Envision HEALTHCARE	Ethics & Compliance Department		
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BILLING FOR SERVICES PROVIDED BY AN ADVANCED PRACTICE PROVIDER

SCOPE:

Applies to all Envision Medical Group ("EMG") teammates who may be involved in billing/coding for services provided by an Advanced Practice Provider. For purposes of this policy, all references to "teammate" or "teammates" include temporary, part-time and full-time associates, independent contractors, clinicians, officers and directors.

PURPOSE:

Envision Healthcare and its subsidiaries and affiliates ("Envision" or "the Company") has adopted this Billing for Services Provided by an Advanced Practice Provider policy to document the Medicare rules in billing for patient services provided by Advanced Practice Providers (APPs) including Physician Assistants and Nurse Practitioners.

POLICY:

Medicare rules give special recognition to the services of APPs under which they can be paid separately from or billed incident to a physician. Applicable regulations stipulate that APPs must meet applicable state requirements governing their qualifications to provide services. In addition, these regulations specify the types of APP services that may be covered by Medicare for payment purposes, as well as the payment limitations that exist when APPs treat patients without direct physician contact.

The Company and its billing entities will bill for all APPs who are enrolled according to state and payor regulations and guidelines. Medicare stipulates that, for payment to be made for services rendered by an APP, the APP must meet the applicable state requirements governing the qualifications for APPs. Medicaid and payor enrollment policies and requirements vary from state to state. The Company monitors third party payor requirements and adheres to all billing regulations as reflected in the service scenario matrix provided in the billing and coding manual.

PROCEDURE:

Billing the APP Benefit Only

When claims do not qualify to bill under the physician, bill under the APP's own provider number with expected payment at 85% of the physician fee schedule for Medicare. In order for APPs to bill Medicare, APPs are required to be enrolled in Medicare.

Billing Physician Services with APP Involvement in a Hospital Setting

When the APP assists the physician, the service is billable under the physician when:

- the physician performed more than half of the cumulative time in qualifying activities; or
- documentation supports the physician's full participation in medical decision making; or
- the physician has documented a history or exam that independently supports the overall visit level.

Additionally, for billing purposes, documentation in the medical record must identify the provider who performed more than half of the cumulative time in qualifying activities or the physician's involvement in the case. Full participation in medical decision making will be evidenced by the physician's attestation or documentation evaluating the patient's condition, reviewing available information, and reviewing the assessment, orders, plan, or disposition. When using the history or exam component, the billing provider must perform the level of history or exam required to support the visit level.

Physician MDM attestation example(s):

- I have seen and evaluated this patient's condition, reviewed the available information, and fully participated in designing this patient's course of treatment.
- I reviewed the history, exam, and the patient; [ex. with interior dislocation of the left shoulder], I approve the plan as documented in the notes.
- I have evaluated the patient. I agree with the APP findings, exam, and treatment plan.

Examples of qualifying activities:

- Preparing to see the patient (ex. reviewing tests);
- Obtaining or reviewing separately obtained history;
- Performing a medically appropriate examination and/or evaluation;
- Counseling and educating the patient/family/caregiver;
- Ordering medications, tests, or procedures;
- Referring and communicating with other healthcare professionals (when not separately reported);
- Documenting clinical information in the electronic or other health record;
- Independently interpreting results and communicating results to the patient/family/caregiver;
- Care coordination (when not separately reported).

If emergency departments use APPs, but as a policy, have physicians treat each patient, then documentation guidelines should capture the degree of physician involvement to justify billing the physician service to Medicare.

Missing Signatures and Co-Signatures

In order to bill for the service rendered, the provider (the APP or the physician) that performed more than half of the cumulative time in qualifying activities, or either the history, exam, or the medical decision-making component, must sign and date the medical record. Additionally, a state, hospital, or payor *may* require the co-signature of the "supervising physician." A supervising physician's co-signature indicates general supervision, not direct supervision. Medicare defines general supervision as a procedure or service furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

The designated contact person at the facility will be notified of any documented charts that are received without a required signature. The provider who performed more than half of the cumulative time in qualifying activities, or either the history, exam, or the medical decision-making component, will be expected to sign and date (signing date) the original chart and return a copy for processing. If additional documentation is added to a chart, beyond the required signature, that documentation will not be utilized when coding the chart. Signed charts that are missing documentation or attestations will NOT receive a request for additional information.

Billing for Incident-To Services in an Office Setting

According to Medicare, services rendered by APPs may also be billed "incident to" a physician's services when the services are:

- An integral, although incidental, part of the physician's professional service in the course of diagnosis or treatment of an injury or illness;
- Commonly furnished without charge or included in the physician's bill;
- Of a type that are commonly furnished in physician's offices or clinics; **AND**
- Furnished under a physician's direct supervision.

For services furnished by APPs to be billed incident to a physician's services, the following procedures must be followed:

- **For new patients or existing patients with new problems**: The physician must perform a direct, personal, professional service to *initiate the course of treatment*; AND must perform subsequent services of a frequency which reflects his or her continuing active participation in and management of the course of treatment.

- **For existing patients continuing with the course of treatment**: The physician must perform subsequent services of a frequency which reflects his or her continuing active participation in and management of the course of treatment.

- The incident-to services must represent an expense to the physician or legal entity billing for the services.

- The services must be of a type considered medically appropriate to provide in the office setting.

- The supervising physician must be present in the office suite and immediately available to provide assistance and direction throughout the course of treatment.

POLICY REVIEW

The Ethics & Compliance Department will review and update this policy, when necessary, in the normal course of its review of the Company's Ethics & Compliance Program.