PerformCARE

Memorandum

To: **PerformCare Provider Network (MH Inpatient Psychiatric Providers)**

From: **Scott Daubert, VP Operations**

Date: **July 1, 2013**

Subject: **PC-11 Use of CRNP's for Inpatient Hospital Care**

Claims Payment and Clinical Policy Clarification

Question/Issue:

What are the requirements regarding the use of Certified Registered Nurse Practitioners (CRNPs) for follow-up care on mental health inpatient units?

Source Documentation / References:

49 Pa. Code § 21.251-21.377
Title 49, Professional and Vocational Standards
Subpart A Chapter 21 – Nursing Services
Subchapter C – Certified Registered Nurse Practitioners

55 Pa. Code § 1141 Medical Assistance Manual: Physicians' Services

55 Pa. Code § 1144 Medical Assistance Manual: Certified Registered Nurse Practitioner Services

55 Pa. Code § 1151 Medical Assistance Manual: Inpatient Psychiatric Services

PerformCare Answer/Response:

The scope of this response is intended to apply to all inpatient psychiatric facilities providing services for HealthChoices Members reimbursed by PerformCare. In 55 Pa. Code § 1151, *Inpatient Psychiatric Facility* refers to both private psychiatric hospitals and distinct part psychiatric units of general hospitals. No retroactive payment adjustments are intended nor will be applied as a result of this payment clarification memo.

Basic Requirements of CRNP – Physician Collaboration

As noted under 55 Pa. Code § 1144.52, all services furnished by the CRNP are conducted in collaboration with and under the direction of a physician licensed to practice medicine in the Commonwealth.

The collaboration requirements are detailed in 49 Pa. Code § 21.251 (relating to definitions). The basic requirements include the following:

Collaboration—A process in which a CRNP works with one or more physicians to deliver health care services within the scope of the CRNP's expertise. The process includes the following:

(i) Immediate availability of a licensed physician to a CRNP through direct communications or by radio, telephone or telecommunications.

(ii) A predetermined plan for emergency services.

(iii) A physician available to a CRNP on a regularly scheduled basis for referrals, review of the standards of medical practice incorporating consultation and chart review, drug and other medical protocols within the practice setting, periodic updating in medical diagnosis and therapeutics and cosigning records when necessary to document accountability by both parties.

Collaborative agreement—The written and signed agreement between a CRNP and a collaborating physician in which they agree to the details of their collaboration including the elements in the definition of collaboration.

Prescriptive authority collaborative agreement—The written and signed agreement between a CRNP with prescriptive authority and a collaborating physician in which they agree to the details of their collaboration.

For the purposes of CRNPs providing hospital care in inpatient psychiatric facilities, these definitions are notable in that the directing physician is not necessarily required to be on-site with the CRNP. However, the directing physician must be immediately available to the CRNP. Specific hospital requirements related to privileges and related to Medicare regulations may potentially be more restrictive and require on-site physician presence. Facilities and physicians/CRNPs working within hospitals should closely adhere to both state / federal regulations and applicable hospital policy.

Disallowed Services by CRNPs

Various MA regulations indicate that a CRNP cannot independently conduct the following services in inpatient psychiatric facilities:

1. Medical and Psychiatric Evaluation
   Source: 55 Pa. Code § 1151.61 Payment conditions: general
   "A medical and psychiatric evaluation shall be made by the attending physician or staff physician under § 1151.63 (relating to medical and psychiatric evaluation)."

2. Certification of Need for Admission
   Source: 55 Pa. Code § 1151.62 Certification of Need for admission.
   "If a recipient is 21 years of age or older, the attending or staff physician shall certify in the medical record either at the time of admission or on the first day of the benefit period, when applicable, or upon application for MA, that acute psychiatric services in a private psychiatric hospital are needed."

"If a recipient under 21 years of age is being admitted, an independent team shall certify at the time of admission the need for acute psychiatric services…The team shall: Include a physician."

Source: 55 Pa. Code **§** 1151.63 Medical and psychiatric evaluation.
The medical and psychiatric evaluation of each applicant's and recipient's need for inpatient psychiatric care shall include the following:....
"A recommendation by a physician concerning admission to an inpatient psychiatric facility or continued care in the inpatient psychiatric facility, whichever is applicable.

3. Plan of Care
   Source: 55 Pa. Code **§** 1151.65 Plan of care.
   "Before authorization for payment for care provided to a recipient 21 years of age or older, the attending or staff physician shall establish, and include in the recipient's medical record, an individual written plan of care."

   Source: 55 Pa. Code **§** 1151.66 Team developing plan of care.
   "The team responsible for developing the plan of care for recipients under age 21…shall include one of the following:
   A Board-eligible or Board-certified psychiatrist.

4. Continued Need for Care
   Source: 55 Pa. Code **§** 1151.67 Payment conditions related to the recipient's continued need for care.
   "Review of the plan of care shall be carried out by:
   *The team specified in **§** 1151.66 (relating to team developing plan of care), if the recipient is 20 years of age or younger.*
   The attending or staff physician and other personnel involved in the recipient's care, if the recipient is 21 years of age or older."

Under the Certification of Need for Admission, Plan of Care and Continued Need of Care sections above, the applicable 55 Pa. Code § 1151.62, 55 Pa. Code § 1151.65, and 55 Pa. Code § 1151.67 subsections only apply to private psychiatric hospitals. Distinct part psychiatric units of acute care general hospitals shall comply with 42 CFR 456.60 (relating to certification and recertification of need for inpatient care) and 42 CFR 456.80 (relating to individual written plan of care). These regulations state the following and are generally consistent with the Pa. Code.

42 CFR 456.60

Certification and recertification of need for inpatient care.

(a) Certification. (1) A physician must certify for each applicant or recipient that inpatient services in a hospital are or were needed.

(2) The certification must be made at the time of admission or, if an individual applies for assistance while in a hospital, before the Medicaid agency authorizes payment.

(b) Recertification. (1) A physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by State law and under the supervision of a physician, must recertify for each applicant or recipient that inpatient services in a hospital are needed.

(2) Recertification's must be made at least every 60 days after certification.

42 CFR 456.80

Individual written plan of care.

(a) Before admission to a hospital or before authorization for payment, a physician and other personnel involved in the care of the individual must establish a written plan of care for each applicant or recipient.

In summary, the Medical and Psychiatric Evaluation, the Certification of Need for Admission, the Plan of Care, and the Review of the Plan of Care must all be carried out by the physician or psychiatrist (individually or as part of a team as defined in each regulation).

Allowed Services by CRNPs

CRNP services in general are regulated by 55 Pa. Code § 1144 Medical Assistance Manual: Certified Registered Nurse Practitioner Services and 49 Pa. Code § 21.251-21.377. Ongoing responsibilities of providers include that the services billed are furnished by the CRNP in collaboration with and under the direction of a physician licensed to practice medicine in the Commonwealth.

Related to hospital services provided in inpatient psychiatric facilities, the following subset of Evaluation and Management (E&M) CPT codes are currently allowable and listed on the HealthChoices Behavioral Health Services Reporting Classification Chart. However, PerformCare is not activating the Initial Hospital Care codes, 99221-99223 due to the MA regulation prohibition (cited above) that CRNPs should not conduct Medical / Psychiatric Evaluations. Those inpatient psychiatric facilities with bundled rates in their PerformCare contracts would not be submitting separate claims for these inpatient professional services, but the services are similarly considered allowed or not allowed by PerformCare under the bundled per diem.

CPT Code	Description	PerformCare Determination of CRNP Billing / Service
99221 SA	Initial hospital care, low complexity	Not allowed.
99222 SA	Initial hospital care, moderate complexity	Not allowed.
99223 SA	Initial hospital care, high complexity	Not allowed.
99231 SA	Subsequent hospital care, low complexity	Allowed.
99232 SA	Subsequent hospital care, moderate complexity	Allowed.
99233 SA	Subsequent hospital care, high complexity	Allowed.
99238 SA	Hospital discharge day management	Allowed.

All claims to PerformCare would be submitted with an SA modifier to denote the service is provided by a CRNP. Allowable Provider Types are 31/339 Psychiatrist and 09/103 CRNP. Thus, services can be billed directly under the CRNP MA number and provider type, or incident to the Physician/Psychiatrist's MA number and provider type. Most importantly under either billing scenario, all claims for services that are delivered by the CRNP must contain the SA modifier for proper payment and identification as a CRNP service. CRNP services are generally paid at 85% of the established psychiatry rate and are also listed specifically on the PerformCare Fee Schedule.

These allowed CPT Codes with the SA modifier can be billed to PerformCare effective for any date of service on or after July 1, 2013.

Disallowed Duplication of Services

Under 55 Pa. Code § 1144.53 Non-compensable services, payment will not be made for the following:
The same service and procedure furnished to the same recipient by a CRNP and physician, with whom the CRNP has protocols, on the same day.

Similarly, PerformCare considers this disallowed duplication of services to extend to all physicians, not just the physician with whom the CRNP has protocols. That is, same or similar professional services (e.g., Subsequent Hospital Care codes 99231-33) in inpatient psychiatric facilities should only be billed once per day. In other words, it is *not* permissible for a nonphysician provider to round on hospitalized patients, enter data in the record (including the history of current illness or vital signs), and bill for the service, and then for the physician to then round on the patients himself or herself later and then also bill for full visits.

In this same scenario where both the CRNP and psychiatrist round on the same hospitalized patient on the same date, PerformCare does consider it permissible for the psychiatrist to bill for the full visit (and not separately bill for the CRNP service). These are known as split/shared services, and providers should follow the current CMS Medicare guidelines for delivery of split/shared services as long as they are not in conflict with a more restrictive state regulation.

Split/Shared Services

The Centers for Medicare and Medicaid Services (CMS) defines a split/shared service as a medically necessary encounter with a patient where the physician **and** a qualified NPP (non-physician practitioner which includes CRNPs and Physician Assistants) each performs a **substantive portion** of the E&M visit, **face-to-face** with the same patient, on the same date of service.

- A substantive portion of an E&M visit involves all or some portion of the history, examination, and medical decision making components of the E&M service.
- At this time, *substantive portion* is not more specifically defined by CMS. However, it is very clear that simply signing the NPP's note does not meet the criteria for a split/shared visit. Both providers must perform a portion of the visit to include a face-to-face visit with the physician.
- The physician and NPP must be in the same group practice or employed by the same employer. (For CRNPs, the collaboration agreement and related standards outlined in the state regulations noted above are considered to meet this requirement by PerformCare.)

CMS guidelines specifically allow split/shared visits for the following services relevant to this Provider Memo:

- Hospital inpatient (99221-99233)
- Hospital discharge (99238)

Examples of split/shared visit scenario

- An NPP performs a hospital inpatient E&M visit (codes 99231-99238) and the physician also performs a face-to-face portion with the same patient as part of the overall visit. If there is clear documentation that there was a face to face encounter between the physician and the patient of a

substantive nature, and it is clear that he/she took part in the service, the service may be billed and reimbursed under the physician's NPI number (without the SA modifier to PerformCare).

- If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face substantive visit with the patient on the same day, the full service may be billed and reimbursed under the physician's NPI number (without the SA modifier to PerformCare).

Split/shared billing not allowed for Medical and Psychiatric Evaluation

It is common for the inpatient Medical and Psychiatric Evaluation to be billed under E&M codes 99221-99223, Initial Hospital Care. As noted above, these are allowable codes by CMS for split/shared billing. However, PerformCare does not allow split/shared billing for the Medical and Psychiatric Evaluation due to the service being restricted to attending or staff physicians under 55 Pa. Code § 1151.

Inpatient Medical and Psychiatric Evaluation Coding

This is also a reminder that the 90792 Psychiatric Diagnostic Evaluation CPT code is limited to outpatient and clinic settings by PerformCare. 90792 coding is not to be billed as the Medical and Psychiatric Evaluation conducted in an inpatient psychiatric facility. Additional claims edits have been put in place which will produce a claims denial for any 90792 billed with a Place of Service (POS) = 21 (Inpatient). However, secondary TPL claims can continue to be billed with the original CPT codes submitted to the primary insurer.

CRNPs, Psychiatrists, and/or inpatient psychiatric facilities who wish to begin billing these allowed services for CRNPs should contact their PerformCare Account Executive to assure that their provider profile and fee schedule is updated.

cc: PerformCare Managers
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