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Health Care Regulatory Update

Exploring Compliance, Reimbursement and Physician Compensation Issues Tied to Nonphysician Practitioners and Shared Care

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Agenda

I. Introduction
II. Medicare Requirements and Expansion/Refinements
III. Compliance and Documentation Considerations
IV. Physician Compensation Considerations
V. Questions

I. Introduction

Advanced Practice Professionals

- Advanced Practice Professionals or Providers
  - Also known as Mid-Level Providers (MLPs), Non-Physician Practitioners (NPPs), or Advanced Practice Clinicians (APCs)
- For Medicare billing purposes, generally refers to nurse practitioners (NPs) and physician assistants (PAs) but can also refer to clinical nurse specialists, clinical nurse mid-wives, clinical psychologists, etc.

Advanced Practice Professionals

- Ability to leverage Primary Care and Specialty Care
  - Improve Patient Satisfaction
  - Increased Payor Coverage
  - BUT, may come with payment reductions
  - AND, comes with compliance concerns
- Must Satisfy Payor Requirement –
  - Medicare, Medicaid & Private Payors
- Must also satisfy state licensure and scope of practice
  - Does not include "special" certifications if not appropriately licensed or within scope of practice
  - Watchout for "scope creep"

II. Medicare Requirements
and
Expansion/Refinements

Medicare – APP Direct Billing

- Direct billing under name/NPI of the APP
  - NP & PA (effective 1/1/2022) can be paid directly
  - Requires enrollment in Medicare and, if applicable, reassignment to billing group (i.e., employer or contracted entity)
  - Payment is generally 85% of the physician fee schedule allowed amount
- Applies in hospital and clinic settings
  - Hospital's cost report implications of Part B professional fees for APPs
    - Similar concept as employed physicians
    - Salary or lease payment for APP is not a reimbursable cost for the hospital's cost report
- Services incident-to the services of an APP are covered in clinic setting
- APPs can supervise diagnostic services
- Consider other payor requirements and payments

Medicare: APP Services in Clinic – Incident to

- Incident-to Services
  - Billed under the supervising physician name/NPI
  - No payment reduction
  - Even if within APP's scope of practice, must satisfy Medicare's incident-to requirements which includes:
    - No new "services" or courses of treatment
    - Generally, requires direct supervision by the physician
  - Includes services ordinarily performed by the physician, such as minor procedures, setting casts or simple fractures, reading x-rays, and other activities that involve evaluation or treatment of a patient's condition
- Consider other payor requirements and payments

Medicare: Split/Shared Care In Hospital

- "Incident-to" billing for professional services does not apply in the hospital setting
  - Services would be considered part of the hospital's facility payment
- Split/Shared Care visit is allowed
  - E/M visit in the facility setting
  - Performed in part by both a physician and NPP who are in same "group"
  - E/M visit can be billed by either the physician or NPP

Medicare: Split/Shared Care In Hospital

- Practitioner who provides the substantive portion of the visit would bill for the visit –
  - Definition of Substantive Portion:
    - Before 2022 – Generally substantive portion (e.g. all or some of history, exam, or MDM)
    - CY 2022 – Either 1) history, exam, or MDM, OR 2) more than half of total time
    - Beginning 1/1/2023 – more than half of the total time spent performing the qualifying activities
  - No longer sub-regulatory, codified at 42 CFR § 415.140
  - Must report split/shared care with a modifier
  - Documentation must identify the two individuals who performed the visit
    - Individual who provided substantive portion must sign and date medical record
    - If NPP, paid 85% of PFS but if physician, 100% of PFS
- Includes new and established patients, initial and subsequent visits and prolonged services

Medicare: Split/Shared Care Critical Care Services

- NPP ability to provide critical care –
  - Before 1/1/2022, NPPs could not bill for split/shared visits for critical care services
  - Beginning 1/1/2022, NPPs can provide critical care services as part of split/shared care
- Billed by practitioner who provides more than ½ of the total time to bill for the visit
  - Separate list of qualifying activities
  - Must consider specific guidance regarding counting of minutes
- As long as specific requirements - CC visits can be billed & paid –
  - on same day as E/M visit
  - in addition to a procedure with a global surgical period

III. Compliance and
Documentation Considerations

Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2022 Definition of Substantive Portion	2023 Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/SNF	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

*Office visits are not billable as split (or shared) services.

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Split/Shared Documentation Requirements – Non-Critical Care

In the 2022 Final Rule, CMS clarified that substantive for 2022 would mean either one element (History, Exam, MDM) or time.

If time is to be the deciding element, the following elements 'whether or not they involve direct patient contact can count when time is used to select an E/M visit Level':

- Preparing to see the patient (for example, review of tests).
- Obtaining and/or reviewing separately obtained history.
- Performing a medically appropriate examination and/or evaluation.
- Counseling and educating the patient/family/caregiver.
- Ordering medications, tests, or procedures.
- Referring and communicating with other health care professionals (when not separately reported).
- Documenting clinical information in the electronic or other health record.
- Independently interpreting results (not separately reported) and communicating results to the patient/ family/caregiver.
- Care coordination (not separately reported).

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Split/Shared Documentation Requirements – Non-Critical Care

In the 2022 Final Rule, CMS clarified that substantive for 2022 would mean either one element (History, Exam, MDM) or time.

If time is to be the deciding element, the following elements would ***not*** count time spent on the following:

- The performance of other services that are reported separately.
- Travel.
- Teaching that is general and not limited to discussion that is required for the management of a specific patient.

Split/Shared Documentation Requirements – Non-Critical Care

CMS Clarified that 'when two or more individuals jointly meet with or discuss the patient, only the time of one individual can be counted.

- From a documentation audit standpoint, a coding compliance auditor would be looking for clear concise documentation from each provider (NPP/MD) as to the amount of time spent and the activities associated with that time. Additionally, if time is spent in collaboration between the NPP/MD, it would be best practice for that time to be stated separately as to not double count the time.

Split/Shared Documentation Requirements – Non-Critical Care

Face-to-Face Requirement:

CMS clarified in the final rule:

'Our final policy is that for ***all*** split (or shared) visits, one of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit. The substantive portion could be entirely with or without direct patient contact and will be determined by the proportion of total time, not whether the time involves direct or in-person patient contact.'

Split/Shared Documentation Requirements – Non-Critical Care

Documentation:

CMS clarified in the final rule:

‘that documentation in the medical record must identify the two individual practitioners who performed the visit. The individual who performed the substantive portion (and therefore, bills the visit) must sign and date the medical record.‘

- From a documentation standpoint, a coding compliance auditor would be looking for documentation from each practitioner providing the split visit to directly document and time their activities in the medical record for determining the billing provider.

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Split/Shared Documentation Requirements – Critical Care

For 2022, CMS stated that Critical Care visits could now be utilized as split/shared services between a NPP and Physician.

- When critical care services are furnished as a split/shared visit, the substantive portion is defined as more than half the cumulative total time in qualifying activities.

Split/Shared Documentation Requirements – Critical Care

Qualifying activities (from the prefatory language for critical care services in the CPT Codebook):

- ‘The time that can be reported as critical are is the time spent engaged in work directly related to the individual patient’s care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.’
- ‘Time spent on activities that occur outside of the unit or off the floor (eg, telephone calls whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the individual is not immediately available to the patient.’

Split/Shared Documentation Requirements – Critical Care

Qualifying activities (from the prefatory language for critical care services in the CPT Codebook):

The following services are included in critical care when performed during the critical period by the physician(s) providing critical care:

- the interpretation of cardiac output measurements (93561, 93562),
- chest X rays (71045, 71046),
- pulse oximetry (94760, 94761, 94762),
- blood gases, and collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data);
- gastric intubation (43752, 43753);
- temporary transcutaneous pacing (92953);
- ventilatory management (94002-94004, 94660, 94662);
- and vascular access procedures (36000, 36410, 36415, 36591, 36600)

Split/Shared Documentation Requirements – Critical Care

CMS Clarified that 'when two or more practitioners spend time jointly meeting with or discussing the patient, the time could be counted only once for purposes of reporting the split/shared critical care visit.'

- From a documentation audit standpoint, a coding compliance auditor would be looking for clear concise documentation from each provider (NPP/MD) as to the amount of time spent and the activities associated with that time. Additionally, if time is spent in collaboration between the NPP/MD, it would be best practice for that time to be stated separately as to not double count the time.

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Split/Shared Documentation Requirements – Critical Care

Time

CMS stated that a physician or NPP spending more than 74 minutes providing critical care service to a patient on a given date may report CPT code 99292 only when they have spent a whole additional 30-minute time increment (in other words, when 104 minutes have been spent), and may bill 99292 for each additional 30-minute time increment completed.

- This varies from CPT guidance and will possibly cause compliance issues in coding and billing of Critical Care services.

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Split/Shared Documentation Requirements – Critical Care

Face-to-Face:

CMS clarified in the final rule:

'Our final policy is that for all split (or shared) visits, one of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit. The substantive portion could be entirely with or without direct patient contact and will be determined by the proportion of total time, not whether the time involves direct or in-person patient contact.'

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Split/Shared Documentation Requirements – Critical Care

Documentation:

CMS clarified in the final rule:

‘To support coverage and payment determinations regarding concurrent care, we indicated that services would need to be sufficiently documented to allow a medical reviewer to determine the role each practitioner played in the patient’s care (that is, the condition or conditions for which the practitioner treated the patient). We stated that, in order to support coverage and payment determinations regarding split (or shared) critical care services, documentation requirements for all split (or shared) E/M visits would apply to critical care visits also.’

- From a documentation standpoint, a coding compliance auditor would be looking for documentation from each practitioner providing the split visit to directly document and time their activities in the medical record for determining the billing provider.

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Split/Shared Documentation Requirements – Modifier

Billing:

CMS clarified in the final rule:

‘for services furnished beginning in CY 2022, we will require a modifier to be reported on the claim to identify split (or shared) visits as such.’

- From a documentation standpoint, a coding compliance auditor would be looking for the FS modifier on the claim.

IV. Physician Compensation
Considerations

Stark's "Big 3" Requirements

Physician Compensation Must:

✓Be consistent with Fair Market Value;

✓Be Commercially Reasonable; and

✓Not "Take Into Account" the volume/value of a physician's referrals of designated health services ("DHS").

"Personally Performed" Under the Stark Employment Exception

411.357(c). Covers payments to a physician with a bona fide employment relationship if:

(1) The employment is for identifiable services.

(2) Remuneration under the employment is—

(i) Consistent with the fair market value of the services; and

(ii) Except as provided in paragraph (c)(4) of this section, is not determined in any manner that "takes into account" the volume or value of referrals [of DHS] by the referring physician.

(3) The arrangement is commercially reasonable.

(4) Paragraph (c)(2)(ii) of this section does not prohibit payment of remuneration in the form of a productivity bonus based on services performed personally by the physician.

(5) Directed referral provisions must satisfy additional requirements [*see* 411.354(d)(4)].

Can't "Take Into Account" Referrals of DHS

- **What services are considered Designated Health Services ("DHS")??**
- **CPT/HCPCS codes identified on the CMS Code List***
  - ✓ Clinical laboratory services
  - ✓ Physical therapy, occupational therapy, and outpatient speech-language pathology services
  - ✓ Radiology and certain other imaging services
  - ✓ Radiation therapy services and supplies
- **Other Categories of DHS**
  - ✓ Durable medical equipment and supplies
  - ✓ Parenteral and enteral nutrients, equipment, and supplies
  - ✓ Prosthetics, orthotics, and prosthetic devices and supplies
  - ✓ Home health services
  - ✓ Outpatient prescription drugs
  - ✓ Inpatient and outpatient hospital services

*Link to CMS Code List: https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral

Can't "Take Into Account" <u>Referrals</u> of DHS

- **What is a "referral" under Stark?**
  - The request by a physician for, or ordering of, or the certifying the need for any DHS.
  - Excludes any DHS <u>personally performed</u> by the referring physician.
  - A DHS is not personally performed by the referring physician if it is performed by any other person, including, but not limited to, the referring physician's employees, independent contractors, or group practice members.
- **CMS Guidance in the 1998 Proposed Rule.**
  - *We regard services as ''personally performed'' by a physician when he or she <u>participates directly in the delivery of the service</u>.*

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Productivity Bonuses for Supervision - Stark Phase II Commentary

Accordingly, physicians may be paid productivity bonuses based on personally performed services, including personally performed DHS.

Nothing in the [Employment] exception precludes a productivity bonus based solely on personally performed supervision of services that are not DHS, since that bonus would not take into account the volume or value of DHS referrals.

Productivity bonuses based on supervising DHS raise a different issue. We are concerned that, in some cases, a payment for supervision services may merely be a proxy payment for having generated the DHS being supervised.

In many cases, especially in hospitals, the supervision required under Medicare rules is minimal, and the supervisor need do nothing more than be present in the facility while conducting other work. Accordingly, we are concerned that such payments could mask improper cross-referral or circumvention schemes. We note that any payment for supervision services must meet the fair market value standard in the exception.

Stipends for Supervision - Stark Phase II Commentary

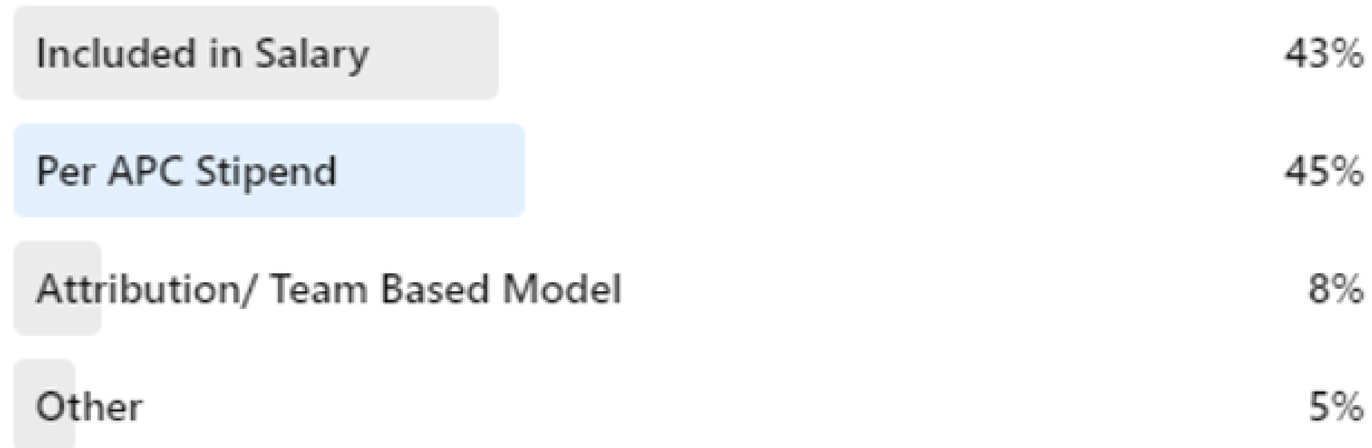
- *<u>Comment</u>: Two commenters asked whether the employment exception would be satisfied if an employer paid an employed physician a flat fee for each mid-level provider he or she supervises in order to compensate the physician for the time spent on supervision.*

- ***<u>Response</u>: We see nothing in the exception that would bar flat fee compensation based on the number of mid-level providers under the physician's supervision, as long as the compensation is FMV for actual time dedicated to supervision services and is not determined in any manner that takes into account, directly or indirectly, the volume or value of DHS referrals generated by the physician. The burden of proving the time will be on the DHS entity.***

Shared Care Physician Compensation Approaches

- **Straight-Forward Approach: Follow the Billing**
  - ✓ Determine production compensation “credit” based on the physician or APP the services were properly billed under.
  - ✓ Pay base compensation or per APP stipends for the performance of supervision services.
  - ✓ Develop care coordination metrics (*e.g.*, panel size, care protocols, directed referral requirements).
- **More Complex Approach: Develop an Allocation/Team-Based Model**
  - ✓ Allocation Model: Determine a percentage of production compensation “credit” based on participation in the service.
  - ✓ Team-Based Model: Attribute a portion of non-DHS productivity to incentive collaboration and care coordination.
  - ✓ More defensible under a Stark “group practice” or a model with <u>controls</u> that exclude any potential DHS from calculations.
- **Regulatory Considerations**
  - ✓ Must be in a position to argue the model does not include a physician’s referrals of DHS as a variable.
  - ✓ Compensation must be consistent with ***FMV*** and ***Commercially Reasonable.***
  - ✓ Auditing, monitoring and reconciliation processes are critical. More complex models should be audited periodically.

APP Supervision Trends – LinkedIn Poll



*This LinkedIn poll was posted on May 4, 2022 by Joe Wolfe and was live for one week. 40 health care organizations responded.

Other Compensation Considerations

- Watch for potential impact of shared/split changes on salary survey data.
- Consider potential reliance on the Stark "group practice" rules.
- Look for opportunities under the new Value-Based Enterprise ("VBE") rules.
  - ✓ Stark Meaningful Downside Risk (10%) Exception
  - ✓ Stark "No Risk" Exception (e.g., adherence to care protocols)
  - ✓ Anti-Kickback "No Risk" Safe Harbor (e.g., provision of care managers)
- Changes could result in increases (or decreases) in compensation and potential disruption to physician/APP collaborations.
- Specialty specific approaches may be needed - likely will impact some specialties more than others.
- Proactively assess potential options/scenarios based on actual modeling.

Potential Next Steps

- Educate key stakeholders (including, physicians, APPs, coders, legal, finance, operations) now.
- Enroll APPs in the Medicare and Medicaid programs, and credential with other payors
- Implement standards for compliance with new requirements & review standards for compliance with existing requirements.
- Review documentation of current APP billing, and split/shared and critical services for compliance with new regulations.
- Model out potential productivity and compensation impacts for physicians and APPs.
- Develop compensation-focused auditing, monitoring and reconciliation processes.

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V. Questions?

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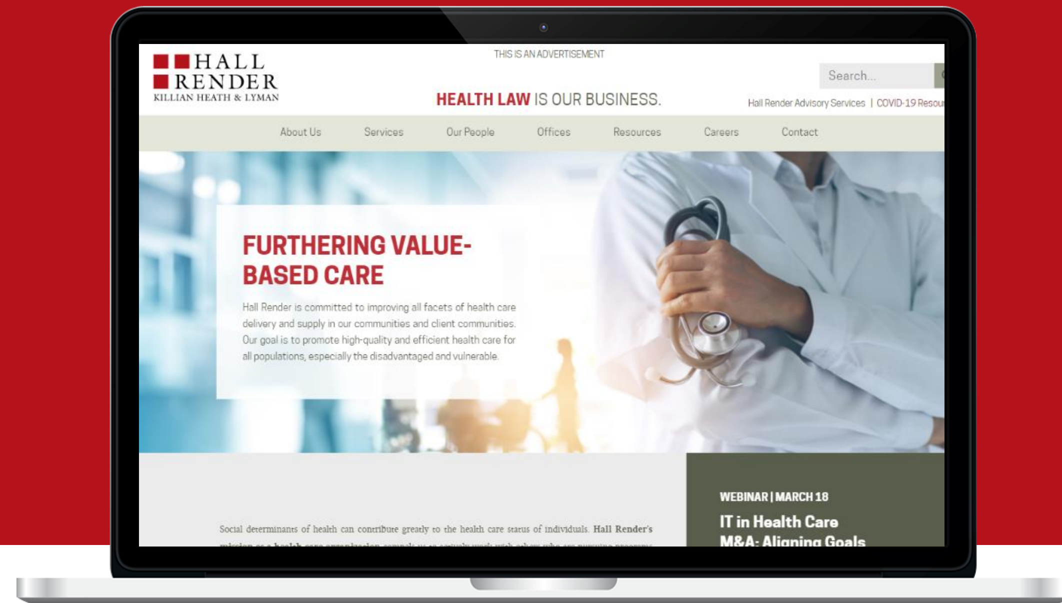

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