior diagnostic test results;
  - Assessment, clinical impression, or diagnosis;
  - Medical plan of care; and
  - Date the service was provide, legible signature, and credentials

# General Documentation Principles

- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented;
- The diagnosis and treatment code reported on the health insurance claim form or billing statement should be supported by documentation in the medical record
- To maintain an accurate medical record, document services during the encounter or as soon as practicable after the encounter

# Consultation Services

- Outpatient (99241 – 99245)
- Inpatient (99251 – 99255)
- Services in which a clinician's advice or opinion regarding diagnosis and treatment or determination to accept transfer of care of a patient that is rendered at the request of another provider or appropriate source.
- A consultation requested by a patient or family member is not to be reported as a consultative service.
- A *referral for treatment* or “Transfer of Care” is not considered a consultation service and should be reported using the New/Established patient CPT codes.

# Consultation Services

## Documentation Requirements

- Request
  - Who requested the consult
  - Why is the consult necessary
- Render
  - History, exam, assessment and opinion/recommendations
- Respond
  - Written report of findings and opinion/recommendation is communicated back to the requesting practitioner
  - Shared medical record
    - Documentation of communication

# Medical Necessity

- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code
- It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.
- The volume of documentation should not be the primary influence upon which a specific level of service is billed
- Documentation should support the level of service reported

# Evaluation and Management (E&M) Key Components



1. History
2. Examination
3. Medical Decision Making



# Evaluation and Management (E&M)

## Key Components

- Chief Complaint is required for every face to face encounter
- Avoid – just using – “follow up” for your reason for the visit.
- Elaborate and explain for what they are following up.
- HPI: Information gathered from the patient and other sources about what is going on, how long, when it happens, modifying factors i.e. “ice pack help’s” etc.

# Review of Systems

- The ROS is an inventory of body systems obtained by asking a series of questions in order to identify signs and/or symptoms that the patient may be experiencing or has experienced.
  - Inquires about the system directly related to the problem(s) identified in the HPI plus all additional organ systems
    - Those systems with positive or pertinent negative responses must be individually documented.
    - For remaining systems, a notation indicating 10 point review of symptoms was completed pertinent positives are documented all other systems are negative is permissible.
    - In the absence of such a notation, at least ten systems must be individually documented.



# History

- CC, ROS, PFSH may be a part of the HPI paragraph and does not have to be a separate section.
- ROS PFSH does not have to be re-documented every time. We do need to know however, if any changes were made and what date you were referring to.
- EPIC has a history report that is looked at often.
- I have seen macros stating that PFSH has been reviewed and there are no changes, in order for that to be true every one of those should be filled out in EPIC and included upon review
- This information can also be recorded by office staff, or the patient on an intake form

# Examination

- May be documented as organ systems or body areas.
- Notation of “Normal” is acceptable
- Must elaborate on any “abnormal” findings

# Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:

- Number of Diagnoses or Treatment Options;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed;
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management option.

# Counseling and/or Coordination of Care

- When counseling and/or coordination of care dominates (more than 50 percent of) the physician/patient and/or family encounter (face-to-face time), time is considered the key or controlling factor to qualify for a particular E/M service
- Remember to document:
  - Total time of encounter visit
  - How much time was spent face-to-face
  - Details of the counseling and/or activities to coordinate care

# NPP are Not Teaching Physicians

Often times NPP's are tasked with teaching residents. This is fine but, NPP's NEVER attest to a residents notes OR use the residents documentation when deciding on the level of billing for their own note.

# Questions??

# Thank you



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—  
OFFICE OF UNIVERSITY COMPLIANCE

**Michelle "Mickey" Coriell, CPC, CPMA**

Physician Billing Auditor

Updated 12/05/2018

[Mickey.Coriell@health.slu.edu](mailto:Mickey.Coriell@health.slu.edu)

314-977-5886



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