Acknowledgement
This project is supported by grant number E1CMS331080 from the Centers for Medicare and Medicaid (CMS) Innovations Center. The content is solely the responsibility of the authors and does not necessarily represent the official views of CMS. We also want to acknowledge the gracious participation of 16 nursing homes in the St. Louis area, their staffs, the APRNs and other staff of the MOQI Initiative. Without everyone's support and hard work, the advances in this Initiative would not be possible.
WHITE PAPER
The Missouri Quality Initiative: APRN Role Sustainability

Background

Nearly 50% of nursing facility resident hospitalizations and 30% of emergency department (ED) visits are potentially avoidable (Research Triangle Institute [RTI], International, 2015; Segal Rollins, Hodges, & Roozeboom, 2014). The cost of medical care for Medicare and Medicaid dually enrolled residents of long term care (LTC) facilities is twice that of non-dually enrolled individuals in the community and LTC facilities combined (Kane, Wysocki, Parashuram, Shipee, & Lum, 2013). In 2005, potentially avoidable hospitalizations cost Medicare and Medicaid $2.6 billion (Polniaszek, Walsh, & Weiner, 2011). Given the rate of avoidable hospitalizations and the rising cost of healthcare for nursing facility residents, the Centers for Medicare and Medicaid Services (CMS), through collaboration of CMS’ Center for Medicare and Medicaid Innovation and Medicare-Medicaid Coordination Office, proposed the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents (CMS, 2015b). The Missouri Quality Initiative (MOQI) is one of seven organizations selected by a CMS grant to participate in the Initiative; the other six are located in Nevada, Indiana, Alabama, Pennsylvania, Nebraska, and New York (CMS, 2015b). The participating organizations have been awarded a four-year grant and were tasked with developing evidence based practice interventions to reduce avoidable hospital admissions and readmissions, improve health outcomes, improve transition of residents between hospitals and nursing facilities, and reduce healthcare costs while preserving access to care (CMS, 2015b).

The MOQI implemented an inter-professional model in 16 nursing facilities in Missouri with advanced practice registered nurses (APRNs) (i.e., nurse practitioners or clinical nurse specialists) at the forefront providing direct care and early intervention to residents; mentoring, role-modeling for, and educating nursing staff; and participating in quality improvement activities (CMS, 2015b; RTI International, 2015; University of Missouri-Columbia [UMC], n.d.). In addition to each facility’s being assigned an APRN, the MOQI provides an intervention team including a Project Medical Director, a social services Care Transition Coach (CTC), a technology Health Information Coordinator (HIC), and a registered nurse (QIPMO/INTERACT coach [QIC]) modeled after the Quality Improvement Program for Missouri Nursing Homes (QIPMO) (UMC, n.d.). The MOQI team collaborates with nursing facility staff and administration to implement preventive services and improve early recognition and management of medical conditions commonly resulting in avoidable hospitalizations; cooperates with facility providers, nursing staff, and resident families to improve quality of care through quality improvement activities involving causes of avoidable hospitalizations; facilitates smooth transition of residents between hospital, nursing facility, and the community via accurate and timely health information exchange; expedites improved communication among providers of the hospitals and nursing facilities; and monitors prescription drugs to reduce polypharmacy and use of inappropriate psychotropic drugs (UMC, n.d.).

Within the first three years of the implementation period, the MOQI has been associated with a statistically significant reduction in all-cause hospitalizations by 0.105 per resident, \( p < .01 \), a
21.4% reduction compared to 2012; in avoidable hospitalizations by 0.071 per resident $p < .01$, a 34.5% reduction compared to 2012; in all-cause emergency room visits by 0.098 per resident $p < .01$, a 27.9% reduction compared to 2012; and in avoidable emergency room visits by 0.041 per resident $p < .01$, a 39.1% reduction compared to 2012 (RTI International, 2016). Although the reduction in total Medicare expenditures was not statistically significant, the MOQI was associated with a statistically significant reduction in spending on all-cause hospitalizations by $729 per resident, $p < .05$; in avoidable hospitalizations by $456 per resident, $p < .05$; in all-cause emergency room visits by $53 per resident, $p < .01$; and potentially avoidable emergency room visits by $15 per resident, $p < .01$ (RTI International, 2016). These data support the substantial impact of the MOQI and the value of adding a full time APRN to the facilities involved.

As the first phase of the Initiative approached its fourth and final year, CMS announced additional funding for a second phase of the Initiative which includes a new payment model to cover “higher-intensity treatment services” and increased provider reimbursement in the participating nursing facilities in order to further discourage avoidable hospitalizations and reduce healthcare costs (CMS, 2015a). Phase two of the Initiative will also include a comparison group of 24 nursing facilities which are eligible for the additional funding for the “higher-intensity treatment services” and increased provider reimbursement rates, but do not implement the evidence based practice models from phase one (CMS, 2015a). The MOQI was one of six organizations awarded the four-year phase two grant which extends through 2020.

Once CMS’ funding for the Initiative is exhausted, it is imperative that there be a succeeding plan in place to sustain the MOQI’s outcomes for the benefit of the residents and facilities involved. One such plan includes the hiring of the APRNs who have provided expertise to facilities throughout the grant period and can not only maintain the MOQI’s success, but also drive additional quality improvement projects. The following will describe the quality of care offered by APRNs; discuss APRN roles in LTC; and review legal and budgetary considerations, including reimbursement opportunities for direct care provided by the APRN, which can offset salary and benefit expenses.

**APRN Quality of Care**

Researchers have investigated the quality of care provided by APRNs since the 1970s. Though much of the research is dated, the span of publications reinforces how APRNs have consistently provided safe and effective care over the past 40 years. Most of the research demonstrates that care provided by physicians and nurse practitioners result in similar favorable health outcomes (Harrocks, Anderson, & Salisbury, 2002; Laurant et al., 2005; Lentz, Mundinger, Kane, Hopkins, & Lin, 2004; Newhouse et al., 2011; Sackett et al., 1974; Swan, Furguson, Chang, Larson, & Smaldone, 2015). In addition, physician and APRN prescribing practices are comparable (Harrocks et al., 2002; Venning et al., 2000), as are referrals to emergency departments and hospitalizations (Newhouse et al., 2011). Moreover, APRNs, when compared to their physician counterparts, often demonstrate better patient satisfaction (Laurant et al., 2005; Lentz et al., 2004; Swan et al., 2015; Venning et al., 2000). While APRN consultations were found to be longer and more frequent than that of physicians, Venning et al. (2000) and Swan et
al. (2015) reported that health service costs were alike and Aigner, Drew and Phipps (2004) found that care by APRNs working with physicians may result in cost and time savings for physicians.

The APRN role is further supported by Oliver, Pennington, Revelle, and Rantz (2014) who documented the impact of nurse practitioners on Medicare and Medicaid patients’ health outcomes. Oliver et al. found that states which fostered independent APRN practice compared to those that had limited or restricted APRN practice had lower rates of hospitalization, means (with standard deviation in parentheses) = 100.18 (22.9) versus 145.85 (33.0), \( p < .0001 \), and improved health outcomes, \( M = 16.82 \) (10.96) versus 29.9 (14.3), \( p < .0001 \), in Medicare and Medicaid patients. Thus, APRNs not only offer safe and effective care similar to that of physicians, but as APRN practice barriers are removed, overall aggregate patient outcomes may further improve.

APRNs in Long Term Care

Studies on APRN practice in LTC facilities concur with those discussed above indicating that APRNs maintain physician, resident, and family satisfaction (Rosenfeld, Kobayashi, Barber, & Mezey, 2004), contribute to the reduction in hospitalization and emergency room visits (Burl, Bonner, & Rao, 1994; Burl, Bonner, Rao, & Khan, 1998), and are associated with positive health outcomes of facility residents (Burl et al., 1998; Ryan, 1999). The results of the first three years of the MOQI intervention reaffirms these findings. Clearly, the research supports the use of APRNs in not only primary care, but also LTC.

The role of the LTC APRN as described in 2004 by Rosenfeld et al., continues to be true in the state of Missouri today. LTC APRNs may be employed by physicians, by managed care organizations, by the LTC facilities, or may be independent providers collaborating with physicians (Rosenfeld et al., 2004). APRNs can impact the quality of care in each of these employment situations. Whereas APRNs employed or working in collaboration with physicians focus primarily on direct patient care and APRNs employed by managed care organizations focus on cost-containment, APRNs employed by LTC facilities have a greater diversity of practice responsibilities including direct patient care and cost-containment (Rosenfeld et al., 2014). LTC-employed APRNs conduct in-service education; attend interdisciplinary team meetings; perform bedside rounds with physicians and nursing staff; provide wound care, preventative care, and hospice care; and evaluate and treat sick residents (Rosenfeld et al., 2014). LTC-employed APRNs also participate in facility quality improvement activities (UMC, n.d.). Although APRNs can only bill for services provided directly to the resident, the other responsibilities conducted by the LTC-employed APRN can reduce staff burden, including facility educators, quality improvement designees, supervisors, and nurses. In addition, these APRNs are in a unique position to impact facility quality measures, reduce hospitalizations and emergency room visits, and contain cost (RTI International, 2016).

Legal and Budgetary Considerations in Employing APRNs

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The literature clearly reinforces the safe and effective care provided by APRNs across the continuum of care. Given the impact of the MOQI model on improving patient outcomes and reducing unnecessary hospitalizations and healthcare costs, LTC facilities are in a unique position to sustain this program by hiring APRNs. The following information provides the LTC facility with the tools necessary to employ an APRN. Understanding salary and reimbursement considerations, collaborative practice requirements, employment contracts, and credentialing and billing are key to maximizing the APRNs value and expertise in the LTC field.

**APRN Salary and Reimbursement**

While APRN salaries in the state of Missouri vary by specialty and practice setting, as of February 2016, the average annual APRN salary is $94,000, with APRNs’ specializing in geriatrics averaging $91,000 per year (Indeed, n.d.). APRNs employed by nursing homes and residential care facilities average $79,400 per year (Nurse Journal, 2015). Some APRN services are reimbursable under Medicare and Medicaid; specifically face to face, medically necessary patient interactions are billable (Baker, 2010; CMS, 2012). These billable services can off-set the salary of APRNs employed by long term care facilities.

In order to bill Medicare and Medicaid for evaluation and management (E&M) CPT (current procedural terminology) codes, APRNs must meet the scope of practice and physician collaboration and supervision requirements for the state in which the APRN is practicing (Baker, 2010; CMS, 2012). In the state of Missouri, APRNs are required by law to collaborate with a physician in order to perform designated physician acts such as prescribing and ordering diagnostic laboratory tests (State Board of Nursing [SBN], 2015), and therefore must be in a collaborative practice arrangement (CPA) in order to bill for their services (Baker, 2010; CMS, 2012). Additionally, APRNs must have their own National Provider Identifier (NPI) number, which requires that the APRN have at least a master’s degree, be nationally certified, and recognized by their state as an APRN. APRNs are reimbursed at 85% of the physician rate (CMS, 2015d) for medically necessary visits. Table 1 delineates the most common CPT codes utilized by APRNs providing services in nursing facilities and assisted living facilities along with the current physician and APRN reimbursement rates for these CPT codes in the St. Louis Metropolitan area (CMS, 2015e).

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Service Description</th>
<th>Physician Rate</th>
<th>APRN Rate (85% of physician)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99304</td>
<td>Nursing Facility Initial Visit</td>
<td>$91.14</td>
<td>$77.46</td>
</tr>
<tr>
<td>99305</td>
<td>Nursing Facility Initial Visit</td>
<td>$129.65</td>
<td>$110.25</td>
</tr>
<tr>
<td>99306</td>
<td>Nursing Facility Initial Visit</td>
<td>$165.43</td>
<td>$140.62</td>
</tr>
<tr>
<td>99307</td>
<td>Nursing Facility Subsequent Visit</td>
<td>$44.43</td>
<td>$37.77</td>
</tr>
<tr>
<td>99308</td>
<td>Nursing Facility Subsequent Visit</td>
<td>$68.75</td>
<td>$58.44</td>
</tr>
</tbody>
</table>

*Nursing Facility*
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate 1</th>
<th>Rate 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>99309</td>
<td>Nursing Facility Subsequent Visit</td>
<td>$90.62</td>
<td>$77.03</td>
</tr>
<tr>
<td>99310</td>
<td>Nursing Facility Subsequent Visit</td>
<td>$134.80</td>
<td>$114.58</td>
</tr>
<tr>
<td>99315</td>
<td>Nursing Facility Discharge (&lt;30 mins)</td>
<td>$72.70</td>
<td>$61.79</td>
</tr>
<tr>
<td>99316</td>
<td>Nursing Facility Discharge (&gt;30 mins)</td>
<td>$105.28</td>
<td>$89.49</td>
</tr>
<tr>
<td>99318</td>
<td>Annual Nursing Facility Assessment</td>
<td>$95.35</td>
<td>$81.05</td>
</tr>
</tbody>
</table>

**Assisted Living Facility**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate 1</th>
<th>Rate 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>99324</td>
<td>New Patient</td>
<td>$55.14</td>
<td>$46.87</td>
</tr>
<tr>
<td>99325</td>
<td>New Patient</td>
<td>$80.32</td>
<td>$68.27</td>
</tr>
<tr>
<td>99326</td>
<td>New Patient</td>
<td>$138.70</td>
<td>$117.90</td>
</tr>
<tr>
<td>99327</td>
<td>New Patient</td>
<td>$184.96</td>
<td>$157.22</td>
</tr>
<tr>
<td>99328</td>
<td>New Patient</td>
<td>$216.16</td>
<td>$183.74</td>
</tr>
<tr>
<td>99334</td>
<td>Established Patient</td>
<td>$60.03</td>
<td>$51.03</td>
</tr>
<tr>
<td>99335</td>
<td>Established Patient</td>
<td>$94.68</td>
<td>$80.48</td>
</tr>
<tr>
<td>99336</td>
<td>Established Patient</td>
<td>$133.96</td>
<td>$113.87</td>
</tr>
<tr>
<td>99337</td>
<td>Established Patient</td>
<td>$192.04</td>
<td>$163.23</td>
</tr>
</tbody>
</table>

*Note. Reimbursement rates include the 20% patient copay. As CPT codes increase, so does complexity of the visit. These CPT codes require specific documentation of medical necessity and complexity of decision-making as designated by CMS. Please refer to https://www.cms.gov/ to access documentation requirements.*

*Nursing facility refers to both skilled nursing facilities and nursing facilities.

Medical necessity and complexity, not the volume and quality of documentation, are the key criteria for billing (Baker, 2010). A face to face evaluation is required, but coding may also be dictated by time spent reviewing the medical record, discussing the case with staff, attending care plan and family meetings with the resident in attendance, and documentation; one cannot bill for telephone calls or meetings in which the resident is not present (Baker, 2010). Only one E&M visit per resident per day is reimbursable; a physician and APRN cannot both bill for the same E&M visit on the same day (Baker, 2010).

Although it varies by the mix of CPT codes used, APRNs must see approximately 10-12 patients per day to meet their salaries and benefits and 14 to 15 patients per day to generate revenue, with a typical caseload averaging 275 patients. While this caseload may not be realistic for APRNs employed by one LTC facility, the APRN can fulfill additional non-revenue producing responsibilities which indirectly affect the revenue base of the facility. If one APRN serves two or more facilities, the proposed caseload becomes more realistic, but limits the APRN’s ability to conduct other job responsibilities such as quality improvement and staff education.

### APRN Billing

When discussing billing considerations, it is important to define the difference between a patient residing in a skilled nursing facility (SNF) bed versus a nursing facility (NF) bed. A resident is occupying a SNF bed when he/she is receiving Medicare A benefits; a resident is occupying a NF bed when he/she is not receiving Medicare A benefits (Baker, 2010; CMS, 2012). The Code of Federal Regulations (CFR) Title 42 §483.40 dictates physician and non-physician provider, including APRN, visits in SNFs and NFs (United States Government Publishing Office [GPO], 2011). The State of Missouri adopted the federal rules and has no state rules regarding physician and non-physician practitioners (NPP) SNF or NF visits (University of Minnesota, 2012). Under CFR §483.40(c)(1), it is federally mandated that all nursing home residents be seen initially by a physician within 30 days of their admission to a SNF, then every 30 days for the first 90 days,
then minimally every 60 days thereafter (CMS, 2016a; GPO, 2011). These federally mandated visits are also known as “required” visits (CMS, 2016a). Per CFR §483.40(c)(4), after the initial SNF visit, a physician may delegate other required visits to an APRN as long as the physician sees the resident every other visit (CMS, 2016a; GPO, 2011). In contrast, per CFR §483.40(f), in a NF, a physician may delegate to an APRN who is not employed by the facility any required visit, including the initial visit (GPO, 2011). APRNs may complete other medically necessary visits prior to or after the physician’s initial comprehensive evaluation (Baker, 2010, CMS, 2016a).

At the same time, CMS dictates specific billing restrictions for APRNs who are employed by LTC facilities. The distinction between a SNF resident and a NF resident is also very important with regard to the billing practices of an APRN employed by the facility. Table 2 identifies which SNF and NF visits and associated orders are approved by CMS for APRNs employed and not employed by LTC facilities. The regulations which restrict the APRN employed by the LTC facility from conducting the initial comprehensive visit, writing admission orders and treatments, and certifying/recertifying admissions presents a potential delay in access to care and a barrier to the further success of the MOQI model. As indicated by CFR §483.40(c)(1), the physician has up to 30 days to see the resident initially (CMS, 2016a; GPO, 2011). If LTC facility employed APRNs had the legal authority to conduct such visits, the residents would receive more immediate access to care rather than potentially waiting 30 days. Furthermore, allowing APRNs employed by the LTC facility to conduct all visits would allow physicians to focus where his/her training and expertise are most needed, on more medically complicated residents.

Revising portions of CFR §483.40 is necessary to allow APRNs, including those employed by facilities, to conduct all visits in NFs and SNFs. Recommended changes to CFR §483.40 are as follows:

- CFR §483.40(c)(1) The resident must be seen by a physician or a NP, CNS, or PA, including those employed by the facility, at least every 30 days for the first 90 days after admission, and at least every 60 days thereafter.

- CFR §483.40(c)(3) At the option of the physician, required visits may be conducted by a physician or a NP, CNS, or PA, including those employed by the facility.

- CFR §483.40(c)(4) Required visits in SNFs may alternate between personal visits by the physician and visits by a NP, CNS, or PA, including those employed by the facility.

- CFR §483.40(f) At the option of the State, any required physician task in a NF or SNF (including tasks which the regulations specify must be performed personally by a physician) may also be satisfied when performed by a NP, CNS, or PA, whether employed by the facility or not.
Table 2  
**APRN CMS Approved Visits and Orders for SNF verses NF**

<table>
<thead>
<tr>
<th></th>
<th>SNF</th>
<th>NF</th>
</tr>
</thead>
<tbody>
<tr>
<td>APRN Not Employed by LTC Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTC Employed APRN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APRN Not Employed by LTC Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTC Employed APRN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Order to Admit</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Admission Treatment Orders</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Initial Comprehensive Visit</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Required Visits</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Medically Necessary Visits</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Medically Necessary Orders</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Certification/Recertification</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Adapted from Baker (2010)

**Collaborative Practice Requirements**

As mentioned above, in Missouri APRNs must be in a CPA with a physician in order to perform designated physician acts and bill for services. If a LTC facility chooses to hire an APRN, but does not expect the APRN to prescribe, order diagnostic tests, or bill for services, a CPA is not required or necessary. However, in this scenario the facility is not taking full advantage of all that an APRN can offer to improve the quality of care and health outcomes of the residents. Furthermore, the facility is losing the financial incentive to bill for the APRN’s services and recuperate a portion of the APRN’s salary expenses.

Missouri statutes and the State Board of Nursing’s and State Board of Registration for the Healing Arts’ rules dictate collaborative practice. House Bill 564 was passed by the Missouri Legislature and signed by the Governor in 1993 resulting in the Missouri Revised Statute (RSMo) 334.104.2 authorizing written CPAs between physicians and nurses (SBN, n.d.). RSMo 334.104.2 was clarified by the State Board of Nursing’s (SBN) and the State Board of Registration for the Healing Arts’ (SBHA) joint rule on Collaborative Practice 20 CSR (Code of State Regulations) 2200-4.200 (Nursing) and 20 CSR 2150.5.100 (Healing Arts) and became law in 1996 (Missouri Secretary of State [SOS], 2016; SBN, n.d.). While this law remains a constant topic of controversy between the SBN and SBHA, CPAs must contain all required wording addressing geographic areas, methods of treatment, and review of services. Appendix A provides a sample CPA which contains all required components included in 20 CSR 2200-4.200
A CPA requires a physician who is willing to collaborate with the APRN, and vice versa. The ideal candidate for collaborating with a facility employed APRN would be the facility’s medical director. The Collaborative Practice Law dictates that a physician may only collaborate with three full-time equivalent (FTE) APRNs (SOS, 2016). As discussed above, most APRNs employed by a LTC facility will not be performing delegated medical acts requiring a CPA on a full-time basis; these APRNs may be considered a 0.5 FTE or less. If the medical director already collaborates with three FTE APRNs and is unable or unwilling to collaborate with the facility’s APRN, other physicians who provide services to the residents of the facility may be considered. If the Missouri legislature were to pass a law removing practice barriers to APRNs and allow them to practice to the full extent of their education and training as recommended by the Institute of Medicine (2011), APRNs would be authorized to provide and bill for services in the absence of a CPA, thus improving LTC residents’ access to care.

**Contractual Employment Agreements**

Although not required, an additional consideration for both the APRN and LTC facility is that of implementing a contractual employment agreement, which protects the interest of both the APRN and the employing facility. A sample employment agreement provided by BKD, LLP can be found in Appendix B. Dumm, Funkenbusch, and Biernat (2016) suggest the contract address the APRN’s scope of practice; licensure, certification, and continuing education requirements; contract term and renewals; non-compete considerations; compensation, including paid time off, continuing education reimbursement, liability coverage, and bonus structure; and compliance with applicable regulations (i.e., Anti-kickback Statute). It is also recommended that compensation incentives be aligned with success in meeting the overall facility quality measures and reimbursement goals (Dumm, Funkenbusch, & Biernat, 2016).

**Medicare and Private Insurance Credentialing**

**National Provider Identification (NPI) Number**

A NPI number, which is required for an APRN to bill for services, is a 10-digit unique identifier which must be obtained prior to completion of the Medicare enrollment forms. Although the application for obtaining an NPI number can be submitted electronically or via pen and paper, Dumm, Funkenbusch, and Biernat (2016) suggest the electronic method due to significant delays in processing the paper application. The NPI number is issued by the National Plan and Provider Enumeration System (NPPES) in compliance with the Health Insurance Portability and Accountability Act (HIPPA) (CMS, 2014). Appendix B includes a detailed outline of the procedure for obtaining a NPI number and offers tips to avoid barriers in the process.

**Medicare Enrollment**

Once an APRN has established a CPA and has obtained his/her NPI number, the APRN must then become credentialed as a provider with Medicare. Credentialing requires extensive provider information and is very time-consuming, often taking up to nine months to complete.
(Dumm, Funkenbusch, & Biernat, 2016). It is essential that the provider initiate credentialing well in advance of employment, and that the administrative team allow adequate time for the credentialing process before expecting the provider to render services (Dumm, Funkenbusch, & Biernat, 2016).

According to Dumm, Funkenbusch, and Biernat (2016), for Medicare, the facility may need to report the addition of the APRN provider using form CMS-855B (Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers). The APRN will need to complete CMS-855I (Medicare Enrollment Application for Physicians and Non-Physician Practitioners) if he/she wishes to receive Medicare reimbursement directly or CMS-855R (Medicare Enrollment Application for Reassignment of Medicare Benefits) if he/she wishes the Medicare payments to go to the facility employer (Dumm, Funkenbusch, & Biernat, 2016). If the LTC facility is employing the APRN, CMS-855I is not applicable. There is no application fee for individual providers (CMS, 2015c). Once the application is submitted to the Medicare Administrative Contractor (MAC), the MAC will issue a Provider Transaction Access Number (PTAN), formerly a Unique Physician Identification Number (UPIN), to the provider (CMS, 2014). While a provider will have only one NPI number, he/she can potentially have several PTANs, one for each medical group or practice and for individual Medicare contractors with which he/she contracts. The NPI number and PTAN(s) are used to identify the provider within the Medicare system (CMS, 2014). See Appendix B for details on how to enroll the APRN as a Medicare provider.

Medicare providers, including APRNs, are required to meet reporting criteria for the Physician Quality Reporting System (PQRS). The PQRS encourages providers to report quality data to Medicare (CMS, 2016b). Because the data is submitted via the electronic health record (EHR), providers must have access to an EHR with meaningful use (CMS, 2016b). If a provider does not participate in the PQRS, he/she will receive a 2% reduction in Medicare reimbursement for all claims (Dumm, Funkenbusch, & Biernat, 2016). Under certain circumstances, providers may be exempt from participating in PQRS and may apply for exemption from the 2% penalty. Information on the exemption can be found on the CMS website by searching for “EHR Hardship Exception.”

**Medicaid Credentialing**

Medicaid credentialing for Medicaid providers is done at the state level. As with Medicare credentialing, an NPI number and CPA are required before applying to be a Medicaid provider (Dumm, Funkenbusch, & Biernat, 2016). In the state of Missouri, provider enrollment is entirely electronic and paper applications are no longer provided or accepted (Missouri Department of Social Services [MDSS], n.d.). Providers must complete the enrollment forms electronically using the latest version of Internet Explorer or Netscape Navigator as other browsers are not compatible (MDSS, n.d.). Appendix B outlines the process for Medicaid enrollment in the state of Missouri. Some Medicaid products are managed by commercial insurance companies or health maintenance organizations (HMOs) which requires enrollment with those entities. Providers are encouraged to contact the individual Medicaid managed care plans or HMOs for credentialing requirements.

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Commercial Insurance and Managed Care Credentialing

After completing the application for Medicare credentialing, the next step is to credential with commercial insurance and managed care organizations. The NPI number and PTAN will be required for commercial insurance and managed care organization credentialing (Dumm, Funkenbusch, & Biernat, 2016). The Council for Affordable Quality Healthcare (CAQH) ProView electronic credentialing system is highly recommended for enrolling as providers in commercial insurance and managed care organizations. CAQH ProView is a free service for the provider and is accessible by most insurance carriers in the United States, eliminating the need to be credentialed by each insurance carrier individually. The provider is required to routinely review, update, and attest the information contained in their CAQH account. Failure to review, update or attest the CAQH account may result in loss of credentialing and ability to receive reimbursement for services. Please refer to Appendix B for a more comprehensive review of the credentialing process.

Billing Fee Schedule Considerations

Medicare providers must agree to accept Medicare assignment. In accepting Medicare assignment, the provider agrees to the Medicare-allowed reimbursement for services rendered and not to bill the patient for any amount above the Medicare rate other than unmet copayment, deductible, and/or coinsurance (Dumm, Funkenbusch, & Biernat, 2016). Some commercial insurance companies and/or managed care organizations reimburse at higher rates than Medicare assignment; therefore, establishing a fee schedule may be appropriate. According to Dumm Funkenbusch, and Biernat, the fee ranges should generally be between 50 and 75 percent above the Medicare assignment, while taking into account the commercial and Medicare allowances to assure that the fee(s) are not too high or too low resulting in underpayment or unnecessary adjustments. The provider bills all insurance entities, including Medicare and Medicaid, based on the fee schedule with hopes of receiving higher reimbursement from some. However, regardless of what is billed, Medicare, Medicaid, and private insurance entities will not pay more than their designated allowed amount. Appendix D has a sample fee schedule developed by the content experts at BKD, LLP.

Choosing a Billing Service

LTC facilities which already bill for Medicare B services are equipped to bill for APRN services. If an outside billing entity is required, there are many services available. Billing entities most often charge for their services in one of two ways. They may charge a fee for each claim, a percentage of the billing fee (Dumm, Funkenbusch, & Biernat, 2016). The amount charged by the billing service often correlates with the volume of claims and a provider who submits a larger volume of claims will likely be charged lower percentages or cost per claim (Dumm, Funkenbusch, & Biernat, 2016). As cost for claim and percentages vary by billing entity, it is important to compare billing services’ charges, collection rate, and business ethics. In addition, if the billing service charges using the percentage method, ensure the percentage is taken from what is collected and not from what is billed. A billing service which charges a percentage of

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what is collected has the added incentive to pursue payments from Medicare, Medicaid, and private insurance companies, as well as to collect copays, deductibles, and coinsurance.

**Summary**

APRNs have a proven record of providing safe, therapeutic, and cost-effective care to their patients (Harrocks et al., 2002; Laurant et al., 2005; Lentz et al., 2004; Newhouse et al., 2011; Oliver et al., 2014; Sackett et al., 1974; Swan et al., 2015; Venning et al., 2000; Aigner et al., 2004). The MOQI capitalized on the expertise of APRNs by providing a full time APRN in each of 16 nursing facilities in Missouri in an effort to meet the goals of CMS’ Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents (CMS, 2015b; RTI International, 2015, UMC, n.d.). In just three years, the MOQI was associated with a significant reduction in all-cause and avoidable hospitalizations and all-cause and avoidable emergency department visits (RTI International, 2016). In addition, the MOQI was associated with a significant reduction in the cost of these hospitalizations and emergency department visits; the MOQI was also associated with a reduction in total Medicare expenditures (RTI International, 2016). The MOQI APRNs have the potential to maintain these outcomes and to influence additional quality improvement projects, which requires commitment from the facilities in which the APRNs have practiced. The nursing facilities can employ APRNs to continue the efforts implemented by the MOQI, while billing for the APRNs’ face to face patient interactions to cover a portion of their salaries. This white paper outlines the outcomes of the MOQI, APRN quality of care, APRN roles in LTC, and APRN legal and budgetary considerations, including steps toward hiring and billing for an APRN (See Appendix E for step by step checklist). With ongoing participation of nursing facilities involved in the MOQI, this model has the potential to disseminate and sustain the effective practices throughout the state and the nation.
References


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Appendix A

Collaborative Practice Agreement with Advanced Practice Nurse

This Collaborative Practice Agreement (hereinafter “Agreement”) is entered into this day of , 20____ and between ____________, MD/DO, a physician licensed to practice medicine in the State of Missouri (hereinafter “Physician”) and ____________, MSN/DNP, a registered professional nurse in the State of Missouri who is also recognized by the Missouri Board of Nursing as an Advanced Practice Registered Nurse (hereinafter “APRN”).

Recognition of Independent Professional Authority

The purpose of this Collaborative Practice Agreement is to delegate to the APRN authority to perform certain medical acts. Notwithstanding the delegation of such medical acts, the parties hereto recognize that APRN is a registered professional nurse with additional education and training in an advanced practice nursing clinical specialty area and as such is authorized by the Nursing Practice Act to engage in professional nursing and perform independent nursing acts consistent with APRN’s specialized knowledge, judgment, skill, training and education without medical supervision or delegation. This Agreement only applies to delegated medical acts and those nursing acts requiring physician orders and not to APRN’s independent practice of nursing.

By entering into this agreement, both Physician and APRN certify and agree that they have read this agreement and acknowledge that they will follow its terms, which are based upon the laws and regulations of the State of Missouri. Physician and APRN further understand and acknowledge that this Collaborative Practice Agreement allows APRN to practice delegated medical acts under the direction and supervision of Physician and APRN may not otherwise practice delegated medical acts independently outside the scope of this agreement. Physician acknowledges that Physician is entering into this Agreement freely and has the right to refuse to collaborate, without penalty, with a particular APRN. Similarly, APRN acknowledges that APRN is entering into this Agreement freely and has the right to refuse to collaborate, without penalty with a particular Physician.

The complete name, credentials, home and business addresses, and phone numbers of the Physician and APRN are (additional offices or locations where the Physician and APRN will practice are listed in Exhibit A):

The Physician and APRN understand and agree that at if the APRN practices at an office setting, each office listed where the APRN practices will post a prominently displayed disclosure statement that informs patients that they may be seen by an APRN and that a patient has a right to see a physician.

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Section 1. Delegation, Scope of Collaborative Practice, Methods of Treatment

1.1 Physician has considered APRN’s skill, training, education and competence and has determined that,
   (a) the responsibilities delegated herein are within the scope of practice of the APRN and are consistent with APRN’s skill, training, education and competence; and
   (b) the methods of treatment and the authority to administer, dispense and prescribe the drugs and medications delegated to APRN herein are consistent with both the Physician’s and APRN’s skill, training, education and competence and within the scope of practice of both.

1.2 Physician hereby delegates to APRN the authority to deliver health care services and/or treatments and to administer, dispense and prescribe drugs pursuant to this Agreement and Exhibit B attached hereto, which are specific to the clinical conditions to be treated by APRN and Physician. This delegation authorizes APRN to provide health care services that include the diagnosis and initiation of treatment for acutely or chronically ill or injured persons.

1.3 The methods of treatment and the authority to administer, dispense and prescribe drugs delegated to APRN may not be further delegated by APRN to any other person except that an RN, a registered physician assistant or other authorized agent may communicate prescription drug orders of Physician or the APRN to pharmacist.

1.4 The authority to administer, dispense, or prescribe drugs delegated to APRN pursuant to Section 1.2 of this Agreement is subject to the following conditions:
   (a) Physician and APRN have decided that all controlled substances require a prescription or a direct order from Physician and APRN may not prescribe any controlled substances nor does Physician delegate any authority to APRN to prescribe any controlled substances. APRN may administer or dispense controlled substances on a case-by-case determination of the patient’s needs following verbal consultation between the Physician and APRN which shall be documented in the patient’s care chart and in the appropriate dispensing log co-signed by the Physician following a review of the records.
   (b) APRN may only dispense starter doses of medication to cover a period of time for seventy-two (72) hours of less.
   (c) The dispensing of drug samples, as defined in 21 U.S.C. 353(c)(1), is permitted as appropriate to complete drug therapy.
   (d) All prescription container labeling requirements outlined in Section 338.059 RSMo shall be followed.
   (e) Consumer product safety laws and Class B container standards shall be followed when packaging drugs for distribution.
   (f) All drugs shall be stored according to United States Pharmacopoeia (USP) recommended conditions.
   (g) Outdated drugs shall be separated from the active inventory.
(h) Retrievable dispensing logs shall be maintained for all prescription drugs dispensed and shall include all information required by state and federal statutes, rules, or regulations;

(i) All prescriptions shall conform to all applicable state and federal statutes, rules, or regulations and shall include the name, address, and telephone number of Physician and APRN.

Section 2. Geographic Restrictions

2.1 Physician’s practice, for the purposes of this collaborative practice agreement, is located at:

The APRN will practice at participating nursing facilities and hospitals where physician is assigned patients which are no greater than 30 road miles from the Physician’s practice. If APRN is providing care in a federally designated health professional shortage area, this distance will not exceed 50 road miles from Physician’s practice. Physician and APRN agree that this distance will not create an impediment to effectively collaborate in the delivery of health care services or the adequate review of those services.

2.2 APRN shall not practice at a location where Physician is not continuously present unless APRN shall first practice at the same location with Physician for a period of at least one calendar month.

Section 3. Review of Services

3.1 Physician shall at all times be immediately available for consultation to APRN, either personally or via telecommunications.

3.2 Physician shall review the work, records, and practice of health care delivered pursuant to this Agreement by reviewing a minimum of 10% of the APRN’s charts at least once every two (2) weeks, which review shall be documented by Physician. The preceding requirement shall not apply during the time period described in Paragraph 2.2 above, in which Physician and APRN are practicing at the same location.

3.3 Except in extraordinary circumstances that shall be documented, Physician shall be present at APRN’s practice location at least every two (2) weeks to participate in review and to provide necessary medical direction, medical services, consultations and supervision of health care staff.

3.4 When APRN utilizes this Agreement to provide health care services for conditions other than acute self-limited or well defined problems, Physician shall see the patient for evaluation and approve or formulate the plan of treatment for any new or significantly changed
conditions as soon as practical but in no case more than two (2) weeks after the patient has been seen by APRN.

3.5 Physician and APRN have determined an appropriate process of review and management of abnormal test results which is described in Exhibit C attached hereto and incorporated herein by reference.

Section 4. Miscellaneous Provisions

4.1 Physician and APRN each agree to maintain copies of this Agreement, and all amendments, all protocols and standing orders and amendments and modifications thereto and any notice of termination of this Agreement for a minimum of eight (8) years after termination of this Agreement.

4.2 Physician shall not enter into collaborative practice arrangements with more than three (3) full time equivalent advanced practice registered nurses, including APRN.

4.3 The process and documentation of review of health care services described in Sections 1.4(a), 3.2 and 3.5 above shall be on file and maintained at the collaborative practice setting as outlined in Exhibit D.

4.4 Attached hereto and incorporated herein by reference as Exhibit E are guidelines for consultation and referral to Physician or a designated health facility for services or emergency care that is beyond the education, training, competence or scope of practice of the APRN.

4.5 Physician hereby designates, , MD/DO to consult, direct or supervise APRN in the event Physician is unable due to temporary illness, injury or absence.

4.6 This Agreement and all Exhibits shall be reviewed and revised annually or as needed upon the mutual written consent of APRN and Physician.

4.7 This Agreement may be terminated at any time by either Physician or APRN upon 30 days written notice to the other.

By signing this Agreement, Physician and APRN represent that they have read this Agreement and all of its Exhibits, they are aware of the contents, and that they agree to follow their terms.

____________________________________________________  ____/____/_______
Signature Physician  Date

____________________________________________________  ____/____/_______
Signature APRN  Date

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Collaborative Practice Agreement

Exhibit A: *Additional locations where the APRN and Physician shall practice.*
Exhibit B: *Primary clinical conditions to be evaluated, diagnosed, and possibly treated by APRN/Physician.*

To include the diagnosis and initiation of treatment of acutely or chronically ill residents in nursing facility and hospital settings where Physician is responsible for patient’s care. Conditions which include but are not limited to the following in the above referenced settings to include routine follow up care, assessment, diagnosis and initiation of treatment at the request of the patient, family member, responsible party, physician, and/or staff:
Collaborative Practice Agreement

Exhibit C: Management and review of abnormal test results

APRN/Physician will review test results on routine basis. APRN will notify Physician directly or instruct reporting party to notify Physician of levels which are reported as “panic” levels immediately.

Routine or stat test results will be reviewed by either APRN or Physician and communicated directly to physician when determined to impact clinical decision making beyond the knowledge, judgment, skill, training and education of APRN.
Collaborative Practice Agreement

Exhibit D: *Process and documentation of Review of health care services requiring controlled substance and review of work records and practice.*

In the event patient’s condition requires the prescribing and administration of controlled substance, Physician shall be consulted on a case-by-case basis between APRN and Physician. In each case Physician will direct the administration and dispensing of controlled substance. In the event the APRN receives direct order from Physician, APRN will document such in patient’s record and will be reviewed per collaborative practice agreement guidelines.

Physician and APRN will not have access to controlled substance therefore will not dispense.

Review of work records will occur on routine basis through process of follow up care for assigned patients in the nursing facility and hospital. Residents in the nursing facility are seen on a routine basis by either APRN or Physician alternating visits between APRN and Physician. Non routine follow up care is performed by either APRN or Physician, in which case work records are review by Physician at the time of next Physician visit. Physician reviews work records of APRN on biweekly basis through the review and signing of telephone orders and patient related documents and on a daily basis by reviewing daily report from the APRN.

Physician will demonstrate review of APRN through the utilization of signature.
Collaborative Practice Agreement

Exhibit E: *Guideline for consultation and referral to Physician, designated health facility or emergency care center.*

In the event the condition of a patient assigned to the care of APRN and Physician exceeds the knowledge, education, training and scope of practice of APRN, APRN will contact Physician directly person-to-person or via telecommunication to discuss the condition and management of patient. In the event emergent care is needed, APRN and Physician will communicate directly with support staff, responsible partly or patient and direct transfer of patient to emergency room.
Appendix B

Employment Agreement

Adapted from BKD, LLP Content Experts, Marla K. Dumm, CPC, CCS-P, Monique D. Funkenbusch, CPC, and Randy A. Biernat, CPA/ABV

This agreement is made and entered into this _______ day of ____________, ______ between ________________________________________, hereinafter referred to as the Facility and ________________________________________, hereinafter referred to as the APRN.

Whereas the APRN has the necessary education, licensure and state recognition to practice as an APRN in the state of _______________ and desires to render professional services as of the effective date of this agreement, upon all the terms and conditions set forth in this agreement and the attachments hereto.

Now, therefore, in consideration of the mutual promises contained in this agreement, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Facility and APRN hereby agree as follows:

1. Employment. Facility does hereby contract with the APRN, the APRN does hereby contract with the Facility to render provider services for the Facility and such additional duties as determined by the Facility in the manner and to the extent permitted by the laws of the state of _______________ and the applicable canons of practice.

2. Term and Renewal.

   A. The term of this agreement shall be for a period of three (3) years commencing at 12:01 a.m. on the _______ day of ____________, ______, and terminating at 12:00 midnight on the _______ day of ____________, ______, unless sooner terminated as provided herin.

   B. This agreement will automatically renew for a successive three (3) year term unless written notice of termination is given as provided herein, prior to the expiration of the original term of the agreement or any extensions thereof.

   C. If either party to this agreement makes a determination that it will not renew this agreement, the non-renewing party shall give the other party written notice of such intent to terminate at least thirty (30) days prior to the expiration of this agreement or any extension thereof.

3. Scope of Duties. During the term of this agreement, and any extensions or renewals thereof, the APRN duties shall include, but not be limited to the following, subject to the direction and instruction of the Administrator, Director of Nursing, and/or Chief Operating Officer:
A. Keeping and maintaining (or causing to be kept and maintained) appropriate, accurate, and timely records relating to all professional services rendered by him/her under this agreement. Such books and records shall include, but shall not be limited to, all requisite reports, charts, patient documentation, management reports, documentation for certification of and preparing and attending to, in connection with such services, all services, all reports, claims, correspondence necessary or appropriate in the circumstances, all of which shall belong to the Facility. Such records must be sufficient to obtain payment for clinic and all profession services and facilities and to facilitate in the delivery of quality patient care. APRN shall maintain the confidentiality of such records as required by law, this agreement, and ethical considerations.

B. APRN agrees to use his/her best efforts in the promotion of the Facility and its interests, to the extent permitted by law and applicable canons of professional ethics.

C. APRN shall be responsible for all aspects of services rendered, including, but not limited to supervision of subordinates, direction of treatment professionals, filing of reports, and assistance as needed and directed by the Administrator, DON, and/or Chief Operating Officer.

D. It is understood and agreed that the Facility shall have the authority with respect to the acceptance or refusal of any patient, the amount of fees charged by the APRN for professional services, and whether the Facility and/or APRN shall be participating providers in any third party payer program. Nothing in this agreement shall be construed to create a joint venture, partnership, association, or other affiliation or like relationship between parties, it being specifically agreed that their relationship is, and shall continue. That of employer or employee. The APRN shall operate generally under the personnel policies of the Facility with such modifications as may be necessary in light of the nature of the APRN’s duties and responsibilities. In no event shall either party be liable for the debts or obligations of the other.

E. All fees, accounts receivable or other remuneration of any kind received by the APRN as a result of the rendition of professional services are the property of the Facility and the APRN hereby assigns any interest in such fees, accounts receivable or other remuneration to the Facility. The parties hereto anticipate that certain payers of health care services or other circumstances will require the APRN’s provider number to be used in submitting charges for services provided in connection with this agreement. With respect to such payers, APRN shall allow the Facility to use his/her provider number in submitting requests for payment, but hereby disclaims and assigns to the Facility any rights he/she may have to such revenue and accounts receivable. APRN shall cooperate with and assist in the collection of accounts receivable, including enforcement of policies which require payment for services at the time such services are rendered. APRN will be employed by the Facility and is in no way enslaved to it.

F. Pursuant to the patient’s wishes, APRN shall admit presenting patients or patients on referral from other APRNs and Providers to the Facility so long as the patients are deemed appropriate for admission. If in the APRN’s professional judgement, a patient requires services not available at the Facility, the APRN shall, pursuant to the patient’s wishes, refer such patient to a facility where such services are available.
G. APRN shall provide services to patients without discrimination on the basis of race, gender, religion, national origin, or sexual preference, or other protected classes.

4. **Compensation.** As compensation for services to be performed by the APRN, the Facility agrees to pay the APRN $__________/hour/year, to be paid in the normal payroll processing cycle and in accordance with all normal employee policies and procedures. APRN is an exempt employee and any hours worked over 40 in a week will be paid at the same hourly rate.

5. **Benefits.** APRN shall be entitled to participate in the benefits package as set forth in Addendum A to this agreement.

6. **APRN’s Responsibilities.**

   A. APRN shall refer patients requiring medically necessary inpatient or outpatient hospital care and treatment as subject to 3.F. of this agreement.

   B. APRN agrees to devote his/her working time, attention, energy, and best effort to rendering the highest quality professional medical services to patients of the Facility on behalf of the Facility and to render such services with competency, efficiency, and fidelity, and shall diligently and to the best of the APRN’s ability perform all duties incident thereto which may from time to time specify. APRN acknowledges his/her responsibility to maintain and improve his/her professional skills and reputation by continuing medical education and participation in professional associations. APRN agrees that the assignment and scheduling of profession and administrative duties are within the sole discretion of the Facility.

7. **Professional Standards.** APRN shall perform his/her duties under this agreement in accordance with such standards of professional ethics and practice as may from time to time be applicable during the term of this agreement.

8. **Termination.**

   A. This agreement may be terminated by either party for any reason, with or without cause, upon the provision of ninety (90) days written notice to the other party.

   B. This agreement may be terminated immediately by the Facility for the following reasons:

      i. Death of the APRN;

      ii. Mental or physical disability of the APRN preventing the APRN from fulfilling his/her responsibilities for a period of one hundred twenty (120) days or longer as determined by an independent provider mutually agreed upon by the parties;
iii. Loss, suspension, termination, or limitation of the APRN’s license to practice or receipt by APRN of any censure, warning, or other disciplinary action from the State Board of Nursing or by the Drug Enforcement Administration;

iv. Loss, suspension, or cancellation of the APRN’s professional liability insurance;

v. Loss, suspension, termination, or limitation of the APRN’s participation in the Medicare and Medicaid programs;

vi. During the term of this agreement or any extension thereof, conviction of the APRN of any crime other than a misdemeanor, or any crime related to drug or alcohol abuse;

vii. During the term of this agreement or any extension thereof, conduct of the APRN in any unprofessional, unethical, illegal, fraudulent, or other conduct which, in the sole discretion of the Facility is detrimental to the reputation, business, character or standing of the Facility;

C. Upon expiration or termination of this agreement for any reason, neither party shall have any further obligations hereunder except for obligations accruing prior to the date of termination, and obligations, promises, or covenants contained herein which extend beyond the term of this agreement. Additionally, the APRN shall do nothing to interfere with any contract of the Facility with any other individual or entity. Likewise, the Facility shall do nothing to interfere with any contract of the APRN with any other individual or entity.

9. Records and Report. All records pertaining to the services rendered by the APRN in the Facility shall be the property of the Facility.

In witness whereof, the parties have executed this agreement on the day and year set forth above.

___________________________________  __________________________
Facility Representative Signature        APRN Signature

___________________________________  __________________________
Date                                    Date
Employment Agreement  
Addendum A  
Benefits

1. **Paid Vacation, Personal Days, and Holidays.** APRN shall be entitled to two (2) noncumulative weeks of vacation per year after the first one-year anniversary of employment. After five (5) years of employment, APRN shall be entitled to three (3) weeks of vacation per year. APRN shall be entitled to ten (10) personal/sick days per year subject to current accrual. APRN shall be entitled to six (6) paid holidays per year, being New Year’s Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day, effective the first holiday after hire date.

2. **Continuing Education.** APRN shall be entitled to a maximum of one (1) noncumulative week for attendance at such professional conventions and seminars which shall be approved by the Facility in advance as to time required, scheduling and expense relating hereto. The cost relating to such approved continuing education seminars and conventions shall be paid by the Facility and shall not exceed $1500/year.

3. **Life Insurance.** APRN shall be eligible to be covered by Facility’s group life insurance plan in the amount of one (1) times the APRN’s annual salary or $100,000, whichever is less. Any premiums relating hereto shall be fully paid by the APRN. APRN is required to enroll for coverage to be effective.

4. **Health Insurance.** APRN shall be covered by medical, dental, and vision coverage in accordance with the plan of the Facility. APRN’s dependents are eligible for coverage under the Facility’s plans.

5. **Long Term Disability Insurance.** APRN shall be eligible, at the APRN’s expense, to participate in the Facility’s long term disability insurance plan.

6. **Professional Dues.** Facility shall be responsible for the payment of the APRN’s license renewal, certification renewal, DEA license renewal.

7. **Professional Liability Insurance.** Facility shall be responsible for the payment of the APRN’s professional Liability Insurance up to $2500/year.

8. **401K or 403B Retirement Savings Plan.** APRN shall be permitted to participate in the Facility’s 401K or 403B Retirement Plan upon employment. The Facility shall match the APRN’s contribution up to 5% of his/her salary.
Appendix C

Employment, Enrollment, Credentialing, and Billing Considerations for Advanced Practice Registered Nurses (APRNs) in the Nursing Facility Setting

By BKD, LLP Subject Matter Expert Contributors:
Marla K. Dumm, CPC, CCS-P, Managing Consultant
Monique D. Funkenbusch, CPC, Managing Consultant
Randy A. Biernat, CPA/ABV, Director

Contractual or Employment Agreements

The nursing facility would need to consider at a minimum, the following key points.

1. A written contract that outlines key employment terms, such as:
   a. Outline of Scope of Services
   b. Expectations re: licensure/certification/CME
   c. Term / Renewals
   d. Non-compete considerations
   e. Compensation, including bonus structure (productivity/quality/patient satisfaction/citizenship)
   f. Compliance with applicable regulations, such as the Anti-Kickback Statute

2. Consider strategically aligning with a health system to contract for such services if recruiting is problematic or there are other alignment benefits.

3. Consider aligning compensation incentives to overall facility reimbursement goals, such as timely completion of mandatory tasks, target re-admit rates, other typical measures of quality/performance.

4. A sample employment contract can be found in Appendix B.

Medicare and Medicaid Provider Credentialing and Enrollment Overview

Obtaining a National Provider Identification (NPI) Number

The NPI is a 10-digit numeric unique identifier needed for Health Insurance Portability and Accountability Act (HIPAA) standard transactions. This number is required for filling out the CMS-855 provider enrollment form(s) (or its Internet-based Provider Enumeration Chain and Ownership System [PECOS] equivalent). The Centers for Medicare and Medicaid Services (CMS) developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

1. There are three ways to apply for the NPI number:
a. Visit the National Plan and Provider Enumeration System (NPPES) website and complete the web-based application at: https://nppes.cms.hhs.gov/NPPES/Welcome.do

b. A paper copy of the NPI application (CMS-10114) which includes the NPI Enumerator’s mailing address is available by request through the NPI Enumerator (1-800-465-3203) or on the Centers for Medicare and Medicaid Services (CMS) website (cms.gov). Please note that it takes a significantly longer time to process the NPI paper application versus the online application.

c. With the provider’s permission, an Electronic File Interchange Organization (EFIO) can submit the application data on the provider’s behalf.

2. Information required for filling out form:
   a. Individual/Organization Name
   b. Individuals: Taxpayer Identification Number (TIN) or Social Security Number
   c. (Organizations: Employer Identification Number (EIN))
   d. Business Mailing Address
   e. Business Practice Location Address and Phone Number
   f. Other Provider Identification Numbers
   g. Provider Type/Specialty Taxonomy Code
   h. State License Information
   i. Authorized Official Information
   j. Contact Person Information

   a. User IDs cannot be changed. Once you have successfully chosen a User ID and secretquestion/answer combinations and submitted the record, the User ID and secret question/answer combinations will remain tied to your record.
   b. Use the application’s navigation buttons, NEXT or PREVIOUS.
   c. Do NOT use the browser’s buttons, BACK and FORWARD.
   d. If you have a problem with the system and cannot continue, wait 20 minutes before logging on again.
   e. Print each page as you complete the application to keep a record of your file.
   f. An Employer Identification Number (EIN) must not be entered in the Individual Taxpayer Identification Number (ITIN) field on the application of a health care provider who is an individual.
   g. When you enter your Medicaid number in section 3.c., list the State that assigned the number.
   h. Post office boxes may not be entered as practice location addresses.

4. Documentation of the NPI number can also be obtained from the NPI Registry at: https://nppes.cms.hhs.gov/NPPES/Welcome.do

Medicare Enrollment Application – CMS-855 Forms
In order to participate with an insurance carrier, individual providers must be credentialed. This process is often time-consuming and may take anywhere from three to nine months to complete. Management must understand the extensive information providers must supply to the organization in order for credentialing to occur. If sufficient time is not allowed and a provider begins rendering services prior to credentialing being complete, the provider will be considered non-participating. If this situation occurs, the patient relationship may be affected in addition to potential loss of reimbursement and referral obstacles. Providers typically do not understand the significant amount of information or process that is required and will need assistance from management in responding in a timely manner (well in advance of the employment start date). Oftentimes, leadership may not fully understand the timeline and tedious steps involved for the provider enrollment process, whether it is for an individual practitioner or for a new facility site.

Additionally, many payers require re-credentialing or revalidation of enrollment information on a periodic basis and lack of responding will render consequences. Organizations are also expected to report changes such as providers’ change in location, change in employment or change of other pertinent information. Changes to existing facility sites may also impact the enrollment information required to be submitted to payers.

Common Medicare provider enrollment applications applicable to individual practitioners associated with a facility setting (e.g., skilled nursing facility) are outlined below and can be found at:  https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html

1. Complete the appropriate Medicare provider enrollment form(s) (or Internet-based Provider, Enrollment, Chain and Ownership System [PECOS] equivalent). As part of the enrollment process, CMS collects information about the applying provider or supplier and secures documentation to ensure he or she is qualified and eligible to enroll in the Medicare Program. Depending upon provider or supplier type, one of the following forms is completed to enroll in the Medicare Program:
   a. Form CMS-855B- Medicare Enrollment Application for Clinics/Group Practices and Certain Other Suppliers: Application used by group practices or other organizational suppliers, except Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers, to initiate the Medicare enrollment process or to change Medicare enrollment information
   b. Form CMS-855I- Medicare Enrollment Application for Physicians and Non-Physician Practitioners (NPPs): Application used by individual physicians or NPPs to initiate the Medicare enrollment process or to change Medicare enrollment information
   c. Form CMS-855R- Medicare Enrollment Application for Reassignment of Medicare Benefits: Application used by individual physicians or NPPs to initiate reassignment of a right to bill the Medicare Program and receive Medicare payments or to terminate a reassignment of benefits

2. Providers are encouraged to download the most current version of CMS-855 provider enrollment forms and related information by going to the CMS website:  https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html

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3. For detailed information pertaining to the Internet-based PECOS, access the following CMS website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

4. CMS-855 provider enrollment form application tips:
   a. Information entered into application should match the information listed within supporting documentation. The Legal Business Name should match IRS documentation exactly, including spaces and abbreviations. The Doing Business As (DBA) name can be entered under ‘Other Name,’ if applicable. The tax identification number should also match IRS documentation.
   b. The practice location address should be a physical address and not a P.O. Box.
   c. The practice location telephone number should be that of the practice location, not the contact person, parent organization, billing agent, management company, or a cell phone number.
   d. If not utilizing the Internet-based PECOS, complete and submit the most current version of the CMS-855 form.
   e. In February 2011, CMS published a final rule, CMS-6028-FC, with provisions related to the submission of application fees as part of the provider enrollment process. An application fee and/or hardship exception must be submitted with any application received from institutional providers initially enrolling in Medicare, adding a practice location, or revalidating their enrollment on or after March 25, 2011. A matrix is available via the CMS website (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareApplicationFee.html) further denoting the instances and provider types for which the application fee is required. The Medicare provider enrollment fee for calendar year 2016 is $554, however the enrollment fee is waived for individual providers. Please note this fee amount is updated each calendar year.
      i. For those who submit applications online via the PECOS website, you will no longer have to separately access Pay.gov to make your application fee payments. Instead, as you proceed through the Internet based PECOS application process, if a fee is required, you will be prompted to submit your payment by credit card or Automated Clearing House (ACH) debit card. Once your payment transaction is complete, you will be automatically returned to the PECOS website to complete the remaining part of your application. PECOS will track the collection transaction and will update payment status, allowing your application to be processed.
      ii. For providers who continue to use the CMS-855 paper provider enrollment form, you submit your application fee using the following URL: https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do. Complete the Medicare Application Fee form and click the ‘PAY NOW’ button. You will be redirected to enter and submit payment collection information. At the conclusion of the collection process, you will receive a receipt indicating the status of your payment. Print a copy for your records. It is strongly recommended you attach a
copy of this receipt to the completed CMS-855 application to be submitted to
your Medicare Administrative Contractor (MAC).

f. Ensure all required signatures and dates are documented. Original signatures are required
on each application (blue ink preferred).
g. Check all applicable boxes and provide effective dates where needed.
h. Ensure all required supporting documents are submitted with your application.
i. Additional tips to facilitate the Medicare enrollment process and to fill out specific
sections of the CMS-855 are included at the beginning of the CMS-855 form or prior to
each section within the form.
j. Ensure the CMS-855 provider enrollment form and supporting documents are mailed to
the correct MAC Provider Enrollment mailing address. Some MAC Provider Enrollment
departments provide a regular delivery mailing address and an overnight delivery mailing
address.

5. Support documentation to be included with the CMS-855 provider enrollment application
(see section 17 of the application for specific requirements) may include the following
(depending upon which of the CMS-855 forms is submitted: CMS-855A, CMS-855B, CMS-
855I, CMS-855R):

a. National Provider Identifier notification that you received from the National Plan and
Provider Enumeration System (NPPES)
b. Licenses, certifications, and registrations required by Medicare or state law
c. Federal, state, and/or local (city/county) business licenses, certifications and/or
registrations required to operate a health care facility
d. Written confirmation from the Internal Revenue Service (IRS) confirming your Tax
Identification Number with the Legal Business Name (e.g., IRS CP 575)
e. Completed Form CMS-588, Authorization Agreement for Electronic Funds Transfer-
This form can be found at: https://www.cms.gov/Medicare/CMS-Forms/CMS-
Forms/downloads/cms588.pdf
f. Copy(s) of all adverse legal action documentation, e.g., notifications, resolutions, and
reinstatement letters (if applicable)
g. Statement in writing from the bank: If Medicare payment due a provider of services is
being sent to a bank (or similar financial institution) where the provider has a lending
relationship (that is, any type of loan), then the provider must provide a statement in
writing from the bank (which must be in the loan agreement) that the bank has agreed to
waive its right of offset for Medicare receivables.
h. Form CMS-460/Medicare Participating Physician or Supplier Agreement- Agreement to
become a Part B participating provider or supplier who will accept assignment of
Medicare benefits for all covered services for all Medicare beneficiaries (if applicable)

6. Additional supporting documentation typically applicable to Medicare provider enrollment
forms for entities only (not individual practitioners):

a. Articles of Incorporation, Organization, or bylaws (if applicable)
b. DBA Certification (if applicable).
c. Copy of all applicable Clinical Laboratory Improvement Act (CLIA) certifications (if
applicable)
d. Copy of an attestation for government entities and tribal organizations (if applicable). If a federal, state, county, city, or other level of government, or a Native American tribe, will be legally and financially responsible for Medicare payments received, the provider must submit a letter on the letterhead of the responsible government or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS.

e. Two copies of a signed and dated attestation statement, Exhibit 177 (for Federally Qualified Health Centers [FQHC] only)
f. Copy of the Health Resources Service Administration (HRSA) Notice of Grant Award (for FQHC only)
g. Copy of Exhibit 5 form B listing the site covered under the Grant (for FQHC only)

7. The completed application and supporting documentation should be returned to your state’s MAC. Contact information for MACs can be found at the CMS website at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf

8. For most applicants, the enrollment process takes approximately 60 days from the day the MAC receives the application. CMS requires MACs to process enrollment applications within certain timeframes. In order to expedite the review, the applicant should be available to assist with questions and respond to requests for additional information. If the applicant does not respond to the information request within the designated timeframe, the application will be rejected. Once the review of the CMS-855 provider enrollment application by the MAC is completed, a recommendation for approval or denial is made by the MAC to the CMS Regional Office (RO). The CMS RO will perform a second review and issue the final determination via a CMS-2007, certification notice (aka Tie-in Notice) and/or provider approval letter.

9. Providers must report changes in their enrollment information to the MAC as soon as possible and no later than 90 days after the reportable event by submitting the information on the application form used to initiate the Medicare enrollment process, with the exception of the following:
   a. Providers must report a change of ownership or managing interest control within 30 days.
   b. DMEPOS suppliers must notify the National Supplier Clearinghouse of changes in their enrollment information within 30 days.

Qualifications for Nurse Practitioners (or other APRN)

Medicare requires the following qualifications be met for Nurse Practitioner (or other APRN):

1. “Registered professional nurse authorized by the State in which you furnish services to practice as a NP (or other APRN) in accordance with State law and meet one of the following:
   a. Obtained Medicare billing privileges as a NP (or other APRN) for the first time on or after January 1, 2003, and

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b. Are certified as a NP (or other APRN) by a recognized national certifying body that has established standards for NPs; (APRNs) and

c. Have a Master’s degree in nursing or a Doctor of Nursing Practice degree;

d. Have obtained Medicare billing privileges for the first time before January 1, 2003, and meet the certification requirements described above; or

e. Have obtained Medicare billing privileges as a NP (or other APRN) for the first time before January 1, 2001.”

2. Must be working under the applicable State scope of practice and be compliant with physician collaborative agreement criteria

Reference: CMS, ICN 901623, February 2015

Missouri Medicaid (MO HealthNet) Provider Enrollment Application

1. The latest version of Internet Explorer or Netscape Navigator is necessary to view and complete the necessary forms. Browsers such as Chrome and Firefox are not compatible. The enrollment process for Missouri Medicaid is entirely paperless and paper forms are no longer available. Following are the web sites for enrolling in Medicaid:

   a. Provider Enrollment site for Missouri Department of Social Services:
      http://mmac.mo.gov/providers/provider-enrollment/

   b. Instructions for Completing the On-line Application form:
      https://peu.momed.com/peu/momed/presentation/providerenrollmentgui/Internetman121103.htm#internet

   c. New Provider Enrollment Application:
      https://peu.momed.com/peu/momed/presentation/providerenrollmentgui/BaseQuestionnaireWindow.jsp

   d. Missouri Medicaid Provider Enrollment Information Guide:
      https://peu.momed.com/peu/momed/presentation/providerenrollmentgui/Internetman121103.htm

   e. Contact information for provider enrollment questions:
      i. Provider enrollment Help Desk: 573-635-3559
      ii. Provider Enrollment Unit email: Mmac.providerenrollment@dss.mo.gov

2. There is no enrollment fee for “Individual” providers (i.e., physicians, nurse practitioners, etc.).

3. All providers providing services for MO HealthNet beneficiaries must have a valid participation agreement with the Missouri Department of Social Services (DSS), Missouri Medicaid Audit and Compliance (MMAC).

4. The DSS will conduct a background investigation for each provider submitted an application for enrollment.

5. Validation of the provider’s participation agreement will be dependent on the Director of Social Services or his/her designee’s acceptance of the application for enrollment.

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6. Each provider must submit a separate application for enrollment

7. When the provider enrollment is finalized, and email will be sent to the individual provider’s email address along with the name of the provider, the NPI number and effective date of approval.

8. The effective date of approval cannot be prior to the effective date of required program documents, such as license, certification, etc.

9. NOTE: The enrolled provider may submit bills to the Medicaid program on and after the effective date of approval noted on the email.

10. The Missouri Department of Social Services, MO HealthNet Provider Enrollment Instructions:
   a. The provider (or enrolling entity) must have the latest version of Internet Explorer or Netscape Navigator to access the electronic enrollment site. Paper applications are no longer available or accepted.
   b. Instructions are listed on the bottom bar of the electronic enrollment screen.
   c. The enrolling provider or entity can click “help” at any time for detailed instructions.
   d. The entire application must be completed on-line.
   e. A partial enrollment application must be saved and retrieved at a later date for completion. All fields must be completed in order to “save” the document.
   f. A PIN is issued to the enrolling provider or entity to use to retrieve an incomplete application.
   g. After finalizing the on-line application, ONLY the provider agreement (signature page” containing the provider’s original (i.e., wet) signature and any program requirement attachments must be faxed in an upright position.
   h. The signature page and attachments MUST be submitted on separate pages in the same transmission.
   i. Fax the signature page and required attachments in one transmission to 573-634-3105. This will go directly to the Provider Enrollment database.
   j. Providers are required to print and retain all pages of their enrollment application to maintain in their files, to include the original signed provider agreement (not a fax or copy).
   k. Any alterations of the application will be automatically denied, to include a typewritten or handwritten form. Fields may not be blacked out, whited out, or crossed out.
   l. If the on-line applications needs to be amended or has changes, a new on-line application must be completed and submitted. If the provider needs to send additional documentation, that can be sent through a letter attached to the signed agreement page.
   m. Do not submit documentation not required for the specific provider type. For additional detail, refer to the “Requirements for Each Provider Type” section. 
   https://peu.momed.com/peu/momed/presentation/providerenrollmentgui/Internetman
121103.htm#req

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n. APRNs will also need to enroll in any Medicaid managed care plan/HMO. See instructions below for commercial or managed care credentialing and/or contact the specific managed care/HMO for specific instructions.

Requirements for Nurse Practitioner (Provider Type 42) Enrollment

1. Required documentation must be submitted with the original signed agreement.

2. Out-of-state (non-bordering) nurses and graduates cannot enroll in the Missouri Medicaid program.

3. Each advanced practice nurse must enroll individually.

4. Must be currently licensed as registered professional nurses and recognized as an advanced practice nurse within a specific clinical specialty area and role by the Missouri State Board of Nursing (4 CSR 200-4.100 Advanced Practice Nurse). [URL]

5. Prescribing nurses must have a current Collaborative Practice Agreement (CPA) with one or more physicians that authorize them to prescribe.

6. The CPA must meet the requirements of statutes 334.104.1, 334.104.2, state regulation 4 CSR 200-4.200, and any other Board of Nursing or Healing Arts statutes or regulations that may apply within the State of Missouri.

7. A Missouri applicant must submit the following with the enrollment application.
   a. A copy of current permanent RN license.
   c. A copy of Medicare letter with individual provider name and Medicare number (i.e., NPI)

Revalidation (If Applicable)
Effective July 1, 2015, Missouri Medicaid will begin revalidating any currently enrolled MO HealthNet providers. During FY-2018, MO HealthNet will revalidate individual providers to include Advanced Practice Nurses. MO HealthNet will send out written notification to those providers who need to revalidate their enrollment with the Medicaid program. Any questions can be directed to MMAC.Revalidation@dss.mo.gov.

Commercial or Managed Care Credentialing

The individual nurse practitioner will also need to credential with commercial and managed care plans in order to submit claims for reimbursement. Some Medicaid products are We recommend contacting all pertinent state plans to verify the specific enrollment procedures. Steps for credentialing with commercial and managed care plans are as follows:

1. The Council for Affordable Quality Healthcare (CAQH) ProView electronic credentialing system is one option for entering data that can be accessed by a majority of payers in the
United States to complete the credentialing process. This is a free service, and allows provider(s) or supplier(s) to:

a. Complete and attest to multiple state credentialing applications in one workflow
b. Upload supporting documentation directly to the CAQH system, eliminating manual submission and improving timeliness
c. Review and approve submitted data before imported
d. Self-register

2. New users will need at a minimum the following information.

a. CAQH-supplied provider ID number
b. Previously completed credentialing application if available (for reference)
c. List of all previous and current practice locations
d. Identification numbers (i.e., UPIN, Medicare, Medicare, and NPI)
e. Scanned copies of:
   i. Curriculum Vitae
   ii. Medical license
   iii. DEA certificate
   iv. IRS Form W-9
   v. Malpractice insurance face sheet
   vi. Summary of pending or settled malpractice cases

3. The link to the CAQH ProView system and instructions has been provided below as well as a link to the user guide.

http://www.caqh.org/solutions/caqh-proview

Medicare Billing and Payment Overview

In order to bill the Medicare program, the enrollment, credentialing, and reassignment (if applicable) processes must be completed. Once Medicare has issued the final determination letter, the billing entity or individual provider is able to process and submit CMS-1500 claims (or the electronic equivalent) to the Medicare program for payment. In addition, the following criteria must be met.

1. Effective February 22, 2011, Medicare implemented a change in instruction for Part B provider on retrospective billing. Specifically, the “effective date for submitting claims to the Medicare program is the later of the following two dates:
   a. The filing date of an enrollment application that was subsequently approved, or
   b. The date the provider first began furnishing services at a new practice location.

2. The provider may bill retrospectively for services when:
   a. The supplier has met all program requirements to include state licensure, and
   b. The services were provided at the enrolled practice location for up to
      i. 30 days prior to their effective date if circumstances precluded enrollment in advance of providing Medicare services

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ii. 90 days prior to their effective date if a presidentially-declared disaster precluded enrollment in advance of providing Medicare services.”

Reference: CMS, MLN Matters MM7270

**Internal Coding and Billing Processes**

The following processes or functions will need to be implemented prior to billing.

1. Establish a fee schedule for professional charges. A preliminary list of pertinent nursing facility and assisted living CPT codes and descriptions has been provided below.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing Facility</strong></td>
<td></td>
</tr>
<tr>
<td>99304</td>
<td>Initial nursing facility care – straightforward/low complexity</td>
</tr>
<tr>
<td>99305</td>
<td>Initial nursing facility care – moderate complexity</td>
</tr>
<tr>
<td>99306</td>
<td>Initial nursing facility care – high</td>
</tr>
<tr>
<td>99307</td>
<td>Subsequent nursing facility care – straightforward complexity</td>
</tr>
<tr>
<td>99308</td>
<td>Subsequent nursing facility care – low complexity</td>
</tr>
<tr>
<td>99309</td>
<td>Subsequent nursing facility care – moderate complexity</td>
</tr>
<tr>
<td>99310</td>
<td>Subsequent nursing facility care – high complexity</td>
</tr>
<tr>
<td>99315</td>
<td>Nursing facility discharge (&lt;30 minutes)</td>
</tr>
<tr>
<td>99316</td>
<td>Nursing facility discharge (&gt;30 minutes)</td>
</tr>
<tr>
<td>99318</td>
<td>Annual nursing facility assessment</td>
</tr>
<tr>
<td><strong>Assisted Living/Domiciliary Care</strong></td>
<td></td>
</tr>
<tr>
<td>99324</td>
<td>Assisted Living new visit – straightforward complexity</td>
</tr>
<tr>
<td>99325</td>
<td>Assisted Living new visit – low complexity</td>
</tr>
<tr>
<td>99326</td>
<td>Assisted Living new visit – detailed history/moderate complexity</td>
</tr>
<tr>
<td>99327</td>
<td>Assisted Living new visit – comprehensive history/moderate complexity</td>
</tr>
<tr>
<td>99328</td>
<td>Assisted Living new visit – high decision making</td>
</tr>
<tr>
<td>99334</td>
<td>Assisted Living established visit – straightforward complexity</td>
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<tr>
<td>99336</td>
<td>Assisted Living established visit – detailed history/moderate complexity</td>
</tr>
<tr>
<td>99337</td>
<td>Assisted Living established visit – comprehensive history/moderate complexity</td>
</tr>
<tr>
<td>99338</td>
<td>Assisted Living established visit – high decision making</td>
</tr>
</tbody>
</table>

2. Determine who will perform billing functions
   a. The individual nurse practitioner
   b. The nursing facility
   c. An outside billing company

3. Implement a practice management system or other electronic billing mechanism

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4. Implement an electronic medical record (EMR) system or method of medical record documentation for professional services

**Medicare Billing Guidelines**

The nurse practitioner may either:

1. “Bill the Medicare Program directly for services using the individual National Provider Identifier (NPI); or
2. Have an employer or contractor bill for your services using the individual NPI for reassigned payment.”

*Reference: CMS, ICN 901623, February 2015*

In the nursing facility setting, the usual “incident-to” guidelines are not applicable. Therefore, all work personally performed by the nurse practitioner would be billed under one of the processes listed above. No personally performed service would be billed “incident-to” a supervising physician.

In the nursing facility, nursing services performed by Registered Nurses (RN), Licensed Practical Nurses (LPN), Medical Assistants (MA), Certified Nursing Assistants (CNAs), or other ancillary staff, would not be billed “incident-to” the nurse practitioner in the nursing facility setting. Those nursing services are covered under the facility’s per diem payment methodology and not separately billable.

**Medicare Secondary Payer (MSP) Guidelines**

MSP guidelines apply when Medicare is not the beneficiary’s primary health insurance plan. Insurance coverage must be verified with the beneficiary prior to billing. The primary payer will need to be identified on the Medicare secondary claim, as they have the primary responsibility for paying the initial claim. A MSP form must be completed and retained on the beneficiary’s medical record, and updated annually or more frequently at the point of service.

**Claim Submission**

All professional services for the employed or contracted nurse practitioner will be submitted on a CMS-1500 claim form with one of the following place of service codes:

- 13 – Assisted Living
- 31 – Skilled Nursing Facility
- 32 – Nursing Facility
- 33 – Custodial Care

All appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes will be reported for personally performed services, to include evaluation and management (E/M) services and minor procedures. The nurse practitioner will

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not submit charges for drugs, solutions, or medications personally administered, or for supplies used in the personal performance of procedures. These charges will be billed by the nursing facility and paid under the facility payment methodology. Refer to Medicare Claims Processing Manual, Chapter 26, for detailed instruction on completion of the CMS-1500 claim form and electronic equivalent.


Claim Processing

Once the claim has been submitted and reimbursement determined, a Remittance Advice (RA) will be received from the payer. This will outline the payments and/or adjustments taken for the billed service. The RA will also include any line specific remarks, such as an explanation when there is no payment or the service has been denied.

Medicare Payment Guidelines for Nurse Practitioners

The nurse practitioner will receive payment based on an assignment basis. “Assignment” is defined as being paid the Medicare-allowed amount as payment in full for the billed professional services, and not billing or collecting from the patient any amount other than unmet copayments, deductible, and/or coinsurance.

The service(s) billed by the nurse practitioner will be paid at 85% of the Medicare Physician Fee Schedule allowance for a physician. Therefore, the payment formula would be as follows:

\[ \text{Allowance} \times 0.80 \times 0.85 = \text{Payment} \]

In addition, a 2% sequestration reduction will be subtracted from the amount determined after the fee schedule allowance, coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments have been made.

If the individual nurse practitioner(s) has not met reporting criteria for Physician Quality Reporting System (PQRS) in the prior reporting calendar year, an additional 2% reduction (or penalty) will be subtracted from the paid fee schedule amount.

The patient is responsible for 20% coinsurance for covered professional services billed to the Medicare Program as long as the patient is enrolled for Part B benefits, as well as any deductible amounts. If the patient is not enrolled to Part B benefits, then the charges would be assigned to patient responsibility.
## Appendix D

### Proposed Fee Schedule for Jefferson City, Columbia, and St. Louis, Missouri

**Note:** *2016 Optum National Fee Analyzer, various geographic adjustment factors as noted in the headers below*

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>National Average*</th>
<th>Jefferson City/ California, MO Geographic Average*</th>
<th>Columbia/Mexico, MO Geographic Average*</th>
<th>St. Louis and area, MO Geographic Average*</th>
<th>WPS GHA 2016 Medicare Physician Fee Schedule for Missouri Locality 01 Effective January 1, 2016 (participating amount)</th>
<th>WPS GHA 2016 Medicare Physician Fee Schedule for Missouri Locality 99 Effective January 1, 2016 (participating amount)</th>
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### Fee Schedule Localities

<table>
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<th>State</th>
<th>Locality</th>
<th>Counties</th>
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<tbody>
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<tr>
<td>Nebraska</td>
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<td>All</td>
</tr>
<tr>
<td>Missouri</td>
<td>01</td>
<td>Saint Louis City, Saint Louis, Jefferson, Saint Charles</td>
</tr>
<tr>
<td>Missouri</td>
<td>02</td>
<td>Clay, Jackson, Platte</td>
</tr>
<tr>
<td>Missouri</td>
<td>99</td>
<td>Those counties not listed under Locality 01 or 02</td>
</tr>
</tbody>
</table>

Fee schedule prepared by BKD, LLP Content Experts, Marla K. Dumm, CPC, CCS-P, Monique D. Funkenbusch, CPC, and Randy A. Biernat, CPA/ABV

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Appendix E

Checklist

☐ Collaborative Practice Agreement (CPA)

☐ Employment Agreement

☐ National Provider Number (NPI) Application

☐ Medicare Enrollment Application
  
  ○ CMS-855B- Application for Clinics/Group Practices and Other Suppliers (if applicable)
  
  ○ CMS-855I- Application for Individual Physicians and NPP (if applicable)
  
  ○ CMS-855R- Application for Reassignment of Medicare Benefits (if applicable)

☐ Council for Affordable Quality Healthcare ProView Application

☐ Medicaid Enrollment

☐ Commercial Insurance/Managed Care Companies Enrollment

☐ Fee Schedule (if applicable)

☐ Electronic Health Record for Physician Quality Reporting System (PQRS) compliance