Section 2

Licensed Nurse Practitioner

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1 General Information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as *Section I: General Information of the Utah Medicaid Provider Manual* (*Section I: General Information*).

1-1 General Policy

Nurse practitioner services are provided to members eligible for or receiving Medicaid and are available to the extent that the nurse practitioner is authorized to practice under state law or regulation including, but not limited to Title 58, Chapter 31b, Nurse Practice Act, Utah Code Annotated. See also the Nurse Practice Act Rule, Utah Administrative Code Rule R156-31b, for additional licensing requirements and information.

1-2 Fee-For-Service or Managed Care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid members. A Medicaid member enrolled in an MCP (health, behavioral health, or dental plan) must receive services through that plan with some exceptions called "carve-out services," which may be billed directly to Medicaid. Medicaid members enrolled in MCPs are entitled to the same Medicaid benefits as fee-for-service members. However, plans may offer more benefits than the Medicaid scope of benefits explained in this section of the provider manual. Contact the Medicaid Member Services hotline at 1(844)238-3091 for further information. Refer to the provider manual, *Section I: General Information,* for information regarding MCPs.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a member enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment in a managed care plan. However, it is the provider's responsibility to verify eligibility and plan enrollment for a member before providing services. *Therefore, if a Medicaid member is enrolled in a plan, a fee-for-service claim will not be paid unless the claim is for a "carve-out service"*. Eligibility and plan enrollment information for each member is available to providers from these sources:

- The Eligibility Lookup Tool: https://medicaid.utah.gov/eligibility
- AccessNow: (800) 662-9651
- Member Services hotline at (844) 238-3091

1-3 Definitions

Definitions of terms used in other Medicaid programs are available in *Section I: General Information of the Utah Medicaid Provider Manual* (*Section I: General Information*).

2 Provider Participation Requirements

2-1 Provider Enrollment

To independently submit claims and receive Medicaid reimbursement, nurse practitioners are required to be enrolled as a Medicaid provider. Refer to provider manual, *Section I: General Information* for provider enrollment information.

2-2 Credentials

Advanced Practice Registered Nurses (APRN) and Certified Nurse Practitioners (nurse midwife (CNM), nurse anesthetist (CNRA)) are registered professional nurses who:

- Are currently licensed to practice in the state as a registered professional nurse
- Are legally authorized by the state or by regulations, to practice as a nurse practitioner or certified registered nurse
- Has completed a program of study and clinical experience as specified by the state

An APRN or Certified Registered Nurse who chooses to change or expand from a primary focus of practice must be able to document competency within that expanded practice based on education, experience and certification. The burden to demonstrate competency rests upon the licensee.

3 Member Eligibility

A Medicaid member is required to present the Medicaid Member Card before each service, and every provider must verify each member's eligibility each time before services are rendered. For more information regarding verifying eligibility, refer to provider manual, *Section I: General Information, Verifying Medicaid Eligibility* and to the Eligibility Lookup Tool located at https://medicaid.utah.gov/eligibility.

4 Program Coverage

Procedure Codes

With some exceptions, procedure codes with accompanying criteria and limitations have been removed from the provider manual and are now found on the Medicaid website Coverage and Reimbursement Lookup Tool at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php

4-1 Covered Services

The nurse practitioner may serve as a primary care provider for men, women, infants, or children under their scope of practice and if authorized in hospital policy, and perform some limited inpatient services related to labor and delivery. Services performed must be within the legal scope of practice as defined under the Utah Board of Nursing licensure. Services performed must be included in the individual nurse practitioner's protocols or a collaborative agreement with a physician as defined by the Utah Board of Nursing.

A. Cognitive Services

Cognitive services are limited to one service per member per day. When a second office visit for the same issue occurs on the same date as another service, the nurse practitioner must combine the services as one service and select a procedure code that indicates the overall care given.

- Nurse practitioners working in collaboration with a physician are required to work with the physician in billing the service appropriately. Duplicative billing for the same issue and level of care on the same date is not appropriate. The services may be billed through the group practice and should not be duplicative of other billings.
- When the condition of the patient is beyond primary care and requires referral, the nurse practitioner must refer the patient to a physician specialist. Referral to another nurse practitioner or physician assistant is not covered.
- After the initial evaluation and plan of care by the physician specialist, the nurse practitioner or physician assistant may provide subsequent visits or follow-up care.

B. Physical Examinations are covered as follows

- Preschool and school age children who are Early Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible and participating in the Child Health Evaluation and Care (CHEC) program. The Child Health Evaluation and Care recommended schedule is found in the CHEC Services Manual at https://medicaid.utah.gov. New patients with an initial complaint where a physical examination, including a medical and social history, is necessary.
- Examinations associated with birth control medication, devices, and instructions for those of childbearing age, including sexually active minors.

C. After-Hours Services

Medicaid covers after-hours add-on codes 99050 and 99058 when added to the basic evaluation and management office visit for a new patient (codes 99201-99205) and an established patient (codes 99212-99215).

When the services are provided during regularly scheduled office hours in the evenings, weekends, or holidays, the provider may bill with the after-hours code 99051. “Evening” means after 6:00 PM and “Holiday” means any federal or state-recognized holiday. Only one of the after-hours office codes can be used per visit in addition to the E&M or service code.

Limitations on use of the after-hours office visit codes:

- They cannot be used in a hospital setting, including the Emergency Department, by a private or staff physician under any circumstances.
- They cannot be used for standby or waiting time for surgery, delivery, or other similar situations.

D. Consultation Services

Consultation services are considered physician services and reimbursed only to the physician under consultation codes. Under “incident to” service in Utah Medicaid, the nurse practitioner may complete the history and examination to assist the physician consultant in working the patient up. The nurse practitioner must personally document in the medical record his/her portion of the consultation. The physician consultant is responsible for the summary of the findings and developing the plan of care.

E. Prolonged Services

The evaluation and management codes include additional time beyond the typical time listed per code. Bill the evaluation and management service at the appropriate care level. When the total evaluation and management time is 30 minutes or more than the *typical* time listed with the code, the prolonged service code may be appropriate. Prolonged service claims require manual review and submission of documentation of the face to face time spent in evaluation and management service with a summary of the education, counseling, and coordination of care service provided.

F. Incidental Edits

Incidental edits occur when a procedure is considered an integral component of another procedure. Diagnostic procedures performed along with larger, major therapeutic procedures are considered incidental to the major procedure, and no additional payment is warranted. Some codes which are considered minor procedures such as urine dipstick, removal of cerumen, and straight catheterization are included in the evaluation and management service as incidental to the service.

G. Injection Code

Injection codes include the cost of the syringe, needle, and administration of the medication. Injection codes may be used with the injectable medication code, or J-Code (NDC), when medication administration is the only reason for an office call.

An office visit, J-Code (NDC), and an administration code cannot be used for the same date of service. Only two of the three codes can be used at any one time or at any one visit.

H. Prenatal and Postnatal Education

Prenatal and postnatal educational sessions are covered for education by the non-physician provider.

I. Rural Services

Services performed in rural areas will be reimbursed at 12% higher than the regular fee schedule. The higher fee is available only when the nurse practitioner practices or travels to the rural setting. Payment is not based on member residence.

J. Telemedicine

Telemedicine or Telehealth services are an additional method of delivering health care to patients. Refer to Section l: General Information, Telemedicine at the Utah Medicaid website at: https://medicaid.utah.gov.

5 Non-Covered Services and Limitations

For additional non-covered services or limitations, refer to the Coverage and Reimbursement Lookup Tool at the Medicaid website at: https://medicaid.utah.gov.

5-1 Non-Covered Services

Medicaid does not cover the following services:

A. Infertility diagnosis or therapy

B. Pre-pregnancy genetic counseling

C. Pap smear is not a separate billable service, but is considered as part of an office call. The laboratory completing the service bills for the service.

D. Problems encountered during pregnancy must not be billed as separate services unless they are severe, unusual complications and require specific separate therapy which can be coded with a specific diagnosis code.

E. Routine, preventive medicine services are not covered for adults. All office calls must be for a specific, identifiable service in relation to a medical need which can be coded by an appropriate ICD-9-CM diagnosis code.

F. The services of an assistant surgeon are specialty medical services covered only for a licensed physician and only on very complex surgical procedures. A nurse practitioner is not authorized to function as an assistant surgeon or as an assistant at surgery. The only exception is a certified nurse midwife may serve as an assistant surgeon on a cesarean section.

   It is Utah Medicaid policy that the modifier 80- assistant surgeon is payable strictly to a qualified surgeon. Physician assistants and nurse practitioners cannot be reimbursed as the assistant surgeon through the physician's provider number as an incident to service.

G. Routine physicals in adults

H. Prolonged educational and counseling services, beyond those included within the initial evaluation and management service are excluded as family planning services.

I. Office visits for administration of medication

J. Experimental, investigational, or cosmetic procedures

5-2 Limitations

Nurse Practitioners must work within their scope of licensure and in association with physicians to whom they refer patients with high risk conditions or complications.

A. The Emergency Services Program includes services for labor and delivery. Labor and delivery codes are billable for an individual with an emergency services only Medicaid Member Card. Other maternity care services (prenatal and postpartum) are not payable for an emergency services only member. For more information on the Emergency Services Program, refer to the provider manual, *Section I: General Information*.

B. Procedures approved by Medicaid for coverage when delivered by a nurse practitioner, are open for their provider type.

   - Procedures completed beyond those approved by Medicaid are not reimbursable. When a non-covered procedure is provided by a nurse practitioner then billed through the collaborating physician, the bill is not considered appropriate. When program integrity identifies billing such as this, a reimbursement will be required.
   - Nurse practitioners who have been approved by the Department to perform a specific procedure, based on their training and certifications, will be allowed to receive reimbursement for specialized services.

- Procedures are focused on primary care and limited to the scope of licensure and certification of the nurse practitioner.

C. Nurse practitioners working in federally designated Rural Health Clinics or Federally Qualified Health Centers function under the federal regulations governing services in such facilities.

D. Nurse practitioners employed as staff working in locally operated hospitals or clinics are not authorized to have their services separately billed.

E. Checklists and Template

Correct use of the Checklist in Evaluation and Management Documentation as outlined in Medicare Part B, June 2006, has been adapted for review of office visits. Review the following documentation guidelines when using a template or checklist:

1. Examination templates and checklists are acceptable documentation provided the provider has clearly indicated what was examined and the findings to support the level of service billed.
2. A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings.
3. Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) must be described.
4. The provider must document and describe any specific and pertinent abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s). A notation of "abnormal" without elaboration is insufficient documentation. A key explaining checklist symbols must be available, if requested.
5. Signature requirements remain the same in the use of checklists. Per NCP PHYS-001, "an indication of a signature in some form needs to be present." Documentation must support legible identification of the billing provider, per the 1995 or 1997 Evaluation and Management Documentation Guideline.
6. The Review of Systems (ROS) and Past Family Social History (PFSH) may be recorded by ancillary staff or completed by the patient, on a form or checklist. The checklist must have a place for the physician to document that he/she reviewed the information and make a notation supplementing or confirming the information recorded by others. If the ROS and/or PFSH are unchanged from an earlier encounter, it does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may be documented by noting the date and location of the earlier ROS and/or PFSH with a description of any new findings and/or a statement that all other elements are unchanged.
7. When referring to an earlier encounter to document the ROS and/or PFSH, all elements documented and performed in the earlier visit must be reviewed in the current visit.
8. Only the provider can perform the History of Present Illness (HPI). The provider is ultimately responsible for submitting appropriate documentation. Each item on a checklist requires an active response for each exam component performed or question asked. It is not appropriate to use a common template which states that all components listed were performed unless otherwise noted by the practitioner. The APRN must clearly document which parts of the evaluation and management service they completed.

9. In addition, there must be a written summary of the assessment, and a treatment plan. The primary components of the E&M service as outlined in the 1995 or 1997 E&M guideline must be clearly documented. For example, a template used for education is not a covered service. At the time of an audit the provider must stipulate which one of the E&M guidelines they are using.

F. Laboratory Procedures

Laboratory services provided by a nurse practitioner in the office are limited to the waived tests or those laboratory tests identified by CMS for which each individual practitioner is CLIA certified to provide, bill, and receive Medicaid payment. Most of the CLIA waived tests must be submitted with the QW modifier.

Clinical diagnostic laboratory tests that are sent to an outside independent laboratory to be completed, must be billed by the laboratory completing the service. The practitioner cannot bill for these services and seek payment from Medicaid.

- Urinalysis (e.g. 81001, 81002) is incidental to an office visit and use of an appropriate E&M code.
- Pulse oximetry (94760, 94761) is a non-invasive measurement of oxygen saturation which requires a minimal amount of time and is considered incidental to an E&M code or anesthesia administration. No additional payment will be made for this procedure.

G. A specimen collection fee is limited to specimens drawn through venipuncture and sent for processing outside of the office (Code 36415).

Venipuncture is not a covered service when finger or heel sticks are done for a reagent strip test with codes listed below (not all inclusive list); these services are not venipuncture procedures.

- 82948-QW blood glucose by reagent strip
- 83036-QW glycated hemoglobin
- 85014-QW hematocrit

Venipuncture code 36415 will be considered mutually exclusive to any of the CPT codes used for reagent strip testing. However, if other blood specimens are ordered which require venipuncture, 36415 reimbursements will be allowed.

Obtaining a pap smear is limited to and included in the reimbursement for an office visit. A specimen collection fee is not separately billable for this service.

H. Finger/heel/ear sticks are limited only to infants under the age of two years by use of CPT Code 36416.

6 Billing

Refer to the provider manual, *Section I: General Information,* for detailed billing instructions.

The licensed nurse practitioner may bill independently or through the collaborating physician. The nurse practitioner must have a working relationship and agreement with a collaborating physician for immediate referral of problem cases identified during the course of practice. Direct reimbursement is available as a payment option to the nurse practitioner practicing independently from a hospital, outpatient clinic, or physician office. The nurse practitioner will be paid at the fee schedule, unless otherwise allowed.

Nurse practitioners may only bill and be directly reimbursed for those services open to their provider type, listed in the Medicaid Coverage and Reimbursement Lookup Tool, located at https://medicaid.utah.gov/health-

care-providers. The nurse practitioner will bill with a National Provider Identifier (NPI), and the billed services must not appear on a facility cost report.

Applicable CPT codes are used to account for program utilization and to differentiate between nurse practitioner services and physician services. Editing will be done with the designated provider type.

Billing Procedure

Use these codes to bill:

90471 - 90474, immunization administration; . . . vaccine/toxoid
Use SL modifier - VFC program

99170 anogenital exam w coloposcopic magnify child trauma
This code is open only to Nurse Practitioners working with the Criminal Justice system who have completed special training to complete the procedure on children.

S3620-BL State laboratory newborn screening kit when used to completed initial and two-week follow-up blood test (when not completed in the hospital)

S9446 member education, noc, non-md provdr, group, per session
This code is open for pre-postnatal education for females 10-55 years of age–Limited to 8 within 12 months.

T1015 clinic visit/encounter, all-inclusive
Used in rural health center.

6-1 Prior Authorization

Prior authorization (PA) may be required for certain services. Failure to obtain prior authorization can result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization *before* providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the member is retro-eligible for the dates of service requested.

Prior authorization information is provided in the provider manual, *Section I: General Information.* Code specific coverage and prior authorization requirements are provided on the Medicaid website, Coverage and Reimbursement Lookup Tool at: https://medicaid.utah.gov.

7 References

Current Procedural Terminology, American Medical Association, current edition

Utah Administrative Code, R156-31b, Nurse Practice Act Rule

Title 58, Chapter 31b, Nurse Practice Act, Utah Code Annotated

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