Promoting Team-Based Care with Non-Physician Providers (NPPs)

Nick Ulmer, MD CPC FAAFP

Objectives

- Define who NPPs are in primary Care
- Understand the basic training and regulatory oversight needed with NPPs
- Define a clinical workflow to optimize quality, access, revenue and decrease burnout

Who are these Non-physician Practitioners (NPPs)

- A naming convention for non-physician, direct care providers in clinical practice – someone who has evaluation and management in their scope
  - Physician Assistants (PA)
  - Advanced Practice Registered Nurses (APRNs)
    - Nurse Practitioners (NPs)
    - Certified Registered Nurse Anesthetists (CRNAs)
    - Certified Nurse Midwives (CNMs)
    - Clinical Nurse Specialists (CNSs)
- Called Non-physician Practitioners (NPPs) by CMS and in 2021, the AMA added "qualified healthcare professionals" (QHPs)
- Also …. Advanced Practitioners (APs), Advanced Practice Professionals (APPs), etc. No set nomenclature standard.

Who are these Advanced Practice Providers (APPs)

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The market is changing

- The US Bureau of Labor Statistics (BLS) expects physician employment to grow 3% from 2020 → 2030
  - NPs to grow by 45% and PAs to grow by 31% - faster than others in market

https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm
https://www.bls.gov/ooh/healthcare/physician-assistants.htm
https://www.bls.gov/ooh/healthcare/physician.htm

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- NP and PA groups expanding scope, searching for recognition
  - NPs now have full independent practice authority in 27 states[2]
  - The American Academy of Physician Assistants had a name change to Physician *Associates*
  - PAs now can bill independently per CMS since the 2022 Medicare Physician Fee Schedule and final rule
- We need to recognize these providers and how to work with them

[1] *PartBNews*, 12/20/2021, p3
[2] In What States Can Nurse Practitioners Practice Independently? (Accessed 01.10.24) https://www.bartonassociates.com/blog/best-states-for-nurse-practitioner-nps/

Medicare Clinical Standard

- Same standard as physicians
  - NPPs must be enrolled in the Medicare Program and be a Provider
    - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Become-a-Medicare-Provider-or-Supplier
    - Medicare Learning Network booklet, *Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants* (ICN MLN901623 April 2020)
  - Care must be reasonable and found to be medically necessary for Medicare to pay for service
  - Services must meet requirements defined by National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
    - LCD[1]: Decision made by a local carrier (Medicare Administrative Contractor, MAC) as to whether a service can be reimbursed. Based on medical necessity. Applies only to the local area.
    - NCD[2]: When CMS makes a decision in response to a direct request. This usually trumps the LCD.
  - The service must be clearly documented in the medical record and stand up to scrutiny upon medical review by an unaffiliated provider

[1]Section 1869(f)(2)(B) of the Social Security Act
[2]https://www.cms.gov/Medicare/Coverage/DeterminationProcess

Physician Services

- Standard of clinical care
  - Services performed by a physician to occur based on the clinical training of his/her specialty of medical practice
    - Patient diagnosis and treatment plans to address clinical conditions
    - Therapy service direction and oversight
    - Surgery procedure decision and performance
    - Consultative service delivery to assess a condition and recommend a plan of care to follow to address the condition at hand
    - Care plan oversight
  - Work in collaboration with other qualified healthcare providers (NPPs)

Non-physician Practitioner Services

- Before you hire
  - Query the insurance carriers you subscribe to for information re:
    - Do you recognize NPPs?
    - Can they be selected as a primary care provider?
    - Do you use PCP provider number or the NPP number with billing?
    - If the PCP affiliated with the NPP is not present today, do you bill under the supervising PCP or the provider that usually supervises the NPP?
    - What level of supervision do you require? Chart audits? Co-sign notes?
    - What is your reimbursement rate for NPPs? (CMS is 85% of the physician rate)
    - Are there documentation requirements for incident-to oversight? ….shared services processes?
    - Are there visit requirements for PCPs with NPP patients?

The Non-Physician Practitioners (NPPs)

- As primary care specialists, we will be working with NPPs in global care delivery
  - Physician Assistants (PA)
  - Advanced Practice Registered Nurses (APRNs)
    - Nurse Practitioners (NPs)
- Both are bound by licensure of the state they work in FIRST
- THEN, they are bound by the employed entity's rules, regulations, and standards which are then applied to the scope of practice for the individual
- And ALL OF THAT must be done under the supervision of a physician … ***unless*** independent practice status has been granted by the state medical governing and credentialling body
  - NPP may feel competent to perform joint injections, may have done 200 in training and may have passed the certification exam, but only if the supervising physician is OK with such – written document in place to outline scope. Updated. Signed by supervising (and other) physician

Who are these Non-Physician Practitioners (NPPs)

- The Physician Assistant (PA)
  - The profession is under the guidance of the Board of Medical Examiners (like physicians)
  - Students enter training with 4-year undergraduate degree with coursework in basic and behavioral sciences
  - Most schools require prior health experience with hands-on patient care, so most applicants have a clinical background (EMT, RN/LPN, CMA, therapists, etc.) with varied amounts of experience pre-admission (up to 3000 hours required for some programs)
  - Programs last 2+ years, certification exam required – acceptance rate most challenging of MD and NPP
  - A PA is an agent of supervising physician (not independent) in the performance of all practice-related activities, including, but not limited to, the ordering of diagnostic, therapeutic, and other medical services.
  - Scope Of Practice document outlines PA duties is submitted to BME and they approve

Who are these The Non-Physician Practitioners (NPPs)

- Nurse Practitioner (NP)
  - The profession is under the guidance of the State Board of Nursing, unlike physicians, under the state Nurse Practice Act
  - Registered Nurse with additional education (2+ yr) resulting in a Master's Degree in Nursing (MSN). The most common type of Advanced Practice RN (APRN) is the 2-year Masters level Nurse Practitioner. There is growing interest in the 1-2 year added training for the Doctor of Nursing Practice (DNP) but this is not globally mandated.
  - Since RN is a pre-requisite, clinical experience is based on the type/years of practice
  - If NP is not independent, must have a Scope of Practice (SOP) agreement with a licensed physician – get state by state guidance
  - SOP must be updated yearly and when there is a change of venue or scope. No "audit" oversight requirement

https://www.scstatehouse.gov/code/t40c033.php

NPP Compliance: Oversight

- To each state and provider his own…
  - Check with your state NP and PA boards and get guidance. Get updates. Fluid.
    - Is there a certain mile radius? Is it within the state? By phone anywhere….?
    - How many NPPs can a physician supervise? How about the alternate physician…?
    - Are there options for waivers due to hardship?
    - Is there a Practice Agreement/Scope of Practice that needs annual (any) update or review
    - If audited, what documentation needs to be readily available for review?
  - Have your NP/PA keep you up to date as well (with documentation to support)

Physician Services: "Incident to" Care

"Incident to" care

- Services furnished as an integral, though incidental, part of the personal professional service by the physician in a non-facility setting. Done under direct (on site) supervision
- Bill for services provided by NPP as though the physician performed service
  - Private payers may have differing rules
- Part of normal course of treatment when the physician/practitioner has personally performed an initial service and remains actively involved in course of treatment – f/u care
  - New problems, New patient workflow decision needed (or no 100%)
- The provider who is directly supervising the service is who bills for the incident to care visit
- Medicare reimburses the provider 100% MPFS for "incident to" care, 85% for NPP-delivered care (non incident to).

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What is supervising?

- Direct Supervision
  - Physician must be present in the office suite and immediately available and able to provide assistance and direction throughout the time the service is performed.
    - “Yell” (per NU)
    - Not in the same room
  - Physician must have subsequent services of a frequency that reflects his or her continuing active participation in and management of the course of treatment (treatment that he/she initiated).
    - No set mandate. “every other”…..AWV/CPX…..but some participation is needed ongoing
  - Documentation to support

Documentation and Incident To

- The progress note must substantiate the service performed and be signed by the person performing it.
- When the physician is involved with a particular service, his or her contribution to the care must be documented. This will assist in substantiating his or her continued involvement in the patient's care.
- The extent of physician involvement should reflect the patient's condition, increasing with instability and uncertainly of the situation.
- All documentation should support the level of care provided.
  - If site of service is office setting (POS 11), then E/M guidelines are to be followed

Documentation To Set Up "Incident to" Process

- The Plan of Care
  - Need to clearly define the disease(s) that are being managed with a patient. Having a plan of care on ALL of the conditions will allow the NPP use this as a "roadmap" or treatment care plan. Do so at EACH encounter to show the medical necessity for your involvement in the patient's care
  - Not "incident to" new probs or diagnostic tests performed separate from physician involvement (FTF)
- Consider:
  - Listing the diagnoses and assess stability. Set a goal, Give direction.
    - HTN: Start Lisinopril 10mg qhs. Dietary measures and focus on lifestyle modifications and weight mgmt. Goal to get BMI below 30 in 3 months. F/U with NPP in 3 wks. Check Chem7 then. Titrate up Lisinopril with HCTZ next visit if needed. Goal < 140/90. See me 2 weeks thereafter.

The "Incident To" Clinical Scenario

- The Plan of Care is pre-set, so condition(s) have been seen by the physician already. Care in outpatient private office (POS 11).
- So:
  - New patient visits can NEVER be incident to (all new problems)
  - Cannot be furnished in a hospital setting (ED, hospital inpatient or outpatient departments, nursing facility, home visit)
  - Cannot be used in established patients on new problems and physician not intimately involved with plan of care (no signature, FTF). Protocol?
  - With these situations, use NPP NPI to bill (and get the 85% rate)

Document the Clinical Scenario

- Identify that the service is medically necessary, that the physician is supervising, available, and any clinical interaction that is provided
- Record needs to support interaction
- Best Practice (per me) for "Incident to":
  - NPP documents that "Dr. Ulmer on-site and available today".
  - Physician provides co-signature of all "Incident to" encounters
    - "I have reviewed and agree with management plan" is an OK attestation
- If this is my NPP and I am off, my partner (if on record as a supervising physician) can serve as being available – Incident To is still OK to bill (100%)
- Can other staff use "incident to"?

Document the Clinical Scenario – Non-provider Staff

- Staff under your direct supervision can perform services on your behalf and bill for medically appropriate services under your name/number, but only 99211 is allowed
  - PharmD, MSW, LPN, etc.
- Non-providers cannot bill Medicare, so the only option would be to bill "99211"

EXAMPLE:

66-year-old with HTN comes in for reck. BP at home 144/99 (confirmed x 2 at pharmacy) and in office today is 155/92. Increase ACEI. F/U 2 wks with nurse, bring in BPs from home. Check BMET that day. F/U PCP 4wks.

F/U 2 wks later for **<u>nurse/lab visit</u>**: BP 139/88 and #s at home much better. BMET drawn. F/U Ulmer in 2wks. No change med. No FTF visit on follow-up, but patient is scheduled to see PCP in 2wks..

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99211 *would be the charge for that encounter, plus charge for lab appointment.*

Split/Shared Services

- A split/shared E/M visit is defined by Medicare Part B payment policy *as a medically necessary encounter with a patient where the physician and a qualified NPP of the same group each personally perform portions of an E&M visit on the same patient and on the same date of service.*
- The billing goes to who documents/performs the Medical Decision Making or >50% of the total time of the encounter
- A split/shared service: NOT allowed in office (POS - 11), but is
  - Hospital Inpatient (POS 21), Hospital Outpatient (POS 19, 22), ED (POS 23)
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf
  - When critical care services can be shared and in nursing homes (as of 01/2022)

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  - When critical care services can be shared and in nursing homes (as of 01/2022)
- Add – **FS Modifier** to claim with Split/Shared billing performed

Total Time Calculation

- Total time for the day of service that is tied to the patient's care delivery ("qualifying time")

1) Preparing to see the patient (review labs, notes, etc.)
2) Obtaining/reviewing separate history
3) Performing the exam
4) Counseling and education of the patient, family, caregiver
5) Order tests, medications, procedures
6) Referral/communication with a provider
7) Documentation of the note
8) Time to do independent interpretation of tests and relay info
9) Time spent in care coordination

Split/Shared Services Documentation

I saw the patient independently with the PA and agree with his note and findings. OK with advancing diet and the radiographic studies ordered. Electrolytes have normalized.

- For dates before 01-01-2022: PERFECT for split/shared

Split/Shared Services Documentation 2024

I saw the patient independently with the PA and agree with his note and findings. OK with advancing diet and the radiographic studies ordered. Electrolytes have normalized.

- For dates before 01-01-2022: PERFECT for split/shared
- For after **01.2024**….document the MDM and bill based on that and assign to whom performed such OR bill based on time (and whomever does >50% bills the time that is additive of each provider for that date of service)
- **- FS Modifier** gets added

NPP Shared Service: Critical Care

- Not allowed pre-2022
- 2024: Document the time each provider (physician and NPP) and bill using the NPI of the provide that spends >50% of the time in critical care
  - Additive for the date of service (24h period)
  - Same group membership
  - Still cannot share procedures or critical care.

NPP Shared Service: Nursing Facility (NF)

- "Incident to" is not allowed in a NF (only in POS 11, physician's office)
- Shared Services are allowed but **not** for visits that are mandated to be done by a physician
  - Initial visit to the skilled services of a NF must be by the physician
    - NPP not employed by the nursing facility may do the initial intake – NOT skilled
  - For skilled care, every other visit (alternating) also required to be a physician
- 2024: Same Split/Shared rules
  - Time (if used) is additive for the date of service (24h period). >50% gets bill

COVID PHE NPP Exception

- Use of real-time audio and video telecommunications technology to allow the supervising provider to observe the patient interaction and provide interaction without physically being present
- NPPs can also oversee diagnostic tests with virtual access to the provider (audio-only or text would qualify)

COVID PHE NPP Exception

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- NPPs can also oversee diagnostic tests with virtual access to the provider (audio-only or text would qualify)
- Even though the Pandemic Waivers were halted 05/2023, they were extended through 2024, so expect more changes with this in January 2025.

Final Thoughts: Physician-NPP Team

- Much broader than your clinical team (front desk, MA, tech, you)
  - High/rising risk in tandem with physician makes the most sense
    - More "high quality touches": the data is thin, but what you will find is more means better clinical control, better patient satisfaction, less clinical team wear/tear (Oak Street, ChenMed, Iona,
    - Hospitalized (look for TCM), CCM-type report, ED f/u (report from hospital), specific disease states (CV, DM, depression, etc.)
    - Most of these will be level 4 types (2 chronic problems with meds) that you would set up in a prior visit. State in note the expectations (A1c goal of 7, adjust semaglutide if not at goal or no weight loss, LDL goal of 75…)
- BUT….That assumes they *know how to code*….

Final Thoughts: Physician-NPP Team

- Much the same w NPPs regarding documentation, coding, billing
- Overcoding (AND undercoding) are prosecutable forms of fraud – and if the NPPs work for you, you commit fraud when they are not compliant. ("the doctor never onboarded me with coding/billing knowledge….")
  - Provide access to education for coding/billing onboarding
    - ACDIS, AAPC, AHIMA, AAFP, CodingIntel, E&M University

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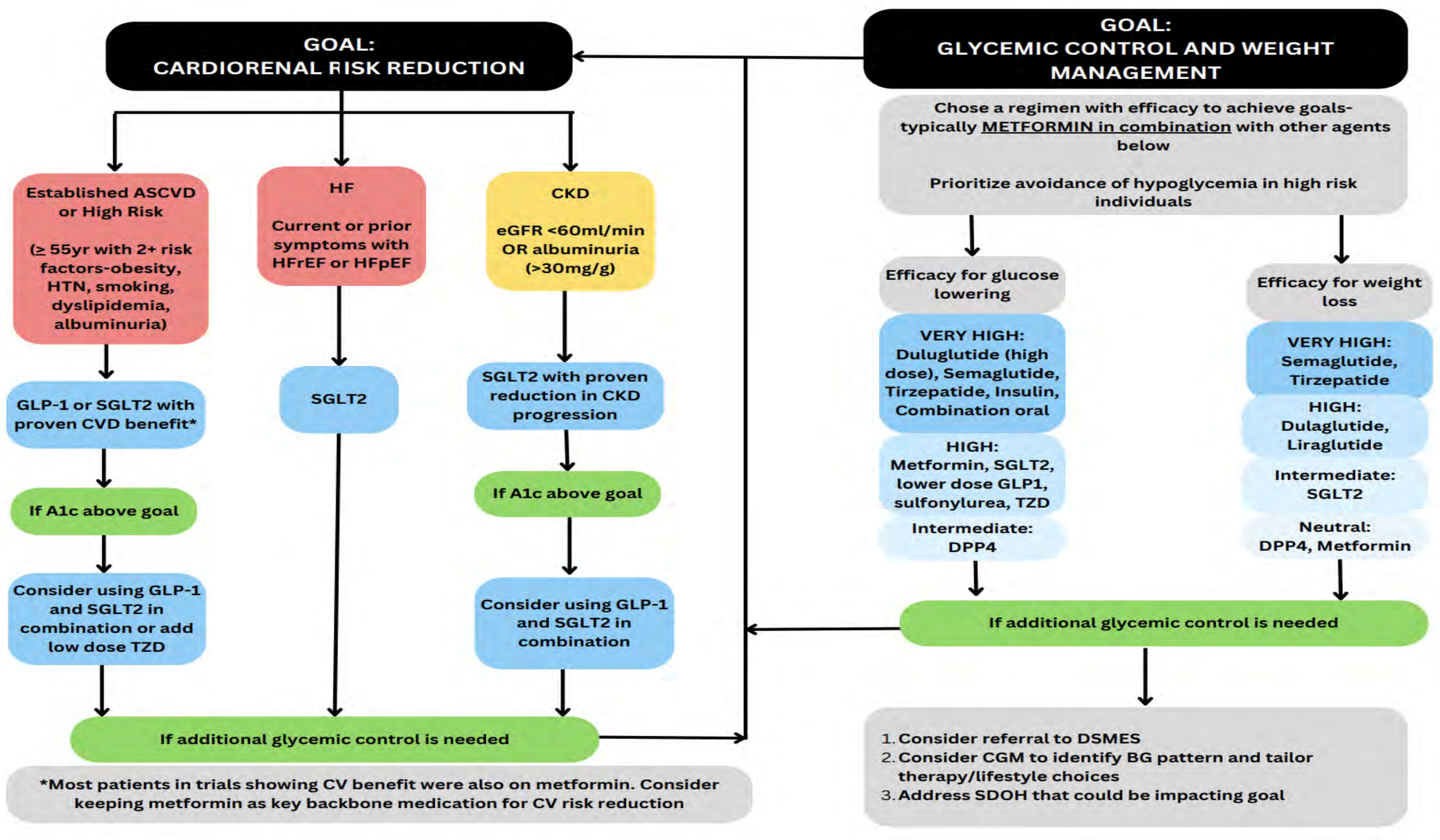
- BUT….That assumes they know how to *practice chronic disease-based medicine*….

Final Thoughts: Physician-NPP Team

- NPPs get ½ the amount education (at best) that physician's do and it is geared often on follow-up condition management and not on developing a clinical treatment pathway.


GOAL:
CARDIORENAL RISK REDUCTION
Established ASCVD or High Risk
(≥ 55yr with 2+ risk factors-obesity, HTN, smoking, dyslipidemia, albuminuria)
GLP-1 or SGLT2 with proven CVD benefit*
If A1c above goal
Consider using GLP-1 and SGLT2 in combination or add low dose TZD
HF
Current or prior symptoms with HFrEF or HFpEF
SGLT2
CKD
eGFR <60ml/min OR albuminuria (>30mg/g)
SGLT2 with proven reduction in CKD progression
If A1c above goal
Consider using GLP-1 and SGLT2 in combination
If additional glycemic control is needed
*Most patients in trials showing CV benefit were also on metformin. Consider keeping metformin as key backbone medication for CV risk reduction
GOAL:
GLYCEMIC CONTROL AND WEIGHT MANAGEMENT
Chose a regimen with efficacy to achieve goals- typically METFORMIN in combination with other agents below
Prioritize avoidance of hypoglycemia in high risk individuals
Efficacy for glucose lowering
VERY HIGH: Duluglutide (high dose), Semaglutide, Tirzepatide, Insulin, Combination oral
HIGH: Metformin, SGLT2, lower dose GLP1, sulfonylurea, TZD
Intermediate: DPP4
Efficacy for weight loss
VERY HIGH: Semaglutide, Tirzepatide
HIGH: Dulaglutide, Liraglutide
Intermediate: SGLT2
Neutral: DPP4, Metformin
If additional glycemic control is needed
1. Consider referral to DSMES
2. Consider CGM to identify BG pattern and tailor therapy/lifestyle choices
3. Address SDOH that could be impacting goal

Final Thoughts: Physician-NPP Team

- NPPs get ½ the amount education (at best) that physician's do and it is geared often on follow-up condition management and not on developing a clinical treatment pathway.
- It is inappropriate to have clinical expectations equal to our own without active engagement
  - Weekly access. Monthly meetings (dashboard). Chart review. CME education. If they have their own panel run their own reports.
  - Access to clinical guideline application is very hard to find. But is it needed to augment the physician lead of the team needed to succeed in healthcare today.

Thanks!

- Thanks for allowing me to present!
- Questions….?

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CME session is OVER

Final Thoughts: Physician-NPP Team

- Overcoding (AND undercoding) concerns …..
- Concerns over *practice of chronic disease-based medicine*….

- Provide access to education for coding/billing onboarding
  - ACDIS, AAPC, AHIMA, AAFP, CodingIntel, E&M University, **or SCAFP**
  - All basic ambulatory and hospital-based coding the above sites have
- Provide access to real-time clinical guideline application to augment the physician lead of the team **on SCAFP** web site ("Practice Enhancement") education
  - HTN, DM, COPD, HF for starters

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