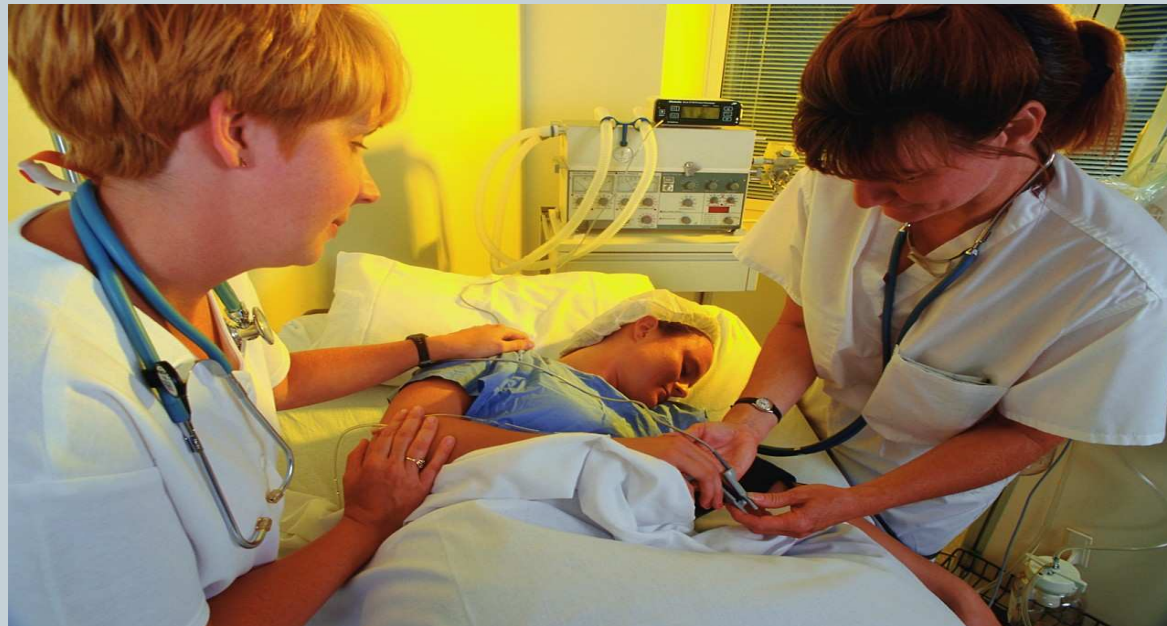


# Nurse Practitioners in Long-Term Care



WHY HAVEN'T WE THOUGHT OF THIS BEFORE?



# The NP's Role in Nursing Facilities



- Medicare requires that the initial visit (history and physical), for the purpose of certifying that the patient requires skilled care, must be performed by a physician. An NP may, however, make a "medically necessary" visit without an initial physician visit; this could occur when a newly admitted Medicare patient in a skilled nursing facility develops a problem that requires medical evaluation and intervention, before being seen by the physician. Girvin-Reisser advised cautious use of this practice because it could be viewed as an unnecessary visit (ie, if the physician were available to see the patient at the time of admission, only one visit would have been needed). All subsequent visits may be performed by an NP (or other non-physician), alternating with the physician.

# The NP's Role in Nursing Facilities



- NPs may perform the initial history and physical for new long-term care (non-skilled) admissions. NPs may also make additional visits, which must be substantiated based on the patient's need (ie, acute illness). Medicare provisions permit 1.5 visits per month; more than this frequency may invite increased scrutiny in the form of an audit. Medical necessity must be documented!

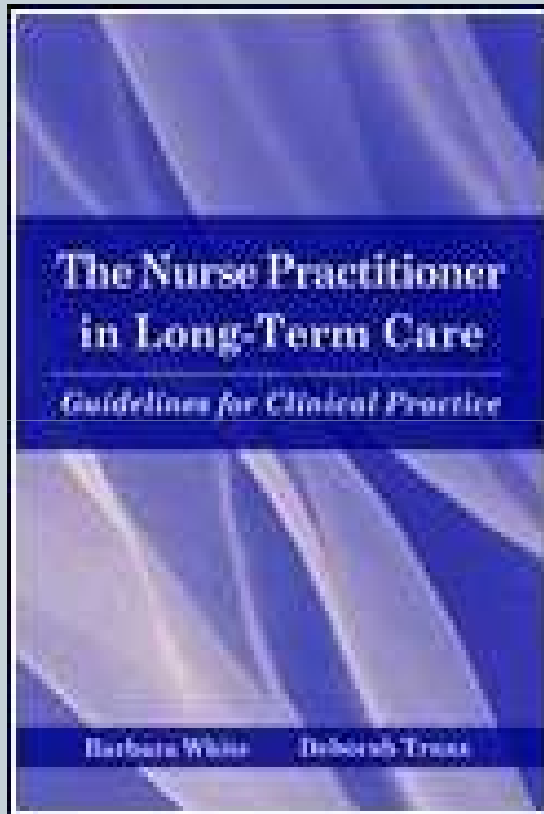
# The NP's Role in Nursing Facilities



- Assuming state law permits, Medicare allows NPs to help with monitoring and managing patient conditions, counseling patients and families, performing certain procedures, annual physical examinations, communication with hospital and community physicians, and discharge visits.



# *The Nurse Practitioner in Long-Term Care: Guidelines for Clinical Practice*



*The Nurse Practitioner in Long-Term Care* addresses the growing trend to utilize the nurse practitioner in the skilled nursing facility (SNF) to manage patients in long-term care and serves as a practical resource for managing those conditions commonly encountered in the geriatric patient. It includes an introduction to nursing homes, medication management, practical health promotion/disease prevention, and management of common clinical conditions specific to the skilled and long term care nursing home settings.

by [Barbara White](#) (Author), [Deborah Truax](#) (Author)

# Medicare Reimbursement



- Medicare has paid for the services of nurse practitioners (NPs) and other midlevel practitioners (MLPs) (eg, physician assistants and clinical nurse specialists [CNSs]) in skilled and non-skilled nursing facilities for some time. Effective January 1, 1998, amendments to the Balanced Budget Act of 1997 authorized NPs and CNSs to bill Medicare directly for their services in any area or setting.<sup>[1]</sup> The NP role, and services that are reimbursed within that role, are influenced by several factors. Medicare policies are complex and are modified frequently. Interpretation of those policies by Part B Carriers varies from state to state. Individual state laws have significant differences regarding scope of NP practice.

# Medicare Reimbursement



- In a presentation to NPs regarding coding for long-term care services, B.J. Girvin-Reisser, RN, CCS, CCS-P, CPC, President of Medical Management Resources, Columbia City, Indiana<sup>[2]</sup> emphasized the importance of understanding all aspects of the billing process. The NP is responsible for the accuracy and adherence to regulations for all billing claims submitted under the NP's Medicare provider number, even though the actual completion of forms may be done by a billing service.

# Medicare Reimbursement



- This summary will provide a brief overview of the process of obtaining Medicare reimbursement for services provided by NPs in nursing facilities. Issues specific to NPs will be addressed, followed by a brief description of Medicare guidelines for Evaluation and Management coding in long-term care settings. Important aspects of documentation will be discussed. The final section will provide a list of resources to obtain information needed to ensure accurate submission of claims for reimbursement. For the purposes of this paper, the term "nursing facility" will include both skilled and non-skilled settings; information applicable to skilled care recipients will be clearly indicated



# Medicare and Nurse Practitioners



- Although most of the information in this review applies to any Medicare provider who bills for services in nursing facilities, certain issues are specific to NPs. Medicare requires NPs to be certified by a recognized national certifying body such as American Nurses Credentialing Center (ANCC) in order to become a Medicare provider. An article by Carolyn Buppert<sup>[3]</sup> provides a list of other approved certifying bodies. In addition, effective January 1, 2003, individuals are required to possess a Master's degree from an accredited program.

# Covered Services



- Medicare covers services an NP is "legally authorized to perform in accordance with State law." In addition, all of the following conditions must be met. Services must be:
- Considered as physician's services
- Furnished by a person who meets the NP qualifications
- Furnished in collaboration with an MD/DO as required by state law
- Within the NP's scope of practice as defined in state law
- Not otherwise precluded from coverage by Medicare law (eg, routine foot care)

# Covered Services



- Clearly, Medicare defers to State law with regard to scope of practice and the nature of collaboration. State laws regarding scope of practice vary significantly and are often vague. They may contain "only a general statement about responsibilities, educational requirements and...duties, and do not explicitly identify services that are...beyond their scope."<sup>[3]</sup> In Michigan, for example, state law provides a definition of the "practice of nursing" that serves as the legal scope of practice for nurses; state law does not delineate a scope of practice specific to NPs.<sup>[4]</sup> NPs must have a thorough understanding of their state's scope of NP practice and may obtain this information through the State Board of Nursing. Contact information is available online at <http://www.ncsbn.org/>.

# Covered Service



- Some states do not require NPs to practice in collaboration with a physician. However, the absence of this requirement by a state does not negate the Medicare requirement for collaboration.<sup>[1]</sup> Medicare defines collaboration as "a process whereby a NP works with a physician to deliver health care services within the scope of the NP's professional expertise with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by Federal regulation and the law of the state in which the services are performed."

# Covered Services



- NPs are encouraged to document their individual scope of practice, which reflects specialized education and training, the individual's knowledge base and specific role, and the patient population served. This scope of practice complements, or may be part of, a collaborative agreement that outlines the relationship between the NP and physician and specifies how issues that are outside of the NP's scope of practice are managed.<sup>[1]</sup>

# Findings and Implications of a National Survey

Rosenfeld P, Kobayashi M, Barber P, Mezey M

- **Results:** Of a total of 870 respondents (response rate 19%), 546 respondents (63%) reported the involvement of NPs in the care of residents in their facilities. In total, respondents identified 1160 NPs involved in care, with a median of two NPs per responding facility (range, 1-10). Respondents reported that NPs make sick/urgent resident visits (96%), provide preventive care to long-stay residents (88%), and perform alternating required regulatory 30/60 (88%), hospice care (80%), and wound care (78%). Significant variations in practice patterns were found between NPs employed by a LTC facility (19% of respondents) as compared with those NPs employed in other arrangements. Large majorities of medical directors stated that NPs are particularly effective in maintaining physician satisfaction (90%), resident satisfaction (87%), and family satisfaction (85%). An additional 34% of the respondents projected an increased need for NPs in nursing homes in the future.

# Findings and Implications of a National Survey



- Conclusion: NPs involved in LTC are more likely to be involved in the care of residents in the nation's larger (>100-bed) LTC facilities. The substantial number and types of services provided by these NPs, coupled with the high resident, family, and physician satisfaction with their services, suggests the need for educational, policy, and reimbursement strategies to encourage the further involvement of NPs in the care of residents in nursing homes

## Nursing Home Resident Outcomes Between Care Provided by Nurse Practitioners Versus Physicians Only



- **Objectives:** The objective of this study was to determine if outcomes of care for nursing home residents differ between two groups of providers: nurse practitioners/physicians and physicians only.
- **Design:** We conducted a retrospective chart review covering the 12-month period from September 1, 1997, until August 31, 1998.

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# Nurse Practitioners Versus Physicians Only



- **Setting:** We studied eight nursing homes in central Texas.
- **Participants:** Two hundred three residents were randomly selected who resided in one of the eight nursing homes during the specified time period.



# Nurse Practitioners Versus Physicians Only



- **Statistical Analysis:** We used chi-squared or Fisher exact test for comparisons of percent and Student t test for comparison of means; comparisons were made with both the FREQ procedure and the univariate procedure.



# Nurse Practitioners Versus Physicians Only



- **Results:** Acute visits were significantly higher for the nurse practitioner/physician team ( $3.0 \pm 2.4$ ) versus the physician-only group ( $1.2 \pm 1.5$ ). The nurse practitioner/physician group treated significantly more eye, ear, nose, and throat and dermatologic diagnoses than the physician-only group.

# Nurse Practitioners Versus Physicians Only



- **Findings.** The NPs had 2315 clinical contacts in the 1-year period; the majority (64%) were follow-up contacts. Many contacts were for uncomplicated medical problems or more complex but straightforward medical issues, and had positive outcomes. Hospital admission was prevented in 39–43% of cases. NPs had a positive impact on improving staff confidence.

# Nurse Practitioners Versus Physicians Only



- **Conclusion:** The level of care provided for patients by the two groups of providers was basically the same and of similar quality; however, the nurse practitioner/physician group patients were seen more often. Increased visits by nurse practitioners are assumed to result in time and cost savings for physicians and improved access to care for patients

# A unique practice model for Nurse Practitioners in long-term care homes

- **Aim.** This paper is a report of a study examining a practice model for Nurse Practitioners (NPs) working in long-term care (LTC) homes and its impact on staff confidence, preventing hospital admission, and promoting early hospital discharge.



# A unique practice model for Nurse Practitioners in long-term care homes

- **Background.** The recent introduction of NPs in LTC homes in Ontario, Canada, provided an opportunity to explore unique practice models. In a pilot project, two full-time equivalent NPs provided primary care to a consortium of 22 homes serving approximately 2900 residents. The practice model was based on the specific needs of the homes and residents.



# A unique practice model for Nurse Practitioners in long-term care homes

- **Methods.** The NPs working in this project prospectively collected data (from July 2003 until June 2004) on their clinical activities and resident outcomes. Directors of Care (n = 18) of the participating homes completed a questionnaire (March 2004) assessing the impact on prevention of hospitalization and staff confidence





# A unique practice model for Nurse Practitioners in long-term care homes



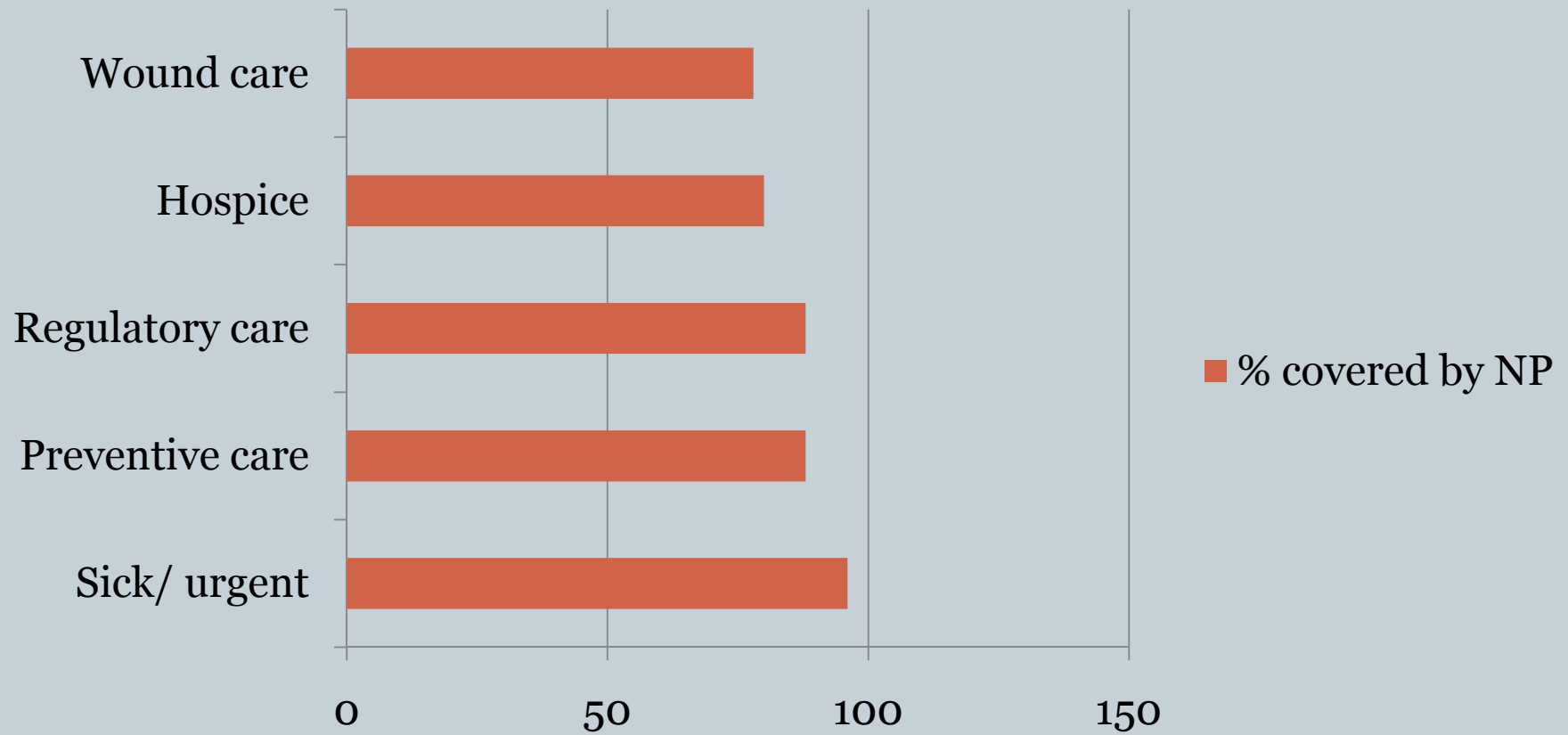
- **Conclusion.** Practice models designed to meet the distinctive needs of LTC homes and residents can enhance quality of care, even with low NP:resident ratios. Participation of key stakeholders in the identification of care priorities and planning contributed to the success of this model.



# On Average Coverage



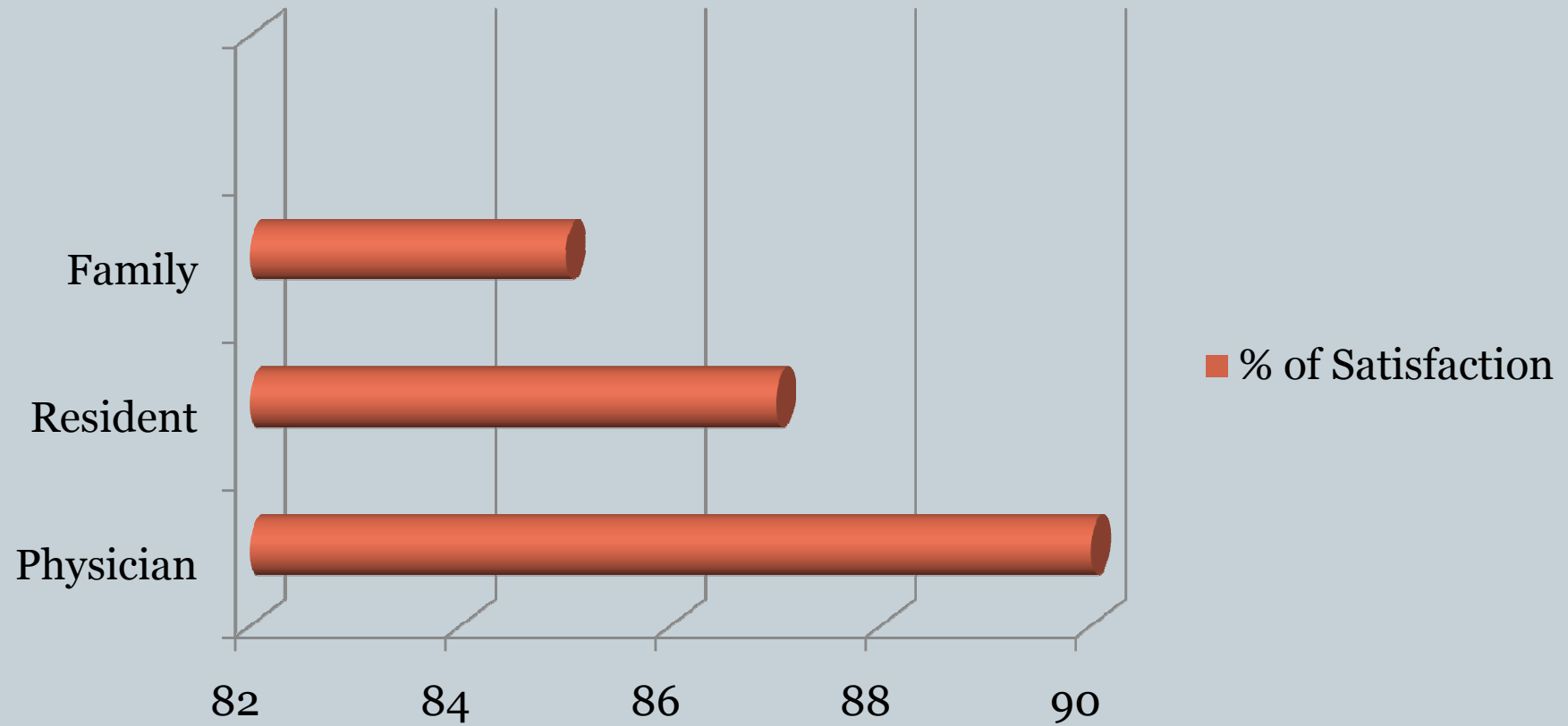
## % covered by NP



# Satisfaction



## % of Satisfaction



# Physician/ NP VS. Physician alone



**# of monthly visits**

