Demystifying Nonphysician Practitioner Billing

by Denisha Lich, MS, RHIA, LHRM

To address today's financial challenges, healthcare facilities are increasing their use of nonphysician practitioners, such as nurse practitioners, clinical nurse specialists, and physician assistants, to provide patient care. As a result, providers need to pay close attention to the employment relationships they have with nonphysician practitioners and identify the appropriate method of billing for the services provided.

The Balanced Budget Act of 1997 allows Medicare coverage for nonphysician practitioner professional services regardless of setting or designation. In hospital settings, non-physician practitioners are eligible for separate Medicare payment if they render professional-type services, provided Medicare does not pay the facility for furnishing their services. In other words, if the practitioner is an employee of a hospital, the practitioner's salary must not be included in the amount the facility charges to Part A and thereby appear in the facility's cost report. If facilitites want to remove the salaries from the cost report, they are encouraged to contact their Medicare Part B carrier to determine the information that will be needed to act as proof that the practitioner's salary has been removed from the cost report. If the carrier accepts the proof, then the hospital may bill for the professional services of the practitioner as his/her employer. If the carrier does not allow the facility to remove the costs associated with the practitioner from the cost report, then the facility cannot bill Medicare separately for the practitioner services. Doing so would constitute double billing.

Providers such as physicians and physician practices currently have the option of billing for the practioner's services either under "incident to" rules or under the individual practitioner's provider number. In order to bill, however, the providers must meet the appropriate requirements for either coverage provision.

Medicare defines "incident to" services as services or supplies that are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. The services must be recognized as types of services that would commonly be performed in a physician's office or clinic. There must be a valid employment arrangement between the physician and the practitioner. To determine the validity, the common-law test of an employer-employee relationship can be used. Furthermore, the services must be furnished under the physician's direct personal supervision.

Direct supervision does not mean that the physician must render a personal professional service on each occasion of service provided by a nonphysician practitioner. Rather, the physician must provide direct personal professional service to initiate the course of treatment. The service performed by the nonphysician practitioner is considered an incidental part. In addition, the physician must demonstrate his/her active participation in, and the management of, the patient course of treatment. This is usually reflected by the frequency of the physician's subsequent services. The physician must be in the office suite and immediately available to provide assistance and direction throughout the time the practitioner is performing services. Practioners' services rendered without the physician's direct personal supervision must be billed under the practitioner's own provider number. Using the physician's provider number in this instance would be construed as fraudulent billing.

There is no Medicare coverage for the services of the physician-employed practitioner as "incident to" physician services in the hospital setting. Therefore it is inappropriate to bill for the physician-employed practitioner services as "incident to" services when the practitioner is providing patient care in a hospital setting. These professional services must be billed under the practitioner's individual provider number.

Denisha Lich *is the corporate compliance officer for Sarasota Memorial Hospital in Sarasota, FL, and a member of AHIMA's Compliance Task Force. She can be reached at denisha-lich@smh.com.*

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