RESOURCES FOR PRACTICE

Implications for cardiology nurse practitioner billing: A comparison of hospital versus office practice

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Abstract

Purpose: To discuss the implications for cardiology nurse practitioner (NP) billing and compare and contrast inpatient Medicare billing practices versus outpatient Medicare billing practices.

Data sources: Selected articles, text books, and government websites.

Conclusions: In today’s complex and expensive healthcare system, there has been a steady decline in the reimbursement rate for professional services to hospitals and physicians. NPs can have a significant impact on reducing this decline by billing for services provided.

Implications for practice: The cardiology NP can enhance institutional reimbursement quality and patient safety. The different billing methods such as independent billing, shared billing, and incident to billing by the cardiology NP can be complex.

Hospitals and physicians have witnessed a dramatic decrease in reimbursement rates since 1983 when Medicare implemented the Prospective Payment System (PPS) (Buppert, 2005a). At the same time, physicians and hospitals are actively seeking ways to increase revenue (Buppert, 2005a). The PPS pays hospitals a preset rate for each Medicare admission. The Medicare admission is based on the patient’s diagnosis-related group (DRG), which is a paid preset rate, regardless of the amount and nature of services provided. Prior to the PPS, hospitals were paid for most of their costs. In the past, hospitals were able to recoupere nurse practitioner (NP) expenses via a cost-reporting structure. As a result of the complexity of the cost-reporting guidelines, hospitals typically have not placed NPs on their cost reports. One method of increasing hospital revenues is to employ cardiology NPs to assist all physicians. However, these cardiology NPs should not be on the hospital’s cost reports and thus may be seen as an expense to the institution (Buppert, 2005a). Cardiology NPs are increasingly being employed in hospitals to improve patient and physician satisfaction, improve quality care, and to help increase revenue (Buppert, 2005b). The cardiology NP may have a specialty focus as an acute care, adult, family, or clinical nurse specialist. According to Buppert (2005a), NPs employed by a hospital have the opportunity to generate revenue. While NPs in primary care have the most experience with billing for their services, cardiology NPs are just beginning to understand and incorporate billing into daily hospital practice.

The three methods for billing Medicare by the cardiology NP are independent billing, shared billing, and incident to billing. This article will examine the implications of cardiology NP billing and the use of these three Medicare billing methods in the hospital and the private cardiologist’s office. This article discusses issues associated with each of these billing methods and provides examples of the services for which the cardiology NP may bill.

Independent billing

The passage of the Balanced Budget Act (BBA) in 1977 allowed NPs to bill independently for services rendered (Buppert, 2005b). However, the BBA also placed many restrictions on the place of service and reimbursements for services rendered in designated rural areas.
In 1997, the BBA lifted this restriction and allowed for NP reimbursement regardless of where the services were rendered. These restrictions are limited to Medicare, as commercial indemnity insurers and health maintenance organizations are not bound by such regulations (Buppert, 2002). Nevertheless, Medicare reimburses NPs at 85% of the physician’s fee schedule (Buppert, 2002). For NPs to bill independently, the following requirements must be met (Buppert, 2002):

- Obtain a Medicare provider number.
- Possess a master’s degree in nursing.
- Be certified by a recognized national certifying body.
- Provide a service that is within the scope of the NP’s practice.
- Bill under the NP name rather than the physician’s name.
- Perform the service in collaboration with a physician.

Collaboration is a process whereby an NP works with a physician to deliver healthcare services within the scope of the NP’s professional expertise (Buppert, 2002). There must be a written agreement between the collaborating physician and the NP. The agreement must be made available to Medicare upon request (Buppert, 2002).

**Independent billing in the hospital**

The employing hospital has the option to bill for services under the cardiology NP’s provider number. For this to occur, the cardiology NP’s salary must not be listed on the hospital’s cost report, and no one else may bill for the service (Buppert, 2002). An independent service performed by the cardiology NP may not be billed by the physician, as the physician did not perform the service (Buppert, 2002). One problem that could arise is duplication of services. If the private cardiologist and hospital employed NP are both seeing the same patient and performing the same services on the same day and the hospital is not billing for the cardiology NP, then an unnecessary duplication of services may be occurring. A careful review of employment structure, cost reporting, and billing practices needs to occur (Buppert, 2005a). Independent billing by the hospital for the cardiology NP’s services can be done to bill for services not captured by the private cardiologist. Examples of billable services for the cardiology NP may include the following: removal of intraaortic balloon pump, cardioversion, arterial line placement, discharge summaries, subsequent diagnosis, smoking cessation counseling, education, and coordination of care (Health Associates Incorporated, n.d.). Education and coordination of care requires documentation of total time spent with the patient, which must be greater than 50% of the items covered in discussion (Health Associates Incorporated, n.d.).

According to the Center for Medicare and Medicaid Services (CMS) guidelines, hospitals cannot provide NPs for private physicians and then bill for their services (Buppert, 2005b). When billing occurs for NP services in a hospital or clinic, current billing guidelines of CMS must be followed. Examples of fraud include billing for services that are not performed, offering incentives to Medicare patients that are not offered to other patients, using inappropriate procedure or diagnoses codes that are not an accurate reflection of the actual care (Vargo, 2008). This is known as up-coding if the reimbursement level is higher than the appropriate code (Vargo).

**Independent billing in the office**

Independent billing by cardiology NPs may increase the profits of a private cardiologist’s practice (Medical Group Management Association, n.d.). For example, a patient may call the cardiologist’s office with complaints of shortness of breath and the patient is told to come to the office. On arrival, the patient receives a chest x-ray, electrocardiogram, and labs. The cardiology NP, within his or her scope of practice, is then able to assess this patient, review the testing, and make an informed diagnosis and a plan of care. The cardiology NP may or may not have collaborated with the physician. The physician performs no face-to-face component of the patients visit, and does not have to be physically onsite. Thus an independent visit is performed by the cardiology NP. In addition, the care of this patient may have involved counseling and coordination of care. These services may be billed for by the cardiology NP as long as there is appropriate documentation of the total time spent, which must be greater than 50% of the items covered in the counseling (Health Associates Incorporated, n.d.). Documentation of the length of time, the education provided, and how the education relates to the patient’s diagnosis is critical in order to get the appropriate reimbursement (Health Associates Incorporated). The complexity of the bill submitted must reflect the level of service and documentation performed.

**Shared billing**

In October 2002, Medicare developed the model of shared visits or shared billing as a way to reflect the shared services of the physician and NP (Magdic, 2006). Shared visits imply that both the NP and physician have seen the patient for a face-to-face evaluation and management (E&M) services, including history taking, performing a physical examination, and
initiating medical decision making. For these services, Medicare is billed under either the physician’s or the NP’s provider number but not both (Magdic). If billed under the physician’s number, the reimbursement rate is 100% versus 85% for the NP.

**Shared billing in the hospital**

Shared visits can occur only in the hospital inpatient, outpatient, or emergency room setting. In order to bill a service as a shared visit in the hospital, four criteria must be met: (a) the NP must be an employee of the same physician group submitting the bill; (b) the service must be within the scope of the NP’s practice; (c) coding of the service must be based on the content of the service; and (d) the services of the NP and physician must occur within the same 24-hour period, either together or separately (Magdic, 2006).

The following is an example of shared billing in the hospital setting. A cardiology NP employed by a cardiologist visits a patient with chest pain on the telemetry floor in the coronary care unit of the hospital. The cardiology NP performs and records an E&M service, starts treatment for the patient’s chest pain, orders labs, and examines the patient. The physician then sees the patient 1 hour later and documents data demonstrating that the two notes are related. The physician writes on the cardiology NP’s written note, “seen and agree; patient stable and without chest pain.” The note by the physician does not need to be detailed; it just needs to show that the physician saw the patient and performed part of the E&M service. This case can be billed using the Current Procedural Terminology (CPT) code 99232, demonstrating medical decision making of moderate complexity (CMS, n.d.b).

Medical need is the determinant of what to bill for, not the amount of documentation. With shared billing, the CMS (n.d.b) E&M guidelines must be followed. Shared visits do not apply to critical care services, consultation services, or surgical procedures. For example, a consult can only be billed by the provider asked to do the consult (CMS, n.d.b).

**Shared billing in the office**

Shared billing is not allowed in the office setting; incident to billing and independent billing must be used (Magdic, 2006). Billing a shared visit requires that a physician–patient encounter takes place per Medicare guidelines and that the visit is shared between the NP and the physician as described above (CMS, n.d.b).

**Incident to billing**

“Incident to” is a Medicare term referring to “the services furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness” (CMS, n.d.a). Incident to services can be provided by NPs and are paid as if the physician had provided them. Incident to services are reimbursed at 100% of the Medicare fee schedule and billed under the physician’s provider number (CMS, n.d.a). The physician must be present in the same building as the cardiology NP, and the physician must have performed the initial assessment (CMS, n.d.b). The physician does not have to see the patient on every visit after the initial assessment, but there needs to be evidence of active participation in the patient’s care (CMS, n.d.b).

**Incident to billing in the hospital**

Incident to services are strictly prohibited in the hospital setting (CMS, n.d.a). In order for the physician to bill for a service, he or she must have performed it in full or in part as explained under shared billing (CMS, n.d.a).

**Incident to billing in the office**

Incident to services performed by the cardiology NP can greatly add to the revenue of the private cardiologist’s office practice if appropriately performed. The following requirements must be met (CMS, n.d.a):

- The cardiology NP must be an employee of the physician or physician’s group; the physician must perform the requisite services on the initial visit.
- The physician must perform the initial visit on each new patient to establish the physician–patient relationship.
- There must be continued documentation of the physician’s participation in the patient’s care.
- There must be direct supervision.

CMS has established three levels of supervision requirements: general, direct, and personal. With general supervision, the physician does not need to be in the office. With direct supervision, the physician needs to be in the office suite. Personal supervision means that the physician has to be in the room with the cardiology NP. The level of supervision depends on the CPT code. An example of direct supervision is a stress test versus an electrocardiogram, which requires only general supervision (CMS, n.d.b).

When the cardiology NP is an independent contractor, services can never be billed as incident to the
physician. There has been an inordinate increase in incident to billing, and CMS is concerned that the incident to billing method is being used inappropriately. The reimbursement rate for incident to is 100%, versus 85% if the service is billed under the cardiology NP’s provider number; consequently, there is potential for abuse. Abuse can take the form of omission of the direct supervision requirement. On occasions, the physician may be unable to be in the office when the cardiology NP is performing services; therefore, incident to billing would not be appropriate in that situation.

Barriers to NP billings

Lack of physician support in the hospital setting seems to be the prominent barrier to cardiology NPs billing for services rendered. The cardiology NP employed by the hospital may meet resistance from the cardiologists if the physicians feel that the hospital is absorbing revenues. However, the cardiology NP employed by the cardiologist and working in the office and hospital will probably have full support. It is equally important to assess what is not being billed by the cardiologist and what can be billed by the cardiology NP. Examples of common, non-captured services by the cardiology NP are education and coordination of care. While these types of services may not directly add revenue to the practice they certainly add value. Other barriers to implementation of billing practices may include the NP’s lack of billing knowledge and motivation to submit billing data in a timely fashion.

Knowledge of appropriate documentation of care is essential in order to be in compliance with coding for E&M services. The level of service provided to a patient is based on three elements of service: history, examination, and medical decision making. Medical decision making is based on three factors, which are the number of diagnoses, the amount and complexity of data reviewed, and the level of risk. Documentation must support the level of medical decision making with the required elements of service in order to appropriately bill for specific levels of service. In order to implement a successful billing program, a significant amount of time and money must be invested in coding and compliance education to ensure overall program compliance and maximum reimbursement. Consulting and enlisting the services of experts who are familiar with the complex CMS rules for billing and coding will prove profitable. The hospital NP’s employment structure must be reviewed by legal counsel to ensure billing compliance (Buppert, 2002). For additional education, the following CMS website describes in detail the documentation needed for the different level of services, http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

Conclusion

Billing for the cardiology NP’s services can potentially increase revenue and support NP utilization for a hospital or office practice. There are many benefits to cardiology NP billings that include increased revenue and increased satisfaction levels of physicians and cardiology NPs. Tracking billings of the cardiology NP can provide financial evidence of their impact on a hospital or office practice. While there are many issues surrounding cardiology NP billing services, most of them can be resolved with a thorough understanding of billing rules and guidelines and careful program implementation. Whether the cardiology NP is employed by a hospital or a cardiologist or is in independent practice, a clear understanding of the three Medicare billing methods for cardiology NPs will increase compliance and subsequent income.

References