LTC Information Series

CLINICAL COLLABORATION

in the Post-Acute and Long-Term Care Setting

amda
The Society for Post-Acute and Long-Term Care Medicine™

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Initial contributors:
Steven Levenson, MD, CMD
Mary Pat Rapp, PhD, RN, GNP-BC
Richard Stefanacci, MD, CMD
Dennis Stone, MD, MBA, CMD
Daniel Swaggerty, MD, CMD

Contributors to 2016 Update:
Erin Brooks, PA-C
Michelle Christian, PA-C
Thomas Edmondson, MD, CMD
Robert Hogikyan, MD, CMD
Kathy Kemle, MS, PA-C
Linda Keilman, DNP, GNP-BC
Nancy Losben, RPh, CCP, FASCP
Kanah May, CNP
Suzanne Ransehousen, CNP

Contributors to 2009 Update:
Karyn Leible, MD, CMD, Project Chair
Debra Bakerjian, PhD, MSN, FNP
Harold Bob, MD, CMD
Alice Bonner, APRN-BC, GNP, FAANP
Jeffrey Burl, MD, CMD
Thomas V. Caprio, MD
Charles Crecelius, MD, PhD, CMD
Len Gelman, MD, CMD
Pat Kappas-Larson, MPH, APRN-BC
Cathy Lipton, MD, CMD
Kathy Kemle, MS, PA-C
Michelle A. Koury, MD, CMD
Mary Pat Rapp, PhD, RN, GNP-BC
Barbara Resnick, PhD, CRNP
Joshua Shor, MD, CMD
Bruce C. Smith, MD, FACP, CMD
Karl Steinberg, MD, CMD
Daniel Swaggerty, MD, CMD
Eric G. Tangalos, MD, FACP, AGSF, CMD
Christopher Unrein, DO, FACP, CMD

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The authors and publisher have made every effort to ensure that the information contained in this manual, including recommendations for evaluation and treatment and guidance on selection, dosing, and monitoring of specific medications, reflects accepted standards and practices at the time of publication. However, because research evidence and clinical standards continually evolve, the reader is urged to check recent publications and product monographs for guidance on treatment decisions.

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INTRODUCTION

Teamed with physicians, advanced practice registered nurses (APRNs) and phy-sician assistants (PAs) may enhance the nursing and medical care available to long-term care facility patients. A variety of roles for APRNs, PAs and assorted practice models have evolved from this collaboration. Facilitated by documented positive outcomes and favorable legislation, the presence of APRNs and PAs continues to grow.

AMDA – The Society for Post-Acute and Long-Term Care Medicine foresees the role of PAs, nurse practitioners (NPs), and clinical nurse specialists (CNSs) in long-term care will continue to grow and has therefore prepared this educational manual.

APRNs are registered nurses with added education and training in preparation for NP or CNS roles. In this manual, they are referred to as APRNs except when Centers for Medicare and Medicaid Services (CMS) policy refers to an "NP." PAs must pass a national certifying exam after completion of an accredited training program, which is usually 28 months in length. Nearly all PA programs require an undergraduate degree and most schools now offer a graduate-level degree. PAs and APRNs working in a long-term care facility are sometimes collectively referred to as nonphysician practitioners (NPPs) in the context of regulations established by CMS.

The purpose of this Manual is to describe the roles of APRNs and PAs and to detail their educational background. In addition, the Manual provides information clarifying the roles of these practitioners as an adjunct to physician services and how to bill for their services. Resource materials from CMS and representing associations are included for further reference. It is the hope this Manual will answer your ques-tions concerning APRNs and PAs or direct you to contacts who can supply you with the information you seek.

Advantages of Teaming With Advanced Practice Registered Nurses and Physician Assistants

Significant changes have occurred recently in requirements and payment for APRN and PA services. Guidance on the implementation of these changes is fre-quently being revised. We will report on ongoing changes in upcoming AMDA news-letters.

Promulgated by changes in the Balanced Budget Act of 1997* (BBA97) (See page 7), the use of APRNs and PAs (often referred to as NPPs in regulations and CMS parlance) is increasingly common in many practice settings, including long-term care. Since 1989, APRNs and PAs have been permitted to alternate required regula-tory SNF visits under Medicare and Medicaid programs with the attending physi-cians. Market developments, such as the higher acuity of patients and the increased oversight required by managed care companies, have encouraged widespread use of APRNs and PAs. The 1998 Medicare changes that improved reimbursement and ex-panded practice settings for APRNs and PAs sparked new interest in collaboration.

Physicians who practice in SNFs, NFs, or other long-term care settings may con-sider teaming with APRNs or PAs for the following complementary or substitutive aspects of care. This is not an all-inclusive list.

Assessment and Management

- CMS requires the initial comprehensive assessment of a Medicare Part A SNF [99304—99306] patient be done by a physician. NPPs may provide and bill for medically necessary services to a patient covered under Medicare Part A before the physician's initial comprehensive assessment. All Medicare Part A admission and certification orders, however, must still be reviewed person-ally or by phone and then signed by the attending physician. The admission orders and certifications for a patient not covered by Medicare Part A may be provided by the NPP directly and do not require physician certification if al-lowed by state law.

- Performing annual assessment visits (periodic physical examinations, 99318)
- Making alternate regulatory-required visits to patients in the SNF or NF
- Monitoring patient conditions to determine the effectiveness of interventions and modifying if necessary. This is particularly important in Medicare Part A SNFs, acute illnesses such as pneumonia, and skilled managed care settings.
- Assisting in managing stable conditions, acute exacerbations of chronic dis-ease states, and acute infectious processes
- Managing acute or episodic problems such as rashes, pressure ulcers, and uri-nary tract infections
- Performing procedures, such as wound debridement, joint injection, bedside urodynamic testing, PICC line insertion, and cryotherapy if they have the ap-propriate training and collaboration with the supervising physician

Performing Consults in Specialty Areas:

- Performing consults in a specialty area including psychiatry-mental health, wound care, incontinence, palliative care, and oncology if these are within the scope of practice of the supervisiving or collaborating physician

Patient Care Services

- Providing patient and family education, such as participating in discussions regarding end-of-life issues and clarifying advanced directives
- Improving care coordination and communication with facility staff, patients, and patients' families
- Communicating patient progress to hospital and community physicians and collecting information regarding why certain diagnostic or therapeutic inter-ventions were or were not undertaken in the past
- Communicating patient progress to managed care organizations

Augmenting the Medical Director Function by:

- Conducting inservice training for staff
- Monitoring quality of care indicators and conducting quality improvement activities

- Assisting the Medical Director in developing, revising, and evaluating rele-vant clinical policies and procedures for the facility.

A wide array of roles and practice models exist for integrating APRNs and PAs with the facility and the physician. This process requires knowledge of practice pa-rameters and restrictions, supervision, and other regulatory requirements that are

usually regulated by each state within a framework established at the federal level. Federal legislative changes often exacerbate already confusing reimbursement pro-cedures. The following sections address common issues.

STATE REGULATIONS

Physician Assistants

All states, the District of Columbia, and most U.S. territories have enacted stat-utes that define the scope of practice of PAs, discuss supervision, and establish regu-lations governing their medical practice. This is usually under the same regulatory body as that which licenses and regulates physicians. Most state practice laws are fairly detailed and describe the credentials and education necessary to be licensed as a PA in the state, the types of services PAs can render, and the degree of physician supervision required. These laws are usually augmented by regulations or rulings of the state agency charged with their administration.

Most states require the PA to have graduated from an accredited PA program and to have passed a national certifying examination. This examination was developed by the National Board of Medical Examiners and is administered by the independent National Commission on Certification of Physician Assistants.

In order to take the NCCPA exam, the PA must graduate from an accredited pro-gram. Most programs are now at the master's level, although a few still award a bac-calaureate or certificate. Programs emphasize clinical assessment and the use of the medical model. Achieving a satisfactory score on the exam allows the use of the C (certified) in PA-C and to maintain certification, the PA must acquire 100 hours of CME every 2 years and re-test every 6 years. However, recertification is not required in all states. In 2014 the NCCPA began transitioning to a 10 year cycle, incorporating a self assessment and quality improvement requirement.

Most states specifically provide that PAs may perform histories, physical exami-nations, and counseling of patients. Some states permit PAs to perform minor sur-gery; many have guidelines as to what types of surgical procedures are permitted.

State laws also vary significantly with respect to prescribing. Nearly all states allow PAs to prescribe non-controlled substances without a specific written order from a physician. Prescribing of controlled substances is permitted in some states, but usually under stricter conditions.

Although specific supervision requirements vary, PAs in most states can practice without the physician being on-site, provided the physician is readily accessible by telephone or other electronic device. Some states have strict time parameters on physician co-signature of PA-initiated orders. Other states also require the physi-cian to periodically review a minimum number of the PA's entries in patient charts. However, in recent years these requirements have been changing, so a review of indi-vidual state laws and rules governing practice should be done by both the physician and physician assistant at least on an annual basis.

A discussion of the laws of each state is beyond the scope of this Manual. How-ever, physicians utilizing PAs in their practices should be familiar with the laws of their state. See Summaries of State Laws and Regulations on the American Academy of Physician Assistants Website to obtain further information about PA licensure and practice in your state.[1]

Nurse Practitioners and Clinical Nurse Specialists

A clinical nurse specialist is a registered nurse with a high degree of knowledge, skill, and competence in a specialized area of nursing, and usually has a master's degree in nursing.

An NP is a registered nurse (RN) who has completed advanced education (a mini-mum of a master's degree) and training in the diagnosis and management of common medical conditions, including chronic illnesses. While there is not a standardized national exam to license or certify NPs, an NP may be certified in his or her specialty area such as Gerontology by one of the two certifying bodies such as the American Nurses Credentialing Center (ANCC). The standardized licensing examination for all nurses, including NPs, is the NCLEX-RN.

Since state board requirements differ, nurse practitioners may have to fulfill ad-ditional requirements, such as certification by ANCC or a specialty nursing organi-zation. The license period varies by state; some require biennial relicensing, others require triennial relicensing.

NPs who are not enrolled as Medicare providers on or after January 1, 2003, must:

1. Be a registered professional nurse who is authorized by the State in which these services are furnished to practice as a nurse practitioner in accordance with State law
2. Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners
3. Possess a master's degree in nursing.

According to the Pearson Report,[2] 12 states as of January 2009 now allow NPs to prescribe and 23 states allow NPs to diagnose and treat without physician col-laboration or supervision (in Maine, after two years of practice) with the exception of the long-term care setting. Some states also give the same practice authority to CNSs. Other states draw a distinction and have more restrictive rules for CNSs. In those states that require collaboration or supervision by the physician, the laws or regulations generally provide that the physician need not be on site. In the SNF or NF, physician billing for "incident to"* services is not accepted by CMS. Some states require the NPs or CNSs and the physician to enter into a protocol defining the scope of practice and physician oversight. This may also include physician co-signatures, but this varies by state. (See laws and regulations with local state Board of Nursing) If the NP or CNS practices in an institution, the institution must often approve the protocol. A few states also require the Board of Nursing to approve the protocol.

While graduate education for a NP is now considered the standard, a few states do not require an NP to have graduate education and have allowed the "grandfather-ing in" of existing APRNs. More recently a Doctor of Nurse Practitioner (DNP) pro-gram is now available. Medicare, however, does require a master's degree to apply for a National Practitioner Identifier (NPI) number.

Some states give APRNs (and sometimes CNSs) independent prescribing author-ity for prescription drugs, including controlled substances. Some states require phy-sician involvement or written delegation of prescription writing.

APRNs choose an area of certification, such as Adult, Family, or Gerontology. The requirements for these certifications are dictated by national professional certifica-

tion boards and require minimum education, practice, and exam scoring standards. Certification standards must be maintained for certification renewal.

To learn more about the NP and CNS scope-of-practice laws in your state, see the most recent update on legislative issues affecting advanced nurse practice[3] and in-formation on how to research scope-of-practice laws in your state. (Visit the GAPNA website at www.gapna.org for further information regarding scope-of-practice laws in your state.)

THE MEDICARE PROGRAM

The Medicare program was enacted by Congress in 1965 to provide health care to the elderly and disabled. The program consists of several distinct parts.

- **Part A** covers services furnished by institutional providers, such as hospitals, SNFs, hospices, and home health agencies. It is loosely referred to as the "in-patient" benefit.

- **Part B** covers physician services, services of certain NPPs, diagnostic tests, ambulance services, and durable medical equipment. It is generally referred to as the "outpatient" benefit.

Medicare Part C now refers to the Medicare Advantage program, a managed care subset of the Medicare program. "Part C" originally referred to an earlier version of managed care titled "Medicare+Choice". Part D was added by the Medicare Pre-scription Drug, Improvement, and Modernization Act of 2003 (implemented Janu-ary 2006) and covers prescription medications. It is referred to as the "prescription drug" benefit. Part D also covers Medicare Advantage (managed care) organizations.

Medicare provides coverage on a graduated per-diem basis under Part A for skilled nursing services provided in Medicare-certified SNFs; it does not cover care it deems to be custodial. In general, Medicare beneficiaries are eligible for SNF ben-efits if they are transferred to the SNF after a three-day qualifying stay in an acute hospital and the physician certifies that the patient needs skilled nursing care. In recent years some Medicare ACO's are allowing admission to SNF without the quali-fying hospital stay. Medicare will pay for up to 100 days of care per "spell of illness" as medically appropriate for current episode of care, although there is a required co-payment for days 80 to 100.

Relatively speaking, reimbursement for SNF care by Part A is a small percent-age (2%) of Medicare's annual expenditures. Physician and NPP services are paid by Medicare Part B as determined by the Medicare Physician Fee Schedule, which is updated annually. All reimbursement, no matter what the payor source is for the patient, falls under Medicare Part B for NPP and physician services.

The Medicare program is administered by CMS, which contracts with private insurance companies to process and pay claims. Part B contractors are commonly re-ferred to as carriers*. CMS provides extensive guidance to its contractors, in the form of manuals, as to how the Medicare program should be administered. However, car-riers are free to implement their own policies provided they do not act inconsistently with any Medicare law, regulation or written CMS policy. Thus, Medicare policy can vary from one contractor region to another. This LTC Information Series manual describes only those policies that apply on a national level. For Medicare carriers by state, go to www.cms.hhs.gov/.../Downloads/02_ICdirectory.pdf.

Education and Certification Requirements for Advanced Practice Registered Nurses and Physician Assistants

As noted below, APRNs and PAs who provide services in Medicare SNFs or long-term care settings must be licensed to practice by the state and must meet state-specific certification or education requirements. (See also the Summaries of State Laws and Regulations for PAs, [1] the most recent update on legislative issues affecting advanced nurse practice,[3] and the Scope and Standards of Practice published by the respective professional organizations.) These additional criteria beyond state licen-sure do not apply to Medicaid long-term care facilities; however, the state may have its own requirements.

Physician Assistant Services

Medicare regulations at 42 CFR § 410.74, require that for the purposes of Part B payment, a PA must meet applicable state requirements as well as the following criteria:

- Have graduated from a PA educational program that is accredited by the Na-tional Commission on Accreditation of Allied Health Education Programs.
- Have passed the national certification examination that is certified by the Na-tional Commission on Certification of Physician Assistants.
- Be licensed by the State to practice as a PA.

Medicare coverage is limited to the services that may be legally performed ac-cording to State law and regulations. The services of a PA may be covered under Medicare if:

- They are of the type that are considered physician services.
- They are performed by a PA who meets the definition above.
- The PA is legally authorized to perform the services in the state.
- They are performed under the supervision of a physician, meaning that the physician is immediately available by phone and in some states cosigns any orders written by the PA.
- They are not otherwise precluded from coverage because Medicare does not cover that service (e.g., routine physicals or foot care).[4]

Nurse Practitioner Services

Medicare requirements at 42 CFR § 410.75, specify that a NP must:

- Possess a master's degree in nursing.
- Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a NP in accordance with state law.
- Be certified as a NP by the American Nurses Credentialing Center (ANCC), and needs recertification every 5 years, or by the American Academy of Nurse Practitioners (AANP), or other national certifying bodies recognized by CMS.

Medicare will then cover services (services and supplies furnished incident to such services) if:

- The services are considered to be physician services.
- The services are performed by a NP who meets the definition above.

The services are not otherwise precluded because Medicare does not cover that service.

Clinical Nurse Specialist Services

Medicare requirements at 42 CFR § 410.76, specify that a CNS must:

- Be an RN who is currently licensed to practice in the state, is authorized to perform the services of a CNS in accordance with state law, and has a master's degree in a defined clinical area of nursing from an accredited educational institution.

- Be certified as a CNS by a professional association recognized by CMS that has certain minimum eligibility requirements.
- Meet the requirements for a CNS set forth above, except for the master's degree requirement, and have received (before three years from effective date of final rule in 1998) a certificate of completion from a formal advanced practice pro-gram that prepares RNs to perform an expanded role in the delivery of primary care.[5]

Medicare Coverage of Physician Assistant, Clinical Nurse Specialist, and Nurse Practitioner Services

Before January 1, 1998, Medicare allowed PAs, NPs, and CNSs to be paid for ser-vices of the type that were considered physician services under specific conditions and in defined locations.

Effective January 1, 1998, amendments to BBA97 removed the restrictions on the areas and settings in which Medicare paid for the professional services of PAs, NPs, and CNSs. Accordingly, payments are now allowed for services furnished by these NPPs in all areas and settings permitted under applicable state licensure laws, but only if no facility or other provider is paid any amounts with respect to the furnish-ing of such professional services. The BBA97 amendments also expanded the profes-sional services benefits for NPs and CNSs by authorizing them to bill the program directly for their services when furnished in any area or setting. However, the cur-rent provision maintains that separate payment may not be made to an APRN or PA when a facility or other provider payment is made for such professional services. In other words, an APRN or PA cannot bill Medicare if they are employed by the facil-ity directly. The PAs bill using their own UPIN number and the reimbursement goes to their employer, whether facility employed or physician employed. They are paid at the same rate as the APRN (85% of physician). They cannot bill independently as the APRN can.

Authority for Non-physician Practitioners to Perform Visits, Sign Orders and Sign Certifications/Re-certifications When Permitted by the State*

	Initial Comprehensive Visit/Orders	Other Required Visits·	Other Medically Necessary Visits and Orders+	Certifications/ Recertification
SNFs				
PA, NP & CNS employed by the facility	May not perform/ May not sign	May perform alternate visits	May perform and sign	May not sign
PA, NP & CNS not a facility employee	May not perform/ May not sign	May perform alternate visits	May perform and sign	May sign subject to State Requirements
NFs				
PA, NP, & CNS employed by the facility	May not perform/ May not sign	May not perform	May perform and sign	Not applicable‡
PA, NP, & CNS not a facility employee	May perform/May sign	May perform	May perform and sign	Not applicable‡

* This reflects clinical practice guidelines.
· Other required visits are the required monthly visits.
+ Medically necessary visits may be performed prior to the initial comprehensive visit.
‡ This requirement relates specifically to coverage of a Part A Medicare stay, which can take place only in a Medicare-certified SNF.

The Medical Director is responsible for the coordination of care within the facil-ity as stated in F Tag 501. This oversight includes the care provided by NPPs working in the facility. For example, Dr. L is a psychiatrist and sends NP's to conduct consults for him at the Medical Director's facility. The Medical Director would have the same oversight of the NP doing consults as he/she would of Dr. L doing consults. This is a responsibility/authority under the Medical Director F501 tag.

Types of Advanced Practice Registered Nurse and Physician Assistant Services Covered by Medicare

Visits by Qualified Nonphysician Practitioners

All evaluation and management (E/M) NPP visits are covered if:

- They are medically necessary.
- They comply with CMS guidelines.
- They are within that particular state's scope of practice and licensure require-ments.
- All the individual state requirements for physician collaboration and physi-cian supervision are fulfilled.

Thus, Medicare does not specifically identify services or procedures that NPPs can provide. Instead, it allows that determination to be made by the states. You will need to review the scope-of-practice laws in your state to determine what limita-tions, if any, exist on physician extenders. Prescriptive authority, in particular, var-ies enormously from one state to another. (See the Summaries of State Laws and Reg-ulations1 and the most recent update on legislative issues affecting advanced nurse practice3 for information on how to research scope-of-practice laws in your state.)

Medically Necessary Visits

In both the SNF and the NF, qualified NPPs may perform medically necessary E/M visits before and after the physician's initial comprehensive visit. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to im-prove the functioning of a malformed body part are payable under the Physician Fee Schedule* under Medicare Part B. CPT codes, Subsequent Nursing Facility Care, per day (99307—99310), shall be reported for these E/M visits even if the visits are provided before the initial visit by the physician.

SNF Setting—Place of Service Code 31. Query the facility as to the patient's coverage designation. After the initial visit by the physician, the physician may del-egate alternate federally mandated physician visits to a qualified NPP who meets the collaboration and physician supervision requirements, is licensed as such by the State, and is performing within the scope of practice in that state.

NF Setting—Place of Service Code 32. Per the regulation, 42 CFR 483.40 (f), a qualified NPP who meets state collaboration and physician supervision require-ments, meets state scope of practice and licensure requirements, and is not employed by the NF may, at the option of the state, perform the initial regulatory visit in a NF. The NPP may also perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings should be addressed to the appropriate state survey and certification agencies for clarification. A list of contacts for state survey agencies is posted on AMDA's Web site as part of the state fact sheets.[6]

Under the code of federal requirements for long-term care facilities, the regula-tions at 42 C.F.R. 483.40(e) state that, "A physician may not delegate a task when

the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies."

CMS identifies federally mandated visits in Transmittal 808 entitled "Nursing Facility Services (Codes 99304–99318)"[7] and in chapter 12 of the Medicare Claims Processing Manual.[8] The initial visit in a SNF or NF must be performed by the phy-sician except as otherwise permitted [42 CFR 483.40(c)(4)]. The physician may not delegate the initial visit in a SNF. In the NF setting, a qualified NPP (i.e., a NP, a PA, or a CNS) who is not employed by the facility may perform the initial visit when state law permits this.

Regarding patients covered by HMOs or private payor sources, the determining factor is the regulatory requirement, not just a payor requirement. The CFR is clear that an initial assessment by a physician is required for a patient who is determined to need "skilled" care (i.e., SNF level care). Thus, upon survey, the surveyor would look to see whether a required physician visit was documented in the chart. This is not a payor issue; it is a regulatory issue. This may be overlooked in the survey, but it could put the facility out of compliance. Some HMOs or private insurance com-panies may pay a NPP for the initial service, but that does not meet the regulatory CMS requirement.

In the SNF, Medicare conditions of payment allow APRNs to sign certifications and recertifications of the continued need for skilled care if they are not employed by the facility, subject to state requirements. (See table above from CMS letter [SNC-04-08]) If employed by the facility, the APRN may write initial orders but the orders must be signed and dated by the admitting physician. A PA employed by a physician or by the facility may not certify or recertify care because the regulation provides this authority only to APRNs.

Services that the Medicare Carriers Manual* specifically notes can be performed by APRNs and PAs, assuming state law permits, include physical examinations, mi-nor surgery, interpretation of x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition.[9]

Physician Supervision and Collaboration

Nurse Practitioners and Clinical Nurse Specialists

Medicare covers services of NPs and CNSs "working in collaboration with a phy-sician" provided the NP or CNS is legally authorized to perform the services under state law. (42 CFR 483.40 (e) Physician delegation of tasks in SNFs. Except as speci-fied in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who — i. (iii) Is under the supervision of the physician)

Medicare law defines collaboration as "a process whereby a NP works with a phy-sician to deliver health care services within the scope of the NP's professional ex-pertise with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by Federal regulation and the law of the state in which the services are performed."

Medicare rules do not require the collaborating physician to be present with the ANP when the service is furnished or to make an independent evaluation of each patient seen by the ANP. The absence of state law or guidelines would not negate the requirement for collaboration; in states that have no regulation regarding collabora-tion with a physician, CMS requires NPs and CNSs to document their scope of prac-tice and indicate the relationship that they have with physicians to deal with issues that may arise outside their scope of practice.[10]

Physician Assistants

The PA's physician supervisor (or a physician designated by the supervising phy-sician or employer under state law or regulations) is primarily responsible for the overall direction and management of the PA's professional activities and for ensuring that the services provided are medically appropriate for the patient. Medicare policy requires that the services of PAs be provided under a physician's supervision. The physician supervisor need not be physically present with the PA when a service is provided to a patient unless state law or regulations provide otherwise. If the physi-cian is not present, however, he or she must be immediately available by telephone or other effective communication method. In some states, orders must be signed by the physician supervisor in a timely manner as determined by state regulation.

Number of Federally Mandated and Medically Necessary Covered Visits

Payment is made under the Medicare Part B Physician Fee Schedule for federally mandated visits. After the initial visit by the physician, payment shall be made for federally mandated visits that monitor and evaluate patients at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. However in the NF, the initial visit may be made by the NPP and then regulatory visits may be alternated as delegated by the attending physician.

Documentation of Services

To request payment for an E/M visit, the service provided must be documented, should substantiate medical necessity, and should include the required parameters of history, physical exam, and medical decision making complexity [all three are preferable, with their extent determining which CPT level is used (refer to §§1862

(a)(1)(A) of the Social Security Act]. Specifically, the initial visit codes for the nurs-ing facility family of codes (99304-99306) require three of three components to be documented. The subsequent codes (99307-99310) require at least two of the three components to be documented.

The E/M visit (Nursing Facility Services) represents a "per day" service per pa-tient as defined by the CPT code. The medical record must be personally document-ed by the physician or qualified NPP who performed the E/M visit, and although forms and checklists may be used, the content must be customized to reflect each unique patient encounter.

Coding of Services

Qualified APRNs and PAs use the same CPT codes that physicians use. In the case of NF visits, the CPT codes are 99304–99306 for the initial comprehensive as-sessment visit when this type of visit is legally permissible to be performed by the APRN or PA, codes 99307–99310 for subsequent NF visits, codes 99315–99316 for discharge day services, and code 99318 to report the regulatory required comprehen-sive annual NF assessment. 99307-310 codes can be used in a SNF.

Additionally, the CPT Editorial Panel refined the descriptors for the nursing fa-cility family of codes (99304-99306, 99307-99310, and 99318) to include the typical times associated with these services. As a result, effective January 1, 2008, prolonged services provided in nursing facilities are eligible for additional payments when the time requirements for the prolonged services codes 99354-99357 are met. There was no change in the nursing facility discharge codes 99315-16.

The CPT Nursing Facility Services codes shall be used with place of service (POS) 31 (SNF) if the patient is in a Medicare Part A-covered SNF. They shall be used with POS 32 (NF) if the patient does not have Part A SNF benefit, is in a NF, or is in a SNF but the stay is not covered (e.g., there was no preceding three-day hospital stay or the individual is in a managed care plan). The CPT Nursing Facility Services code defi-nition also includes POS 54 (intermediate care facility/mentally retarded) and POS 56 (psychiatric residential treatment center). For further guidance on POS codes and associated CPT codes, refer to §30.6.14.

Since January 1998, all APRN and PA services (unless billed as "incident to"; see the section **Medicare 'Incident to' Coverage and BBA97 Changes**), have been paid at 80 percent of the lesser of either the actual charge or 85 percent of the Physician Fee Schedule.

Medicare Payment Policies

Billing Requirements

As noted above, the BBA97 not only expanded the sites in which APRNs and PAs can practice but also gave them direct billing rights that allow them to submit claims to Medicare directly and receive payment. In order to bill Medicare, APRNs and PAs must obtain a NPI from their local Part B carrier. Please visit AMDA's NPI page for the latest changes and updates on CMS's implementation of the NPI.[11]

Payment for PA services is made only to the PA's employer for medical services performed by a physician assistant, regardless of whether the PA is employed as a

W-2 employee* or is a "1099 employee"* who is an independent contractor. Some PA's have their own corporations which employ them and the payment would go to the corporation.

When PAs are rendering services, Form CMS-1500 must contain the Provider Identification Number (PIN) of the PA after "PIN" in item 33. Item 33 must also con-tain the employer's name and address where payment is to be directed.

If the employer is a group practice, the group PIN must be included in item 33 after "GRP PIN," including the name and address where payment is to be directed.

For NSF claims, providers must submit the individual PA's PIN in field NSF FAO 23.0 of the electronic claim record. Providers submitting ANSI claims must submit the individual PA's PIN in X12N 837 [2-500.E-NM109 (mp,zz)]. The group PIN will be reported in NSF BA0-09 and ANSI X2N 837 in 2-003-PRV03.

Physicians should be careful that the independent contractor arrangement meets Internal Revenue Service requirements for independent contractors and that the re-lationship is not really that of employer/employee. The Internal Revenue Service will reclassify individuals as employees and hold the employer responsible for taxes that should have been withheld as well as penalties if it finds that the arrangement is really one of employer/employee. Crucial to the distinction is the degree to which the employer (i.e., physician) has supervision and control over the employee (PA). Because both state laws and Medicare require PAs to be under physician supervi-sion, this underscores the need to be exceptionally cautious if using an independent contractor arrangement with a PA.

Billing Requirements for Nurse Practitioner and Clinical Nurse Specialist Services

To prevent duplicate billings or payments, CMS is requiring NPs and CNSs to submit claims to the Medicare Part B carrier under their own respective billing num-ber for their professional services furnished in a facility or other provider setting, ex-cept when the services of the APRN are clearly facility services and are specifically included in the costs that are covered by the intermediary payment to the facility. Only the facility can bill and be paid for APRN services when the services are bill-able as facility services and are bundled or included in the facility payment.

Physicians and NPPs who order or refer services (e.g., consults, DME, therapy) must submit their names and their NPIs on Form CMS-1500. This information must appear in blocks 17 and 17a of Form CMS-1500. For NSF claims, the NPI must ap-pear in record/field FBI-09.0 as the ordering/referring provider. Providers submitting ANSI claims must submit a NPI in X12N837 field:2-500.E-NM109.

Services of a NP or a CNS who is working in collaboration with, but is indepen-dent of, a physician would be considered covered services as defined in §§1861(s)
(1) and 1861(s)(2)(A). Therefore, a NP or CNS who is treating the beneficiary can order or prescribe items of durable medical equipment and supplies (DMEPOS) and can complete Section D of the Certificate of Medical Necessity (CMN) if he or she is permitted to prescribe items of DMEPOS by the state in which the services were rendered. NPs and CNSs must bill by using their own provider numbers and they must attest, as a physician must, that they have treated the beneficiary and that all information presented in Section B of the CMN, or on the order, is true, accurate, and complete to the best of their knowledge. The name and NPI of the NP or CNS are required on the CMN.

In some states, NPs, CNSs, and PAs can order home health care but they cannot sign the plan of care. In addition, as of December 8, 2003, NPs can bill Medicare for services to patients on hospice benefits but cannot certify a terminal illness or 6-month prognosis. NPs can serve as primary care practitioners (PCP's) under the hospice contract if so listed by the hospice. NPs may not certify a 6 month terminal illness prognosis. A collaborative physician must sign the 6 month terminal illness prognosis statement. However, NPs may write all other orders. NP's can bill for care of hospice patients if they are listed as the PCP. That is, if a NP is listed as the PCP, a physician can cover for a NP. However, if a physician is listed as the PCP a NP cannot cover for a physician. NP's who are hospice employees cannot bill for care provided, since it would be globally included within the hospice rate.

For NPs or CNSs who are members of a physician group practice, the PIN of the performing NPP must be entered in item 24k of Form CMS-1500. The group practice must enter its group practice PIN after "GRP PIN" in item 33. The group practice must also include the name and address to which payment should be directed.

For NSF claims, providers must submit the PIN in field NSF FAO 23.0 of the electronic claim record. Providers submitting ANSI claims submit the PIN in 2-500. B-NMI09 (mp,zz). The group practice PIN will be reported in NSF BA0-09 and for ANSI X12N 837 claims in 2-003-PRV03. When services of several different members within a physician group practice are billed on the same CMS-1500 claim form, the PIN of the performing NPP is entered in the corresponding line item.

Reassignment of Billing Rights by Nurse Practitioners and Clinical Nurse Specialists

Medicare regulations generally prohibit practitioners (including NPs and CNSs) from reassigning their billing rights to third parties. However, a few exceptions to this rule exist. One important exception allows payment to be made to the individ-ual's employer if the individual is required as a condition of his or her employment to turn over his or her fee to the employer. Thus, a physician who employs a NP or CNS could, under this exception, bill for that individual.

A second important exception allows reassignment to a facility (defined to in-clude a SNF or a NF) if the service is provided in the facility and there is a contrac-tual arrangement between the facility and the individual under which the facility submits the bill for the service and this arrangement is permissible under local and state law.

In addition, in the Medicare Carriers Manual, CMS has specifically stated that a NP or CNS can reassign billing rights for services in rural areas to a SNF, a NF, or a physician group practice with which the NP or CNS has an employment or contractual relationship. This guidance predates the BBA97 and, as such, is limited to rural areas.

Thus, Medicare reassignment rules permit a physician or physician group prac-tice to either employ or contract with a NPP and to bill for his or her services both in SNFs and other locations. Medicare also permits a SNF to employ or contract with a NPP and to bill for his or her services provided in the facility. However, as discussed in more detail below, Medicaid places limitations on the services of APRNs and PAs who are employed by a NF.

Amount of Payment

All three types of NPPs are reimbursed at the lesser of either 80 percent of the actual charge or 85 percent of the Physician Fee Schedule amount for professional services. In other words, unless actual charges are less than the fee schedule, NPPs are paid 85 percent of what physicians are paid for performing the same service. As-signment is mandatory for APRNs and PAs. In other words, APRNs and PAs must accept the Medicare allowed amount as payment in full and may bill the patient only the applicable deductible and co-payment. If the physician "does not accept assign-ment" and has opted out of the Medicare program entirely, he or she may bill above Medicare Maximal Allowable Charges.

Documentation

Services of APRNs and PAs must be documented to the same extent as physician services. Medicare has documentation guidelines for E/M services that apply in all settings. The guidelines set forth three key components of E/M services that deter-mine the appropriate level of E/M services to be billed. These are history, examina-tion, and medical decisionmaking. APRNs and PAs providing E/M services must be familiar with these documentation requirements. If a physician, medical group, or facility is billing Medicare for the services of an APRN or a PA, the physician, medical group, or facility is responsible if the services are disallowed or if Medicare demands restitution after a post-payment audit. However, the NP is attesting to the medical necessity of the provided service.

In addition to the E/M guidelines, Medicare conditions of participation for NFs provide that for each required regulatory visit, the physician (or APRN or PA) must review the patient's total program of care, including medications and treatments; write, sign, and date progress notes at each visit; and sign and date all orders, at time of review.

Duplicate Payment Issues

APRNs and PAs can be paid for professional services only when the services have been personally performed by them and no facility or other provider is paid for the same services. Medicare will not pay for the same service under Part A and Part B. Thus, SNFs that employ or contract with an APRN or PA cannot bill under Part B for those services if they also include the APRN's or PA's salary and other costs on their cost reports. The facility would have to offset the cost of the APRN or PA or have the Part B payment disallowed. This may raise difficult issues when part of an employee APRN's or PA's time is spent providing care to individual patients and part is spent in administrative or other services not covered by Part B of Medicare. In such cases, it may be advisable to allocate the APRN's or PA's time between patient care services that are billable under Part B and administrative services that are paid for under Part A.

In addition, no separate payments may be made to APRNs or PAs for services pro-vided in rural health clinics or federally qualified health centers because Medicare payment for their services is included in the all-inclusive payment rate that Medi-care makes to those facilities.

Consolidated Billing Amendment in BBA97

Since July 1, 1998, payments for certain Part B services provided in SNFs either under arrangements or through contracts with third parties must be made to the SNF. However, APRN or PA services and physician services are specifically exempted from this rule.

Medicare "Incident to" Coverage and BBA97 Changes

"Incident to" billing can be reimbursed in hospital; it can also be used in nursing homes under certain circumstances, although it is seldom applicable in the SNF or NF setting. (See manual Sec. 60.1-60.3.) Medicare billing for shared office or clinic visits are billed as by either the physician or the NP, depending on whether the NP services were provided incident to those of the physician. Medicare billing for shared hospital visits depends on whether there is a face-to-face physician encoun-ter with the patient. If there is no face-toface encounter between the patient and the physician (e.g., if the physician participated in the service only by reviewing the patient's medical record), the service is billed under the NP's billing number.[8] In nei-ther instance can both the physician and the NP submit a bill for the same service.

MEDICAID COVERAGE AND PAYMENT RULES

Coverage of Advanced Practice Registered Nurse and Physician Assistant Services

States are required to provide Medicaid recipients with the services of certified family NPs and certified pediatric NPs but, remarkably, not those of NPs certified in gerontology. There can be age range restrictions placed on who the GNP can care for (i.e., individuals must not be under the age of 50) within certain states. Several states have opted to pro-vide coverage for NP services generally; many provide coverage for PAs.

Employment by the Facility

Medicaid law requires that the health care of NF patients be provided under the supervision of a physician. At the option of the state any required tasks may be satis-fied by a NPP who is not an employee of the facility but works in collaboration with a physician. Thus, a NF cannot employ an APRN or PA to substitute for the physician with respect to supervising the health care of patients.

A facility could employ APRNs and PAs to perform other tasks in the facility, including furnishing care to patients, provided the APRNs or PAs were not charged with "supervising" the patient's care.

In addition, a physician who contracts with a facility could employ an APRN or PA to assist him or her in furnishing services to facility patients. Medicaid will pay for covered physician services and services under the physician's "personal supervision".

Contract Arrangements

As described above, the Medicaid law gives states the option of using APRNs or PAs instead of physicians to supervise the care of non-SNF patients. In those states that have elected this option, the facility can contract with APRNs or PAs to super-vise the care of its patients. In this case, physician supervision or collaboration is not required unless it is a requirement of state licensure law.

In addition, a physician could contract with an APRN or PA to assist in provid-ing services to NF patients. Medicaid would cover the services provided they were under the physician's "personal supervision" and were otherwise appropriate.

Direct Billing Rights for Certain Advanced Practice Registered Nurses

Services of certified pediatric NPs and certified family practice APRNs are cov-ered by Medicaid even if furnished without physician supervision, provided the services are within the APRN's scope of practice as defined by state law. In addition, states are required to give these APRNs direct billing rights as well as allowing for payment to the APRN's employer. Some states operating under a Medicaid waiver may not be subject to this requirement. This can only be done in a Medicaid-only bed.

In addition, some state Medicaid plans have chosen to extend reimbursement to NPs and CNSs generally and to allow for direct payment. Other states require that payment be made to the NP's or CNS's employer. Because Medicaid plans differ from state to state, it is important that you review the policy in your state.

Payment Rates

Medicaid payment for services of APRNs and PAs is generally based on a fee schedule. In some states, APRNs and PAs are reimbursed at the same rate as physi-cians; in other states, reimbursement is less than the physician rate.

REFERENCES

1. American Academy of Physician Assistants. Summaries of State Laws and Regu-lation. Available at: http://www.aapa.org/gandp/state-law-summaries.html (ac-cessed January 30, 2008).

2. Pearson LJ. The Pearson Report. Am J Nurse Pract 2007; 11: 10-101. Available at: http://www.webnp.net/images/ajnp_feb07.pdf (accessed January 30, 2008).

3. Phillips SJ. A comprehensive look at the legislative issues affecting advanced nursing practice. Nurse Pract 2007; 32(1): 14-17.

4. Health Care Financing Administration. Medicare Carriers Manual § 2156 (B).

5. Balanced Budget Act of 1997, Pub Law 105-217, §§ 4511 and 4512.

6. American Medical Directors Association. Governance. Available at: http://www. amda.com/governance/ (accessed January 30, 2008).

7. Centers for Medicaid and Medicare Services, US Department of Health & Human Services. CMS Manual System. Pub 100-04. Medicare Claims Processing. Trans-mittal 808. January 6, 2006. Available at: http://www.cms.hhs.gov/transmittals/ downloads/R808CP.pdf (accessed January 30, 2008).

8. Centers for Medicaid and Medicare Services, US Department of Health & Human Services. Medicare Claims Processing Manual. Chapter 12 Physicians/Nonphysi-cian Practitioners. Available at: http://www.cms.hhs.gov/manuals/downloads/ clm 104c12.pdf (accessed January 30, 2008).

9. 63 Federal Register 58878 (1998).

10. 63 Federal Register 58871 (1998).

11. American Medical Directors Association. Advocacy. Available at: http://www. amda. com/advocacy/ (accessed January 30, 2008).

CMS & Joint Commission Requirements for Physician Visits

	CMS	Joint Commission
F 387 **Frequency of Physician Visits/ Timeliness of Visits**	**(c) Frequency of Physician Visits** **(1)** The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. **(2)** A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. **(3)** Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. **(4)** At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section. [42 CFR 483.40(c); Tag F387]	The attending physician visits the patient or resident in accordance with the patients' or residents' needs at least once during the 30 days after admission. **STANDARD** PC.02.01.13 The organization assesses and reassesses the patient or resident and his or her condition according to defined time frames. **STANDARD** PC.01.02.03 (1)(2)(3)(4)
F 388 **Personal and Alternating Physician Visits** **F 390** **Physician Delegation of tasks in SNFs/ Performance of Physician tasks in NFs**	C (4) At the option of the physician, required visits in SNFs after the initial may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section. [42 CFR 483.40(c)(4); Tag F388] (e) Physician Delegation of Tasks in SNFs Except as specified in paragraph e(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who —	A medical director oversees the care, treatment, and services provided to patients and residents. **STANDARD** LD.01.06.01 The organization provides services that meet patient and resident needs. **STANDARD** LD. 04.03.01 Care, treatment and services provided through contractual agreement are provided safely and effectively. **STANDARD** LD. 04.03.09 The organization complies with law and regulation. **STANDARD** LD. 04.01.01

(continued)

continued

CMS & Joint Commission Requirements for Physician Visits

	CMS	Joint Commission
F 390 **Physician Delegation of tasks in SNFs/ Performance of Physician tasks in NFs** **(continued)**	(i) Meets the applicable definition in § 491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State; (ii) Is acting within the scope of practice as defined by State law; and (iii) Is under the supervision of the physician. (2) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies. [42 CFR 483.40(e); Tag F390] (f) Performance of physician tasks in NFs. At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician. [42 CFR 483.40(f); Tag F390]	The organization permits licensed independent practitioners to provide care, treatment, and services. **STANDARD** HR. 02.01.04 Care, treatment and services provided through contractual agreement are provided safely and effectively. **STANDARD** LD. 04.03.09

Regulatory Definition of Collaboration:

42 C.F.R., Section 410.75(c)

(i) Collaboration is a process in which a nurse practitioner works with one or more physicians to deliver health care services within the scope of the practitioner's expertise, with medical direction and appropriate supervision as provided for

in jointly developed guidelines or other mechanisms as provided by the law of the State in which the services are performed.

(ii) In the absence of State law governing collaboration, collaboration is a pro-cess in which a nurse practitioner has a relationship with one or more physicians to deliver health care services. Such collaboration is to be evidenced by nurse prac-titioners documenting the nurse practitioners' scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. Nurse practitioners must document this collaborative process with phy-sicians.

(iii) The collaborating physician does not need to be present with the nurse prac-titioner when the services are furnished or to make an independent evaluation of each patient who is seen by the nurse practitioner

RESOURCES

MLN Matters article related to S&C-04-08 “Nonphysician Practitioner Questions and Answers” Available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/ SE0418.pdf

“Pearson Report of Advance Practice Nursing” Available at http://www.webnp.net/ images/ajnp_feb07.pdf

CMS presentations on NP, PA, CNS practice, regs for skilled nursing facility available at http://www.cms.hhs.gov/MLNProducts/70_APNPA.asp

FREQUENTLY ASKED QUESTIONS REGARDING ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS IN LONG-TERM CARE

1.. When can an APRN or PA make a visit to a nursing facility patient?

An APRN or PA can make any visit to a patient in a Medicare Part A SNF other than the initial comprehensive assessment visit, which must be performed by the physician. The physician also must perform every other subsequent regulatory visit, that is, alternating the required every 30-day visit in the first 90 days and every 60-day visit thereafter. Interim visits for acute problems can be made as often as neces-sary, but documentation in the chart must show that the visit is medically reasonable and necessary. Individual states may have additional requirements for visits, such as a requirement that a physician, APRN, or PA see a patient within 72 hours of admis-sion.

In Medicare SNF's accredited by the Joint Commission, if the "initial workup" is referring to the History and Physical, then it needs to be completed 24 hours before or 72 hours after admission with a few caveats (See PC.2.120 EP.10 and 11). If the "initial workup" is referring to the comprehensive assessment (i.e., MDS), then it needs to be completed in 14 days (PC.2.120 EP.8).

For non-skilled visits, an APRN or PA not employed by the facility can make the initial visit and alternate regulatory visits with the attending physician. Interim vis-its for acute problems can be made as necessary but documentation must show the visit is medically reasonable and necessary.

2.. What CPT codes do I use to bill for APRN or PA services?

The CPT codes are the same, regardless of who sees the patient. APRNs and PAs should have their own NPI from their Medicare carrier and should use that for bill-ing. Please visit AMDA's NPI page for the latest changes and updates on CMS's im-plementation of the NPI: http://www.amda.com/advocacy/npi.cfm.

3.. What are some of the most effective ways to team with APRNs and PAs?

In addition to alternating regulatory visits, APRNs and PAs can help to teach fa-cility staff, perform patient assessments, and handle counseling activities (e.g., med-ication management, advance directives). They also can handle procedures, such as wound debridement, joint injection, bedside urodynamic testing, PICC line inser-tion, and cryotherapy, if they have the appropriate training and collaboration with the supervising physician.

Additionally, Medical Directors have suggested using APRNs for the following:

- Handling acute or episodic problems such as rashes, pressure ulcers, and uri-nary tract infections.
- Performing annual physical examinations and assessments.
- Communicating patient progress and providing updates to hospital and com-munity physicians and getting information about whether and why certain di-agnostic or therapeutic interventions were or were not undertaken in the past.

- Facilitating communication with patients and families.
- Conducting in-services for staff and conducting quality-improvement activities.
- Writing protocols for licensed nurses for commonly occurring events.
- Assisting the medical director in developing, revising, and evaluating relevant clinical policies and procedures for the facility.
- Discussing a patient's condition and plan of care with family members.

4.. Are physicians who hire APRNs or PAs at increased risk of malpractice?

Concerns about heightened malpractice exposure may be keeping some practices from hiring APRN or PAs. As shown in the National Practitioner Data Bank (http:// www.bhpr. hrsa.gov/dqa/), however, APRN or PA providers as a group are many times less likely than physicians to be named as primary defendants in a malpractice case. Given that many malpractice cases arise because the patient didn't perceive that they were listened to (Glabman, 2004; Pritchard, 2005; Worthington, 2004), the addition of an APRN or PA provider can improve communication with patients and their families and thereby decrease the risk of malpractice complaints.

Sources:

Glabman M. The top ten hospital malpractice claims—and how to minimize them. Trustee 2004; 57(2): 12-6.

Pritchard DJ. A plaintiff attorney's candid view of medical malpractice. Clin Perina-tol 2005; 32(1): 191-202.

Worthington K. Customer satisfaction in the emergency department. Emerg Med Clin North Am 2004; 22(1): 87-102.

5.. Are there activities that APRNs or PAs should not perform?

APRNs and PAs should not participate in activities outside their scope of prac-tice, as determined by state and federal regulations. They can augment, but should not be solely responsible for, the attending physician's role. APRNs and PAs cannot act as primary providers in either the SNF or the NF; all care must be provided in collaboration with a physician 483.40 (f) Performance of physician tasks in NFs. At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physi-cian assistant who is not an employee of the facility but who is working in collabora-tion with a physician. (See Appendix 1)

These practitioners may have limitations for prescribing controlled substances and should not perform activities or procedures that are beyond their training and expertise. PAs and NPs, like every member of the health care team, should work to their maximum level of licensure for greatest efficiency and value.

ACRONYMS AND ABBREVIATIONS

AMDA	American Medical Directors Association
ANSI	American National Standard Institute
APRN	advanced practice registered nurse
BBA97	Balanced Budget Act of 1997
CMS	Centers for Medicare & Medicaid Services
CNS	clinical nurse specialist
CPT	current procedural terminology
E/M	evaluation and management
NF	nursing facility (nonskilled)
NP	nurse practitioner
NPI	National Practitioner Identifier
NPP	nonphysician practitioner
NSF	National Standard Format
PA	physician assistant
SNF	skilled nursing facility

GLOSSARY

"1099 employee.." An individual who can suffer a loss or make a profit, has a prin-cipal place of business, makes services available to the public as a self-employed individual, and works as an independent contractor on a nonexclusive basis.

American National Standards Institute (*ANSI). . A nonproprietary claim format used to import data for electronic submission of claims.

Balanced Budget Act of 1997 (BBA97).. Enacted legislation that had wide-ranging implications for health care. Principally, the Balanced Budget Act formally allowed provider-sponsored organizations to participate in the Medicare program, changed the way in which health plans are paid for Medicare enrollees, altered greatly what types of home health services the Medicare program will pay for and how they will be reimbursed, and provided funding to states for President Clinton's Children's Health Insurance Program. This law made sweeping changes in the Medi-care and Medicaid programs. Several of the significant provisions of the BBA were payment reductions to health care providers, new prospective payment systems for health care providers, and reduction of coverage of health care services by the Medi-care and Medicaid programs.

Carriers, Medicare Part B.. Private insurance companies that contract with the fed-eral government to process Medicare claims and make payments for services and supplies covered by Part B.

Centers for Medicare & Medicaid Services (CMS).. The federal agency responsible for administering Medicare and overseeing states' management of Medicaid.

CMS Form 1500.. The standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional carriers (DMERCs) when a provider qualifies for a waiver from the Administrative Simplifi-cation Compliance Act (ASCA) requirement for electronic submission of claims. It is also used for billing of some Medicaid State Agencies.

"Incident to.." Services or supplies that are furnished as an integral, although inci-dental, part of the physician's personal professional services in the course of diagno-sis or treatment of an injury or illness.

Long-term care.. Services ordinarily provided in a skilled nursing, intermediate care, personal care, supervisory care, or elder care facility.

Medicare Carriers Manual.. The Medicare program's operating instructions for the Part B contractors who are responsible for administration of the Supplementary Medical Insurance Program-Part B of Medicare.

Nursing facility.. An institution (or a distinct part of an institution) which is primar-ily engaged in providing to patients skilled nursing care and related services for patients who require medical or nursing care, rehabilitation services for the reha-bilitation of injured, disabled, or sick persons, or on a regular basis, health-related

care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases.

Physician fee schedule.. A comprehensive listing of fees used by either a health care plan or the government to reimburse physicians and other health care providers on a fee-for-service basis.

Scope of Practice.. A terminology used by state licensing boards for various profes-sions that defines the procedures, actions, and processes that are permitted for the licensed individual. The scope of practice is limited to that which the law allows for specific education and experience, and specific demonstrated competency.

Skilled Nursing Facility.. A facility, either freestanding or part of a hospital, that ac-cepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in the acute care setting of a hospital. A "skilled nursing facility" is defined as an institution (or a distinct part of an institution) which is primarily en-gaged in providing skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases.

APPENDIX 1

The following is a list of November 2008 verbal clarifications from CMS on tasks physicians must perform personally:

Tasks the Physician Must Perform

Regulation	Language	Clarification
483.40	Each patient must remain under the care of a physician.	A physician can not delegate the responsibility for the total care of the patient. They can only delegate certain tasks.
483.40 (a)(1)	The medical care of each patient is supervised by a physician.	The supervisory physician's role can not be delegated. However, even in states that allow nonphysician practitioners to handle the care of the patient, the patient must remain under the care and supervision of a physician.
483.40 (e)	Physician delegation of tasks in SNFs. Except as specified in paragraph (e)(2) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who— i. (iii) Is under the supervision of the physician.	The physician's supervisory role can not be delegated. The emphasis in the regulations at 42 C.F.R. 483.40(f):"At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician."
483.40 (d)	A nursing facility must— (B) provide for having a physician available to furnish necessary medical care in case of emergency.	A physician must be available to furnish care in the case of an emergency. The overall responsibility for care of the patient can never be delegated away from the physician.

Statutory Definition of Collaboration:

Section 1861(aa)(6) of the SSA provides: The term "collaboration" means a pro-cess in which a nurse practitioner 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 guide-lines or other mechanisms as defined by the law of the State in which the services are performed.

ADDITIONAL RESOURCES

Physicians

American Medical Directors Association (AMDA)
11000 Broken Land Parkway, Suite 400 Columbia, MD
21044
410-740-9743 fax:
410-740-4572
http://www.amda.com/

Physician Assistants

American Academy of Physician Assistants (AAPA) 2318
Mill Road
Suite 1300 Alexandria,
VA 22314 703-836-
2272
fax: 703-684-1924
http://www.aapa.org/

Physician Assistant
Education Association 655
Street NW, Suite 700
Washington, DC 20001-2385
703-548-5538 paeaonline.org

Commission on Accreditation of Allied Health Education Programs (CAAHEP) 1361
Park Street
Clearwater, FL 33756
727-210-2350
fax: 727-210-2354
http://www.caahep.org/

National Commission on Certification of Physician Assistants (NCCPA) 12000
Findley, Suite 100
Johns Creek, GA 30097
678-417-8100
Fax 678-417-8135
http://www.nccpa.net/

Nurse Practitioners

American Academy of Nurse Practitioners (AANP) PO
Box 12846
Austin, TX 78711
512-442-4262 fax:
512-442-6469
http://www.aanp.org/

American College of Nurse Practitioners (ACNP) 1501
Wilson Blvd., Suite 509
Arlington, VA 22209
703-740-2529
fax: 703-740-2533
http://www.acnpweb.org/

American Nurses Association (ANA)
8515 Georgia Avenue
Suite 400
Silver Spring, MD 20910
800-274-4262
fax: 301-628-5001
http://www.ana.org/

National Certification Corporation for Obstetric, Gynecologic and Neonatal Nurse Specialties (NCC-OGNN)
PO Box 11082 Chicago,
IL 60611-0082 312-951-
0207
fax: 312-951-9475
http://www.nccnet.org/

National Certification Board for Pediatric Nurse Practitioners and Nurses (NCC-PNP) 800 South Frederick Avenue
Suite 104
Gaithersburg, MD 20877
301-330-2921
fax: 301-330-1504
http://ww.pnpcert.org

Gerontological Advanced Practice Nurses Association (GAPNA) 7794
Grow Drive
Pensacola, FL 32514
866-355-1392
fax: 850-484-8762
http://www.gapna.org

National League for Nursing (NLN) 61
Broadway, 33rd Floor
New York, NY 10006
800-669-1656
fax: 212-812-0393
http://www.nln.org/

Clinical Nurse Specialists
National Association of Clinical Nurse Specialists (NACNS) 2090
Linglestown Road, Suite 107
Harrisburg, PA 17110
717-234-6799
fax: 717-234-6798
http://www.nacns.org

BIBLIOGRAPHY

American Academy of Nurse Practitioners. Scope of Practice for Nurse Practitioners. Revised 2007. Austin, TX: AANP.

Bonnel W, Belt J, Hill D, Wiggins S, Ohm R. Challenges and strategies for initiating a nursing facility practice. J Am Acad Nurse Pract 2000; 12(9), 353-9.

Garrard J, Kane RL, Radosevich DM, et al. Impact of geriatric nurse practitioners on nursinghome patients' functional status, satisfaction, and discharge outcomes. Med Care 1990; 28: 271-83.

Intrator O, Feng Z, Mor V, Gifford D, Bourbonniere M, Zinn J. The employment of nurse practitioners and physician assistants in U.S. nursing homes. Gerontolo-gist 2005; 45(4): 486-95.

Kane RL, Garrard J, Buchanan JL, Rosenfeld A, Skay C, McDermott S. Improving pri-mary care in nursing homes. J Am Geriatr Soc 1991; 39: 359-67.

Kearnes DR. A productivity tool to evaluate NP practice: monitoring clinical time spent in reimbursable, patient-related activities. Nurse Pract 1992; 17(4): 50-52, 55.

Kramer AM, Fox PD, Morgenstern N. Geriatric care approaches in health mainte-nance organizations. J Am Geriatr Soc 1992; 40: 1055-67.

McDougall GJ, Roberts B. A gerontologic nurse practitioner in every nursing home: a necessary expenditure. Geriatr Nurs 1993; 14: 218-20.

Melillo KD. Utilizing nurse practitioners to provide health care for elderly patients in Massachusetts nursing homes. J Am Acad Nurse Pract 1993; 5: 19-26. Mezey M. GNPs on staff. Geriatr Nurs 1990; 11: 145-7.

Mezey M, Burger SG, Bloom HG, et al. Experts recommend strategies for strength-ening the use of advanced practice nurses in nursing homes. J Am Geriatr Soc 2005; 53(10): 1790-7.

Miller SK. Impact of a gerontological nurse practitioner on the nursing home elderly in the acute care setting. AACN Clin Issues 1997; 8: 609-15.

Rapp MP. Opportunities for advance practice nurses in the nursing facility. J Am Med Dir Assoc 2003; 4(6): 337-43.

Resnick B, Bonner A. Collaboration: Foundation for a successful practice. J Am Med Dir Assoc 2003; 4(6): 344-9.

Rollet J. Annual legislative update. State initiatives in 2004. Adv Nurse Pract 2004; 12(12): 51-53, 56.

Yawn BP, Geier GR Jr. Should a geriatric nurse practitioner become part of a multi-specialty group? Minn Med 1995; 78: 17-21.

SAMPLE COLLABORATIVE AGREEMENT

The following is a supervisory agreement between (Name), APRN, and (Name), MD

1. The parties are employees of (name of place). The following physicians will provide supervisory support in the absence of (MD above) and (List of doctors).

2. Scope of practice: (Name of APRN), Nurse Practitioner, will practice in the general area of Geriatrics.

3. In conformance with 243 CMR 2.10, the Nurse Practitioner may perform any of the following functions not struck out. Any other specific delegated tasks will be listed on an attached document.

3.1.1 Screen patients to determine the need for medical attention.
3.1.2 Review patient records to determine health status.
3.1.3 Take a patient history.
3.1.4 Perform a physical examination.
3.1.5 Perform developmental screening examination on children.
3.1.6 Record pertinent patient data.
3.1.7 Make decisions regarding data gathering and appropriate management and treatment of patients being seen for the initial evaluation of a prob-lem or the follow-up evaluation of a previously diagnosed and stabi-lized condition.

3.1.8 Prepare patient summaries.
3.1.9 Initiate requests for commonly performed initial laboratory studies.
3.1.10 Collect specimens and carry out commonly performed blood, urine, and stool analyses and cultures.
3.1.11 Identify normal and abnormal findings on history, physical examina-tion, and commonly performed laboratory studies.
3.1.12 Identify appropriate evaluation and emergency management for emer-gency situations, for example, cardiac arrest, respiratory distress, inju-ries, burns, and hemorrhage.
3.1.13 Perform clinical procedures such as:
- i. venipuncture
- ii. intradermal tests iii. electrocardiogram
- iv. care and suturing of minor lacerations
- v. casting and splinting
- vi. control of external hemorrhage
- vii. application of dressings and bandages
- vii. administration of medications as listed below, intravenous fluids, whole blood and blood components (if ordered by the Physician Assistant supervisor for a named patient)
- viii. removal of superficial foreign bodies
- ix. cardiopulmonary resuscitation
- x. audiometry screening xii. visual screening
- xiii. carrying out aseptic and isolation techniques

3.1.14. Provide counseling and instruction regarding common patient prob-lems.

4. The Nurse Practitioner will perform the above tasks using previously agreed upon protocols (see attached).

5. Prescribing: The Nurse Practitioner may prescribe and dispense drugs in com-pliance with 243 CMR 2.10. Attestation by the supervising physician that he/she has knowledge and experience with any drug that the Nurse Practitioner will prescribe is attached. [Draw a single line through each and any class below which the physi-cian does not wish to include in this agreement.]

a. antihistamines
b. anti-infective agents
c. antineoplastic agents, unclassified therapeutic agents, devices, and phar-maceutical aids (if originally prescribed by the collaborating physician and approved by the collaborating physician for ongoing therapy)
d. autonomic drugs
e. blood formation, coagulation and anticoagulant drugs, and thrombolytic and antithrombolytic agents
f. cardiovascular drugs
g. central nervous system agents (excluding general anesthetics and mono-amine oxidase inhibitors)
h. contraceptives (including foams and devices)
i. diagnostic agents
j. disinfectants for agents used on objects other than skin
k. electrolytic, caloric, and water balance agents
l. enzymes
m. antitussive, expectorants, and mucolytic agents
n. gastrointestinal drugs
o. local anesthetics
p. eye, ear, nose, and throat preparations
q. serums, toxoids, and vaccines
r. skin and mucous membrane agents
s. smooth muscle relaxants
t. vitamins
u. hormones and synthetic substitutes

Guideline may be found in current year PDR, Epocrates or other agreed upon data-base.

6. Reviews of initial prescriptions or changes in medication of controlled sub-stances will be performed on an ongoing basis and/or monthly.

7. The Nurse Practitioner shall report to the Nurse Practitioner's Supervising Phy-sician (orally or in writing) the medical regimens executed or relayed by him/her while the supervising physicians was not physically present, along with necessary reasoning.

8. (APRN name) has a valid license to practice as a Nurse Practitioner in the State of (State).

9. The Nurse Practitioner and the Supervising Physician will review the patient records upon which entries are made, personally and regularly, but at least every 3 months.

10. The Nurse Practitioner will serve in the following location(s) and practice setting(s):

11. Resolution of disagreement: in the event of a disagreement between the Nurse Practitioner and the Physician regarding patient evaluation or management within the designated scope of practice, the Physician (or the Physician covering in his absence) shall have the final decision after discussing the situation with the Nurse Practitioner.

12. This Practice Agreement will be reviewed, signed and dated annually by the Nurse Practitioner and the Supervising Physician.

This agreement is signed on (date) by

Notes

AMDA — The Society for Post-Acute
and Long-Term Care MedicineE
11000 Broken Land Parkway, Suite
400 Columbia, Maryland 21044
www.amda.com

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