Reimbursement of Advanced Practice Registered Nurse Services: A Fact Sheet

Purpose:

To provide the Advanced Practice Registered Nurse (APRN) with information to understand the opportunities and challenges in acquiring reimbursement for professional services.

Originated By:

Reimbursement Task Force, APRN Work Group, of the WOCN® Society’s National Public Policy Committee, 2011.

Date Completed:

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Background:

In order for the APRN role to survive in many settings, a revenue stream may need to be developed. There are increased opportunities for billing of APRN services and it is important that APRNs understand the issues involved in capturing third party reimbursement. There are many legal and financial issues that need to be appreciated by the APRN as they relate to reimbursement. Reimbursement is a complex structure that includes regulatory factors both at the state and federal level. For example, APRNs may bill Medicare under the physician payment system only if the APRN has the legal authority under state law to perform the service to be billed (“Balanced Budget,” 1997). Clarification on the issue of legal authority will be covered under the definition of an advanced practice nurse, since states license APRNs, there is variation between states on the definition of an APRN. Rules for billing are complicated, scattered throughout Federal and State law, and vary from payer to payer (Buppert, 2007). While this fact sheet will cover Medicare billing regulations, many insurers will follow Medicare guidelines. However, the APRN should remember that insurers may regulate reimbursement in their own way.

The history of APRN reimbursement is important to understand as it provides context to what follows. In 1990, direct APRN reimbursement by Medicare was available only in rural areas and skilled nursing facilities (Frakes, 2006). In 1997, Medicare expanded reimbursement for Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP; as well as nurse anesthetists
and nurse midwives, however these roles will not be covered in this fact sheet) to all geographical and clinical settings allowing direct Medicare reimbursement to the APRN, but at 85% of the physician rate (“Balanced Budget,” 1997). This success was won because of the powerful political action of the American Nurses Association, utilizing outcome data to show how CNS’ and NPs make a difference in cost and quality, and the political action partnerships established with specialty organizations and grassroots actions of local nurses.

This fact sheet will provide an overview of reimbursement and issues related to billing for advanced practice nurse services. The regulatory environment is complex and APRNs should understand the regulations to maximize reimbursement opportunities and investigate billing possibilities. It is important to note that in addition to federal billing guidelines, each state has licensing authority for APRNs and this licensing authority can be different depending upon the state in which the APRN practices. Each APRN will need to review their state licensing regulations as well as confer with their billing experts on the interpretation of the billing regulations. This fact sheet contains the best interpretation of the APRN reimbursement issues as of the date it was written. It is hoped that this fact sheet will provide a starting place for the APRN to become acquainted with billing issues and opportunities, but is not meant to be an authoritative paper on all issues related to billing.

**Definition: Advanced Practice Registered Nurses**

The American Nurses Association (ANA) has advocated that all advance practice nurses have one title of Advance Practice Registered Nurse (APRN). According to the ANA, the APRN holds a high level of expertise in the assessment, diagnosis and treatment of complex responses of individuals, families or communities to actual or potential health problems, prevention of illness and injury, maintenance of wellness and provision of comfort. The APRN has a master’s or doctoral degree concentrating in a specific area of advanced nursing practice, had supervised practice during graduate education, and has ongoing clinical experiences. APRNs include clinical nurse specialists, nurse practitioners, nurse anesthetists, and nurse midwives ([http://nursingworld.org](http://nursingworld.org)). While education, accreditation, and certification are necessary components of an overall approach to preparing an APRN for practice; the licensing boards governed by state regulations and statutes-are the final arbiters of who is recognized to practice within a given state. Currently, there is no uniform model of regulation of APRNs across the states. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry-into advanced practice, and the certification examinations accepted for entry-level competence assessment. Thus, it is suggested that each APRN examine the state regulations in the state or states where they will practice (APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee, 2008).

The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education (APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee, 2008) has been endorsed by 41 nursing organizations, including the WOCN® Society. The APRN Consensus Model defines advanced practice registered nurse practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation. This important document should be accessed to see the recommendations that
reflect a need and desire to increase the clarity and uniformity of APRN regulation with hope that in the future this document will be used as a reference for regulatory issues. (See Table 1: Consensus Model: Definition of Advanced Practice Registered Nurse.)

An APRN may be prepared as a clinical nurse specialist, a nurse practitioner, a certified nurse midwife, or a certified registered nurse anesthetist. This paper will utilize the term advanced practice nurse to only include the clinical nurse specialist and the nurse practitioner. The term provider will include the APRN and the physician.

Medicare’s Definition and Qualifications of an APRN

The following definition of an APRN is Medicare’s required qualifications (MLN, 2010). It appears that many other payer sources utilize Medicare’s APRN qualifications.

- Clinical Nurse Specialist:
  - Is an RN currently licensed to practice in the State where he/she practices and is authorized to furnish the services of a CNS in accordance with State law.
  - Has a Master’s degree or Doctor of Nursing Practice in a defined clinical area of nursing from an accredited educational institution and
  - Is certified as a CNS by a recognized national certifying body that has established standards for CNSs.

- Nurse Practitioner:
  - Must be a registered professional nurse authorized by the state in which services are furnished to practice as a NP in accordance with state law and meet one of the following
  - Obtained Medicare billing privileges as a NP for the first time on or after January 1, 2003 and
  - Is certified as a NP by a recognized national certifying body that has established standards for NPs and
  - Has a Master’s degree in nursing or a Doctor of Nursing Practice degree.
  - Obtained Medicare billing privileges as a NP for the first time before January 1, 2003 and meets the certification requirements described above, or
  - Obtained Medicare billing as a NP for the first time before January 1, 2001.

The national certifying bodies that Medicare recognizes are (CMS, 2011a):

- The American Nurses Credentialing Center,
- The National Certification Corporation for Obstetrics, Gynecologic, and Neonatal Nursing Specialties,
- The American Academy of Nurse Practitioners,
- The Pediatric Nursing Certification Board (formerly National Certification Board of Pediatric Nurse Practitioners and Nurses),
- The Oncology Nursing Certification Corporation,
• The Critical Care Certification Corporation now called AACN Certification Corporation, and
• National Board of Certification of Hospice and Palliative Nurses.

Medicare Coverage Criteria for Medicare Services Furnished by Advanced Practice Registered Nurse

The following are the Medicare required APRN coverage criteria (MLN, 2010):

• Services or supplies that must be medically reasonable and necessary:
  o Are proper and needed for the diagnosis or treatment of the beneficiary’s medical condition,
  o Are furnished for the diagnosis, direct care and treatment of the beneficiary’s medical condition,
  o Meet the standard of good medical practice, and
  o Are not mainly for the convenience of the beneficiary, provider, or supplier.

• The following must be met:
  o Services are performed in collaboration with a physician. Collaboration occurs when the APRN works with one or more physicians to deliver health care services within the scope of their professional expertise. Medical direction and appropriate supervision is provided as required by the law of the state in which the services are furnished (it is not required for the collaborating physician to be present when services are furnished or to independently evaluate patients).
  o Services are the type considered physician’s services if furnished by a medical doctor or a doctor of osteopathy,
  o Services are not otherwise precluded due to a statutory exclusion, and
  o He or she is legally authorized and qualified to furnish the services in the state where they are performed.

Additionally, a nurse practitioner may be selected as a hospice beneficiary’s attending physician, but he/she cannot certify or recertify a terminal illness with a prognosis of six months or less.

The APRN may bill the Medicare program directly for services using his/her national provider identifier (NPI) or under an employer’s or contractor’s NPI. A NPI is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). The NPI has replaced the unique provider identification number (UPIN) as the required identifier for Medicare services, and is used by other payers, including commercial health care insurers. A NPI may be applied for at https://nppes.cms.hhs.gov. If billing is done via “incident to” services, these claims must be submitted under the supervising physician’s NPI and identified on provider file by specialty code 50 for nurse practitioners and 89 for clinical nurse specialists. “Incident to” billing is beyond the scope of this fact sheet; for information on incident to billing, refer to the WOCN® Society fact

Payment is made only on an assignment basis, which means that payment will be the Medicare allowed amount as payment in full and the APRN may not bill or collect from the beneficiary any amount other than unmet copayments, deductibles, and/or coinsurance. Services are paid at 85% of the Medicare Physician Fee schedule amount. When services furnished to hospital inpatients and outpatients are billed directly, payment is unbundled and made to the APRN.

Advanced Practice Nurses must enroll in the Medicare program to be eligible to receive Medicare payment for covered services provided to Medicare beneficiaries. Form CMS-8551 is used for physicians and non-physician practitioners (i.e., APRNs) to initiate the Medicare enrollment process. If the APRN is part of a clinic or group practice, Form CMS 855B is used to initiate the enrollment process. There is an Internet based Provider Enrollment, Chain and Ownership System (PECOS) that can be used. For many APRNs this enrollment process is initiated by their employer (CMS, 2011b).

The APRN must understand and meet the state licensing requirements in the state where his/her delivery of services will take place, must meet the Medicare requirements to bill Medicare, and have a NPI. Reimbursement by private insurance companies is separate from the Medicare process and may require a credentialing process.

**Credentialing and Privileging**

Provider credentialing and privileging is a practice in which documented recognition and verification is administered to a practicing professional. The credentialing system is used by various organizations and agencies to ensure that their health care practitioners meet all the necessary requirements and are appropriately qualified. This process frequently occurs before the provider is hired. It is used to confirm the provider’s license, education, training, decision-making, and overall quality. The process varies between facilities but may include completion of an application for credentialing and privileging, primary source verification of credentials, review board and approval. The application may include a curriculum vitae, copy of current licensure, verification of graduation from approved program, copy of certification, letters of recommendation, malpractice history, and other documents as identified by the place of employment. Health care facilities set their own guidelines regarding how often a provider is re-credentialed to maintain their status.

**APRN Inpatient Reimbursement**

The following principles on inpatient APRN reimbursement are based on Medicare rules. Not all payers follow Medicare rules and this includes Medicaid. Hospitals planning to bill Medicaid, may query state Medicaid and commercial payers about their rules and policies (Buppert, 2007).

Medicare inpatient hospital billing principles are identified as:
1. The service must be a physician service.
2. The service cannot be just one part of a bundled service.
3. The service must be within the APRN’s scope of practice under state law. State laws specify the physician services that APRNs are authorized to perform and each state’s definition is slightly different.
4. The service must be medically necessary.
5. The APRN must meet the payer’s credentialing requirements.
6. Documentation of the service must conform to the payer’s requirements for the procedure code billed.
7. Generally, the APRN’s services should be billed under the APRN’s provider number. However, there are exceptions to this statement.
8. It is permissible to bill visits “shared” with physicians, under certain conditions.
9. Medicare will pay only one charge per day, per patient, per specialty, for Evaluation and Management billing.
10. A hospital may not bill Medicare Part B for an APRN’s services if the hospital receives any reimbursement for the APRN’s salary under the hospital cost report.
11. The services of residents, nursing students, medical students, physician assistant students and APRN students cannot be billed under an APRN’s provider number.
12. Employment relationships affect who has the right to bill for an APRN’s services.
13. An APRN must accept the payment from Medicare as full payment for the services provided.

State laws authorize APRNs to perform nursing services and some physician services. Nursing services are reimbursed through prospective payments or payments based on direct Diagnosis Related Groups (DRG). If an APRN performs a complicated dressing change or pouching procedure, which is a nursing service, it is not a billable service. That service is covered by the DRG payment or the per diem payment to the hospital. Medicare prospective payments made to hospitals are administered through Medicare Part A (Buppert, 2007). Provider (both an APRN and a physician) services are reimbursed separately from the DRG system.

Provider services are reimbursed separately from other services provided in hospitals. Medicare payments for provider services are reimbursed through Medicare Part B. Provider services are defined by Federal regulations as diagnosis, therapy, surgery, consultation, care plan oversight; and home, office and institutional visits. Charges for inpatient services are done using the Current Procedural Terminology (CPT) code system. The Evaluation and Management (E&M) service is the most common service provided by an APRN in the hospital. The E&M service includes history taking, examination, medical decision-making (diagnosis and therapy) counseling, and coordination of care. CPT procedural codes can be billed by any qualified provider.

The hospital can bill for the APRN’s services under the physician/provider payment system if the salary and benefits of the APRN are not reimbursed under the hospital’s cost report. The salary of the APRN must be unbundled from the hospital’s cost report. The hospital cannot bill Medicare if the APRN’s salary is being reimbursed under Part A of Medicare (“Balanced Budget,” 1997; Buppert, 2007).
There are some services provided by the APRN that are physician services but are not billable. For example, “rounding” is a physician service but not billable. Initiating transfers and writing transfer orders are physician services but are not billable. Writing orders to change an intravenous solution is not a billable service. There are no separate CPT codes for these services. These services are part of the package of treatment and communication services bundled together and identified by the CPT codes for E&M.

When an APRN evaluates and manages a patient’s illness or injury through history taking, examination and medical decision making, the work is billable because all of the required elements of the service have been performed. If an APRN changes a dose of digoxin based on the laboratory results from earlier in the day, it is considered a provider service (medical decision-making). However, if the documentation is lacking the history or examination, the service is not billable because it is just one part of a package of services or E&M bundled together for reimbursement purposes (Buppert, 2007).

Hospital discharges are billable if the service includes performing the final examination of the patient, discussion of the hospital stay, instruction for continuing care to all caregivers, prescriptions and referral forms and preparation of discharge records. However, if the APRN simply dictates the discharge summary and/or orders without performing the other functions, the APRN’s services are not billable.

Medicare and other payers will reimburse providers for items or services that are “reasonable and necessary for a diagnosis or injury or to improve the functioning of a malformed body member” (42 CFR, 2005). Both the medical record and billing claim must describe or indicate why the service was necessary. Administrators of Medicare, Medicaid, and commercial insurers may have policy level input into ordering decisions. Local Medicare contractors may specify the clinical circumstances under which a service is considered reasonable and necessary. Policies may vary from region to region.

Shared or split billing in the hospital inpatient/outpatient/emergency department setting. When an E&M is shared between a physician and APRN from the same group practice and the physician provides any face to face portion of the E&M encounter with the patient, the service may be billed under the physician’s or the APRN’s NPI number. However, if there was no face-to-face encounter between the patient and the physician (for instance, the physician only reviewed the chart), then the service may only be billed under the APRN’s NPI entered on the claim. An example is if the APRN sees the patient in the morning and the physician performs a face to face in the afternoon on the same day, the physician or the APRN may report the service.

If a hospital or medical practice bills for an APRN service when another provider has already billed that same service one of the bills may be denied. Therefore, it is necessary for the APRN and physician to coordinate their visits. If an APRN performs sections of the E&M and a provider of the same specialty then repeats that exam or adds to the APRN service, there is a choice to be made. Either the service can be billed under the APRN and receive 85% of the physician’s scheduled rate or the service can be billed under the physician’s number and receive 100% of the physician’s rate (CMS, 2011c). If the APRN and the physician are employed by
different groups and both groups submit bills, the second bill to arrive at the payer’s office will be denied.

If the APRN is performing pre-operative examinations and post-operative E&M for surgical patients, this is included in the global surgical package for major surgery. The global surgical package is a fixed fee to cover all treatment and services related to the surgical procedure including pre-operative visits after the decision is made to operate beginning with the day before the surgery, intraoperative services, and complications following surgery. The time frame depends upon the surgical procedure and is 90 days, 10 days or 0 days; with major surgery, the global period is 90 days; and minor surgery varies between 0-10 days (42 CFR, 2005).

**Current Procedural Terminology Codes**

Medicare Billing is done using either current procedural terminology (CPT) codes or evaluation and management (E&M) codes. This section will cover current procedure terminology, evaluation and management codes will follow.

Current procedural terminology (CPT) codes are a systematic listing and coding of procedures/services performed by providers that serve as the basis for health care billing. CPT codes are developed, maintained, and copyrighted by the American Medical Association (AMA). The five-digit number assigned to each code refers to a specific service or procedure that a provider may supply to a patient including medical, surgical, and diagnostic services. The purpose of the CPT code is to provide a uniform language that accurately describes services rendered. The uniform language serves as an effective means for reliable nationwide communication between medical practitioners, patients, and third parties (CPT, 2011). Third parties (e.g., insurers) use the CPT codes to determine the amount of reimbursement to be paid to the practitioner.

In the CPT codebook, sold only by AMA or AMA designees, codes are listed in six sections or code sets. These code sets are then sub-sectioned by anatomic, procedural, condition, or descriptor subheadings. Services and procedures, with their identifying codes, are listed in numeric order with the exception of the Evaluation and Management (E&M) codes. E&M codes, which are numbered 99201-99249, are listed at the beginning of the code sets as these codes are the most frequently used by medical practitioners for reporting services.

At the beginning of each code set, specific guidelines identify items that are necessary for appropriately interpreting and reporting the services and procedures within that set. The guidelines may include information such as settings of services (e.g., office, hospital, etc.), special reports that are required as part of the service, supplies, and materials provided and/or face-to-face time as a basis for selection of a specific code. Diligence is required in selection of the appropriate code for services rendered since the code reported dictates the amount of reimbursement.

On occasion, there are services or procedures that are not found in the CPT codebook. For that reason, the AMA has designated several specific code numbers for reporting unlisted
services/procedures, which should be described using the section specific guidelines. The CPT codes are updated annually to include new services and/or procedures and to remove obsolete ones. Therefore, the designated unlisted service/procedure codes are monitored by the AMA for recurrent use. Repeated and frequent use of the code may lead to the development of a CPT for that service/procedure.

Some procedural codes are commonly carried out in addition to the primary procedure performed. Add on codes describe additional intra-service work associated with the primary procedure and must be performed by the same provider. A descriptor of an add-on code would contain phrases like “each additional” or “list separately in addition to primary procedure code.”

Modifiers can also be added to CPT codes as a means of reporting or indicating that a service/procedure rendered has been altered by some specific circumstance but that it did not change the definition or code. The modifiers allow medical practitioners to effectively respond to payment policy requirements established by other entities. The modifiers have specific numeric identifiers (listed in the appendices of the codebooks) and cover one of the following alterations in the service/procedure:

- Service/procedure had both a professional and technical component.
- Service/procedure was performed by more than one provider and/or in more than one location.
- Service/procedure was increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- Service/procedure was provided more than once.
- Unusual events occurred (CPT, 2011).

APRNs seeking specific codes related to services and/or procedures provided in the WOC nursing arena, will find no specific codes for ostomy care. E&M codes will have to suffice at this time. There are codes related to wounds and continence services. The following two examples are provided as a guide in using the CPT codebook (CPT, 2011).

**Section/code set:** Surgery  
**Sub-section:** Anatomic  
**Sub-heading:** Integumentary  
**Debridement:**

Wound debridement (codes: 11042-11047) is reported by the depth of tissue that is removed and by the surface area of the wound. These services may be reported for injuries, infections, wounds, and chronic ulcers. When performing debridement of a single wound, report depth using the deepest level of tissue removed. In multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths. For example, when a bone is debrided from a 4 sq cm heel ulcer and from a 10 sq cm ischial ulcer, report the work with a single code, 11044. When subcutaneous tissue is debrided from a 16 sq...
cm dehisced abdominal wound and a 10 sq cm thigh wound, report the work with 11042 for the first 20 sq cm and 11045 for the second 6 sq cm. If all four wounds were debrided on the same day, use modifier 59 with 11042, 11045, and 11044 (CPT, 2011).

Debridement Codes:

11042: Debridement, subcutaneous tissue (includes epidermis and dermis, if performed): first 20 sq cm or less.
11045: Each additional 20 sq cm, or part thereof. (List separately in addition to code for primary procedure; CPT Codebook 2011.)

Section/code set: Medicine
Sub-section: Biofeedback

Codes:

90901: Biofeedback training by any modality.
90911: Biofeedback training, perineal muscles, anorectal or urethral sphincter, including Electromylogram and/or manometry.

(For testing of rectal sensation, tone, and compliance, use code 91120.)
(For incontinence treatment by pulsing magnetic neuromodulation, use code 53899; CPT, 2011).

Evaluation and Management Services Codes

The CPT codes which describe physician-patient encounters are often referred to as Evaluation and Management Codes. Evaluation and Management Services refer to visits and consultations furnished by providers. A provider’s Medicare benefit allows him/her to bill for E&M services and the services must be provided within the scope of their practice in the state in which the provider practices.

Health care payers may require rational documentation to assure that a service was consistent with the patient’s insurance coverage and to validate the place of service, the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided. It is also necessary to document that the services provided have been accurately reported.

Documentation of each patient’s encounter should include seven key components:

- The chief complaint or reason for the visit and relevant history;
- Physical examination findings and prior diagnostic test results;
- Medical decision making;
- Counseling;
- Coordination of care;
- Nature of presenting problem; and
- Time spent with the patient.
Included should also be the assessment, clinical impression or diagnosis, medical plan of care and date, and legible identity of the observer. Appropriate health risks should be identified. If not charted, the rationale for ordering diagnostic and other ancillary services should be easily inferred. Past and present diagnoses should be easily accessible to the treating and consulting providers. The patient’s progress, response to and changes in treatment, along with the revision of diagnosis should be documented. The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation on the medical record. It is the responsibility of the provider to ensure that the submitted claim is correct and reflects the services provided. A billing specialist or alternate source may review the documented services before the claim is submitted to the payer.

E&M services are arranged into different settings depending on where the service is provided. Examples include, office or outpatient setting; hospital inpatient; emergency department; and nursing facility. Patients are identified as either new or established depending on previous encounters with the provider or the provider’s group.

The code sets used to bill for E&M services are organized into various levels and categories. The more complex the visit, the higher the level of code that the provider may bill within the appropriate category. The volume of charting does not dictate the level of billing. The services must meet the definition of the code.

There are three key components required when selecting the appropriate level of E&M service provided: history, examination, and medical decision making. Visits that consist primarily for counseling and/or coordination of care are an exception to the rule.

The elements required for each type of history are listed in the following table:

<table>
<thead>
<tr>
<th>Type of History</th>
<th>Chief Complaint</th>
<th>History of Present Illness</th>
<th>Review of Systems</th>
<th>Past, Family, and/or Social History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Required</td>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focus</td>
<td>Required</td>
<td>Brief</td>
<td>Problem Pertinent</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed</td>
<td>Required</td>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Required</td>
<td>Extended</td>
<td>Extended</td>
<td>Complete</td>
</tr>
</tbody>
</table>

The levels of E&M services are based on four types of examinations: problem focused, expanded problem focused, detailed, and comprehensive. The type and extent of the examination performed is based upon clinical judgment, the patient’s history, and the nature of the presenting problem.

There are two versions of the documentation guidelines – the 1995 and the 1997 versions. Either version may be used (but not both) by the provider for a patient encounter. The most
substantial difference between the two versions is in the examination section. Any provider, regardless of specialty, may perform both types of examinations. It is important to keep in mind with both the 1995 and 1997 documentation guidelines, that noting an abnormal or unexpected finding in an examination requires further description, whereas a brief statement or notation indicating a negative or normal finding is sufficient for documentation related to unaffected areas or asymptomatic system(s) (MLN, n.d.-a; MLN, 1999).

Medical decision-making refers to the complexity of making a diagnosis and/or selecting management choice. This is determined by considering the following factors: number of possible diagnoses or management options, the amount and/or complexity of medical records, diagnostic tests and/or other information that must be obtained, reviewed, and investigated, the risk of significant complications, morbidity, and/or mortality as well as co-morbidities associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the potential management options.

Below is a chart that lists the elements of each level of medical decision making. Note that to qualify for a given type of medical decision-making, two of the three elements must either be met or exceeded.

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Number of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Significant Complications, Morbidity, and/or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

When counseling and/or coordination of care takes more than 50% of the provider/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital or nursing home), the time is considered the key or controlling factor to qualify for a particular level of E&M service. The total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care. The Level I and Level II CPT books available from the AMA lists average time guidelines for a variety of E&M services. These times include work performed before, during and after the encounter.

Split/Shared Services are an encounter where a Physician and a NPP each personally perform a portion of the E&M visit. There are rules for reporting these services.

For office/clinic setting encounters with established patients that meet the “incident to” requirements, report using the physician’s National Provider Identifier (NPI). For encounters that
do not meet “incident to” criteria, report using the APRN’s NPI. In the hospital inpatient, outpatient and Emergency Department (ED) setting encounters shared between a physician and an APRN from the same group practice, when the physician provides any face-to-face portion of the encounter, report using either provider’s NPI. When the physician does not provide a face-to-face encounter, then report using the APRN’s NPI (CMS, 2010; MLN, n.d.b; MLN, 2011).

**Liability (Malpractice) Insurance**

APRN (as with all other practitioners who provide medical services/procedures) are working in a lawsuit driven environment. There are numerous factors that contribute to the risk for being named in a lawsuit, among them are patient load, voluminous paperwork associated with care provided, and staffing shortages. One negative outcome, whether real or perceived by the patient or caregiver, can easily result in a lawsuit. Professional liability (malpractice) insurance can protect the practitioner’s family, savings, personal belongings, home, and any other assets of value.

Institutions, such as medical centers and/or hospitals, long-term care facilities and/or home health agencies, carry “blanket” liability on employees but the primary purpose of this insurance is to protect the employing agency. If a medical lawsuit is filed naming an individual practitioner along with the facility, the practitioner’s interests in the defense may differ greatly from those of the facility/employer, who must protect its own reputation and finances.

In addition, an employer’s policy does not protect the APRN’s license to practice. Conflict of interest can arise between the APRN and the employer itself. For instance, if being named jointly with an employer in a lawsuit, the employer can argue that facility’s procedures were not followed to the letter. Maintaining that argument can devastate the practitioner’s career, even if the case is dismissed from court or the practitioner is acquitted of malpractice. The employer would retain the right to file a complaint against the practitioner to his/her licensing body (i.e., the state’s Board of Nursing). An investigation will be triggered and the practitioner will be required to hire his/her own defense attorney. If the Board decides to file disciplinary action against the practitioner, his/her career as an APRN could be tainted or ruined.

APRNs should question their actual or potential employer about the policy carried to cover them as employees. The following are issues to investigate:

1. Is the APRN protected individually under the policy (specifically named as an insured party)?
2. Does the insurance include License Protection to help with defense of the APRN in an administrative or disciplinary situation?
3. If the APRN leaves the employment of the facility/agency, does the policy cover for an incident that occurred while still employed (is the employer’s policy “Occurrence”)?
4. Does the APRN have individual limits of liability?
5. What level of coverage does the APRN have with the policy (per incident, per lifetime, etc.)?
6. Ask to see the policy (if the APRN has a personal attorney, can he/she review the policy)?
7. Does the policy cover 24 hours/day?
8. What is the employer’s insurance company’s stability rating (NSO, 2011)?

APRNs are held legally accountable to their scope of practice and are therefore facing greater malpractice exposure than ever before, especially in two key areas:

1. Diagnostic Responsibilities – greater numbers of APRNs are able to work in a collaborative agreement rather than working for a physician in a complementary role.
2. Prescriptive Authority – APRNs can prescribe under their own signature in many states.

To date, APRN liability (malpractice) insurance premiums are less expensive than their counterparts (physicians and physician assistants). According to Nurses Service Organization (NSO, 2011), this is subject to change as the number and severity of claims against APRNs is on the rise. As practitioners of any level are named in lawsuits, insurers will increase premiums to cover the outlay resulting from those suits.

There are multiple sources of APRN liability insurance available. As the APRN determines his/her practice site preference, he/she will need to investigate levels of minimal as well as maximal coverage for their practice, which is generally based on risk association for the type practice (some areas of practice have higher litigious rates and therefore higher premiums). While negotiating a contract, liability (malpractice) insurance coverage is a key issue to be addressed. APRNs can request the employer to provide individual liability insurance as a part of their benefit package as long as it truly meets the APRNs coverage needs.

“Incident to” Billing

“Incident to” refers to a Medicare billing mechanism, allowing services furnished in an outpatient setting to be provided by auxiliary personnel and billed under the provider’s NPI number. The provider can be a physician, nurse practitioner, clinical nurse specialist, physician’s assistant, nurse midwife, and clinical psychologist. The services provided must be under the provider’s direct supervision; he/she must be in the area where care is delivered and be immediately available to provide assistance and supervision. The provider must initiate a course of treatment and the services done by the auxiliary staff include follow up care, and assisting in the plan of care. In some outpatient settings, there may be an opportunity for a non-provider (i.e., non-APRN) to provide care and obtain reimbursement as “incident to” the provider’s services. The provider can be a physician or an advanced practice nurse so there may be opportunities for an APRN to direct care of patients with wound, ostomy and continence care issues and for non-APRNs to provide the care. A potential downside to “incident to” billing, when done by the APRN, is that the APRN’s services are folded into the physician’s information and this makes it difficult to document the exact services rendered by the APRN or the revenue generated by them (“Reimbursement,” 2004). It is beyond the scope of this fact sheet to cover “incident to” in
detail, the reader is referred to the WOCN® Society fact sheet entitled: *Understanding Medicare Part B Incident to Billing: A Fact Sheet*. (In press, 2011.)

**Summary**

Understanding and in some cases pursuing reimbursement for advanced practice nursing services may be key for survival in today’s health care environment. To be prepared to participate in today’s health care industry, APRNs need to be competent clinicians but also need to be well versed in the business side of providing care. Understanding the key concepts of APRN definition, Medicare billing regulations, other insurance’s regulations, credentialing for privileges in the health care setting, inpatient versus outpatient billing issues, the use of CPT codes, and other topics as defined by the specific setting in which the APRN works is critical for success. This fact sheet was written to provide the reader with an overview and is not meant to be an exhaustive authority on this subject. The information provided may change, depending on the current reimbursement environment and it is suggested that the reader seek out the references and additional reading resources listed below.
References:


CPT Codebook 2011, AMA.


Additional Reading:


Glossary:

**Advanced Practice Registered Nurse (APRN):** A registered nurse, licensed by the state in which they practice who has completed an accredited graduate level educational program preparing her/him for one of the four recognized advanced practice roles, clinical nurse specialist, nurse practitioner, nurse midwife, or nurse anesthetist. The APRN has passed a national certification examination that measures APRN, role and population focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification programs. (Adapted from the LACE consensus model.)

**Credentialing:** A method to document recognition and verification of a provider’s qualifications to practice in a health care setting.

**Current Procedural Terminology (CPT):** Systematic listing and coding of procedures/services performed by providers that serve as the basis for health care billing.

**E&M Services:** Evaluation and management services are CPT codes which describe physician-patient encounters are often referred to as Evaluation and Management Codes. Evaluation and Management Services refer to visits and consultations furnished by providers.

**Hospital Cost Report:** All Medicare certified institutional providers are required to submit an annual cost report to the Fiscal Intermediary. The report contains information such a facility characteristics, utilization data, cost, and charge by cost center and financial statement data. This information is used by Medicare to provide reimbursement, collect statistics, and make future decisions upon reimbursement.

**International Classification of Disease, Diagnosis, and Procedural Codes (ICD-10):** Is a replacement for ICD-9-CM diagnosis and procedure codes. It will be used for services provided on or after October 1, 2013, for all Health Insurance Portability and Accountability Act covered entities.

**Medicare:** Federal health insurance program for the elderly and disabled. There are two Medicare programs, Part A: covers hospitalization, hospice, skilled nursing facilities and some home care services and Part B, which covers physician services, outpatient hospital services, laboratory charges, medical equipment, and other home health services. The Medicare programs are administered by the Center for Medicare and Medicaid Services (CMS). Medicare Part A is managed by a contracting agency called an intermediary agency; Medicare Part B is managed by a contracting agency called a carrier.

**Medicaid:** State administered program for low-income families and children, pregnant women, the aged, blind and disabled and long-term care.

**NPI Number:** Unique identification 10 digit numeric ID for covered health care providers. Information: [www.cms.gov/nationalprovidentstand/](http://www.cms.gov/nationalprovidentstand/)
Table 1. Consensus Model: Definition of Advanced Practice Registered Nurse

The definition of an Advanced Practice Registered Nurse (APRN) is a nurse:

1. Who has completed an accredited graduate-level education program preparing him/her for one of the four recognized APRN roles;

2. Who has passed a national certification examination that measures APRN, role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification program;

3. Who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care; however, the defining factor for all APRNs is that a significant component of the education and practice focuses on direct care of individuals;

4. Whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy;

5. Who is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions;

6. Who has clinical experience of sufficient depth and breadth to reflect the intended license; and

7. Who has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP).

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