Optimizing Reimbursement of the Clinical Team in Long Term Care

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Physician and Nurse Practitioner Collaboration in LTC Facilities

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Collaboration Versus Supervision

• *Supervision* implies some on site or direct oversight, and conveys a more hierarchical relationship.
• *Collaboration* is a joint and cooperative enterprise that integrates the individual perspectives and expertise of various team members.
  • Some commonly identified themes of collaborative relationships include collegiality, teamwork, open communication, recognition of the other person’s expertise, and a strong level of trust and respect.
Source of Section 483.40
Supervision in SNFs vs. Collaboration in NFs

• Adopted via 56 Fed. Reg. 48856 et seq (September 26, 1991)
• HCFA intent: to increase flexibility concerning physician services with “increased delegation of tasks to physician extenders.”
• Based on the statutory distinction: physician supervision is required in SNFs but collaboration is permitted in NFs
• Even in SNFs: regulations on alternating visits “should allow for the effective utilization of [what it called “physician extenders”] in the nursing home setting.

Definitions

• Physician collaboration is a requirement of participation in Medicare in order to bill for nurse practitioner services.
• Collaboration must adhere to state law and is generally defined as providing medical management of care with physician direction or supervision.
• There are no clear guidelines as to how this collaboration needs to be documented to meet Medicare guidelines.
• Attempts should be made to optimize the skills of each party and to allow each participant to provide care within his or her scope of practice.

Federal Survey and Certification of SNFs and NFs: Physician Services

• Statutory Source of the distinction between SNFs and NFs under 42 C.F.R., Section 483.40(e) and (f).
• Medicare SNFs: SSA, Section 1819(b)(6)- carried forward older requirement that all SNF care must be under the "supervision" of a physician.
Supervision in SNFs vs. Collaboration in NFs

- Medicaid NFs: Section 1919(b) (amended by Section 4801(d) of OBRA of 1990) NFs must "require that the health care of every resident be provided under the supervision of a physician (or, at the option of a State, under the supervision of 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):

- Section 483.40(e)(1)(iii) requires SNFs to ensure care is under physician supervision
- Section 483.40(f) permits, at the state's option, physician tasks (including those required to be personally performed by a physician) to be provided by an NP who is not an employee of the NF but who is working "in collaboration"

MEDICARE

In addition to service provision NP may:
- Order medically necessary therapy services
- Initial certification and recertification
- Order DME and certify medical necessity
- Bill for services and supplies provided "incident to" the NP’s services under similar criteria as previously outlined: Caution-ensure compliance with state law
- Prescribe medications
Medicare Coverage Rules

• NPs who are not enrolled as Medicare providers on or after January 1, 2003, must:
  • 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;
  • Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; and
  • Possess a master’s degree in nursing.

Place of Service: Incident To Billing

• In a LTC facility must be in a discrete part of the facility designated by the physician as an office.
• Place of Service 11
• Codes that apply pertain to Office or Other Outpatient Codes: 99201-99215

Developing a Collaborative Agreement

• The requirements describe what a nurse practitioner can do in a particular practice setting:
  • the diagnosis, treatment, and management of acute and chronic health problems
  • ordering, interpreting and performing lab and radiology tests;
  • prescribing medications, including controlled substances;
  • receiving and dispensing stock and sample medications; and
  • performing other therapeutic or corrective measures as indicated.
Developing a Collaborative Agreement

- The relationship between the physician and the nurse practitioner should be well delineated within the collaborative agreement.
- The collaborating team must establish what their relationship will be—for example, how often the nurse practitioner and physician will interact, how that interaction will take place (i.e. face to face or via the telephone, email, etc.), and how the interaction will be documented (i.e. charts signed, log book kept).
- Make this realistic

Developing a Collaborative Agreement

Recommendations for Development and Use of Collaborative Agreements
1. Keep guidelines general: avoid specifics except for procedures
2. Avoid setting specific time frames
3. Make it realistic
4. Read, sign, and know what the agreement states and adhere to it
5. Document evidence of adherence (i.e. keep record of consultations and narcotic prescribing)

Developing a Collaborative Agreement

6. Provide a general list of treatable health problems, prescriptive abilities, and types of tests and procedures either ordered for patients or independently performed (or refer to scope of practice as outlined in other documents)
7. Know the scope of practice for the nurse practitioner within the state and make sure the agreement is in alignment with the current scope of practice
8. Provide documentation of nurse practitioner skills with regard to specific procedures
9. Add new providers to the collaborative agreement when they join the practice and update the appropriate agency (e.g. the State Board of Nursing, Board of Medicine)
Developing a Collaborative Agreement

• The collaborative agreement should outline the nurse practitioner’s prescriptive privileges.
• Done by listing drug categories (e.g., antihypertensives, antipsychotics, schedules II-IV drugs) rather than specific names of medications.
• Follow/adhere to state regulations.

Tricks of the Trade for Successful MD/NP Collaboration & Practice

• Communication
  • Signing and discussion of the collaborative agreement should ideally be done face to face.
  • Set up the communication lines—how often, what method (pager, phone, email), for what and when.
  • Differences of opinion on the plan of care should never be aired in front of other staff, patients, or families. This should, however, be addressed privately as soon as possible between the collaborating physician and nurse practitioner.

Roles and Responsibilities

NP Practice Options:
• Takes calls from facilities or office practices and contacts physicians only as necessary
• Assesses patients with change in condition or intercurrent illness
• Provides detailed assessment of the patient for physician review
• Maintains ongoing and up to date patient information
• Provides current updates on patients’ general health status
• Coordinates and facilitates specialty referrals and communication between specialists and primary care providers
Roles & Responsibilities

• Pharmacy recommendations and rehabilitation referrals
• Patients and family care conferences
• Ongoing education of nursing staff to enhance quality of care delivered to patients
• Routine procedures as delineated by the collaborative practice agreement
• Alternate (every other) regulatory visits in long term care settings, as appropriate.

Who Will DO.....

• Monthly visits?
• Family meetings?
• Health promotion activities?
• Pre op evaluations?
• Post fall evaluations?
• Quality assurance activities?

Advantages to NP/MD Practice

• The true purpose of collaborative practice is to deliver comprehensive care, in any setting, that best meets the needs of a particular practice population.
• Better early detection/assessment and management of nursing relevant problems (e.g. bowel & bladder).
• More comprehensive family communication.
• Physicians can see more complicated patients, perform additional services, or engage in medical direction activities/QA
Protective Actions

- Physicians & NPs should each maintain their own liability insurance.
- Rigorously comply with the guidelines established in the collaborative agreement if required by the state.
- Document, document, document
- Encourage and facilitate communication

Four Models

- Facility/Company Employed NPs
- Physician Employed NPs
- NP Practices
- Managed Care Organization (MCO) Employed NP’s

Facility/Company Employed NPs

- Advantages
  - More control over the selection of the NPs
  - Greater ability to use NPs for medical services and other roles
  - Potentially greater acceptance by nurses and medical staff
  - Training and flexibility enhanced
Facility/Company Employed NPs

- Disadvantages
  - Company has to bear the cost
  - Requires the facility to understand medical services billing and coding
  - Requires enhancement of corporate compliance to include this dimension
  - Limitation under federal requirements related to NF mandatory visits depending on company employment
  - Medical staff may see this as competitive

Physician Employed NP’s

- Advantages
  - Greater integration into medical practice; support for medical director where this is the hiring practice
  - Financial responsibility does not rest with the facility
  - Existing knowledge of medical coding, documentation and compliance in medical group

Physician Employed NP’s

- Disadvantages
  - Less facility control; may be other demands on NP time
  - NP may have more limited role in non-medical services unless a separate contract for those services is signed
  - Additional cost
  - Stark and Anti-kickback compliance
  - May be more difficult for the NP to provide additional support and back up for residents under care of other medical groups
NP Practices

• Advantages
  • More focused on NP services as a main function rather than incidental to medical services
  • Physicians contracted to support the practice more likely to be supportive and integrated
  • If mainly focused on facility based care, no conflict with office based practice
  • May be seen as less threatening to medical practices otherwise supporting the facility’s residents

NP Practices

• Disadvantages
  • May more difficult to gain acceptance within the medical community
  • Depending on situation with hospital privileges may be more difficult to follow residents into the hospital
  • Depending on scope of practice may not be able to provide certain support such as employee health support
  • Cannot act as medical directors

MCO Employed NP’s

• Advantages
  • Enhanced patient care through more intense involvement
  • NP extensively trained in geriatric care via corporate training model
  • Nursing staff acceptance
  • After hours call coverage
  • Facility and MD bear no additional expenses
  • Cost savings system wide
MCO Employed NP’s

- Disadvantages
  - Less control over specific NP hiring
  - Perception of loss of Part A reimbursement to facility
  - Perception of limits to hospitalizations
  - Different reimbursement model vs. Medicare

Conclusion

- NP involvement is essential to meet the rising shortage of primary care providers and increasing focus on quality of care
- Consider economic impact of NP involvement
- Goal is to find the optimal balance for the greatest patient benefit.

Billing to Support Interprofessional Collaboration in LTC Facilities

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Agenda: Two Parts

1. Billable Services
   • Required elements
   • Estimated reimbursement
   • How-to for implementation

2. Billable Teams
   • Leveraging everyone to achieve Merit-based Incentive Payments
   • Toward Alternative Payment Models

Billable Services*

• Annual Wellness Visits
• Advance Care Planning
• Chronic Care Management
• Cognitive Assessment
• Care Planning

*Traditional Medicare beneficiaries

Annual Wellness Visits

• “The purpose of the visit is to deliver evidence-based preventive services by an appropriate clinical provider in the appropriate clinical setting” (CMS guidance)

• Also
  • MUST include Personal Preventive Services Plan
  • Should include Advance care planning
  • Could include E/M visit

• Is NOT
  • A physical (no stethoscope)
Annual Wellness Visits: Required Elements

**ASSESS**
- Health Risk Assessment
- Current Provider List
- Depression Risk
- Safety Assessment
- Routine Physical Measures
- Cognitive Impairment

**COUNSEL**
- Screening guidance
- Plan for risk factors identified
- Advance care planning

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Annual Wellness Visits: HRA

(HEALTH RISK ASSESSMENT)

At a minimum:
- Demographic data
- Self-assessment of health status
- Psychosocial risks
- Behavioral risks
- Activities of Daily Living (ADLs)
- Instrumental ADLs

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Annual Wellness Visits: Family/Medical History

- Opportune time to update the problem list
- Use of all diagnostic codes better classifies patients for risk-adjustment
- Hierarchical Clinical Conditions (CMS-HCC) framework
Annual Wellness Visits: Physical Measures

• Height, weight and BMI
• Blood pressure
• Other routine physical measurements “as deemed appropriate based on medical and family history”

Cognitive Impairment

• Based on direct observation with consideration from reports of others (claims data, friends and family)

Annual Wellness Visits: Screening Guidance

• Screenings that are appropriate based on
  • USPSTF recommendations
  • Age-appropriate
  • Patient’s medical, social history, functional status

• List risk factors for which interventions or referrals would be appropriate

• Furnish personalized health advice
  • Fall prevention
  • Nutrition
  • Physical activity
  • Tobacco-use cessation
  • Weight loss

Annual Wellness Visits: Reimbursement*

• AWV first time (G0438)
  • $162.21 Non-facility
  • $177.21 Non-facility Limiting
• AWV subsequent (G0439)
  • $109.35 Non-facility
  • $119.47 Non-facility Limiting
• AWV (G0439) + Advance care planning, 30 min (99497)
  • $109.35 + 57.86 + $187.91 Non-facility
  • $109.35 + 57.40 + $183.47 Facility
  • $119.47 + $85.83 + $205.30 Non-facility Limiting

*MAC 1010200 Alabama
Annual Wellness Visits: How-To

Strongly Recommended Elements

- Explanation brochure or form letter or email
  - What AWV is, what AWV is not
- Pre-created documentation form
  - Including required elements
- Identification of roles and responsibilities for completion
  - RN
  - Provider
- Care Plan* template

*to be explained in the Care Planning section

Advance Care Planning

- The explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional;

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

Advance Care Planning: Reimbursement

- Advance Care Planning first 30 minutes (99497)
  - $39.89 Non-facility
  - $30.97 Facility
  - $43.58 Non-facility Limiting
  - $33.84 Facility Limiting
- Advance Care Planning subsequent 30 minutes (99498)
  - $69.04 Non-facility
  - $69.04 Facility
  - $75.42 Non-facility Limiting
  - $75.42 Facility Limiting
Advance Care Planning: How-To

- Conduct during AWV
  - No co-pay for the visit or service
- Conduct during E/M visit
- Conduct as standalone visit
  - For long discussions ideally
- Create documentation template

Chronic Care Management

- Covers time spent coordinating and managing care for Medicare beneficiaries while they are not in clinic

- Time spent must total at least 20 minutes in a month
  - Higher charge when time spent totals 60 minutes in a month
  - Then charge in 30 minute increments

CCM: Required Elements

- For qualified beneficiaries
  - At least 2 chronic conditions that have potential for exacerbation and/or death
- Patient consent
- Written and shared comprehensive Care Plan
CCM: Estimated Reimbursement

• CCM, first 20 minutes (99490)
  • $39.89 Non-facility
  • $30.97 Facility
  • $43.58 Non-facility Limiting
  • $33.84 Facility Limiting
• CCM, 60 minutes (99487)
  • $86.47 Non-facility
  • $50.34 Facility
  • $94.47 Non-facility Limiting
  • $54.78 Facility Limiting
• CCM, additional 30 minutes (99489)
  • $43.40 Non-facility
  • $25.23 Facility
  • $47.41 Non-facility Limiting
  • $27.57 Facility Limiting

CCM: How-To Implement

• Initiating visit to establish CCM services, gather consent

• Creation of Care Plan
  • Sharing of Care Plan
• Process for recording CCM activities
• Roles and responsibilities involved in CCM
  • Typically RN or LCSW conduct CCM activities
  • Under the supervision and direction of a qualified provider (MD, DO, PA, NP, CNS)

Cognitive Assessment

• Medicare reimbursement for services aimed at improving detection, diagnosis, and care planning and coordination for patients with Alzheimer's disease and related dementias (ADRD) and their caregivers
• A clinical visit that results in a comprehensive Care Plan
Cognitive Assessment: Required Elements

• Assessment of
  • Cognition
  • Function
  • Safety
  • Neuropsychiatric and behavioral symptoms
  • Pain (new in 2017)
• Review of
  • Medications
  • Caregiver needs
• Counseling regarding
  • Safety
  • Driving

Cognitive Assessment: Reimbursement

• Cognitive Assessment (G0505)
  • $223.03 Non-facility
  • $169.49 Facility
  • $243.66 Non-facility Limiting
  • $185.16 Facility Limiting
• PLUS Care Planning (G0506)
  • $282.53 Non-facility
  • $213.37 Facility
  • $308.66 Non-facility Limiting
  • $233.10 Facility Limiting

Care Planning: Required Elements

• Summary of assessments
• Goals and instructions
• Recommended preventive care
• Medication reconciliation
• Inventory of all clinicians and services involved in their care
Care Planning

• Time spent outside the E/M visit in the creation of a care plan
• Used with CCM or with Cognitive Assessment or with AWV

Care Planning: Reimbursement

• Care Planning (G0506)
  • $59.50 Non-facility
  • $43.88 Facility
  • $55.00 Non-facility Limiting
  • $47.94 Facility Limiting
• Required/expected to furnish with Cognitive Assessment
  • Can use for other services requiring or benefiting from care plan

MACRA: Push for Quality

• Currently held to reportable quality measures for reimbursement in 2018
• Primary care measures
  • Preventive
  • Screening
  • Chronic disease management
    • Process
    • Outcome
The Whole Team for Quality

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Team Member(s) Involved</th>
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<tbody>
<tr>
<td>Immunizations</td>
<td>Medical secretary, Registered nurse</td>
</tr>
<tr>
<td>Preventive care</td>
<td>Medical secretary, Registered nurse, Nurse practitioner</td>
</tr>
<tr>
<td>Screenings</td>
<td>Registered nurse, Nurse practitioner</td>
</tr>
<tr>
<td>Chronic disease process measures</td>
<td>Registered nurse, Nurse practitioner</td>
</tr>
<tr>
<td>Chronic disease outcome measures</td>
<td>Nurse practitioner, patient/caregiver</td>
</tr>
</tbody>
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Summary

- Evidence is mounting that quality aims are achieved through **high-functioning** interprofessional teams
- CMS has shifted reimbursement to strongly encourage services that are both beneficial to patients and require a team-based approach