

Billing For Nurse Practitioner Services: Guidelines for NPs, Physicians, Employers, and Insurers

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Introduction

Medical practices, facilities, and agencies have found that nurse practitioner (NP)/physician teams are key to providing high-quality and cost-effective care.^[1,2] However, the problem of deciphering how federal and state law, often written in general terms, applies to a specific practice situation can deter groups from fully utilizing NPs. Furthermore, wide variances in states' laws and significant differences in the policies of third-party payers on reimbursement for NPs' services make the quest for payments a journey through a maze.

This article provides the basic rules for billing NP services, examples of the issues that arise, and answers to 10 of the most frequently asked questions.

What Benefits Does an NP Bring to a Medical Practice?

An NP can bring the following to a practice:

- Profit
- Respite for a sole practitioner
- Patient satisfaction
- High-quality care^[3]
- A choice for the patient

Revenue, Expenses, and Profit-Generation for an NP in a Family Practice

The NP as revenue generator. A full-time NP who gets 1 week off for continuing education, 2 weeks vacation, and has 2 weeks of holiday days will work 5 days a week, 47 weeks per year. A reasonable patient load for a full-time NP is 20 patients per day. According to 1999 figures from Medicare, the average payment for an NP visit was approximately \$40. (Though the average payment for all insurers may be higher than Medicare, these projections will rely on Medicare data.) Based on these projections, the annual revenues generated by this NP would be \$188,000.

NP as employee -- expenses to consider. NP salaries vary by geographic region. The NP national salary

average is approximately \$63,000. If full benefits at 25% of salary are offered, the personnel expense runs about \$78,750. If the additional overhead expenses of employing an NP are \$40,000 (additional space, furniture, assistants, supplies, telephone, continuing education, and so on), the full expense of employing an NP would be approximately \$118,750.

NP as a potential profit maker. In the example above, the practice's profit would be \$69,250. Profits could surpass that amount for the NP whose average reimbursement per visit was greater than \$40, or who attended to more than 20 patients per day.

NP Services: Reimbursement Basics -- The Payers

The categories of third-party payers who may reimburse for NP services are:

- Medicare
- Medicaid
- Commercial indemnity insurers
- Commercial managed care organizations (MCOs)/health maintenance organizations
- Businesses or schools wanting health services for employees or students

Each of these categories of payers and each of the commercial insurers has different rules on reimbursing NP services. The basics for each category of payer are described below.

Medicare Considerations

Medicare's rules for NPs. Medicare pays NPs under the following terms and conditions:

1. The NP meets Medicare qualification requirements;
2. The practice or facility accepts Medicare's payment, which is 85% of the physician fee schedule rate for bills submitted under an NP's provider number*;
3. The services performed are "physician services" or those for which a physician can bill Medicare^[4];
4. The services are performed in collaboration with a physician;
5. The services are within the NP's scope of practice as defined in state law; and
6. No facility or other provider charges or is paid with respect to the furnishing of the services.

Each of these rules or conditions is explained in greater detail below.

Medicare qualifications for NPs. To qualify as an NP eligible to become a Medicare provider, an individual must hold a state license as an NP and be certified as an NP by a recognized national certifying body. The recognized NP national certifying bodies are:

- [American Academy of Nurse Practitioners](#)
- [American Nurses Credentialing Center](#)
- [National Certification Corporation](#)
- [National Certification Board of Pediatric Nurse Practitioners and Nurses](#)
- [Oncology Nursing Certification Corporation](#)
- [Critical Care Certification Corporation](#)

Effective January 1, 2003, individuals applying for Medicare provider numbers as NPs must possess a master's degree from an NP program, as well as national certification and state licensure.

Medicare pays NPs 85% of physician rate. Medicare pays 80% of the patient's bill for physician services and the patient pays 20%. Medicare reimburses NPs at a rate of 85% of the physician fee, as stated in Medicare's Physicians Fee Schedule.[†] So, Medicare pays NPs 80% of the 85% of the Physicians Fee Schedule rate for a procedure.

For example, assume the Physicians Fee Schedule rate for a particular service is \$100. If a physician performs the service, Medicare pays the physician \$80; the patient pays the physician \$20. If an NP performs the service, Medicare pays the NP \$68; the patient pays the NP \$17.

* In general, Medicare requires that practices bill services under the provider number of the individual clinician performing the service. However, Medicare rules allow "incident-to" billing -- submitting bills under a physician's provider number for services provided by a supervised employee -- under certain circumstances. If billing an NP's services "incident to" a physician's service, practices may be reimbursed at 100% of the Physicians Fee Schedule rate. To submit bills under the "incident-to" provision, certain rules must be followed. See "Incident-to Billing: Billing an NP's Service Under a Physician's Provider Number," below.

† The US Department of Health and Human Services, Center for Medicare and Medicaid Services, publishes the Physicians Fee Schedule annually. It appears in the *Federal Register*, and Medicare providers can request copies from their local Medicare carrier.

Incident-to Billing

Incident-to Billing: Billing an NP's Service Under a Physician's Provider Number

If an NP and a physician work together to provide physician services, the services can be billed under the physician's provider number, to get the full physician fee, under the Medicare provision for "incident-to billing." However, certain rules must be followed when billing services under the incident-to provision. The rules are:

1. The services are an integral, although incidental, part of the physician's professional service.
2. The services are commonly rendered without charge or included in the physician's bill.
3. The services are of a type commonly furnished in physician's offices or clinics.
4. The services are furnished under the physician's direct personal supervision and are furnished by the physician or by an individual who is an employee or independent contractor of the physician. Direct supervision does not require the physician's presence in the same room but the physician must be present in the same office suite and immediately available.
5. The physician must perform "the initial service and subsequent services of a frequency which reflect his or her active participation in the management of the course of treatment."
6. The physician or other provider under whose name and number the bill is submitted must be the individual present in the office suite when the service is provided.

The incident-to rules are stated in the Medicare Carriers Manual (Part 3, Chapter II, section 2050), available online at

http://www.hcfa.gov/pubforms/14_car/3b2000.htm

Incident-to Billing -- Appropriate Use

A physician evaluates a patient, and diagnoses hypertension. The physician initiates treatment. The physician employs an NP. The NP conducts follow-up visits with the patient, monitoring and treating the hypertension over weeks, months, or years. The physician sees the patient every third visit, under a policy adopted by the practice. The NP's work may be billed under the physician's provider number, and the practice will receive 100% of the physician's fee schedule rate for the services performed by the NP.

Incident-to Billing -- Appropriate Use Unclear

If the scenario described above continued, but one day the hypertensive patient arrived for a follow-up visit with the NP

and announced a new complaint of sinusitis, for example, it is not clear that incident-to billing would be appropriate. There are differing interpretations among clinicians and auditors of the phrase "the physician must perform the initial service," found in the "incident-to" rules. Some clinicians may interpret this rule to mean that only the first visit to the practice must be conducted by the physician. Others interpret "perform the initial service" to mean that when there is a new problem, the NP must either bill under his or her own number or refer the patient back to the physician. The Centers for Medicare & Medicaid Services (CMS) has not defined "initial service." Neither has CMS clarified the phrase "subsequent services of a frequency which reflect [the physician's] active participation in the management of the course of treatment." "Active participation" may mean different things to different clinicians, auditors, and administrators. For example, active participation may mean chart review, or face-to-face visits, depending upon the reader's interpretation.

Incident-to Billing -- Illegal Use

A physician employs an NP to work in a satellite office. The physician is never present. Incident-to billing is inappropriate, as the requirements are not met. However, the NP's services may be billed under the NP's provider number, and Medicare will pay 85% of the physician rate for the services.

Billing an Assistant's Services Under an NP's Provider Number

A medical practice may bill the services of a non-NP incident to an NP's services (ie, bill an assistant's services under an NP's provider number), if the rules for incident-to billing are followed. For example, if an NP sees a patient and orders an electrocardiogram (EKG), and an office technician performs the test, the NP may bill for the EKG as if the NP had performed it, under the incident-to billing provision.

More Payer Considerations

Services for Which a Physician Can Bill Medicare

Medicare operates 2 programs, Medicare Part A and Medicare Part B. Part A covers hospitalization, skilled nursing facility services, and some home health services. Part B covers physician services, outpatient hospital services, laboratory procedures, medical equipment, and some home health expenses.

NPs may bill Medicare Part B for services which would be physician services if performed by a physician, but which are performed by an NP. Medicare defines physician services as diagnosis, therapy, surgery consultation, and care plan oversight. Specifically, physician services are those that can be described by a *Current Procedural Terminology (CPT)* code^[5] and an *International Classification of Diseases, 9th revision (ICD-9)* code.^[6]

A service that does not meet Medicare's definition of a "physician service" will not be reimbursed. For example, health services that are within the realm of nursing but are not "physician services" are not covered under Medicare Part B. Furthermore, Medicare does not reimburse for all physician services. For example, regular physical examinations, health maintenance screening, and counseling for well patients are assumed by the general public to be physician services, but these services are not within Medicare's definition of covered services. For a list of noncovered services, contact the local Medicare Carrier. Contact information is available online at <http://www.medicare.gov/Contacts/Home.asp>.

Medicare Requirement for Collaboration

Federal law defines "collaboration" as "a process in which a NP works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanism as defined by the law of the State in which the services are performed."^[7] States vary in their requirements for collaboration between physician and NP. Information on State Boards of Nursing is available online at http://www.ncsbn.org/public/regulation/nursing_practice_acts.htm.

In 8 states, there is no requirement that an NP have a formal agreement with a physician or other healthcare provider promising collaboration or supervision. For example, Oregon law states: "The nurse practitioner is responsible for recognizing limits of knowledge and experience, and for resolving situations beyond his/her NP expertise by consulting with or referring clients to other health care providers."^[8] However, most states require NPs to have a collaborative agreement with a physician. And, while Medicare generally defers to state law requirements, Federal law requires that an NP billing Medicare have a collaborative relationship with a physician. So, even in Oregon, an NP must establish a collaborative connection with a physician. For the law of each state on collaboration requirements, query the [state board of nursing](#).^[9]

NP Services as Defined by Medicare

Medicare defers to states' laws authorizing the scope of practice of NPs (ie, the types of services an NP may perform under state law). Each state defines the scope of practice for NPs in its nurse practice act. For scope of practice, contact the [state board of nursing](#).^[9]

For example, Oregon law states: "The NP is independently responsible and accountable for the continuous and comprehensive management of a broad range of health care, which may include:

- promotion and maintenance of health
- prevention of illness and disability

- assessment of clients, synthesis and analysis of data and application of nursing principles and therapeutic modalities
- management of health care during acute and chronic phases of illness
- admission of his/her clients to hospitals and long term care facilities and management of client care in these facilities
- counseling
- consultation and/or collaboration with other care providers and community resources
- referral to other health care providers and community resources
- management and coordination of care
- use of research skills
- diagnosis of health/illness status
- prescription and/or administration of therapeutic devices and measures including legend drugs and controlled substances...consistent with the definition of the practitioner's specialty category and scope of practice."^[8]

Some states' laws are more vague than Oregon's. For example, South Carolina law states: "The Nurse Practitioner, Clinical Nurse Specialist functioning in the extended role, or Certified Registered Nurse Anesthetist is subject, at all times, to the scope and standards or practice established by the nationally recognized credentialing organization representing the specialty area of practice, and must function within the scope of practice of the South Carolina Nurse Practice Act and shall not be in violation of the South Carolina Medical Practice Act. The scope and standards of practice for each specialty area of nursing practice shall be on file in the Board office and available upon request."

[10]

The variation and vague language in state laws led the federal agency responsible for prosecuting Medicare fraud to complain that "most scopes of practice contain only a general statement about the responsibilities, educational requirements and a non-specific list of allowed duties and do not explicitly identify services that are complex or beyond their scope. Carriers voice concerns over non-physician practitioners performing such services as surgery and endoscopies. Further, when a service is not addressed in a scope, it cannot be assumed that a non-physician practitioner cannot provide that services."^[11] Nevertheless, the CMS continues to defer to state laws on scope of practice. Any recent attempts by NPs or physicians to change or clarify [state scope of practice laws](#) ^[9] have resulted in costly and embarrassing turf battles.

Prohibition Against Dual Payments

Occasionally, services performed by a physician and services performed by an NP for the same patient on the same day may overlap. Medicare requires that a practice or facility billing Medicare for NP services ascertain that "no other

facility or provider has charged for the furnishing of services." Physician practices and NPs must coordinate billing to avoid seeking duplicate payments.

Practice employs physicians and NPs. Potential for overlap of physician and NP services occurs when a medical practice employs an NP to evaluate, manage, and provide consultations on hospitalized patients. A physician employed by the practice may evaluate the same hospitalized patient as the NP on the same day, and perform some of the same history, examination, and medical decision-making services. The practice may submit only 1 charge for those services. The practice may bill under either the physician's provider number or the NP's provider number. If the NP has performed more extensive services than the physician, it is appropriate to bill the services under the NP's provider number, under an appropriately high-level consultation code, knowing that the reimbursement will be at 85% of the physician rate. Alternatively, the practice may choose to bill the services under the physician's provider number under a lower-level consultation code, and get 100% of the rate published in the physician fee schedule. The choice is up to the practice, as long as the services are billed only once.

Hospital is reimbursed for NP's salary through Medicare, Part A. There is potential for billing NP services when a hospital employs an NP to provide a variety of medical services to inpatients. There also is potential for double billing. The hospital must make a choice about the method of seeking reimbursement from Medicare for the NP's services. If a hospital includes the NP's salary on the Medicare cost report (seeking payment under Medicare Part A) and if the hospital receives any reimbursement under that cost report, then the hospital may not bill the NP's services to Medicare under Medicare Part B (physician's services). On the other hand, if the NP's salary is not on the cost report, or the hospital receives no reimbursement from Medicare under the cost report, then the hospital may bill Medicare for the NP's services to patients as physician services under Medicare Part B, assuming no other provider has billed those services.

In the past several years, the Medicare payment system for hospitals has gradually changed from reimbursement for reasonable costs (as stated in annual cost reports) to prospective payment based on diagnostic related groups. As hospitals have diminished opportunity to recoup NP salaries under the cost reports, it becomes more important to bill NP services where possible under Part B.

Applying physician rules to billing NP services. The laws and guidelines applicable to physicians billing Medicare apply to NPs. Those rules include:

1. Services must be medically necessary;
2. Services must have been provided as billed, as supported by the medical record;
3. The clinician providing the service must have a Medicare provider number;

4. The entity seeking payment must submit an HCFA 1500 form (available online at <http://www.hcfa.gov/medicare/edi/edi5.htm#Form>) appropriately completed;
5. The entity seeking payment must accept Medicare's rates;
6. Providers may not provide kickbacks for referrals**;
7. Services must be billed under the provider number of the clinician performing the service; and
8. Medicare will pay only certain parties.

Reassignment: Medicare will pay only specified parties.

Medicare's rule on reassignment requires that Medicare pay only the NP, the NP's employer, a facility that has contracted with the NP, an organized healthcare delivery system if there is a contractual arrangement between the organization and the NP, a physician under a locum tenens arrangement, a government agency, or a billing service working under contract with an NP. A medical practice, which has an independent contractor relationship with an NP, may be paid under the provision for an organized healthcare delivery system.

[12]

Obtaining a provider number. NPs, like physicians, apply for Medicare provider status by filling out and submitting an application form. The form is available at <http://www.hcfa.gov/medicare/enrollment/forms/>. While awaiting action on the NP's provider application, the practice should hold bills until the provider number arrives, then fill in the number and submit.

**** It is illegal to solicit, pay, offer, or receive any remuneration, in cash or in kind, for the referral or to induce the referral of a patient, or for ordering, providing, recommending or arranging for the provision of any service payable by federal healthcare programs. The federal antikickback rules apply to nurse practitioners.**

More Billing Considerations: NP Services in Various Settings

Billing Home Visits Conducted by an NP

Because NPs are authorized by law to perform both nursing and physician services, it is important to keep the distinction clearly in mind when an NP provides a home visit. If an NP is performing a service billable to Medicare Part B as a physician service -- in general, a service described by a code found in *CPT*^[5] made necessary by a diagnosis described by an *ICD-9* code,^[6] to a patient who is homebound -- the NP does not need a physician's order to perform the visit, and could bill Medicare under the NP's provider number.

However, if an NP is providing nursing services -- billable under Medicare Part A -- the NP would need a physician's order for the home visit, the visit would need to be conducted through a home care agency enrolled as a Medicare provider, and the bill would be submitted by and paid to the agency under the prospective payment system.

Billing Nursing Home Visits Conducted by an NP

An NP may bill Medicare for physician services the NP performs in a nursing home with the following 4 provisos:

1. An NP may do the admission evaluation only if state law authorizes an NP to perform that function and only if a physician delegates that function to an NP. Otherwise, a physician must do the admission evaluation.
2. An NP may conduct all "required physician visits" (ie, a visit every 30 days for the first 90 days after admission, then once every 60 days) if the state authorizes NPs to do so, and if the NP is not employed by the nursing facility and if the NP is working in collaboration with a physician.
3. If the state does not authorize NPs to conduct all required physician visits, but a physician responsible for the visits delegates the visits to an NP, then an NP may alternate required visits with a supervising physician.
4. An NP may conduct and bill for visits to evaluate and manage illnesses, as medically necessary.

Billing hospital visits and procedures conducted by an NP

In recent years, hospitals and physician groups have been hiring NPs to take care of hospitalized patients, and programs that educate acute care NPs have proliferated. An NP may provide physician services to a hospitalized patient if the services are within the scope of practice of an NP under state law, or if a physician delegates to the NP the authority to perform the services. See the section, "NP Services as Defined by Medicare."

Generally, evaluation and management of acute and chronic illnesses are within an NP's scope of practice under state law. States may also authorize NPs to perform diagnostic and therapeutic procedures. Where state law is silent or unclear, an NP may perform procedures specifically delegated by a physician. For state law, contact the [state board of nursing](#).^[9]

NPs are not free to take over the care of hospitalized patients on their own, however, even in permissive states like Oregon. A physician must be involved in the process of care for hospitalized patients, because, under federal law governing hospitals, a hospital must require that "every patient be under the care of a physician."

The general conditions for billing Medicare for physician services performed by NPs in hospitals are:

1. The services must be billed under the NP's provider number. There is no opportunity for incident-to billing in the hospital setting.

2. If an NP is an employee of a hospital and the NP's salary is included in the hospital cost report, and if the hospital receives reimbursement from Medicare under the cost report, then the services of that NP may not be billed to Medicare under Part B.
3. If the services an NP is providing are part of a surgical or maternity package, reimbursed under a global fee, and if a surgeon or obstetrician has billed the global fee, then the NP's services may not be billed, as the surgeon or obstetrician already has billed those services. However, when a service is reimbursed under a global fee, there are mechanisms for transferring care and for separating the components of the global fee, which would allow an NP's services to be billed.

Reimbursement Under Medicare + Choice

The laws addressing Medicare + Choice (the Medicare managed care program) do not specifically address NPs. Reimbursement from Medicare to an MCO and from an MCO to a physician or physician group is made under the terms of contracts -- between Medicare and MCO and between MCO and physician group. Generally, an MCO reimburses only those providers admitted to the organization's provider panel. Some managed care plans admit NPs to provider panels; others do not. Some managed care plans will pay for services rendered by NPs if delegated by a physician who is on the provider panel; others will not. See the section on "Commercial MCOs' Coverage of NP Services," below.

The answers to the preceding questions may differ when the insurer is Medicaid, a commercial indemnity plan, a commercial managed care plan, or a private business.

Medicaid Rules on Billing NP Services

Medicaid rules do not mimic Medicare rules. The Medicaid program is administered by the states, and state regulations vary regarding the billing of NP services. For example, federal law mandates that states reimburse family NPs and pediatric NPs for services provided to patients covered by Medicaid, but does not mention adult NPs, geriatric NPs, or NPs with other specialties. States may elect to broaden federal law and reimburse adult NPs and geriatric NPs as well as pediatric and family NPs. Some states have elected to reimburse all types of NPs and other states reimburse only pediatric NPs and family NPs.

Medicaid reimbursement is further complicated by the fact that many Medicaid recipients are enrolled in managed care plans. Managed care plans' policies on reimbursement differ from the state and federal rules governing reimbursement when the patient is not enrolled in managed care.

Billing NP Services Under Medicaid Fee-for-Service

An NP who has a Medicaid provider number may bill Medicaid on a fee-for-service basis for physician services provided to a patient covered by Medicaid if the patient is not enrolled with a managed care plan. In most states, Medicaid pays NPs 100% of the physician's fee. In some states, Medicaid reimburses NPs at a reduced rate. For details of each state's policies, contact the state Medicaid agency. For a list of contacts by state, see <http://medicaid.aphsa.org/members.htm>.

NP Reimbursement and Medicaid Managed Care Plans

If a patient is enrolled with a Medicaid managed care plan, the plan's policies and contracts will determine who may be reimbursed for physician services. In general, managed care plans reimburse only those providers admitted to the plan's provider panel. Medicaid MCO policies on empanelment of NPs vary, and include:

- Admitting NPs to provider panels and
- Declining to admit NPs to provider panels but allowing NPs to provide services for patients on a physician's panel.

A practice wishing to have an NP admitted to a managed care provider panel must query each managed care plan regarding its policies.

Billing Commercial Indemnity Insurers for NP Services

Indemnity insurers reimburse healthcare providers on a fee-for-service basis. Each company has its own policy regarding reimbursement of NP-provided services. The policies vary, and include:

1. Payment at the same rate as physicians without requirement for admission to a provider panel,
2. Payment at a reduced rate,
3. Payment for NP-provided services when billed under a physician employer's name, and
4. Denial of payment for services provided by NPs.

Some states' laws require commercial indemnity insurers to reimburse NPs for physician services. Other states' laws are silent on the matter. Commercial insurers may adopt Medicare's rules and guidelines on billing NP services, or may adopt completely different policies. Each practice must query each insurer about the insurer's policies. Practice managers may find it useful to prepare grids that track the various insurers' policies.

Commercial MCOs' Coverage of NP Services

In general, MCOs reimburse only those providers admitted to the plans' provider panels. MCOs do not admit every

physician to provider panels and may or may not admit NPs to provider panels. Commercial MCO policies on empanelment of NPs vary, and include:

1. Admitting NPs to provider panels,
2. Declining to admit NPs to panels but allowing NPs to provide services for patients on a physician's panel, and
3. Declining to admit NPs to provider panels and permitting only those on provider panels to see patients.

Some MCO contracts allow a designated primary care provider (PCP) -- a provider admitted to an MCO's panel of providers -- to delegate to his or her employees the authority to provide services. Other contracts are silent on delegation. Some contracts may require that a designated PCP provide the patient services. If so, an MCO may consider it fraud for someone other than that PCP to provide physician services.

If an MCO will not credential a group's NPs, and if the contract between MCO and the practice is silent on the issue of PCP delegating the care of patients to an NP, and if the practice intends to offer care by NPs to an MCO's patients, then the practice should ask the MCO for written authorization, as part of the contract, for NPs to provide services and receive reimbursement.

Businesses Contracting With NPs or Practices Directly

A business wanting an NP to provide health services to employees may contract with a practice or NP under whatever financial terms satisfy both parties. State law requirements for NP practice would need to be fulfilled.

Frequently Asked Questions

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 and the physician has conducted the initial visit, which reflects his or her active participation in the management of the course of treatment).

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 finding 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](#).^[9]

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](#).^[9]

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: No. Incident-to billing is not allowed in a hospital. The services must be billed under the NP's provider number, assuming no other provider has billed the service and the NP's salary has not been reimbursed by Medicare under the hospital's cost report.

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 filing a form (see <http://www.hcfa.gov/medicare/enrollment/forms/>).

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 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.

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 visit 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 surgeon's 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 NP's services?

Answer: The reassignment rules have implications on billing services provided in a setting where NPs and physicians practice together but have different employers. Example: an NP is employed by a hospital, and performs preoperative evaluations, postoperative visits, and discharge services for surgeons' patients. The NP spends 1 afternoon a week in a surgeon's office, seeing patients the NP had followed in the hospital, for the postoperative office visit. The surgeon is incorporated, and is an employee of his or her own corporation. The hospital's goal in hiring the NP is to improve the efficiency of admissions and discharges. The hospital is no longer getting any reimbursement from Medicare under its cost report, and the hospital wishes to bill the NP's services to Medicare under Part B as physician services.

The Medicare billing issues are as follows:

- Who can bill for the NP's preoperative evaluations, postoperative visits, and admission and discharge services to the surgeon's patients?
- Who can bill for the NP's visits conducted in the surgeon's office?

The basic principles are as follows:

1. An NP's services in a hospital must be billed under the NP's own number.
2. Only 1 bill may be submitted for any given service to any given patient on any given day.
3. Services must be billed under the provider number of the provider performing the service, unless billing incident to is appropriate and the rules are followed.
4. 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.
5. Under the reassignment rules, Medicare will pay only the NP, or the NP's employer, or the facility in which services are rendered if there is a contractual relationship between NP and facility.

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

1. If this 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. Furthermore, incident-to billing is not allowed in the hospital setting, so the NP's services would be correctly billed under the NP's own provider number. Because the surgeon does not employ the NP, payments for services submitted under the NP's provider number must be made to either the NP or the NP's employer -- the hospital.
2. If the surgeon is billing the NP's visits to patients in his office under his own number, presumably under the incident-to rules, the payments for the NP's work have to go to the NP's employer, under the reassignment rules.
3. Finally, if the surgeon is billing and receiving payment for work done by the NP, 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.

A series of contracts between surgeon, hospital, and NP could correct the legal problems inherent in this example, and enable the hospital 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 make 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 30 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.

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