CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Advanced Practice Registered Nurse (APRN) Services

Rule Number(s):

RULES ADDRESSED IN BUSINESS IMPACT ANALYSIS:

New: 5160-4-04

To Be Rescinded: 5160-8-21, 5160-8-22, 5160-8-23, 5160-8-24, 5160-8-25

RULES NOT SUBJECT TO BUSINESS IMPACT ANALYSIS, INCLUDED FOR INFORMATION ONLY:

To Be Rescinded: 5160-8-20, 5160-8-27

Date: March 19, 2015; May 24, 2016; revised and resubmitted September 9, 2016

Rule Type:

- ☑ New
- ☐ Amended
- ☑ 5-Year Review
- ☑ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rules concerning the coverage of and payment for advanced practice registered nurse (APRN) services are set forth in seven existing rules located in Chapter 5160-8 of the Ohio Administrative Code. Relevant provisions of two of these seven rules are combined into a single new rule located in Chapter 5160-4 of the Ohio Administrative Code. The remaining five rules are rescinded.

   New rule 5160-4-04, "Advanced practice registered nurse (APRN) services," sets forth coverage and payment policies for services provided by an APRN, a term that encompasses a certified registered nurse anesthetist (CRNA), clinical nurse specialist (CNS), certified nurse-midwife (CNM), and certified nurse practitioner (CNP). This rule replaces rules 5160-8-22 and 5160-8-23.

   Rule 5160-8-20, "Advanced practice nurses," sets forth definitions of various types of ambulatory health care clinics and advanced practice nurses. This rule is rescinded.

   Rule 5160-8-21, "Advanced practice nurses; eligible Ohio medicaid providers," sets forth the provision that certified nurse practitioners, clinical nurse specialists, and certified nurse midwives can enroll independently as independent providers (and therefore can submit claims to Medicaid directly) or enroll as a professional medical group. This rule is rescinded.

   Rule 5160-8-22, "Advanced practice nurses: practice arrangements and reimbursement," identifies various practice and employment arrangements and payment provisions applicable to APRNs under the Medicaid program. This rule is rescinded; some of its provisions are incorporated into new rule 5160-4-04.

   Rule 5160-8-23, "Advanced practice nurses: coverage and limitations," identifies the scope of coverage for APRNs in the Medicaid program. This rule is rescinded; some of its provisions are incorporated into new rule 5160-4-04.

   Rule 5160-8-24, "Eligible providers of certified registered nurse anesthetist (CRNA) services," sets forth the provision that CRNAs can enroll independently and submit claims directly to Medicaid or can enroll as a member of a professional medical group. This rule is rescinded.

   Rule 5160-8-25, "Coverage, limitations, and reimbursement of anesthesia services provided by certified registered nurse anesthetists (CRNAs)," identifies various practice arrangements and sets forth coverage, payment, and claim-submission provisions for CRNAs. This rule is rescinded.

   Rule 5160-8-27, "Advanced practice nurses: modifiers," delineates the two-character procedure code modifiers used in claims to denote the type of APRN who provided the service. This rule is rescinded.

The text of the new rule looks considerably different.

- The term *advanced practice nurse (APN)* is updated to *advanced practice registered nurse (APRN)*.
- Unnecessary references, duplicative provisions, and references to obsolete rules are removed.
- Lengthy specifications of requirements and criteria for APRNs are replaced by a reference to another chapter of the Ohio Administrative Code pertaining to the Ohio Board of Nursing and by a statement that payment for an APRN service may be made only if the service is within the scope of practice of the particular APRN who provided it.
- A provision is removed that required documentation beyond a countersignature alone for direct services rendered to individual hospital patients by APRNs employed by or under contract with the hospital.
- Claim-submission instructions are removed. This information is available in formats other than administrative rule.

Despite the transformed appearance of the new rule, there are only two substantive policy changes.

- Coverage is simplified. Unless a specific exception is noted, all other Medicaid rules that pertain to services performed by a physician now will apply also to APRNs.
- The list of non-covered services is removed. Instead, a set of conditions is given under which payment for a covered APRN service may be made.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Section 5164.02 of the Ohio Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   No.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These rules do not exceed federal requirements.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   Medicaid rules perform several core business functions: They establish and update coverage and payment policies for medical goods and services. They set limits on the types of entities that can receive Medicaid payment for these goods and services. They publish payment formulas or schedules for the use of providers and the general public.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The success of these rules will be measured by the extent to which operational updates to the Medicaid Information Technology System (MITS) result in the correct payment of claims.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   Medicaid staff members met in person with representatives of the Ohio Association of Advanced Practice Nurses (OAAPN). After the in-person meetings, Medicaid staff members continued to communicate with OAAPN by phone and e-mail.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the agency?**

   OAAPN requested that fourteen specific changes be made in the rules. Thirteen of the requested changes were made:

   a. Replacement of the term "advanced practice nurse (APN)" with the more current form "advanced practice registered nurse (APRN)";
   b. Updating of the definition of APRN to include the phrase "a valid certificate of authority issued by the Ohio board of nursing in accordance with section 4723.42 of the Revised Code" (a result accomplished instead through reference to Chapter 4723-08 of the Ohio Administrative Code);
   c. Removal of unnecessary lists of practitioner types and specialties;
   d. Removal of references to section 4723.52 of the Ohio Revised Code, which has been repealed;
   e. Removal of unnecessary provisions concerning standard care arrangements (SCAs), because no APRN can practice in Ohio without a SCA;

f. Removal of an unnecessary provision requiring documentation beyond a countersignature alone for direct services rendered to individual hospital patients by APRNs employed by or under contract with the hospital;

g. Removal of the unnecessary phrase "in a capacity other than one of advisory, collaborating, or for the purpose of prescribing pharmaceuticals, medical devices, or other diagnostic and therapeutic services when the advanced practice nurse lacks the prescriptive authority required" applied to a physician, because it is redundant with other provisions of Ohio law;

h. Removal of the coverage/payment restriction on initial hospital evaluation and management requiring medical decision-making of high complexity (represented by CPT procedure code 99223), because it is no longer applicable;

i. Removal of the coverage/payment restriction on assistant-at-surgery services;

j. Removal of the coverage/payment restriction on the evaluation and management by an APRN of a patient during initial hospital care if medical decision-making of high complexity is required (represented by CPT procedure codes 99284 and 99285), because APRNs currently perform such services and receive Medicaid payment for doing so;

k. Removal of the coverage/payment restriction on certain services provided by a certified nurse-midwife, because it duplicates scope-of-practice provisions administered by the Ohio Board of Nursing in accordance with national certification standards;

l. Removal of the provision that no payment will be made for a test performed by an APRN that requires the expertise of a physician, because it is an unnecessary restatement of the scope-of-practice principle; and

m. Clarification that the 85%/100% payment structure applies only to services rendered by a CNS, CNM, or CNP and that payment for services rendered by a CRNA is made in accordance with the anesthesia services rule (5160-4-21).

An initial request to set payment at 100% rather than 85% of the Medicaid maximum amount for a service provided in a hospital setting was considered but rejected. Medicare similarly differentiates payment on the basis of professional credential.

9. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

Utilization and expenditure data drawn from ODM's Quality Decision Support System were used in projecting the fiscal impact of the proposed changes.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    These rules involve the coverage of and payment for APRN services. Whatever the policy may be, the form of the rule is the same; no alternative is readily apparent.

11. **Did the Agency specifically consider a performance-based regulation? Please explain. Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.**

    The concept of performance-based regulation does not apply to these services.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    Rules involving Medicaid providers are housed exclusively within agency 5160 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. It is clear which rules apply to each provider type and item or service. In this instance, there was no duplication.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    The policies set forth in these rules will be incorporated into the Medicaid Information Technology System (MITS) as of the effective dates of these rules. They therefore will be applied by the Department's electronic claim-payment system automatically and consistently whenever an appropriate provider submits a claim for an applicable service.

Adverse Impact to Business

14. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**

    a. **Identify the scope of the impacted business community;**

       These rules affect advanced practice registered nurses (certified registered nurse anesthetists, clinical nurse specialists, certified nurse-midwives, and certified nurse practitioners).

    b. **Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and**

       Existing rule 5160-8-21 requires specific types of licensure or certification.

Existing rule 5160-8-22 predicates payment on certain licensure requirements and practice arrangements, and it requires documentation (beyond a countersignature alone) for direct services rendered to individual hospital patients by APRNs employed by or under contract with the hospital.

Existing rule 5160-8-23 provides that "[o]nly advanced practice nurses who are certified nurse midwives may perform and [submit claims] for deliveries."

Existing rule 5160-8-24 predicates payment on certain licensure requirements.

Existing rule 5160-8-25 limits payment to a CRNA on the basis of employment arrangement, and it prescribes a specific (and outdated) claim format to submit when the automatic "Medicare crossover" claim process fails.

These rules are being rescinded. New rule 5160-4-04 includes none of these provisions.

Note: Since the previous submissions of this Business Impact Analysis, paragraphs (B)(3) and (B)(4) of new rule 5160-4-04 have been removed, a provision concerning specific priority of payment has been reduced to a general injunction against submission of duplicate claims, an unnecessary provision concerning collaborative or supervisory work arrangements has been removed, and unnecessary references to a "site-based APRN" have been removed.

Paragraph (B)(2) of new rule 5160-4-04 now delineates payment constraints related to scope of practice and Medicaid enrollment. Direct payment may be made to an APRN only if five conditions are met:

(a) The APRN is enrolled as an Ohio Medicaid provider;
(b) The service is rendered to a Medicaid-eligible Ohio recipient in a state in which the APRN is licensed or authorized to practice;
(c) The service is within the scope of practice of the APRN's specialty;
(d) The APRN personally rendered the service to an individual patient; and
(e) The service cannot be performed by someone who lacks the skills and training of an APRN.

Condition (a) affects only the method of payment; payment for the services of a non-enrolled APRN is made to the provider submitting the claim, which in turn pays the APRN. Condition (b) allows payment for APRN services rendered outside Ohio and grants full faith and credit to the licensure process in other states. Condition (c) recognizes the heterogeneity of APRNs; a CNM and a CRNA, for example, perform very different services. Conditions (d) and (e) are included as program integrity measures to ensure that APRN services are performed by APRNs.

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

The certification and licensure requirements in the existing rules are eligibility limitations rather than directives to obtain credentials.

The time needed to document an APRN's involvement in direct patient care is less than five minutes per encounter. This estimate is based on the observations of several ODM staff members who have seen medical practitioners enter a single piece of information into a medical record.

The time needed to resubmit failed crossover claims (which is now accomplished through the Medicaid web portal) is no more than five minutes per claim. This estimate is based on ODM's experience with procedure codes and claim submission, with the process of keying data, and with the ODM claim-payment system.

The existing rules are being rescinded. None of these provisions is included in new rule 5160-4-04.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The provisions in the existing rules that have an adverse impact were enacted as program integrity measures, intended to ensure the delivery of high-quality services to Medicaid recipients. Such a level of prescriptive detail is now considered to be not only unnecessary but even at times counterproductive.

New rule 5160-4-04 describes constraints on payment for an APRN service. These constraints, which include enrollment as an Ohio Medicaid provider, are not new obligations imposed on APRNs but rather indications of when they may receive payment directly from ODM rather than through another entity.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

These rules outline actions all providers must take in order to receive Medicaid payment. The requirements are applied uniformly and no exception is made based on an entity's size.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

These rules impose no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers that submit claims through an electronic clearinghouse (a "trading partner") can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

Policy questions may be directed via e-mail to the Non-Institutional Benefit Management section of ODM's policy bureau at *noninstitutional_policy@medicaid.ohio.gov*.

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.

TO BE RESCINDED

5160-8-20 **Advanced practice nurses.**

(A) All the definitions set forth in rule 4723-08-01 of the Administrative Code apply to rules 5101:3-8-20 to 5101:3-8-23 of the Administrative Code unless otherwise indicated.

(B) Definitions.

(1) "Fee-for-service clinics" are clinics that are eligible and bill the department as ambulatory health clinics in accordance with Chapter 5101:3-13 of the Administrative Code.

(2) "Cost-based clinics" are clinics that are eligible and bill the department as a rural health clinic (RHC), a federally qualified health center (FQHC), or an outpatient health facility (OHF) in accordance with Chapters 5101:3-16, 5101:3-28 and 5101:3-29 of the Administrative Code, respectively.

(3) "Advanced practice nurse" for the purpose of rules 5101:3-8-21 to 5101:3-8-23 of the Administrative Code is a registered nurse who holds a certificate of authority issued by the board of nursing to practice as a certified nurse practitioner, clinical nurse specialist, or certified nurse midwife in accordance with section 4723.42 of the Revised Code and meets the criteria set forth in rule 5101:3-8-21 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	03/01/1994 (Emer), 05/12/1994, 05/01/1997, 06/01/2002, 01/01/2008

TO BE RESCINDED

5160-8-21 **Advanced practice nurses: eligible Ohio medicaid providers.**

(A) A certified nurse practitioner approved under section 4723.42 of the Revised Code is eligible to become an Ohio medicaid provider as an individual nurse practitioner upon the execution of an Ohio medicaid provider agreement if both of the following are met:

(1) The certified nurse practitioner holds a valid certificate of authority issued by the Ohio board of nursing in accordance with section 4723.42 of the Revised Code.

(2) The certified nurse practitioner is certified by a national certifying organization approved by the Ohio board of nursing as at least one of the following:

(a) An adult nurse practitioner;

(b) A family nurse practitioner;

(c) A pediatric nurse practitioner;

(d) An obstetrical-gynecological/women's health care nurse practitioner;

(e) A neonatal nurse practitioner;

(f) A gerontological nurse practitioner;

(g) An acute care nurse practitioner;

(h) A psychiatric nurse practitioner; or

(i) A palliative care nurse practitioner.

(B) A clinical nurse specialist approved under section 4723.42 of the Revised Code is eligible to become an Ohio medicaid provider as an individual clinical nurse specialist upon execution of an Ohio medicaid provider agreement if both of the following are met:

(1) The clinical nurse specialist holds a valid certificate of authority issued by the Ohio board of nursing in accordance with section 4723.42 of the Revised Code.

(2) The clinical nurse specialist is certified by a national certifying organization approved by the Ohio board of nursing as at least one of the following:

(a) An oncology clinical nurse specialist;

(b) A clinical nurse specialist in adult health;

(c) A gerontological clinical nurse specialist;

(d) A psychiatric clinical nurse specialist;

(e) A palliative care nurse specialist;

(f) An acute care clinical nurse specialist; or

(g) A pediatric clinical nurse specialist.

(C) Clinical nurse specialists and certified nurse practitioners not meeting the criteria in paragraphs (A)(1) and (A)(2) or (B)(1) and (B)(2) of this rule, as applicable, are not eligible for enrollment as a provider in the medicaid program.

(D) A certified nurse midwife approved under section 4723.42 of the Revised Code is eligible to become an Ohio medicaid provider as an individual nurse midwife upon execution of an Ohio medicaid provider agreement if all of the following are met:

(1) The certified nurse midwife holds a valid certificate of authority issued by the Ohio board of nursing in accordance with section 4723.42 of the Revised Code.

(2) The certified nurse midwife has completed an accredited course of study.

(3) The certified nurse midwife is certified by the American college of nurse-midwives, the American midwifery certification board, or the American college of nurse midwives certification council.

(E) An advanced practice nurse group is eligible to enroll in the medicaid program if it meets the criteria as a professional medical group as defined in paragraph (C) of rule 5101:3-1-17 of the Administrative Code.

(F) Advanced practice nurses enrolled in the medicaid program may be members of any physician group practice enrolled in the Ohio medicaid program.

(G) Out-of-state advanced practice nurses providing services to Ohio medicaid recipients must be licensed, certified, or authorized as required by the state in which the recipient is located at the time the service is provided. In addition, out-of-state advanced practice nurses must meet the provisions of rule 5101:3-1-11 of the Administrative Code addressing out-of-state coverage.

(H) Any advanced practice nurse practicing in Ohio who applies to become a medicaid provider must be authorized by the Ohio board of nursing to practice as an advanced practice nurse in accordance with sections 4723.41 and 4723.42 of the Revised Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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Prior Effective Dates:	03/01/1994 (Emer), 05/12/1994, 05/01/1997, 06/01/2002, 01/01/2008, 08/02/2011

TO BE RESCINDED

5160-8-22 **Advanced practice nurses practice arrangements and reimbursement.**

(A) Advanced practice nurses enrolled in the Ohio medicaid program may practice in a variety of practice or employment arrangements as specified in the nurse's standard care arrangement in accordance with section 4723.431 of the Revised Code. Whether an advanced practice nurse or a group of advanced practice nurses is entitled to direct reimbursement under the Ohio medicaid program is dependent entirely on the practice or employment arrangement of the advanced practice nurse or group.

(B) Practice arrangements.

(1) Independent practice.

An "advanced practice nurse" is considered to be in an independent practice if the medical services rendered to a patient are the responsibility of an advanced practice nurse who is in solo practice or a member of an advanced practice nurse group practice and the practice is free of the fiscal, administrative, and professional control of an individual physician practice, a physician group practice, a hospital, a fee-for-service clinic, a cost-based clinic, a long term care facility, or any other medicaid provider. "Free of professional control" does not mean that the advanced practice nurse practices in the absence of a standard care arrangement. Each advanced practice nurse, including those in independent practice as defined in this rule, must maintain a standard care arrangement as required by section 4723.431 of the Revised Code.

(2) Provider-based practice.

An "advanced practice nurse" is considered to be in a provider-based practice if the advanced practice nurse is under the fiscal, administrative and professional control of an individual physician practice, a physician group practice, a hospital, a fee-for-service clinic, a cost-based clinic, a long term care facility, or any other medicaid provider through an employment, a contractual, or any other legally binding arrangement. Advanced practice nursing services provided in provider-based practices are considered incidental to the employing or contractual provider (i.e., as physician services if provided in a physician-based practice, as clinic services if provided in a clinic-based practice, as hospital services if provided in a hospital-based practice, etc.).

(C) Reimbursement.

(1) Services provided by advanced practice nurses are subject to the site differential payments set forth in rule 5101:3-4-02.2 of the Administrative code and the office incentive payments set forth in rule 5101:3-4-09 of the Administrative Code.

(a) The total reimbursement for services and procedures subject to the site differential payment is either the provider's billed charge or the reimbursement rate established in paragraphs (C)(3) and (C)(4) of this rule multiplied by the site differential percentage rate, whichever is less.

(b) The total reimbursement for services and procedures subject to the office incentive payment is either the provider's billed charges or the reimbursement rate established in paragraphs (C)(3) and (C)(4) of this rule plus the incentive payment rate, whichever is less.

(2) Separate reimbursement is not available for any service included in the global payment of another service (e.g., evaluation and management services provided for post-operative care), whether the global payment was made directly to the advanced practice nurse or to another medicaid provider.

(3) Only advanced practice nurses who practice in an independent practice arrangement are eligible to bill and receive direct reimbursement under the Ohio medicaid program. For independent practices, reimbursement is the lesser of the provider's billed charge or one of the following:

(a) Eighty-five per cent of the medicaid maximum when services are provided in a hospital setting; or

(b) One hundred per cent of the medicaid maximum when services are provided in a nonhospital setting.

(4) Services provided by advanced practice nurses in provider-based practices are reimbursable only to the employing or contracting provider.

(a) For individual physician-based practices, group physician-based practices, fee-for-service clinic-based practices, or hospital-based practices, reimbursement for advanced practice nursing services is the lesser of the provider's billed charge or one of the following:

(i) Eighty-five per cent of the medicaid maximum when services are provided by an advanced practice nurse in the following places of service: inpatient hospital, outpatient hospital, or hospital emergency department; or

(ii) One hundred per cent of the medicaid maximum when services are provided by an advanced practice nurse in any nonhospital place or service.

(b) For RHC-based, FQHC-based and OHF-based practices, reimbursement for advanced practice nursing services is the medicaid maximum set forth in Chapters 5101:3-16, 5101:3-28, and 5101:3-29 of the Administrative Code, respectively.

(c) For all other nonhospital, provider-based practices, reimbursement for advanced practice nursing services is bundled into the payment for that provider type and is the maximum allowed under the medicaid program for the services rendered by that provider type (e.g., services provided by a nurse practitioner employed by a home health agency would be bundled into the payment for a home health service).

(d) When services incident to advanced practice nurse services are provided by an individual who is not an advanced practice nurse in an office or clinic setting, the services rendered must be within the scope of licensure (if licensure is required) of the individual who is not an advanced practice nurse or a service for which the individual is legally authorized to provide under Ohio law and documented in the patient's medical records.

(i) The services rendered by the individual who is not an advanced practice nurse must be rendered under the direct supervision of the advanced practice nurse. The records must be reviewed and countersigned by the supervising advanced practice nurse.

(ii) "Direct supervision" in the advanced practice nurse's office or clinic setting means that the advanced practice nurse must be present in the office suite throughout the time the individual who is not an advanced practice nurse is providing the service and immediately available to provide assistance and direction throughout the time the individual who is not an advanced practice nurse is performing services. Direct supervision does not mean the advanced practice nurse must be in the same room while the

individual who is not an advanced practice nurse is providing services. The availability of the advanced practice nurse by telephone or the presence of the advanced practice nurse somewhere in the institution does not constitute availability.

(iii) All of the provisions relating to direct supervision described in rule 5101:3-4-02 of the Administrative Code must be met.

(5) Hospital-based advanced practice nurses.

(a) For hospital-based practices, separate reimbursement is available to hospitals for professional services provided by advanced practice nurses only if the requirements set forth in paragraph (C)(5)(c) of this rule are met. Reimbursement for professional services provided by hospital-based advanced practice nurses is in accordance with paragraph (C)(4)(a) of this rule. In addition, certain services are subject to the site differential payment in accordance with paragraph (C)(1) of this rule.

(b) Services provided by advanced practice nurses that include teaching, research, administration, supervision of professional and/or technical personnel, supervision of nursing and advanced practice nursing students, service on hospital committees, and other hospital-based activities that are of benefit to patients, generally do not meet all of the requirements set forth in paragraph (C)(5)(c) of this rule.

(i) Such services are reimbursable only as hospital services and are bundled into the hospital's inpatient or outpatient facility payment in accordance with Chapter 5101:3-2 of the Administrative Code; and

(ii) The portion of the expenses associated with the provision of the type of services identified in paragraph (C)(5)(b) of this rule by an advanced practice nurse, may be included on the hospital cost report.

(c) Reimbursement for services rendered directly to, and for the benefit of, individual patients by advanced practice nurses who are employed by or under contract with a hospital is separately reimbursable to the hospital on a fee-for-service basis as advanced practice nursing services (i.e., in addition to the inpatient or outpatient hospital facility payment) if the following requirements are met:

(i) The services are personally furnished for an individual patient by an advanced practice nurse who is currently enrolled as an Ohio medicaid provider.

(ii) The services contribute directly to the diagnosis or treatment of an individual patient.

(iii) The services ordinarily require performance by a physician or an advanced practice nurse.

(iv) The services are not the type of services routinely performed by registered nurses or other hospital-employed nonphysicians.

(v) For services identified in paragraphs (C)(5)(c)(i) to (C)(5)(c)(iv) of this rule, documentation must exist that demonstrates the advanced practice nurse's involvement in the service rendered. A countersignature alone in the records is not considered sufficient documentation of advanced practice nursing services.

(vi) The portion of the expenses associated with the provision of the type of services identified in paragraphs (C)(5)(c)(i) to (C)(5)(c)(iv) of this rule by advanced practice nurses are excluded from the hospital cost report.

(6) In an institutional setting, advanced practice nurses will only be reimbursed by the medicaid program for the services that have been personally rendered by the advanced practice nurse.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 4723.41 to 4723.50
Prior Effective Dates:	09/24/1983, 04/01/1988, 05/15/1989, 03/01/1994 (Emer), 05/12/1994, 05/01/1997, 06/01/2002, 01/01/2008

TO BE RESCINDED

5160-8-23 **Advanced practice nurses: coverage and limitations.**

(A) The coverage of services provided by advanced practice nurses shall be limited only to the extent that the condition of the patient and/or the limited scope of practice of an advanced practice nurse as it is recognized under Ohio law warrants the intervention and/or care of a physician in a capacity other than one of advisory, collaborating, or for the purposes of prescribing pharmaceuticals or medical devices when the advanced practice nurse lacks prescriptive authority.

(B) Chapter 5101:3-14 of the Administrative Code and all the rules set forth in Chapter 5101:3-4 of the Administrative Code that pertain to services a physician is legally authorized to perform under Ohio law shall apply to advanced practice nurses except, the term "physician" as it is defined in rule 5101:3-4-01 of the Administrative Code shall be replaced with the term "advanced practice nurse" as it is defined in rule 5101:3-8-21 of the Administrative Code.

(C) In addition to being subject to the applicable rules set forth in Chapter 5101:3-4 of the Administrative Code, advanced practice nurses are subject to the following coverage and limitations:

(1) For services provided in a teaching setting for advanced practice nurses, paragraphs (A) to and (E)(2) in rule 5101:3-4-05 of the Administrative Code shall apply except the term "physician" in this rule shall be replaced by the term "advanced practice nurse" and the term "resident, intern, or fellow" shall be replaced by the term "individual in training for an advanced practice nursing certification."

(2) Under no circumstances will an advanced practice nurse be eligible to bill or be reimbursed for the following evaluation and management CPT code: 99223,

(3) Consultations performed by an advanced practice nurse are covered.

(4) Except when precluded by Ohio law, inpatient hospital evaluation and management services are covered only if the advanced practice nurse is acting in the capacity of the patient's "primary treating provider" for the day and no physician is acting concurrently as the primary treating provider, and billing for evaluation and management services. For purposes of this rule, "primary treating provider" is a physician or advanced practice nurse who is responsible for managing the patient's inpatient hospital care for that day.

"Primary treating provider" does not include a sub-specialist provider who may be treating the patient concurrently for specialty care, (e.g. a nephrologist).

(5) Antepartum services may be provided by advanced practice nurses who are certified in an advanced practice nurse specialty that is qualified to perform antepartum services.

(6) "Covered nurse midwifery services" are defined as those services that constitute the management of preventive services and those primary care services necessary to provide health care to women antepartally, intrapartally, postpartally, and gynecologically. Only advanced practice nurses who are certified nurse midwives may perform and bill for deliveries. In addition, the following services are noncovered when performed by nurse midwives, except in unavoidable, emergency situations:

(a) Management of an acute obstetric emergency, including any obstetric operation;

(b) Version or delivery of breech or face presentation; and

(c) Use of forceps;

(7) Therapeutic injections, prescribed drugs, diagnostic and therapeutic services, laboratory services, and radiology services are covered as an advanced practice nursing service only if the service was ordered and/or prescribed by a physician, an advanced practice nurse, or any other provider who has the authority to order and/or prescribe the services under, and in accordance with, Ohio law.

(8) With the exception of those laboratory procedures listed as physician-performed microscopy procedures (PPMP), laboratory services that require performance by a pathologist or a physician who is regarded as a specialist in pathological or hematological medicine (e.g., physician professional services associated with the gross or microscopic examination of surgical pathology tissues), are not covered if they are performed by an advanced practice nurse.

(9) Professional radiology or diagnostic and therapeutic services are covered by an advanced practice nurse if the advanced practice nurse is within his or her scope of practice.

(10) If a physician and an advanced practice nurse provide the same covered

service, (e.g. any evaluation and management service), or participate in the provision of a global/all-inclusive service that involves multiple visits on the same or different days, only one provider is entitled to reimbursement for the service.

(a) Unless otherwise agreed upon by the two providers, the physician or the employing provider of the physician shall be the provider entitled to reimbursement if the condition of the patient and/or the limited scope of practice of an advanced practice nurse warrants the intervention and/or care of a physician in a capacity other than one of advisory, collaborating, or for the purpose of prescribing pharmaceuticals, medical devices, or other diagnostic and therapeutic services when the advanced practice nurse lacks the prescriptive authority required.

(b) Separate reimbursement is not available for the physician's supervision of or collaboration with an advanced practice nurse. Any cost associated with the supervisory role of a physician is the responsibility of the advanced practice nurse or advanced practice nurse group if the advanced practice nurse is in an independent practice arrangement, or the responsibility of the employing provider if the advanced practice nurse is in a provider-based practice arrangement.

(D) The following services are noncovered:

(1) Emergency room visit codes 99284 and 99285 are not covered if billed by an advanced practice nurse who is in an independent practice as defined in rule 5101:3-8-22 of the Administrative Code.

(2) All services exceeding the policies and limitations defined in Chapters 5101:3-1, 5101:3-4 and 5101:3-14 of the Administrative Code and rules 5101:3-8-20 to and 5101:3-8-25 of the Administrative Code;

(3) All services exceeding the scope of practice of an advanced practice nurse under, and in accordance with, Ohio law;

(4) Any service exceeding the scope of practice of an advanced practice nurse as defined in the standard care arrangement;

(5) Services determined by the department as not medically necessary as defined in rule 5101:3-1-01 of the Administrative Code or that are duplicative in respect to a service provided concurrently by a physician or other valid medicaid provider;

(6) Assistant-at-surgery services;

(7) Services of residents, interns, and fellows provided in a teaching setting supervised by an advanced practice nurse; and

(8) All services itemized as noncovered in rule 5101:3-4-28 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Rule Amplifies:	5162.03, 5164.02, 4723.41 to 4723.50
Prior Effective Dates:	09/24/1983, 03/01/1994 (Emer), 05/12/1994, 05/01/1997, 06/01/2002, 01/01/2008

TO BE RESCINDED

5160-8-24 **Eligible providers of certified registered nurse anesthetist (CRNA) services.**

(A) Any certified registered nurse anesthetist (CRNA) who holds a current, valid certificate of authority issued under, and in accordance with, Ohio law entitling the holder to practice as a nurse anesthetist is eligible to participate in Ohio's medicaid program and provide covered CRNA services upon the execution of the Ohio medicaid provider agreement.

(B) A CRNA group practice must meet the criteria as a professional group practice as defined in paragraph (C) of rule 5101:3-1-17 of the Administrative Code and is organized for the purpose of providing CRNA services.

(C) A CRNA who is licensed or holds a current certificate, or similar document under another state's law entitling the holder to practice as a nurse anesthetist, is eligible to participate in Ohio's medicaid program and provide covered CRNA services as long as the following are met:

(1) The services are rendered to eligible Ohio recipients in the state in which the CRNA is authorized to practice;

(2) The provider of CRNA services has a currently valid provider agreement with the department; and

(3) The provisions in rule 5101:3-1-11 of the Administrative Code addressing out-of-state coverage are met.

(D) A CRNA that meets the criteria set forth in paragraphs (A) to (C)(2) of this rule is entitled to receive an Ohio medicaid legacy number. CRNA services may be billed if the following conditions are met:

(1) The provisions of paragraph (B) or (C) of rule 5101:3-8-25 of the Administrative Code are met; and

(2) The provisions outlined in rule 5101:3-1-17 of the Administrative Code are met.

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TO BE RESCINDED

5160-8-25 **Coverage, limitations, and reimbursement of anesthesia services provided by certified registered nurse anesthesists (CRNAs).**

(A) The department will reimburse a CRNA for general, regional or supplementation of local anesthesia services (monitored anesthesia care as described in paragraph (I) of rule 5101:3-4-21 of the Administrative Code) provided during a surgical or diagnostic procedure. Anesthesia services include the basic preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluid and/or blood products incident to the anesthesia or surgery, and the usual monitoring procedures. Anesthesia services include ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry as usual monitoring procedures. Unusual monitoring procedures (e.g., intra-arterial, central venous, and swan-ganz) are not included and may be separately billed and reimbursed as long as the performance of these services are not limited by Ohio law.

(B) A CRNA is considered to be self-employed if the CRNA is in a solo practice and the practice is free of the fiscal, administrative, and professional control of a CRNA group practice, an individual physician practice, a physician group practice, a hospital, a fee-for-service clinic, a cost-based clinic, or any other medicaid provider type.

(C) An independent CRNA group practice is a practice composed solely of two or more CRNAs enrolled under the medicaid program and the practice is free of the fiscal, administrative, and professional control of an individual physician practice, a physician group practice, a hospital, a fee-for-service clinic, a cost-based clinic, or any other medicaid provider.

(D) Reimbursement for anesthesia services provided by a CRNA may be made directly to a CRNA provider type only if the services were provided by a self-employed CRNA or by a CRNA employed by an independent CRNA group practice.

(E) A CRNA's provider number may be listed on a medicaid invoice under the following circumstances only:

(1) When a claim is being submitted for anesthesia services provided by a CRNA who either is self-employed or a member of an independent CRNA group practice;

(2) When a crossover ("F-type") claim is being submitted, in accordance with paragraph (G)(2) of this rule, for medicare co-insurance and deductible payments;

(3) When a claim is being submitted, in accordance with paragraph (H)(2) of this rule, for anesthesia services that were provided by a non-medically directed physician-employed CRNA; or

(4) When a claim is being submitted in accordance with paragraph (H)(1) of this rule, for anesthesia services that were provided by a medically-directed or medically-supervised physician-employed CRNA.

(F) A CRNA is considered to be:

(1) "Medically directed" if anesthesia services are provided with a physician who meets all of the conditions set forth in paragraph (C) of rule 5101:3-4-21 of the Administrative Code;

(2) "Nonmedically directed" if anesthesia services are provided without a physician who meets all of the conditions set forth in paragraph (C) of rule 5101:3-4-21 of the Administrative Code; and

(3) "Medically supervised" if anesthesia services are provided with a physician who meets all of the conditions set forth in paragraph (C)(4) of rule 5101:3-4-21 of the Administrative Code.

(G) Separate reimbursement will be made for the medicare coinsurance and deductible amounts due for medicare covered CRNA services provided to a patient who is dually eligible for medicare and medicaid, even if direct reimbursement would not be allowable if the anesthesia services are provided to a patient covered only under the medicaid program (e.g, hospital-employed CRNA services, physician-employed CRNA services, etc.).

(1) The co-insurance and deductible payments should normally be made through the automatic crossover mechanism.

(2) If the claims did not get paid through the automatic crossover mechanism, the provider must submit a medicaid crossover "F-type 6780" claim, in accordance with the crossover billing instructions except that the CRNA's provider number must be submitted as the rendering provider and the employing provider number must be submitted as the pay to provider.

(H) The following CRNA reimbursement policies apply when services are provided to medicaid patients who are not also covered under medicare.

(1) Reimbursement of anesthesia services provided by a medically directed or medically supervised physician-employed CRNA.

When anesthesia services are provided by a CRNA who is under the employment of an individual or group physician practice and medical direction was provided by a physician in the practice, reimbursement for the services of the CRNA and the directing physician is paid to the employing physician or physician group practice as described in paragraph (H)(3)(b)(ii) of rule 5101:3-4-21 of the Administrative Code. For reimbursement, the physician who provided the medical direction would be listed as the rendering provider and the appropriate modifier indicating medical direction listed in paragraph (D)(1) of rule 5101:3-4-21 of the Administrative Code must be billed.

(2) Reimbursement of anesthesia services provided by a non-medically directed and non-medically supervised physician-employed CRNA.

(a) When anesthesia services are provided by a CRNA who is under the employment of an individual or group physician practice and medical direction was not provided by a physician in the practice, reimbursement for the services of the CRNA is reimbursable only to the employing physician or physician group practice.

(b) For reimbursement:

(i) The provider number of the employing individual physician practice or the employing physician group practice must be listed in the group practice space on the invoice;

(ii) The provider number of the CRNA must be listed in the rendering provider space on the invoice; and

(iii) The appropriate anesthesia code must be modified with the QZ modifier.

(3) Reimbursement of anesthesia services provided by hospital-employed CRNAs.

Direct reimbursement is not available for anesthesia services provided by a hospital employed CRNA. The reimbursement for the services provided by

the CRNA is bundled into the facility payment made to the hospital. When a physician provides medical direction to a CRNA who is employed by the hospital, only the physician who provided the medical direction to the CRNA is entitled to reimbursement on a fee-for-service basis.

(4) Reimbursement of anesthesia services provided by self-employed CRNAs or CRNAs who are members of an independent CRNA group practice.

(a) Direct reimbursement for anesthesia services provided by a self-employed CRNA or a CRNA who is a member of an independent CRNA group practice is available whether or not the CRNA is medically directed by a physician.

(b) When a physician provides medical direction or medical supervision to a CRNA who is self-employed or a member of an independent CRNA group practice, reimbursement for the medical direction of the CRNA is also available to the physician and must be billed in accordance with rule 5101:3-4-21 of the Administrative Code.

(c) Reimbursement is not available for supervision services provided by a physician when the physician does not meet the conditions set forth in paragraph (C) of rule 5101:3-4-21 of the Administrative Code.

(d) The CRNA or CRNA group practice must bill the code for the appropriate anesthesia code modified by either the QX or QZ modifier and report the total anesthesia time in minutes.

(i) If the CRNA was medically directed or medically supervised, the procedure code must be modified with the QX modifier.

(ii) If the CRNA was not medically directed, the procedure code must be modified with the QZ modifier.

(e) The policies contained in paragraphs (B), (D)(3), (E), (F) and (G) of rule 5101:3-4-21 of the Administrative Code also apply when anesthesia services are provided and billed by CRNAs.

(I) When a CRNA provides supervision and personal direction to a student nurse anesthetist involved in the provision of anesthesia services, reimbursement for the services of the CRNA is available in accordance with paragraph (G) of this rule. Reimbursement for the services of the student nurse anesthetist is bundled into the reimbursement made to the facility or hospital.

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Prior Effective Dates:	03/30/1995, 05/01/2001, 09/01/2005

TO BE RESCINDED

5160-8-27 **Advanced practice nurses: : modifiers.**

Effective for services provided on and after October 1, 2003, when billing for any service provided by an advanced practice nurse (APN), whether the APN is in independent practice or a provider-based practice as described in rule 5101:3-8-22 of the Administrative Code, all services provided by an APN must be billed with a modifier to denote the type of APN which provided the service:

(A) Bill the modifier "SA" e.g. 99201SA, if the APN is a nurse practitioner;

(B) Bill the modifier "SB" e.g. 99201SB, if the APN is a nurse mid-wife; or

(C) Bill the modifier "UC" e.g. 99201UC if the APN is a clinical nurse specialist.

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5160-4-04 Advanced practice registered nurse (APRN) services.

(A) Definition. "Advanced practice registered nurse (APRN)" has the same meaning as in Chapter 4723-08 of the Administrative Code. The term encompasses a certified registered nurse anesthetist (CRNA), clinical nurse specialist (CNS), certified nurse-midwife (CNM), and certified nurse practitioner (CNP).

(B) Coverage.

(1) Unless a specific exception is noted, all other rules in agency 5160 of the Administrative Code that pertain to services performed by a physician apply also to APRNs.

(2) Payment for an APRN service may be made only if the service is within the scope of practice of the particular APRN who provided it.

(3) If a physician and an APRN provide the same covered service to the same patient and if the condition of the patient warrants the direct involvement of a physician, then unless the two providers agree otherwise, payment will be made to the physician or the employing provider of the physician in preference to the APRN.

(4) No payment will be made for either of the following services:

(a) A service provided by an APRN employed by or under contract with a hospital if the service is routinely performed by registered nurses or other hospital-employed nonphysicians; or

(b) Supervision of or collaboration with an APRN by a physician.

(C) Claim payment.

(1) Payment for a service rendered by a CRNA is made in accordance with rule 5160-4-21 of the Administrative Code.

(2) Payment for a service rendered by a CNS, CNM, or CNP is the lesser of the billing provider's submitted charge or the applicable amount from the following list:

(a) For a service provided in a hospital setting (inpatient hospital, outpatient hospital, or hospital emergency department), eighty-five per cent of the medicaid maximum; or

(b) For a service provided in a non-hospital setting, one hundred per cent of the medicaid maximum.

Replaces: 5160-8-22, 5160-8-23
Promulgated Under: 119.03
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Rule Amplifies: 5162.03, 5164.02, 5164.70
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5160-4-04 **Advanced practice registered nurse (APRN) services.**

(A) Definition. "Advanced practice registered nurse (APRN)" has the same meaning as in Chapter 4723-08 of the Administrative Code. The term encompasses a certified registered nurse anesthetist (CRNA), clinical nurse specialist (CNS), certified nurse-midwife (CNM), and certified nurse practitioner (CNP).

(B) Coverage.

(1) Unless a specific exception is noted, all other rules in agency 5160 of the Administrative Code that pertain to services rendered by a physician apply also to services rendered by an APRN.

(2) Payment may be made for a covered service rendered by an APRN only if the following conditions are met:

(a) The APRN is currently enrolled as an Ohio medicaid provider;

(b) The service is rendered to a medicaid-eligible Ohio recipient in a state in which the APRN is licensed or authorized to practice;

(c) The service is within the scope of practice of the APRN's specialty;

(d) The APRN personally rendered the service to an individual patient; and

(e) The service cannot be performed by someone who lacks the skills and training of an APRN.

(3) An APRN employed by or under contract with a physician, group practice, hospital, long-term care facility, or other medicaid provider must not submit a claim for service that would result in duplicate payment.

(C) Claim payment.

(1) Payment for a service rendered by a CRNA is made in accordance with rule 5160-4-21 of the Administrative Code.

(2) Payment for a service rendered by a CNS, CNM, or CNP is the lesser of the billing provider's submitted charge or the applicable amount from the following list:

(a) For a service rendered in a hospital setting (inpatient hospital, outpatient hospital, or hospital emergency department), eighty-five per cent of the medicaid maximum; or

(b) For a service rendered in a non-hospital setting, one hundred per cent of the medicaid maximum.

(3) Payment for services rendered by a hospital-employed APRN will be made to the hospital.

Replaces: 5160-8-22, 5160-8-23

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