Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare Coverage of Non-Physician Practitioner Services

June 2001
OEI-02-00-00290

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EXECUTIVE SUMMARY

PURPOSE

To describe the scope of services nurse practitioners, clinical nurse specialists, and physician assistants provide to Medicare beneficiaries, and to identify any potential vulnerabilities that may have emerged since the Balanced Budget Act of 1997.

BACKGROUND

Nurse practitioners, clinical nurse specialists, and physician assistants are health care providers who practice either in collaboration with or under the supervision of a physician. We refer to them as non-physician practitioners. States are responsible for licensing and for setting the scopes of practice for all three specialties. Services provided by them can be reimbursed by Medicare Part B.

The Balanced Budget Act of 1997 (BBA97) modified the way the Medicare program pays for their services. Prior to January 1, 1998, their services were reimbursed by Medicare only in rural areas and certain health care settings. Payments are now allowed in all geographic areas and health care settings permitted under State licensing laws. Furthermore, nurse practitioners and clinical nurse specialists are now allowed to bill Medicare directly. The services of a physician assistant, however, must continue to be billed by an employer.

Our study is based on: a review of the State scopes of practice; an analysis of Medicare billing data from the years 1997, 1998, and 1999; and information obtained from Medicare Part B carrier medical directors.

Because this inspection's intent is to be a first look at the effect of the new coverage rules under BBA97, the findings are descriptive in nature. The inspection presents what the billing data show. It also describes the State scopes of practice that are used to control billing. It is not the purpose of this inspection to evaluate the benefits or disadvantages of non-physician practitioner services.

FINDINGS

Non-Physician Practitioner Billings Are Rising Rapidly

It appears that the Balanced Budget Act of 1997 is having a substantial effect on non-physician practitioner billing. In 1999, Medicare paid for 5.2 million services, compared to 1.2 million services in 1997. Because some of these services had been billed as "incident to" prior to 1997, we were unable to determine how much of the increase in

billings was due to real growth in services and how much was due to simple changes in billing practices. The top services billed were for office or outpatient visits in office settings.

State Scopes of Practice Provide Little Guidance to Carriers

Our analysis found that the State scopes of practice are broad and as a result provide little guidance that carriers can use to process claims. Most scopes of practice contain only a general statement about the responsibilities, education requirements, and a non-specific list of allowed duties and do not explicitly identify services that are complex or beyond their scope. Carriers voice concerns over non-physician practitioners performing services such as surgery and endoscopies. Furthermore, when a service is not addressed in a scope, it cannot be assumed that a non-physician practitioner cannot provide that service. Scopes, as well as Medicare, call for collaboration with a physician. This may have the effect of either limiting or expanding the services that are allowed. If a nurse practitioner is directed by a cardiologist to make a complex diagnosis, there is nothing in the scopes preventing such a practice. In fact, States generally have a vague definition for acts such as diagnosis.

Carrier Monitoring of Non-Physician Practitioner Claims is Limited

Although all but one Medicare carrier acknowledges that non-physician practitioners are included in post-payment reviews, most carriers confirm that no pre-payment edits exist to monitor their claims. Several carriers state that monitoring is limited by the broad language in their scope of practice. Sixteen carriers do not verify that the non-physician practitioners are working within their scope, and at least 22 carriers do not check the collaborative or supervisory agreements. Most information given to carriers from HCFA include basic Balanced Budget Act language, and directives to treat non-physician practitioners as a physician when monitoring their claims.

CONCLUSION

The Balanced Budget Act successfully opened up the medical practice to non-physician practitioners, regardless of care settings. Non-physician practitioner billings are rising rapidly, but controls, which are based on scopes of practice, are limited. State scopes of practice are vague and broad. As such, carriers do not have sufficient guidance to distinguish which non-physician practitioner services should be reimbursed by the program and which should not. This creates potential vulnerabilities, both from payment and quality of care standpoints. Therefore it may be appropriate to consider other additional controls for Medicare payments to non-physician practitioners. We plan to monitor non-physician practitioner services for both overall trends and for complex services.

Agency Comments

We received comments on the draft report from the Health Care Financing Administration. They concur with our conclusion regarding vulnerabilities when non-physician practitioners bill Medicare. They are, however, sensitive to increasing the monitoring burden on contractors. The HCFA expressed a willingness to work with the OIG to monitor vulnerabilities in non-physician practitioner billings. We plan to do additional work to identify specific vulnerabilities by examining the billing practices of non-physician practitioners.

The full text of HCFA's comments are contained in Appendix F.

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INTRODUCTION

PURPOSE

To describe the scope of services nurse practitioners, clinical nurse specialists, and physician assistants provide to Medicare beneficiaries, and to identify any potential vulnerabilities that may have emerged since the Balanced Budget Act of 1997.

BACKGROUND

Nurse practitioners, clinical nurse specialists, and physician assistants are health care providers who practice either in collaboration with or under the supervision of a physician. States are responsible for licensing and for setting the scopes of practice for all three specialties. Nurse practitioners and clinical nurse specialists are licensed advanced practice registered nurses who have specialty training in primary care or acute care of patients. Both of these nurse specialties must practice in collaboration with a physician. In contrast, a physician assistant is a licensed health care professional who practices under the supervision of an immediately available physician responsible for delegating medical services to the physician assistant. All States limit the number of physician assistants a physician is allowed to supervise. Although there are other types of non-physician practitioners, such as clinical nurse midwives and nurse anesthetists, for the purposes of this inspection we will refer to nurse practitioners, clinical nurse specialists, and physician assistants collectively as “non-physician practitioners.”

Medicare Payment

Medicare provides health insurance to people who are 65 years and older, people who are disabled, and, people with permanent kidney failure. Medicare consists of two primary parts: Hospital Insurance, also known as Part A, and Supplementary Medical Insurance, also known as Part B. Medicare Part A provides coverage of institutional care such as inpatient hospital care, skilled nursing facility care, home health services, and hospice care. Medicare Part B pays for the cost of non-institutional care such as physician services, outpatient hospital services, medical equipment and supplies, as well as services provided by non-physician practitioners. Medicare uses entities called contractors to process claims. Fiscal intermediaries process Part A claims and carriers process Part B claims. Each Medicare Part B carrier must employ a medical director whose duties include: assisting in the review of claims; providing clinical judgment in medical review of claims; directing carrier personnel on the correct application of policy during claim adjudication; and providing advice to the Health Care Financing Administration (HCFA) on national coverage and payment policy.

To be reimbursed by Medicare, the non-physician practitioner must practice in accordance with State law. This law is embodied in the State nurse practice acts, which are also known as the State scopes of practice. The scope of practice typically defines the practitioner's practice, qualifications, board representation, and fee/ renewal schedule. The scopes may also list specific examples of responsibilities such as taking histories, patient care, education and training.

The Balanced Budget Act of 1997

Allowed Expanded Billing. The Balanced Budget Act of 1997 modified the way the Medicare program pays for non-physician practitioner services. Prior to January 1, 1998, these services were reimbursed by Medicare Part B only in certain geographical areas and health care settings. Nurse practitioner and clinical nurse specialist services were covered when provided in collaboration with a physician in nursing facilities in urban areas and in all settings in rural areas. They could also bill Medicare directly for services provided in rural areas. Physician assistant services were covered when provided under the supervision of a physician in hospitals and nursing facilities, as an assistant to surgery, in physician offices and patient homes in rural areas, and in a rural area designated as a health professional shortage area.

The Act also removed the restrictions on settings. Effective January 1998, payment is now allowed for non-physician practitioner services in all geographic areas and health care settings permitted under State licensing laws, but only if no facility or other provider charges are paid in connection with the service. Nurse practitioners and clinical nurse specialists are now allowed to bill directly in all settings in both rural and urban areas. The services of a physician assistant, however, must continue to be billed through an employer.

Clarified Education/Certification. The 1997 legislation clarifies the educational and/or certification requirements for certain non-physician practitioners to receive Medicare reimbursement. The regulations spell out the requirements as follows:

Nurse practitioners must:

- be a registered professional nurse;
- be authorized to perform services in the State where they practice;
- be certified by the American Nurses Credentialing Center (ANCC) or comparable certifying agency; **and**
- hold a Master's degree in Nursing, as of January 1, 2003.

Clinical nurse specialists must:

- be a registered nurse;
- be licensed in the State where they practice;
- be certified by the ANCC; **and**

- hold a Master's degree in a defined clinical area of nursing from an accredited educational institution.

Physician assistants must:

- be licensed and authorized in the State where they practice **and**
- either have graduated from an accredited educational program, or passed the National Certification Examination.

Modified Reimbursement. The Act also set new reimbursement levels. It allows payment of 80 percent of the lesser of either (1) the actual charge or (2) 85 percent of the scheduled physician fee. Prior to the Act payment for nurse practitioner or clinical nurse specialist services, when furnished in all settings in a rural area, could have been made either directly to the nurse practitioner or clinical nurse specialist, or to the employer or contractor of the nurse practitioner or clinical nurse specialist at 75 percent of the physician fee schedule for services furnished in a hospital, 85 percent of the physician fee schedule for services furnished in other settings, and at 65 percent for assistant at surgery services. Payment for nurse practitioner services when furnished in skilled nursing facilities and nursing facilities in an urban area was made to the employer of the nurse practitioner at 85 percent of the physician fee schedule. Before the Act, payment for physician assistant services was made to the employer at 85 percent of the scheduled physician fee and at 65 percent of physician fee schedule for assistant to surgery services.

Because the Act removed the restrictions on settings, interest has increased in the services non-physician practitioners are providing. The General Accounting Office's January 2000 report, *Lessons Learned From HCFA's Implementation of Changes to Benefits,* recommended that HCFA implement a recommendation made by an internal HCFA group that studied potential vulnerabilities brought about by the Act's changes. This group suggested that HCFA (1) survey the States to establish a national database of allowable practices for possible use in forming policies, (2) work with national accreditation bodies to establish standard minimum scopes of practice, and (3) that HCFA conduct a baseline study to determine the volume and type of services billed by clinical nurse specialists and nurse practitioners. At the present time, HCFA's Program Safeguard Contractor is conducting a baseline study in three States to determine the volume and type of services clinical nurse specialists and nurse practitioners are providing.

The American Medical Association (AMA) is also interested in non-physician practitioner services. The AMA is leading a coalition of medical organizations that is concerned HCFA is not ensuring that advanced practice nurses are working in collaboration with a physician and within their scope of practice.

***Incident to* services.** The Act did not affect any services provided *incident to* physicians services. *Incident to* services are provided by employees of the physician under the physician's direct on-site supervision. *Incident to* services may be provided by nurse

practitioners, clinical nurse specialists, physician assistants, medical assistants, technicians, nurses, and others employed by the physician. These services continue to be paid at 100 percent of the physician fee schedule amount as though the physician personally performed the services. The physician does not have to indicate on the claim that a non-physician practitioner performed the service. This inspection did not set out to examine *incident to* services. It focuses on services that the non-physician practitioner bills directly and services that are billed, as is always the case for physician assistants, through the employer with the non-physician practitioner specialty indicated. Carriers have complained that *incident to* services are difficult to track.

SCOPE

This inspection is intended to be a first look at the effect of the Balanced Budget Act of 1997 which enables non-physician practitioners to bill Medicare for all allowable services in all settings. The findings of this inspection are descriptive in nature.

The inspection presents what the billing data show about the services provided to Medicare beneficiaries. It also describes the States' scopes of practice that govern these practitioners. Any agreements between the physician and the practitioner, however, are not the focus of this inspection. These agreements are unique to each physician and practitioner. In order to effectively evaluate these agreements as a control mechanism, they would have to be reviewed on a case by case basis. That level of scrutiny was beyond the scope of this inspection. It is also not the purpose of this inspection to evaluate the benefits or disadvantages of services performed by non-physician practitioners.

METHODOLOGY

Data were collected from three sources: the State scope of practice; Medicare billing data from the years 1997, 1998, and 1999; and interviews with carrier medical directors.

Scopes of practice. We collected scopes of practice for physician assistants in 50 States and Washington, D.C., and both the advanced practice scope and the registered nursing scope for clinical nurse specialists and nurse practitioners in 50 States. First, we reviewed a sample of State scopes to determine common characteristics of responsibilities. From these common characteristics we developed a review document for all scopes. This document included educational requirements, written collaborative agreements, Board oversight, physician supervision, a statement of scope, and particular services such as taking histories, diagnosis, therapy, and treatment/ care plan development. We reviewed each scope of practice and noted the services allowed in each State for each specialty. We also reviewed the requirements for both the supervisory and

collaborative agreements between the physician and the non-physician practitioner as well as the prescriptive authority addressed in each State's scope of practice. See Appendix E for more details.

Billing Data. We analyzed Medicare Part B services data for each of the three specialties from the Medicare Part B Extract and Summary System (BESS) for 1997, 1998, and 1999. All service and charge data mentioned in this report reflect data for "allowed services" and "allowed charges." We also examined settings and procedure codes. We concentrated on billing changes that have occurred since BBA97 and analyzed procedures with high increases in allowed services and/ or allowed charges. We also looked at procedures considered vulnerable by carrier medical directors.

Medical Director Practices. We interviewed the 41 carrier medical directors from all the Medicare Part B carrier contractors. Our interviews focused on the process of reviewing non-physician practitioner claims and any changes in that process since BBA97. We asked about carrier screens and edits, use of State scopes of practice, and any concerns or potential vulnerabilities. The carriers also forwarded any of their non-physician practitioner medical review policies and any instructions sent to them by HCFA.

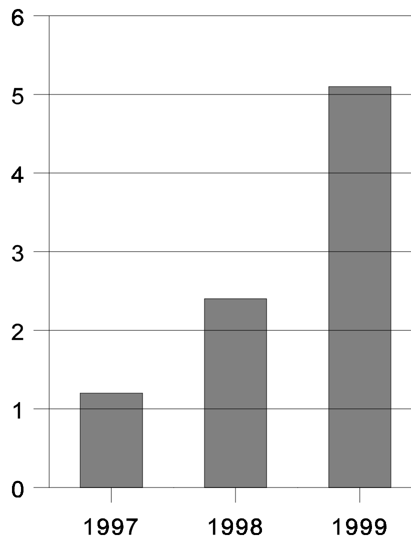
This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

F I N D I N G S

Non-Physician Practitioner Billings Are Rising Rapidly

It appears that the Balanced Budget Act is having a substantial effect on non-physician practitioner billings to the Medicare program. In 1999, BESS data show that Medicare paid for 5.2 million non-physician practitioner services (See Chart 1). This is a fourfold increase since 1997, the year BBA97 expanded settings and allowed nurse practitioners and clinical nurse specialists to bill Medicare directly in additional settings. During this same period, allowed charges also increased nearly fourfold from $55 million to $202 million (See Appendix A). Because some of these services had been billed as "incident to" prior to 1997, we were unable to determine how much of the increase in billings was due to real growth in services and how much was due to simple changes in billing practices.

Chart 1: Non-Physician Practitioner Allowed Services (in millions)



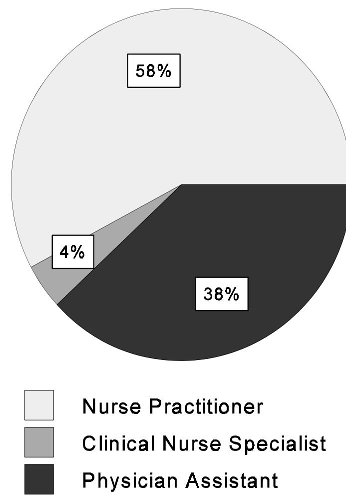
Source: Medicare BESS data

In 1999, non-physician practitioners billed about half of their services in an office setting and another quarter of services were billed from skilled nursing or nursing facilities. The top three services billed in 1999 were office or outpatient visit for the evaluation and management of an established patient, subsequent nursing facility care for the evaluation and management of the new or established patient (25 minutes), and subsequent nursing facility care for the evaluation and management of the new or established patient (15

minutes), comprising almost a third of all services billed. See Appendix B for more details on billing data.

Although clinical nurse specialists have shown the greatest proportional increases in services, nurse practitioners and physician assistants account for most of the overall services in 1999 (See Chart 2).

Chart 2: Allowed Services 1999



Source: Medicare BESS data

State Scopes of Practice Provide Little Guidance to Carriers

Our analysis found that the State scopes of practice are broad and as a result provide little guidance that carriers can use to process claims. Scopes, as well as Medicare, call for collaboration with a physician which may have the effect of either limiting or expanding the services that non-physician practitioners may perform.

Generally, State Nursing Boards set the scope of practice for clinical nurse specialists and nurse practitioners, while State Medical Boards set the physician assistant scope. Some States also defer to a national certifying body's scope, such as that of the American Nurses Credentialing Center, which similarly lacks detail (see Appendix C). Characteristics of the scopes are critical because they control what non-physician practitioners can do in their State and thus what Medicare will reimburse. It is important to note that scopes were designed to implement medical practice and not to direct Medicare reimbursement.

Most scopes contain a statement about the responsibilities, a list of allowed duties, education requirements, supervisory/collaborative agreement requirements, and prescriptive authority. The scopes differ in the amount of detail given to each element. Additionally, with the exception of few physician assistant scopes, we found that no scope explicitly identifies services that these practitioners are *not* allowed to perform. Using just the scopes, it is difficult to determine if non-physician practitioner could provide highly complex services and be reimbursed by the Medicare program. Several carrier medical directors note that relying on the scopes to determine services that can be billed to the program may be problematic. One medical director comments that the scopes are "so vast and vague. [Non-physician practitioners] can do anything that is assigned to them." A few medical directors suggest that more clarifications of duties are needed to improve the way their claims are reviewed.

Also, non-physician practitioners may provide services if they are delegated by the collaborating or supervising physician (as mentioned, the nurse practitioner and the clinical nurse specialist must collaborate with a physician, and a physician assistant must be supervised by a physician). For example, if a nurse practitioner working in collaboration with a cardiologist is directed to make a complex diagnosis, there is nothing in the scopes of practice preventing such a practice. In fact, States generally have a vague definition for acts such as diagnosis.

Scopes in 11 States provide guidance for an agreement between the clinical nurse specialist and/or the nurse practitioner and the collaborating physician. In some cases the guidance for the collaborative agreements merely contains a definition of collaboration. More State scopes provide requirements of what the physician's supervisory role is in relation to a physician assistant. For example, some physician assistant scopes may require a supervisory agreement to provide specific information about the availability of the supervising physician, type of supervision required (physical, electronic, or continuous), or whether the agreement must be in writing. However, in the case of either the collaborative or the supervisory agreement, details that are not addressed within the State scope are left to the discretion of the physician and the non-physician practitioner.

Scopes do not fully describe non-physician practitioner responsibilities

The scopes typically contain a broad statement of responsibilities. In these statements, 25 States allow nurse practitioners to provide health care according to their own area of specialization; and in 19 States, physician's assistants may provide health care as approved by State Nursing Board. In addition to the broad statement, State scopes usually give a general list of duties allowed to be performed which most often include the following: treatment/care plan development; diagnosis; assessments; dispensing medication; counseling; referrals; and education/teaching.

Table 1: Selected Non-physician Practitioner Responsibilities

Responsibilities	Number of State Scopes Allowing Specific Service		
	Clinical Nurse Specialist (N=44*)	**Nurse Practitioner** (N=50)	**Physician Assistant** (N=50)
Treatment plan development and implementation	36	37	19
Diagnosis	26	35	15
Assessment/history/exam	33	37	26
Dispensing medication	24	20	18
Counseling	24	31	16
Referrals	14	26	12
Education/teaching	28	29	15

*44 States recognize CNSs.

Within the list of duties, scopes offer few specific guidelines. For example, diagnosis is allowed by many States, but few States define what diagnosis actually means or entails. Also, in the States where the scope is silent, such as the 19 States that do not address counseling by nurse practitioners, it cannot be assumed that the practitioner cannot perform these services. Even when a service is addressed, it is done in a very general manner. One State defines a treatment plan as "[The nurse practitioner] coordinates the health care plans to enhance the quality of health care and diminish both fragmentation and duplication of service." Another State defines education/teaching as "develop individualized teaching plans with the client based on overt and covert health needs." Other examples of services allowed but not fully outlined are counseling, referrals, and emergency expansion of role.

State scopes generally have a clear definition of the education requirements for non-physician practitioners. Although BBA97 currently requires only clinical nurse specialists to have a Master's degree to receive reimbursement, most States' education requirements stipulate that both the clinical nurse specialist and the nurse practitioner must have a graduate degree. There appears to be a difference between Federal and State requirements in that 11 States do not require clinical nurse specialists to have a master's degree whereas Federal reimbursement requirements described in 42 CFR §410.74-76 do. The remainder of the States do not stipulate whether a Master's degree is required.

As of January 1, 2003, nurse practitioners will also be required to have a Master's degree for Part B reimbursement. Physician assistants are not required to have a degree for Part B reimbursement.

Every State addresses the prescriptive authority for at least one specialty. Forty-eight States provide guidance for the prescriptive authority of physician assistants and 41 States do so for nurse practitioners. However, only 23 of the 44 States that recognize clinical nurse specialists provide any guidance for prescriptive authority in their scopes. See Appendix D for details of prescriptive authority.

Some practices raise concerns

Thirty-seven carrier medical directors cite at least one concern about non-physician practitioner services and/or payments. Common concerns include settings, procedures, and training and supervision.

Settings. Our analysis of 1999 billing data indicates that 81 percent of all non-physician practitioner services were performed in three settings: offices, inpatient hospitals, and skilled nursing facilities/nursing facilities. Twenty-five carrier medical directors cite nursing facilities and skilled nursing facilities as problematic settings. Most think that these settings are problematic for at least one of the following reasons: medically unnecessary procedures performed; excessive billing; and lack of oversight. As one carrier medical director notes, "There's not a lot of oversight in nursing homes and there is a great potential for abuse where there is not much oversight." The carrier medical directors also discuss concerns about home health, hospitals, rural clinics, and both inpatient and outpatient mental health facilities, and give similar reasons for these concerns.

Procedures. Nineteen carrier medical directors cite specific procedures that are problematic. Of these, most mention evaluation and management codes. Fifty-eight percent of all non-physician practitioner allowed services are for evaluation and management codes, and 8 of the top 10 procedures in 1999 are evaluation and management codes. Evaluation and management services and charges have increased by four times their 1997 levels. Several carrier medical directors express that it is problematic for non-physician practitioners to bill evaluation and management codes, especially those of a complex nature. Our data show that most evaluation and management services provided by them are of low-complexity. However, in 1999, eight percent of non-physician practitioner evaluation and management services were of high complexity. In order to merit high complexity, *two of three* key components (history, examination, or medical decision making) must meet the following criteria: the number of diagnoses or medical options must be extensive; the amount and/or complexity of the data to be reviewed must be extensive; and the risk of complications and/or morbidity or mortality must be high.

Within evaluation and management codes, complex consultations is one area of particular concern. A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. Other procedures that carriers find problematic due to their complexity are surgery, psychiatry, endoscopies, colonoscopies, and sigmoidoscopies.

Training and Supervision. Eleven carrier medical directors express concerns about non-physician practitioners' lack of training. Some carrier medical directors believe that too many complex procedures are being performed by these practitioners. One medical director recalls fighting efforts to allow complex procedures performed by non-physician practitioners, believing that some procedures are too close to physician work and are more complex than their training allows.

Five carrier medical directors note that the lack of supervision of non-physician practitioners could be problematic. One mentions that their "background and education is not parallel with physicians; they were originally created as physician extenders but now they are operating independently." Another worries that the non-physician practitioners' ability to practice independently could exacerbate medical problems. Three carrier medical directors express concerns that the practitioners and their collaborating physician(s) share too many responsibilities. One of these directors adds that he can't address his concerns because there are no guidelines for non-physician practitioners.

Carrier Monitoring of Non-Physician Practitioner Claims is Limited

Carrier medical directors may monitor non-physician practitioner claims through pre-payment or post-payment reviews. Pre-payment reviews are automated edits in the claims payment system that occur before the claim is paid, and either involve requesting additional documentation or denying the claim outright. When asked if any specific pre-payment screens or edits exist for non-physician practitioners, 30 of the 41 carrier medical directors confirm that no edits exist specifically to monitor these claims. Some of the specific edits include surgery, assistant at surgery, anesthesia, nursing home procedures, and particular evaluation and management codes. One carrier plans to implement edits that will disallow complex-level services provided by non-physician practitioners. This carrier is awaiting feedback from HCFA about these edits.

All carriers but one include non-physician practitioners in their post-payment reviews. These are conducted manually after the claim is paid, and are triggered by such things as aberrant billing or outliers. One type of post-payment review is a comprehensive medical review, which looks at one specific provider's billing over a period of time. In the last 2 years, 11 carrier medical directors report conducting comprehensive medical reviews on non-physician practitioners. In one example, nurse practitioners were visiting nursing

homes and changing patients' bandages but billing for debridement, a surgery code which is both more complex and more expensive. Another carrier medical director reports conducting three comprehensive medical reviews. All three involved nurse practitioners, and resulted in overpayments totaling over $900,000. The cases involved duplicate billings, upcoded claims, and self-referrals.

Several medical directors mention that monitoring is limited by the broad language in their scopes of practice. Because the scopes offer little detail, carrier medical directors may not use them. One medical director says, "Unfortunately, in [this State] it is impossible for [non-physician practitioners] not to be within their scope of practice. There is no way we can deny [the claim] based on the scope of practice." Sixteen carrier medical directors state that they do not verify that non-physician practitioners are performing services within their State scope of practice in pre-pay or post-pay activities. Only seven carrier medical directors check with the State nursing board or the scope of practice to verify services. At least 22 carriers do not check the collaborative or supervisory agreement. Additionally, the carriers acknowledge that they do not have specific settings or procedures which prompt them to refer to the agreements consistently.

Carrier medical directors report receiving memoranda or other guidelines from HCFA regarding non-physician practitioner claims when the 1997 legislation went into effect. Some report receiving the BBA97 guidelines. Others report receiving information from the carrier manual or program memoranda, and some say they were told to treat non-physician practitioners like medical doctors. Six carrier medical directors report receiving no instructions from HCFA regarding these claims. Most carriers say they have not changed the way they review claims as a result of the Act. Some carriers, however, say they now pay more attention to non-physician practitioner claims.

In addition to the general guidance given by HCFA, a few carriers have implemented their own medical review policies affecting non-physician practitioners. One example is a policy that offers specific instructions for the amount of supervision needed for myocardial perfusion imaging, a diagnostic procedure that is performed in order to evaluate how well blood is flowing to the heart.

Moreover, some carrier medical directors would like to have additional pre-payment review or edits. Examples of the desired edits include specific evaluation and management codes*, incident to* services, and setting-specific edits. Some carrier medical directors would also like to have additional post-payment reviews, including level-specific reviews, specialty-specific reviews, psychiatric service reviews, and spot checks of collaborative agreements. Other medical directors suggest modifying State laws or having further clarification of non-physician practitioner duties as a means of improving the way these claims are reviewed.

Some carrier medical directors state that although they want to monitor more closely, they are limited in their ability to do so. Five carrier medical directors mention the need

for national guidelines on how to use the scopes to review claims. One carrier explains, “We’d like some instructions- to have a list from HCFA on codes that are inappropriate.” Another carrier medical director comments that the carrier is hindered: “[We] can’t develop every claim—[we] have no way of monitoring if they overstep their bounds—our hands are tied.”

CONCLUSION

The Balanced Budget Act successfully opened up Medicare billing for non-physician practitioners, regardless of care settings. Non-physician practitioner billings are rising rapidly, but controls, which are based on scopes of practice, are limited. State scopes of practice are vague and broad. As such, carriers do not have sufficient guidance to distinguish which non-physician practitioner services should be reimbursed by the program and which should not. This creates potential vulnerabilities, both from payment and quality of care standpoints. Therefore it may be appropriate to consider other additional controls for Medicare payments to non-physician practitioners. Until such controls are developed, the situation deserves careful monitoring. We plan to do so for both overall trends and for complex services.

Agency Comments

We received comments on the draft report from the Health Care Financing Administration. They concur with our conclusion regarding vulnerabilities when non-physician practitioners bill Medicare. They are, however, sensitive to increasing the monitoring burden on contractors. The HCFA expressed a willingness to work with the OIG to monitor vulnerabilities in non-physician practitioner billings. We plan to do additional work to identify specific vulnerabilities by examining the billing practices of non-physician practitioners.

The full text of HCFA's comments are contained in Appendix F.

APPENDIX A

Services and Costs 1999, by Category

	Nurse Practitioner		Clinical Nurse Specialist		Physician Assistant		All Non-Physician Practitioners	
	Services	Charges	Services	Charges	Services	Charges	Services	Charges
Anesthesia	137	$14,397	3	$151	159	$21,963	299	$36,511
Integumentary	50049	$1,623,825	7093	$262,846	62408	$2,683,342	119550	$4,570,013
Musculoskeletal	10905	$732,838	706	$88,378	92646	$12,734,886	104257	$13,556,102
Respiratory	595	$53,750	19	$2,941	7169	$844,971	7783	$901,662
Cardiovascular	3455	$430,214	272	$49,364	123066	$21,424,366	126793	$21,903,944
Lymphatic	14	$1,176	19	$2,088	586	$37,393	619	$40,657
Mediastinum	27	$4,328	0	$0	364	$39,925	391	$44,253
Digestive System	1655	$151,939	319	$32,412	11497	$1,050,466	13471	$1,234,817
Urinary	6274	$365,168	226	$14,399	2256	$163,322	8756	$542,889
Male Genital	69	$9,033	2	$391	667	$110,433	738	$119,857
Laparoscopy (Elim)	435	$62,401	81	$8,206	4179	$393,070	4695	$463,677
Female Genital	2358	$126,500	149	$6,328	1497	$120,566	4004	$253,394
Maternity	62	$7,503	0	$0	9	$3,170	71	$10,673
Endocrine/ Nerves	2349	$209,462	233	$28,343	23473	$2,426,799	26055	$2,664,604
Eye	73	$4,116	0	$0	693	$91,044	766	$95,160
Ear	11229	$325,073	47	$1,428	8369	$246,676	19645	$573,177
Radiology	36872	$1,174,244	583	$31,287	48730	$1,245,475	86185	$2,451,006
Pathology/ Lab	249021	$1,935,797	2002	$12,602	136528	$1,118,289	387551	$3,066,688
Medicine	361401	$9,906,512	103358	$6,115,443	121261	$2,455,480	586020	$18,477,435
Evaluation & Mgmt	1855424	$73,999,925	67433	$3,622,695	1103259	$46,597,602	3026116	$124,220,222
Temp	437430	$4,210,872	5302	$74,871	228974	$2,635,335	671706	$6,921,078
Total	3029834	$95,349,073	187847	$10,354,173	1977790	$96,444,573	5195471	$202,147,819

These categories are in order of their Current Procedural Terminology (CPT) number
Source: Medicare BESS data

APPENDIX B

Most Frequent Settings and Services, 1999

1. Most Frequent Settings, 1999

Health Care Setting	Number of Services
Office	2,598,999
Skilled Nursing Facility (SNF)	757,564
Nursing Facility (NF)	433,169
Inpatient Hospital	414,285
Other - unlisted facility	316,571
ER - hospital	241,995
Outpatient Hospital	199,994
Home	85,837
Custodial Care	49,616
Community Mental Health Center	35,234
Proportion of all Services	**98.8%**

Source: Medicare BESS Data, 1999

APPENDIX B (cont.)

2. Most Frequent Services, 1999

CPT Code	Service Description	Number of Services	Percent of total
99213	**Office or outpatient visit** for the evaluation and management of an established patient which requires at least two of these components: C an expanded problem focused history; C an expanded problem focused examination; C medical decision making of low complexity. The presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family	645,979	12.4%
99312	**Subsequent nursing facility care**, per day, for the evaluation and management of the new or established patient, which requires at least two of these components: C an expanded problem focused interval history; C an expanded problem focused examination; C medical decision making of moderate complexity. Usually, the patient is stable, recovering or improving. Physicians typically spend 25 minutes as the bedside and on the patient's facility floor or unit.	508,954	9.8%
99311	**Subsequent nursing facility care**, per day, for the evaluation and management of the new or established patient, which requires at least two of these components: C a problem focused interval history; C a problem focused examination; C medical decision making that is straightforward or of low complexity. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes as the bedside and on the patient's facility floor or unit.	420,926	8.1%
99212	**Office or outpatient visit** for the evaluation and management of an established patient which requires at least two of these components: C a problem focused history; C a problem focused examination; C straightforward medical decision making The presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family	353,654	6.8%
G0001	**Routine venipuncture** for collection of specimen(s).	206,094	4.0%

CPT Code	Service Description	Number of Services	Percent of total
99214	**Office or outpatient visit** for the evaluation and management of an established patient which requires at least two of these components: C a detailed history; C a detailed examination; C medical decision making of moderate complexity. The presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family	148,671	2.9%
99313	**Subsequent nursing facility care**, per day, for the evaluation and management of the new or established patient, which requires at least two of these components: C a detailed interval history; C a detailed examination; C medical decision making of moderate to high complexity. Usually, the patient is stable, recovering or improving. Physicians typically spend 35 minutes as the bedside and on the patient's facility floor or unit.	100,231	2.0%
99283	**Emergency department visit** for the evaluation and management of a patient, which requires these components: C an expanded problem focused history; C an expanded problem focused examination; and C medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate severity.	98,636	1.9%
90862	**Pharmacologic management**, including prescription, use, and review of medication with no more than minimal medical psychotherapy.	94,969	1.8%
99231	**Subsequent hospital care**, per day, for the evaluation and management of a patient, which requires at least three of the following components: C a problem focused interval history; C a problem focused examination; C medical decision making that is straightforward or of low complexity. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.	79,738	1.5%
	Total	**2,657,852**	**51.2%**

Source: Current Procedural Technology 1999, Standard Edition and Medicare's National Level II Codes--HCPCS 1997, American Medical Association

APPENDIX C

States' Recognition of Non-Physician Practitioners

State	NP	CNS	PA
AL	T	T	T
AK	N, T	V	T
AZ	T	T	T
AR	T	T	T
CA	T	T	T
CO	T	T	T
CT	T	T	T
DE	T	T	T
DC	NR	NR	T
FL	T	V	T
GA	T	MH	T
HA	T	T	T
ID	T	T	T
IL	T	T	T
IN	T	T	T
IA	T	T	T
KS	T	T	T
KY	N, T	N, T	T
LA	T	T	T
ME	T	T	T
MD	T	T	T
MA	T	V	T
MI	N, T	V	T
MN	T	T	T
MS	T	T	V
MO	N, T	N, T	T

State	NP	CNS	PA
MT	T	T	T
NE	T	T	T
NV	T	T	T
NH	T	V	T
NJ	T	T	T
NM	T	T	T
NY	T	MH	T
NC	T	T	T
ND	T	T	T
OH	T	T	T
OK	T	T	T
OR	T	D	T
PA	T	T	T
RI	T	MH	T
SC	N, T	N, T	T
SD	T	T	T
TN	i	i	T
TX	T	T	T
UT	N, T	N, T	T
VT	T	MH , N	T
VA	T	T	T
WA	T	V	T
WV	T	T	T
WI	T	T	T
WY	T	T	T

T - Recognized to practice in State
NR- Not Recognized
MH- Mental health clinical nurse specialists only.
i - Not board certified. Recognizes only RNs. However, NP may obtain a certificate of fitness to prescribe drugs.
N- Defers to national certifying body.
D - Drafting Scope
V - Non-respondent

APPENDIX D

Prescriptive Authority

Number of States allowing service

Prescriptive Authority	Clinical Nurse Specialist (N = 44)	Nurse Practitioner (N = 50)	Physician Assistant (N = 50)
Medical devices	4	11	16
Legend drugs	9	18	17
Starter dosages/samples	12	19	15
Schedule I *	0	2	2
Schedule II*	5	14	14
Schedule III*	8	20	26
Schedule IV*	9	20	26
Schedule V*	8	20	26

* Controlled substances
Source: State Scopes of Practice

The prescriptive authority usually contains specific information about dispensing samples, prescribing prescriptive or legend drugs (the legend of the prescription must contain the dosage amount and the frequency with which to take the drug), controlled substances (any narcotic or barbiturate drug ranging from simple cough medicine to heroin), and medical devices.

APPENDIX E

Review Criteria for State Scope of Practice

In reviewing the State scopes of practice, our review instrument focused on the following responsibilities:

- Assessments, histories, and physical exams, including screening and interpretation of lab data;
- Therapy, including physical, occupational, and respiratory, as well as therapeutic diets and therapeutic interventions; we did not review drug therapy;
- Treatment plan/ care plan development, including formulating, implementing, reviewing, and evaluating plans;
- Patient care and management, including hospital rounds, accessing catheters and tubes, and care of sprains and fractures;
- Surgery, including first assistant, minor surgery and suturing;
- Supervision;
- Education and teaching;
- Counseling;
- Emergency services, including EMT;
- Expansion of scope in the event of an emergency;
- Collaboration with Physician/ Supervision of non-physician practitioner, and;
- Other relevant services such as anesthesia, diagnostic problems, and subspecialization in fields like optometry or obstetrics.

APPENDIX F

Agency Comments

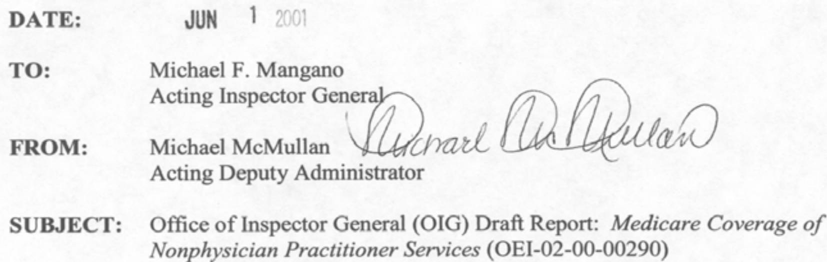
DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: JUN 1 2001

TO: Michael F. Mangano
Acting Inspector General



FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Medicare Coverage of Nonphysician Practitioner Services* (OEI-02-00-00290)

Thank you for the opportunity to review and comment on the above-referenced draft report regarding Medicare coverage of services provided by nurse practitioners, clinical nurse specialists, and physician assistants to beneficiaries. While there were no recommendations noted in the report, the Health Care Financing Administration (HCFA) agrees with OIG's conclusion identifying program vulnerabilities when nonphysician practitioners bill Medicare directly for services. We also respect beneficiaries' choices and their need for access to medical services. While appreciative of OIG's suggestion that "it may be appropriate to consider other additional controls for Medicare payments to non-physician practitioners," we are sensitive to fairness and equity issues possibly associated with differential treatment of different classes of providers. As appropriate, we will work with the OIG as it monitors nonphysician practitioner services for both overall trends and for complex services.

Medicare currently defers to state licensing boards for regulating and enforcing scope of practice laws. Before issuing a Medicare provider billing number to a nurse practitioner or a nurse clinical specialist, contractors first determine whether the applicant has a valid license within the state. If a licensing board subsequently acts to suspend a provider's license to practice, then Medicare suspends payments under that provider's Medicare billing number. This practice is the same for physician and nonphysician practitioners.

In order to protect the integrity of the Medicare program, all claims submitted for payment are subject to data analysis that may lead to a focused or a random review by a Medicare contractor. Contractors processing Medicare claims normally do not consider whether the service provided to the beneficiary conforms to all state regulations. If Medicare is to begin monitoring providers for compliance with state laws and regulations, the program will have to develop additional regulations and policies and impose additional workloads on contractors.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises. Our technical comments on the audit report are attached for your consideration.

Attachment