HANDBOOK FOR
ADVANCED PRACTICE NURSES

CHAPTER N–200
Policy and Procedures for Advanced Practice Nurse Services

Illinois Department of Public Aid

CHAPTER N-200
ADVANCED PRACTICE NURSE SERVICES
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FOREWORD

PURPOSE

This handbook has been prepared to provide information and guidance of advanced practice nurses (APNs) who provide medical services and covered preventive services to participants in the Department's Medical Programs. Coverage of APNs for participation was enabled by Omnibus Budget Reconciliation Act of 1987 (OBRA) legislation for the purpose of improving access to primary medical care for children and pregnant women. Included as APN providers are Certified Nurse Midwives (CNM), Certified Family Nurse Practitioners (CFNP), Certified Pediatric Nurse Practitioners (CPNP) and Certified Registered Nurse Anesthetists (CRNA). The handbook is designed to provide specific policy guidelines applicable to APNs. The handbook includes information on provider eligibility criteria, covered services, reimbursement methodology, and billing instructions.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's web site at http://www.state.il.us/dpa/

CHAPTER N-200

ADVANCED PRACTICE NURSE HANDBOOK

N-200 BASIC PROVISIONS

For consideration to be given by the Department for direct payment to an advanced practice nurse (APN), the services rendered must be provided by an APN enrolled for participation in the Department's Medical Programs. The APN handbook provides participation, enrollment, and payment information which is unique to APNs.

This handbook is intended to be used in conjunction with both Chapter 100, Handbook for Providers of Medical Services and Chapter A-200, Handbook for Physicians. Chapter 100, Handbook for Providers of Medical Services, contains general policy, procedures and appendices applicable to all participating providers. Chapter A-200, Handbook for Physicians, includes policy guidelines and specific billing information applicable to all providers of primary care services. The stated policy and procedures apply to APNs except as noted herein.

N-201 PROVIDER PARTICIPATION

N-201.1 PARTICIPATION REQUIREMENTS

It is required that each APN enroll with the Department in order to be eligible for reimbursement for services by the Department. For the purpose of being eligible to enroll as a provider, the Department defines advanced practice nurse as:

Certified Pediatric Nurse Practitioner (CPNP) and Certified Family Nurse Practitioner (CFNP)

A CPNP or CFNP must be licensed as an advanced practice nurse who holds a valid license in the state of practice and is legally authorized under state law or rule to practice as a CPNP or CFNP pursuant to the Nursing and Advanced Practice Nursing Act (225 ILCS 65) and its implementing regulations or comparable law in the state of practice.

A CPNP and a CFNP must be currently certified as a pediatric nurse practitioner or a family nurse practitioner by a certifying body recognized by the Illinois Department of Professional Regulations (DPR) and maintain a written collaborative agreement with a physician licensed to practice medicine in all its branches. Refer to Topic N-206.1 for the policy regarding the written collaborative agreement.

Certified Nurse Midwife (CNM)

A CNM must be licensed as an advanced practice nurse who holds a valid license in the state of practice and is legally authorized under state law or rule to practice as a nurse midwife pursuant to the Nursing and Advanced Practice Nursing Act (225 ILCS 65) and its implementing regulations or comparable law in the state of practice.

The CNM must maintain a written collaborative agreement with a physician licensed to practice medicine in all its branches. The CNM who attends deliveries must have a written collaborative agreement with a physician who has hospital privileges. Refer to Topic N-206.1 for the policy regarding the written collaborative agreement.

Certified Registered Nurse Anesthetist (CRNA)

A CRNA must be licensed as an advanced practice nurse who holds a valid license in the state of practice and is legally authorized under state law or rule to practice as a nurse anesthetist pursuant to the Nursing and Advanced Practice Nursing Act (225 ILCS 65) and its implementing regulations or comparable law in the state of practice. CRNAs may enroll and provide services within the scope of their individual license and established protocols. If services are provided in a licensed physician's office, licensed dentist's office, or a licensed podiatrist's office, the CRNA must maintain a written practice agreement. Refer to Topic N-206.2 for the policy regarding the CRNA written agreement.

PROCEDURE: **The provider must complete and submit:**

- Form DPA 2243 Provider Enrollment/Application
- Form DPA 1413 Agreement for Participation
- W9 Request for Taxpayer Identification Number

The following documentation must be provided with the application, if appropriate.

- CLIA Certificate (if the APN provides laboratory services)
- Medicare's assigned provider number if the APN is enrolled with Medicare
- A copy of a valid APN license
- Appropriate certificate - Refer to Topic N-201.1 (CFNP and CPNP only)
- Written Collaborative Agreement - Refer to Topic N-206.1
- Written Practice Agreement - Refer to Topic N-206.2
- License to prescribe controlled substance, if appropriate. Refer to Topic N-206.6 for policy and procedures regarding prescriptive authority.

Enrollment forms may be obtained from the Provider Participation Unit at (217) 782-0538 or by sending a request to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

E-mail requests for enrollment forms should be addressed to:
PPU@mail.idpa.state.il.us

The written collaborative or practice agreements are defined in Topic N-206. The agreements must be completed (printed in ink or typewritten) and signed and dated in ink by the APN and the collaborative physician. For APNs that have an agreement with more than one physician, a copy of all written collaborative or practice agreements must be submitted with the initial application for enrollment. A copy of the agreement(s) should also be retained by the APN.

The Department's enrollment forms must be completed (printed in ink or typewritten), signed and dated in ink by the provider, and returned to the Provider Participation Unit. The provider should retain a copy of the forms. The date on the application will be the effective date of the enrollment unless the provider requests a different enrollment date and it is approved by the Department.

N-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet. This sheet will list all the data being carried in the Department's computer file including the categories of services the APN is enrolled to provide and the effective date of enrollment. The APN should review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, refer to A-200, Handbook for Physicians, Appendix A-7 and A-7a.

If all information is correct, the APN should retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to insure that all identifying information required is an exact match to that in the Department's file.

If information is incorrect, refer to Topic N-201.4

N-201.3 PARTICIPATION DENIAL

Written notification to a provider of denial of an application for participation will include the reason for the denial.

Within ten calendar days after such notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for such denials are stated in 89 Ill. Adm. Code 140.14. Department rules concerning administrative proceedings involving terminations or suspensions of medical vendors are stated in 89 Ill. Adm. Code 104, Subpart C.

N-201.4 PROVIDER FILE MAINTENANCE

The information carried in Department files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is that carried in Department's computer files. Each time the provider receives a Provider Information Sheet, the provider must review it carefully for accuracy. Inasmuch as the Provider Information Sheet contains information to be used by the provider in the preparation of claims, any inaccuracies found must be corrected and the Department notified immediately.

Anytime a provider makes a change that causes information on the Provider Information Sheet to become invalid, the provider must notify the Department. When possible, notification should be made in advance of a change.

Procedure: The provider must line out the incorrect or changed data, enter the correct data and sign the Provider Information Sheet on the line provided with an original signature. Forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure by a provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

Whenever there is any change in a provider's enrollment status or any changes submitted by the provider, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date. The updated Provider Information Sheet will be sent to the provider and to any payees listed if the address is different from the provider.

N-202 ADVANCED PRACTICE NURSE REIMBURSEMENT

N-202.1 CHARGES

Charges made to the Department must be the provider's usual and customary charges to the general public for the services provided.

Providers may charge only for services they personally provide.

Covered services must be billed to the Department on form DPA 2360, Health Insurance Claim Form, using the Current Procedural Terminology (CPT) book or alpha numeric HCPCS codes.

N-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services which do not require attachments or accompanying documentation may be billed electronically. Further information can be found in Chapter 100, Handbook for Providers of Medical Services, Topic 112.3.

Providers should take special note of the requirement that Form 194-M-C, Billing Certification Form, which the provider will receive with the remittance advice, must be signed and retained by the provider for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies, or other adverse actions. Refer to Chapter 100, Handbook for Providers of Medical Services, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, the provider should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for the provider to contact their software vendor if the Department determines that the claim rejections are being caused by the submission of incorrect or invalid data.

N-202.3 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Handbook for Providers of Medical Services, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Handbook for Providers of Medical Services, Topics 112.5 and 120.1.

For specific billing instructions, refer to A-200, Handbook for Physicians, Appendix A-1.

N-202.4 PAYMENT

Payment made by the Department for allowable services or supplies provided to patients is based on the individual provider's usual and customary fees, within the limitations established by the Department. The payment made is the lesser of the provider's charge or the maximum established by the Department. APNs will be reimbursed at 70% of the physicians' payment established by the Department, if billing in the APN's name. If the billing is in the name of the collaborative physician, the physician will be reimbursed at 100% of the maximum allowable fee. An APN cannot enroll and receive enhanced rates as a Maternal and Child Health provider. Refer to Topic N-240.

N-203 COVERED SERVICES

A covered service is a service for which payment will be made by the Department. Refer to A-200, Handbook for Physicians, Topic A-203.

Services provided by a CNM, CFNP, or a CPNP, pursuant to a current written collaborative or practice agreement, will be covered in any setting to the extent that the service would be covered if it were rendered by a physician.

N-203.1 DELIVERY SERVICES

The APN may be reimbursed for vaginal delivery of babies under one of the following circumstances:

- The provider of service is a CNM; or
- The CFNP or CPNP is in an emergency situation (i.e., delivery is inevitable and the physician is not available) and is the most qualified person available to deliver the baby.

NOTE: Payment may be made for a vaginal delivery that the CNM performs in the patient's home. Refer to A-200, Handbook for Physicians, Topic A-290 for billing instructions.

N-203.2 CERTIFIED FAMILY AND PEDIATRIC NURSE PRACTITIONER (CFNP and CPNP)

Services provided by CFNPs and CPNPs, pursuant to a current written collaborative agreement will be covered in any setting to the extent that the service would be covered if it were rendered by a physician. Such services may include but are not limited to exams, suturing, casting, diagnostic procedures and surgical assistant for C-Sections.

NOTE: When an APN is functioning in the role of surgical assistant with the collaborative physician, the APN must bill in their name and will be reimbursed at 70%. The collaborative physician cannot submit a claim for both the surgeon and the surgical assistant using their own name and individual provider number.

N-203.3 CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)

A licensed CRNA may provide anesthesia services pursuant to the order of a licensed physician, licensed dentist, or licensed podiatrist in a licensed hospital, a licensed ambulatory surgical treatment center, or the office of a licensed physician, the office of a licensed dentist, or the office of a licensed podiatrist.

CRNAs are authorized to select, order, and administer drugs and apply the appropriate medical devices in the provision of anesthesia services under the anesthesia plan agreed to by the anesthesiologist or the physician in accordance with hospital alternative policy or the medical staff consulting committee policies of a licensed ambulatory surgical treatment center. In a physician's office, dentist's office, or podiatrist's office, the anesthesiologist, operating physician, operating dentist, or operating podiatrist shall agree to the anesthesia plan, in accordance with the written practice agreement. Refer to Topic N-206.2 for an explanation regarding the written practice agreement.

N-204 NON-COVERED SERVICES

Services for which medical necessity is not clearly established are not covered under the Department's Medical Programs. Refer to A-200, Handbook for Physicians, Topic A-204, and Chapter 100, Handbook for Providers of Medical Services, Topic 104 for a list of services for which payment will not be made.

N-205 RECORD REQUIREMENTS

Refer to Chapter 100, Handbook for Providers of Medical Services, Topic 110 for record requirements applicable to all providers. Providers must maintain an office record for each patient. In group practices, partnerships, and other shared practices, one record must be kept with chronological entries by the individual practitioner rendering services.

The record maintained by each provider must include the essential details of the patient's condition and of each service provided. Any services provided to a patient by the provider outside the office must be documented in the medical record maintained in the provider's office. All entries must include the date and must be legible and in English. Records which are unsuitable because of illegibility or because they are written in a language other than English may result in sanctions if an audit is conducted.

For patients residing in nursing facilities, the primary medical record indicating the patient's condition, treatment program, and services ordered and provided during the period of institutionalization may be maintained as a part of the facility chart. However, an abstract of the facility record including diagnosis, treatment program, dates and times services were provided, must be maintained by the provider as an office record to show continuity of care.

The Department and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post payment audits.

In the absence of proper and complete medical records, no payments will be made and payments previously made will be recouped.

N-206 WRITTEN PRACTICE AGREEMENT GUIDELINES

N-206.1 CFNP, CPNP AND CNM WRITTEN COLLABORATIVE AGREEMENT

The written collaborative agreement is the instrument which defines the relationship between the collaborative physician and the CNM, CFNP, or the CPNP. The collaborative physician must be currently licensed to practice medicine in all its branches. The written collaborative agreement must be mutually developed by the APN and the collaborative physician and must be approved by both. The written collaborative agreement identifies the medical services to be provided within the scope of each practitioner's expertise, with medical direction and supervision where appropriate, as defined by federal regulations and state law. The written collaborative agreement is a key to what services the APN may provide and the agreement should indicate at what point the APN should not proceed on their own. Until that point, the APN has autonomy and the physician need not be present. The services to be provided must be services which the physician generally provides his or her patients in the normal course of the practice. The agreement must encompass or include the following items at a minimum:

- acknowledgment of statutory and clinical limits of the APN's authority to provide medical care and the APN's accountability in relation to established goals and needs of patients;
- listing of medical procedures which the APN is delegated by the physician to provide and listing of authorized procedures that require the physician's presence as the procedures are being performed;
- an explanation of how the physician's directions are to be communicated to the APN;
- an explanation of how the APN may assist in treating or responding to medical emergencies;
- an explanation of the criteria for consultation with the physician, as needed, and required documentation in the patient's record of such consultation;
- a description, as needed, of the criteria and process for referrals of patients to a specialist;
- arrangements for a substitute physician when the collaborative physician is on vacation or unavailable;
- a provision that the physician and the APN shall periodically assess the implementation of the arrangement, including progress toward established objectives, shall report the results of the assessment briefly in writing and shall maintain this documentation with the agreement;
- a provision that the APN shall identify himself or herself to patients as a nurse practitioner or nurse midwife.

NOTE: When services are provided that are not indicated in the written collaborative agreement, the collaborative physician's countersignature is required in the record.

N-206.2 CRNA WRITTEN PRACTICE AGREEMENT

CRNAs are required to maintain a written practice agreement if services are provided in a physician's office, dentist's office, or podiatrist's office.

The agreement shall describe the working relationship of the CRNA and the anesthesiologist, physician, dentist, or podiatrist and shall authorize the categories of care, treatment, or procedures to be performed by the CRNA, in accordance with 225 ILCS 65/15-25.

N-206.3 APNs EMPLOYED BY A GROUP PRACTICE

When the APN is employed by a group practice, but works primarily with one physician, it is only necessary to have a written collaborative agreement with the collaborative physician. However, more than one physician may have a written practice agreement with the same APN. Other physicians in a practice may serve as a consulting physician when the collaborative physician is not available without having a written practice agreement.

N-206.4 APNs EMPLOYED BY A HOSPITAL

When an APN is employed by a hospital, an agreement with a collaborative physician is still required. Refer to Topic N-206.1. However, when an APN is employed by the hospital, any services provided that fall under the hospital's all-inclusive rate cannot be billed by the APN. The all-inclusive rate is a specified rate which includes all services provided in an inpatient or outpatient setting for each day a patient is treated. The all-inclusive rate is considered to cover all services provided by salaried hospital personnel, all drugs administered and provided for take-home use, all equipment and supplies used for diagnosis and treatment on the hospital premises, and all x-ray, laboratory and therapy provided to the patient on the same day. The hospital must bill using the hospital's fee-for-service provider number for services provided that do not fall under the all-inclusive policy. Examples of such services, that fall outside of the all inclusive rate, which would be provided by an APN are antepartum and postpartum care.

N-206.5 NOTIFICATION TO THE DEPARTMENT

All services billed to the Department by the APN must be provided within the

provisions of the written practice or collaborative agreement. The agreements must be reviewed at least annually and be updated as appropriate. A copy of the written practice or collaborative agreement must be on file at each practice location. The Department must be notified immediately if the agreement is dissolved because the APN's enrollment must be terminated at that time.

N-206.6 PRESCRIPTIVE AUTHORITY

The CNM, CFNP, CPNP and the CRNA may be delegated limited prescriptive authority by the collaborating physician as part of a written collaborative agreement. This authority may, but is not required to, include prescription and dispensing of legend drugs and legend controlled substances categorized as Schedule III, IV, or V controlled substances, as defined in the Illinois Controlled Substance Act. To prescribe Schedule III, IV, or V controlled substances, an APN must obtain a mid-level practitioner controlled substance license. Medication orders must be reviewed periodically by the collaborating physician.

The collaborating physician must file with the Department of Professional Regulations notice of delegation of prescriptive authority and termination of such delegation.

N-210 GENERAL LIMITATIONS AND CONSIDERATIONS ON COVERED MEDICAL DIAGNOSTIC AND TREATMENT SERVICES

All limitations that apply to physician services also apply to services provided by APNs. Program policies and procedures as stated in A-200, Handbook for Physicians, applicable Department bulletins and publications, and the CPT should be referenced for explanations of coverage.

N-210.1 RESPONSIBILITY FOR SERVICES

Determination of the medical necessity and appropriateness of service is the responsibility of the physician as stated in the terms of the written collaborative agreement, and is subject to review for conformity with accepted standards of medical care and practice.

The APN and the collaborative physician will be held responsible for any unnecessary, excessive, or otherwise inappropriate services rendered personally or by another enrolled provider pursuant to either the APN's or physician's order(s).

As appropriate, the APN or the collaborative physician will be subject to any corrective action, including recovery of payment made for inappropriate services.

Existence of the agreement does not relieve the APN or the physician of the responsibility for the appropriateness of services and adherence to the Department's Medical Programs policy and to federal and state statutes.

N-210.2 DUPLICATE PAYMENT

If the APN works in a hospital, home health agency, long term care facility, family planning clinic, or other participating provider and bills the Department directly for services provided at those sites during the period of the APN's employment contract, it is the responsibility of the APN to ensure that the facility or the collaborative physician is not also billing the Department for the same services. Any duplicate payment will be recovered from the APN and appropriate referrals will be made to the Office of the Inspector General.

N-222 MEDICAL DIAGNOSTIC AND TREATMENT SERVICES

N-222.1 LABORATORY SERVICES

APNs providing laboratory services must comply with the Clinical Laboratory Improvements Amendment (CLIA) Act.

A laboratory serving a physician or physicians in a group practice is considered a physician's office laboratory. If laboratory services are included in the written collaborative agreement, the APN may submit claims for laboratory services using the CLIA certificate issued to the physician's office. Refer to the A-200, Handbook for Physicians, Topic A-222.1 for further discussion on the Department's laboratory policy and procedures.

N-240 MATERNAL AND CHILD HEALTH PROGRAM

The Maternal and Child Health (MCH) Program is a primary health care program coupled with case management services for pregnant women and children enrolled in the Department's Medical Programs. The MCH program is designed to increase provider participation through special incentives for the providers for certain services provided to pregnant women and children through age 20.

An APN cannot enroll as a Maternal and Child Health provider. An APN who performs MCH services, will be reimbursed at 70% of the lesser of the provider's charge or the maximum established by the Department, excluding the enhanced physicians' rate. Payment will be made at the enhanced rate, if the collaborative physician who is enrolled in MCH delegates the services to the APN through the written collaborative agreement and such services are submitted for reimbursement under the name and provider number of that physician.