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CMP Settlement: Services 'Personally Performed' by Mid-Levels Were Attributed to Doctor

National Medical Services II in Florida has agreed to pay $923,660 in a civil monetary penalty settlement over mid-level provider and physician compensation. The allegations hint at one aspect of the challenges around billing and compensation for services provided by nonphysician practitioners (NPPs), also known as advanced practice providers (APPs), which include incident-to billing and the new Medicare requirements for split/shared services. Coloring inside the compliance lines for billing and productivity compensation is becoming increasingly difficult with split/shared billing, experts say.

According to the settlement, which was obtained through a Freedom of Information Act request, the HHS Office of Inspector General (OIG) alleged that National Medical Services II submitted claims to Medicare, Medicaid, TRICARE and the Department of Veterans Affairs for services that were false or fraudulent. From Sept. 8, 2014, to Nov. 30, 2018, mid-level providers employed by National Medical Services II "fraudulently recorded personally performed services as if the services were performed" by an employed physician (who isn't identified in the settlement). "Respondent improperly submitted claims for those physician services," OIG alleged.

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The settlement stemmed from a self-disclosure. National Medical Services II was accepted into OIG's Self-Disclosure Protocol on Oct 14, 2021. The vice president for Tenet Physician Resources signed the settlement, indicating National Medical Services II is or was owned by Tenet at the time of the covered conduct. Tenet didn't respond to several requests for comment, and it didn't admit liability in the settlement.

Although additional details were unavailable, the settlement is a reminder of the various billing and Stark Law compliance issues around APPs and physicians. "This is another compliance aspect that organizations may not be thinking about, but with the surge and growth in the use of APPs and with the goal of working collaboratively with physicians and effectively allowing them to leverage their time, it is becoming more prevalent," said Lyle Oelrich, a principal in PYA.

Under Medicare, there are three models for billing services performed by APPs who work in physician practices: billing for services under their own national provider identifiers (NPIs), which Medicare reimburses at 85% of the physician fee schedule; billing incident to the physician's services, which pays 100% of the fee schedule but requires direct physician supervision and has other strings attached; and billing for split/shared services, which applies to hospital and other facility settings. If hospitals have financial relationships with referring physicians and designated health services are payable by Medicare, they have to satisfy a Stark exception, and for employed physicians, that's the employment exception or in-office ancillary exception for physicians employed by a group practice that meets the Stark definition.

The employment exception states that "any amount paid by an employer to a physician (or immediate family member) who has a bona fide employment relationship with the employer for the provision of services" will not constitute remuneration if certain conditions are met. Among other things, the exception "does not prohibit payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or immediate family member of the physician)."

It's that last part—personally performed services—that can trip up compliance with APP and physician compensation, Oelrich said. "People need to understand what the Stark definition of personally performed actually means," he said. "It is still misunderstood by some in the industry." When physicians and APPs collaborate—through incident-to billing, split/shared services and global billing—they

have to tread carefully with Stark when it comes to productivity compensation.

For example, to satisfy the Stark employment exception, hospitals have to back out the productivity of APPs from productivity compensation for employed physicians, attorneys say. Productivity compensation, which usually means work relative value units (work RVUs), probably can't take into account the services rendered by APPs incident to the physician's services or during split/shared visits because the employment exception requires physicians to personally perform the services.

With incident to, NPPs are billing under the supervising physician's NPI as if the physician personally performed the services. "So while they're meeting the Medicare definition of personally performed services, they may not be meeting the Stark definition of personally performed services," Oelrich said. Also, physicians who are paid a productivity bonus have to understand how productivity will be attributed between physicians and APPs. For example, global surgery is billed under the physician's NPI, but with certain procedures, such as hip surgeries, some postsurgical visits may be performed by APPs. "Those can get a little tricky, and you really need to understand who is doing what, when and where, so you make sure physicians get the appropriate productivity credit according to Stark."

Split/Shared: There's Room for Work RVU Credit

Meanwhile, CMS in the 2022 Medicare Physician Fee Schedule rule implemented new requirements for split/shared billing that are driving some providers up the wall.[1] Effective Jan. 1, split/shared visits are billed under the NPI of the physician or NPP who provided the "substantive portion" of the services. As CMS explained in the rule, "the practitioner who spends more than half of the total time, or performs the history, exam, or MDM can be considered to have performed the substantive portion and can bill for the split (or shared)" evaluation and management service. In 2023, providers won't have a choice; they must determine the substantive portion by time. CMS credits NPPs and physicians for time spent with or on the patient, and only one of the providers in split/shared visits—the physician or NPP—is required to see patients face to face. Other services, such as ordering medication, tests or procedures, may be performed for patients without seeing them.

"Compliance oversight of documenting the face time with patients will be a challenge," said attorney Bob Wade, with Barnes & Thornburg LLP. "If the documentation is not adequate, it is possible that payers will claim that the encounter should have been billed under the NPP as opposed to the physician. This could result in substantial dollars being lost or subject to repayment through internal or payer audits."

Possibly even more confounding will be crediting the physician for their productivity when they don't spend the majority of time with the patient. Although the work RVUs of NPPs won't be credited to the physician, Wade said there's nothing wrong with awarding work RVUs to the physicians for their own services. "In a production compensation arrangement, compliance will need to understand how to credit the physician if the physician does not perform the majority of the time with the patient," he noted.

He said there are three ways to approach this:

1. Give all the work RVU credits to the person (physician or NPP) who the services are billed under. "If the physician does the majority of the work, the physician gets 100% [of the work RVUs]," Wade said. "This is the cleanest way from a compliance perspective."
2. Come up with an allocated percentage to reward physicians on average for performing a certain percentage of the split/shared services without having to calculate it for every patient.
3. Give physicians work RVU credit patient by patient based on the time they spend, but Wade doesn't recommend it "because I don't know how someone would do this." It's not practical.

Stipends: Another Way to Pay Physicians for APPs

Hospitals and group practices also are permitted to compensate physicians for supervising NPPs. In fact,

CMS Transmittals and *Federal Register* Regulations, April 22-28

Transmittals

Pub. 100-04, Medicare Claims Processing

- Claims Processing Instructions for the New Hepatitis B Vaccine Code 90759, Trans. 11362 (April 22, 2022)
- Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 15 - Ambulance, Trans. 11365 (April 28, 2022)
- Update to the Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) for Calendar Year (CY) 2022, Trans. 11384 (April 28, 2022)

Pub. 100-20, One-Time Notification

- Section 127 of the Consolidated Appropriations Act: Graduate Medical Education (GME) Payment for Rural Track Programs (RTPs), Trans. 11366 (April 28, 2022)

Federal Register

Proposed rules

- Medicare Program; Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules, 87 Fed. Reg. 25,090 (April 27, 2022)

stipends for physicians who supervise APPs are common, driven partly by state supervision requirements. It's fine in most cases to pay stipends because supervision is personally performed by physicians, Oelrich said. "But you should compensate reasonably and consistently," he noted.

Stipends must be fair market value, said Darcy Devine, president of Buckhead FMV in Atlanta. They range from $10,000 to $30,000 per year, but there are situations where the amount is too high or too low, she said. "It's all about how the practice is set up and how they work together. Doctors work so many different models with mid-levels," she noted. How much to pay for stipends also depends on facility and regulatory requirements, Devine noted. Some states and licensing boards have chart review and meeting requirements. Another factor in valuations for stipends is the maturity and experience of the mid-levels, she said. With palliative care, for example, a lot of supervision is required because of the delivery of controlled substances. And physicians may supervise multiple mid-levels in team-type approaches, such as medical homes. Even with all the variation, "the standard thing is to slap on $10,000 to $30,000 a year thinking you are probably pretty good, but it undervalues what we see happening in some of our assignments."

Free APPs For Independent Docs Are a Risk

In another risk area with respect to APPs, hospitals should be wary of lending the services of their employed APPs to independent physicians at no charge because it may run afoul of the Stark Law and/or Anti-Kickback Statute, depending on the details, said Los Angeles attorney Charles Oppenheim, with Hooper, Lundy & Bookman. "What we're seeing is a lot of these situations," he said.

Hospitals provide APP services free to physicians on the medical staff because it facilitates higher quality of care and improves throughput, Oppenheim said. But free APP services possibly could turn into remuneration if they supplant physician services rather than supplement them.

This isn't just a hypothetical risk. St. Vincent's Medical Center in Bridgeport, Connecticut, agreed to pay $747,973 to settle a civil monetary penalty case with OIG in 2020.[2] OIG alleged that for almost seven years, from June 1, 2012, through Feb. 8, 2019, the hospital paid remuneration to certain physicians through APP staffing arrangements. The remuneration was "in the form of providing clinical staff without cost, or at a reduced cost, to the physicians to assist them in treating inpatients at the hospital respondent formerly owned and operated until Oct. 1, 2019," the settlement states. St. Vincent's reported problems to OIG and was accepted into its Self-Disclosure Protocol, according to the settlement, which was obtained through the Freedom of Information Act. OIG alleged the hospital paid remuneration in violation of the Civil Monetary Penalties Law's provisions applicable to kickbacks and created financial relationships that resulted in the submission of claims for referrals for designated health services. The hospital didn't admit liability in the settlement and declined to comment.

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Endnotes

1. Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements, 86 Fed. Reg. 64,996 (November 19, 2021).
2. Nina Youngstrom, "Hospital Settles CMP Case Over Free APP Services for Physicians," *Report on Medicare Compliance* 29, no. 22 (June 15, 2020), https://bit.ly/3hZVvCF.