Billing for Midlevels: Your Questions Answered

MONTE SANDLER

One of the biggest challenges for urgent care practices is staffing. Midlevels are a great solution. As states pass laws giving midlevels more autonomy to compensate for physician shortages, however, there is some confusion on how to bill for these providers' services. I will attempt to answer some of your billing questions.

- *Do I need to credential my midlevels?* Yes and no. This is dependent on your contract. For some group contracts, any new provider will be viewed the same as the rest of the group. You will just need to notify the plan. Some contracts, however, will require full credentialing for all providers.
- *I know government payers (ie, Medicare, Medicaid, and TRICARE) have to be billed under the rendering provider. What about nongovernment payers?* Correct. There is no flexibility for government payers. All midlevels will need to be credentialed. For nongovernment payers, claims need to be submitted under the rendering provider when the contract requires it. Risks of violating your contracts include increased scrutiny of claims, recoup of previous payments, and even the loss of your contract.
- *What if they are temporary and will only work as needed to cover absences?* Unlike physicians, there is no fee-for-time compensation arrangement (formerly called locum tenens) for midlevels. Even though the midlevel is temporary, practices need to credential the same as they would for a permanent hire.
- *What if the physician signs off on all the charts?* Signing the chart does not matter from a billing perspective. It fulfills requirements of your collaborative practice agreement. These requirements will vary by state. Billing requirements are dictated by federal guidelines and payer policies.

Monte Sandler is Executive Vice President, Revenue Cycle Management of Experity (formerly DocuTAP and Practice Velocity).

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- *What about "incident-to" guidelines?* If requirements are met and the payer allows it, midlevels may report their services as incidental to a physician's treatment plan. Unfortunately, this is extremely rare in the urgent care setting where patients present for new or worsening conditions.
- *What are the requirements for "incident-to"?* Services must be an integral, although incidental, part of the physician's professional service. The billing physician must provide direct supervision. For a service to be incidental, it must be a part of a physician's treatment plan. This eliminates new patients, existing patients with new conditions, and patients who are not meeting treatment goals. If the midlevel makes an adjustment to the treatment plan (eg, a change in medication), it is no longer "incident-to."
- *Our standard protocol is for the midlevel to share medical decision-making with the physician. Can't I bill under the physician?* Again, this is dependent on your contract. If full credentialing is required, the provider that performs the face-to-face service is the billing provider.
- *What if we both see the patient?* A "shared" visit is when the level of service is determined by documentation from both the physician and a midlevel provider for a date of service. The physician and midlevel each personally perform a portion of the visit. The encounter could then be billed under the physician. In the office setting, the incident-to guidelines described previously must be met, so this is also extremely rare.
- *What if we code the level based on time?* That may be a good solution. If both the midlevel and the physician see the

patient, you can add each provider's time together and level the visit based on the total. You can only count one provider per minute if both the midlevel and the physician are seeing the patient at the same time.

- *What are the other requirements to bill based on time?* The total time includes both face-to-face and non–face-to-face time on the date of service. You can count time when the patient is not in the office (eg, reviewing lab results or charting). You can't count time spent by clinical staff (eg, nurses or medical assistants). You also can't count the time spent performing procedures, including diagnostic testing. As explained previously, you can include time spent by midlevels.
- *Are the requirements for nurse practitioners and physician associates (formerly physician assistants) the same?* No, they are not always the same. Some plans may require full credentialing of nurse practitioners, but the physician associate can bill under their supervising physician and vice versa.
- *So, what do I do with the claims while the midlevel is being credentialed?* You have two options. Of course, they both have pros and cons. The first is to bill the services out-of-network. This may result in a higher bill for the patient. The second is to hold the claims until the provider's credentialing is effective. However, not all plans will allow retroactive effective dates so you may see timely filing denials.
- *What if the midlevel is documenting for me?* Services would be reported by the rendering provider when a midlevel is working as a scribe. The role of a medical scribe is to chart encounters in real time for the provider.
- *How do I document when a midlevel is a scribe?* When a midlevel provider operates as a scribe, they would not have their own schedule as they are not working independently and are not performing any portion of the service. The scribe would be documenting as the rendering provider. The midlevel's signature is not required on the note. Instead, they would add a note similar to "Jane Doe scribing for Dr. Smith for this encounter on 03/24/2021." The documentation should clearly identify who performed the service and be signed and dated by the rendering provider with a statement that they agree the documentation is accurate and complete.

Take heart—it's not all doom and gloom. These challenges arise only when contracts require full credentialing. This is a good reason to let a credentialing professional handle your contracting. That will help ensure you get the best plans possible for your practice. ■