



Compliance

TODAY

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A portrait of Ryan Meade, a middle-aged man with short, light-colored hair, wearing a dark suit, a light blue shirt, and a patterned tie. He is smiling slightly and looking directly at the camera. The background is a blurred interior space with large windows and what appears to be a library or study area with bookshelves.

The mission of making Compliance an academic discipline

an interview with **Ryan Meade**
Director, Center for Compliance Studies
Loyola University Chicago School of Law

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by Charles Oppenheim, Esq. and Amy Joseph, Esq.

Caution: Hospital nurse practitioners may raise Stark issues

- » Hospital-employed NPs and non-hospital employed physicians sometimes collaborate to provide E/M services.
- » This can cause unforeseen Stark law issues and raise issues regarding proper billing of Part B services.
- » The question is whether the NP services are a benefit to the physicians at the hospital.
- » Medicare Part B billing rules for split/shared services also can be unclear.
- » Stark Law analysis is recommended when NPs and physicians share E/M services.

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In many ways, hospital-employed non-physician practitioners, such as nurse practitioners (NPs) and physician assistants (PAs), fill a similar role to that provided by hospitalists. Employment of such practitioners can be a useful tool in providing quality hospital care in a cost-efficient manner. In our experience, for these and other reasons, hospitals are increasingly employing NPs to assist with patient care management issues. Although NP employment may come from the best intentions, the federal physician self-referral law¹ (the Stark Law) could be implicated when the physician is not also employed by the hospital (for purposes of this article, any reference to a physician assumes the physician is not hospital-employed).

In particular, when hospital-employed NPs and physicians collaborate to provide evaluation and management (E/M) services to the hospital's inpatients, tricky issues arise. For

example, a common scenario is where both the NP and the physician separately conduct rounds to see the same patient in the same day (effectively "sharing" the service). The questions become whether the physician should bill for the E/M service, despite the services of the NP; whether, if the physician does bill under these circumstances, the hospital is effectively providing free use of the NP's services to the physician; and whether that constitutes a financial benefit (i.e., remuneration) to the physician.

The Stark Law

The Stark Law prohibits a physician from referring Medicare beneficiaries for certain types of services, including inpatient and outpatient hospital services, to entities (such as hospitals) with which the physician has a financial relationship, unless an exception applies. The Stark Law also prohibits entities, such as hospitals, from billing for services provided pursuant to a prohibited referral. Whether a hospital "intends"



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to provide remuneration to a physician in exchange for referrals is not determinative. Unlike the federal Anti-Kickback Statute (AKS), violation of the Stark Law is not based on intent. Unless the financial relationship meets all of the elements of one of the Stark Law exceptions, which are highly technical and specific, the arrangement can violate the Stark Law regardless of the motivation for the arrangement.

A financial relationship includes any “compensation arrangement,” defined as “any arrangement involving remuneration, direct or indirect, between a physician (or a member of a physician’s immediate family) and an entity.”² Remuneration, in turn, is defined as “any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind.”³

Although the definition of remuneration is fairly broad, it has limits. Importantly, it hinges on whether something can be viewed as a “payment or other benefit” between the parties. If something provided to a physician has no financial value to the physician, it is logical to conclude that it does not “benefit” the physician in a remunerative sense, although it might “help” the physician and provide an intangible benefit (e.g., a physical, emotional, spiritual, or psychological benefit). Likewise, the provision of services would not normally be considered a type of “payment” to a person if the services do not confer any financial advantage or financial benefit to the recipient.

Billing for split/shared E/M services

When a physician bills for an E/M service, despite the fact that a hospital-employed NP has provided some components of the E/M service, the question is whether the hospital has provided some form of remuneration to a physician in violation of the Stark Law. To analyze this question, one might start by

analyzing the billing rules for “shared services” under Medicare Part B. Unfortunately, the Medicare billing rules do not clearly address this situation.

The Medicare program normally pays the attending physician for one E/M visit per day during an inpatient stay. The Medicare program will also pay for E/M services provided by certain non-physician practitioners, including NPs.⁴ Even when performed in a hospital setting, NP services are not considered inpatient hospital services, covered by Part A, under the Medicare Prospective Payment Systems.⁵ Instead, NP services (as part of an E/M visit) are treated the same way as physician services and are paid under Medicare Part B.⁶

In addition, Medicare specifically permits a physician to bill for the entire E/M visit, even when an NP performs certain components of the E/M visit, otherwise referred to as “split/shared” E/M visits.⁷ Medicare rules state that, as long as the physician performs some face-to-face portion of an E/M visit with a patient, even when an NP performs part of the service, the physician is entitled to bill for the entire service. As an example, Medicare guidance describes a scenario where an NP sees a hospital inpatient in the morning, and the physician follows with a face-to-face visit later that day.

Arguably, it follows that, from the standpoint of the Medicare program, physicians are not impermissibly receiving a financial benefit from the services performed by a hospital-employed NP, as long as the physician performs enough of the E/M visit to earn the full payment. The next question is: How do we know when the physician has performed enough of the E/M visit to earn the full payment? The answer depends on what portion of the service each practitioner provided. Ultimately, this is a fact-intensive inquiry that will vary depending on the specific situation.

Factors to consider might include: (1) How much independence did the NP exercise in performing services?; (2) How involved was the physician in the provision of E/M services?; (3) What proportion of services provided by the NP could be categorized as services reimbursed under Medicare Part B versus Medicare Part A?; (4) Did the NP's services supplement or supplant the physician's services (i.e., did the patient receive extra care from the NP's services, or instead, did the NP's services result in a corresponding reduction in physician care)?; (5) Did the physician derive any financial benefit from the NP's involvement (e.g., ability to see and bill for more patients in the same timeframe)?; and (6) Did the hospital know (or should it have known) the physician was billing for E/M services provided by the NP?

On the other hand, a contrary argument could be made that a physician is not entitled to bill for the E/M visit, even if the physician performs a substantial amount of the services. The Medicare rules for billing an E/M visit that is split/shared between a physician and an NP expressly apply only when the physician and NP are in the same group practice, meaning a group that is legally organized as a corporation, partnership, or similar association and which meets certain other requirements.^{8,9} Therefore, arguably it might be inappropriate for a physician to bill and be paid for an entire E/M visit that the physician shared with a hospital-employed NP.

There may be some logic to distinguishing between a scenario involving a physician and a hospital-employed NP sharing an E/M visit and the scenario where two practitioners are in the same group practice, because the practitioners who share the E/M visit

and are in the same group practice should be able to determine how to bill and collect for split/shared services within their own medical practice, subject to applicable laws. However, under the scenario addressed in this article, a regulator might take the position that because a physician is expressly permitted to bill for split/shared E/M services only when the physician and NP are part of the same group practice, the omission of the express permission to bill for shared visits under other circumstances is intentional, and thus the practice is not permitted under other circumstances.

Therefore, it is not entirely clear whether a physician may bill for an E/M visit when the visit is split/shared with a hospital-

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employed NP and, when it does happen, the question of whether this creates a Stark Law issue may turn on a fact-intensive inquiry as to whether the physician received a financial benefit from

doing so. Furthermore, the enforcement agencies have traditionally been leery of arrangements in which items or services are seemingly provided for free, especially to a referral source, so having to defend itself in this type of scenario is a position that a hospital might wish to avoid.

A somewhat comparable, although different, analysis applies in the case of surgical inpatients. Medicare generally pays the surgeon a single, global payment that covers the professional component of the surgery and all of the post-operative patient visits by the surgeon for a specified period of time. However, the Medicare program does not require any minimum number of visits, nor are there any explicit expectations regarding how many post-operative visits there will be

for particular types of surgeries. Accordingly, issues may arise when an NP provides some of those post-operative visits.¹⁰

Although outside the scope of this article, other potential compliance issues that could arise in this scenario include whether the NP's salary is appropriately reflected on the hospital's cost report, the extent that the NP is providing services reimbursable under Medicare Part B, and whether physicians might be viewed as inappropriately or falsely billing Part B to the extent they bill for an E/M visit that was partly performed by a hospital-employed NP.

Practical considerations

Given the potential Stark Law risk described above, hospitals might consider whether certain of the following practices would help to support the position that they are not providing remuneration to physicians when the hospital-employed NP and a physician provide split/shared E/M services.

For example, if a hospital-employed NP is providing services reimbursable under Medicare Part B, the hospital might consider billing for these services, rather than allowing the physician to do so. Of note, physician supervision of non-physician practitioners is required, so the physician may already be receiving compensation related to the provision of such services, in which case, logically, the physician should not be paid twice for the same time (i.e., payment from the hospital for supervision and payment from Medicare for the Part B services).

Hospitals might consider developing and implementing policies that address applicable billing rules, and periodically training hospital workforce and medical staff physicians on these policies. Clear communication of billing rules to physicians may help to protect against billing practices that inadvertently run afoul of Part B rules and/or the Stark Law. Clear

communication of these billing rules to workforce members, particularly to NPs providing the services in question, might encourage such NPs to report identified variances with the policies, allowing the hospital to take swifter action to remedy any compliance issues (and potentially limiting any period of non-compliance).

Hospitals also might consider periodically monitoring and auditing the services provided by employed NPs. For example, if a hospital-employed NP is asked specific questions about the types of services performed during his/her annual employee review, including questions regarding E/M services provided and physicians with whom that NP works, then these responses may help to identify any potential areas of non-compliance that require closer examination.

Conclusion

As hospitals continue to identify ways to increase quality of care and improve patient experience, while also reducing cost, employment of NPs can be an effective tool to assist with patient care management issues. However, in doing so, hospitals should take care not to violate the Stark Law by providing impermissible financial benefits to physicians. In particular, potential compliance issues might arise if a physician bills for E/M services shared with NPs employed by the hospital, if the physician is viewed as impermissibly billing for services performed by the NP, and thus the NP's services are viewed as remuneration from the hospital to the physician, in violation of the Stark Law. 

1. 42 U.S.C. Section 1395nn.
2. 42 CFR § 411.354(c).
3. 42 CFR § 411.351.
4. CMS: *Medicare Claims Processing Manual* Chapter 12, § 30.6.1.
5. 42 C.F.R. § 412.50(a)(3).
6. 42 C.F.R. § 414.56(b).
7. *Ibid*, Ref #4.
8. *Idem*.
9. CMS: *Medicare General Information, Eligibility, and Entitlement Manual*, Pub. 100-1, Ch. 5, Definitions, § 90.4.
10. See generally, *Medicare Claims Processing Manual*, Ch. 12, §§ 40 et seq.