Priority Health	BILLING POLICY No. 002
ADVANCED PRACTICE PROFESSIONAL (APP)	
Effective date: Nov. 11, 2024 **Date of origin: Sept. 2024**	**Review dates: 2/2025**

DEFINITION

This policy defines billing and payment requirements for services rendered by an Advanced Practice Provider (APP).

APPs are health care providers, other than physicians who are licensed by the state in which they provide health care services either in conjunction with or act in place of a physician. This is in accordance with state and federal laws. This includes Physician Assistants (PA), Nurse Practitioners (NP), Clinical Nurse Specialists (CNS), Advanced Practice Registered Nurse (APRN), and Certified Nurse Midwives (CNM). *Note: This isn't an all-inclusive list.*

- Services performed outside of scope of practice or as defined outside of state or federal regulations will be denied.
- Unlicensed APP clinicians or auxiliary staff (nurses, medical assistants, etc.) who are in training under the supervision of a licensed APP provider can't bill for services rendered.
- Registered nurses, certified scrub techs, medical assistants, certified surgical assistants, and certified registered nurse assistants aren't classified as APP.
- APP providers who meet direct billing requirements should follow plan requirements for credentialling.

POLICY SPECIFIC INFORMATION

Direct billing

APPs should bill directly for services they're licensed to provide under state and federal law. These services should be billed under the APP own name and NPI number.

- APP is providing the entire service to member
- Reimbursement of services is at 85% of physician's fee schedule
- APP can initiate and make changes to the plan of care without physician oversight
- APP provides services to new or established members with routine, new or existing problem(s), perform office visits, office procedures or other services defined within their scope of practice (state laws and regulations)
- APP provides services in an office or hospital setting, including ER and/or critical care services
- A physician doesn't need to be in the office suite for office visits

Supervising provider under incident-to services

APPs who are reporting services under the direct supervision of a physician under "incident to" bill under the physician's name and NPI number. The APP is licensed to provide these services under state and federal regulations.

- Reimbursement of services is at 100% of fee schedule
- APP provides the service in its entirety
- Physicians must have performed an initial service and provided a plan of care on a date prior to this visit. APP can then perform services in accordance with this plan of care

- APP can only provide services to established patients who aren't encountering a new problem; APP can't treat a new problem – this must be done by the physician who details a plan of care for treatment
- Supervising physician must be actively participating in patient's care (i.e., regular intervals, change in care plan)
- APP must be employed by the physician office or practice as contracted, full-time or part-time
- Providing direct patient care under delegation and supervision of a physician requires the supervising physician and NPI to be listed on the claim
- Services by APP must be performed in the office setting. A physician is required to be in the office supervising the APP (not necessarily the physician who provided plan of care).
- SA modifier is required for APP billing when reporting as "incident to" services.

The physician signing the record alone doesn't meet the requirements for APP billing under physician. All requirements defined above and as outlined by CMS must be met. Priority Health would align to CMS "incident to" requirements.

Split / shared billing

If services performed by an APP and physician fall within the split billing guidelines, reference our shared or split billing guidelines for appropriate billing provider.

- Shared services shouldn't be split billed when a physician and a hospital-employed APP perform a shared visit. The physician would use their own documentation to determine the level of service coded and billed. The APP documentation can't be used in this determination.

All services are based on contracted rates, member benefits, clinical edits and/or authorization requirements as defined in Priority Health policies.

APPs in multi-specialty groups (for Medicare)

Effective for dates of service on or after Dec. 1, 2024: Additional information may be provided to support possible separate Medicare payment for evaluation and management services if provided by a different specialty for separate clinical conditions.

- When the diagnosis is different from the specialty of the APP, indicate which specialty the APP is working under on the claim.
    - Item 19 of CMS 1500 form
    - Loop 2300 NTE segment or line NTE in 2400 loop for 837P electronic claims
- Use both the 2-digit specialty code and description.

Reimbursement

Most services are reimbursed at 85% of the professional fee schedule. Medicaid is exempt from this 85% mid-level (APP) reduction.

Some services may be paid at the 100% of the physician fee schedule, if you are contracted to provide them:

- Anesthesia
- Labs, including venipuncture and radiology
- Immunizations, vaccines and toxoids
- Injectables and supplies and ancillary services
- Services provided by APPs who are credentialed as Primary Care providers
- Services provided by APPs who are credentialed as CNMs

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

REFERENCES

- MedicaidProviderManual.pdf (state.mi.us)

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 5, 2025	Added the section on "APPs in Multi-Specialty Groups" as Priority Health aligns with updated billing requirements from the Centers for Medicare and Medicaid Services (CMS) effective Dec. 1, 2024.