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OIG Issues Favorable Advisory Opinion for Hospital's Provision of Nurse Practitioner Services

Authors: Sanford V. Teplitzky, Joseph B. Keillor
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In one of the final advisory opinions of 2022, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) took a broad view that a hospital's provisions of care by nurse practitioners to patients of participating physicians in inpatient or observation status would constitute remuneration under the Federal Anti-Kickback Statute (AKS). The OIG ultimately concluded, however, that the nature and scope of the specific and limited arrangement submitted by the requestor would not lead to the imposition of sanctions.

In Adv. Op. No. 22-20, published on December 19, 2022, the requestor described a program involving general care medical units under which the hospital would provide employed nurse practitioners to patients of participating physicians to perform a wide variety of patient care and related functions in between daily physician rounding. Such care would be performed in collaboration with the treating physician and would not be billed by the hospital. Further, participating physicians would be required to "conduct their own patient assessments and generate their own documentation" to bill payors, and conversely would be prohibited from relying on the nurse practitioners' services or documentation to bill for any services.

The OIG first concluded that the arrangement does implicate the AKS "because Requestor is providing remuneration in the form of NP services to Participating Physicians that could induce such physicians to make referrals to Requestor for items and services reimbursable by a federal health care program." The OIG said the "remuneration," while not direct payment, could "potentially relieve the Participating Physician of a range of tasks and services for which they otherwise would have to expend their time and resources." This is, indeed, an incredibly broad statement – providing a "break room" in the hospital would relieve physicians in need of a cup of coffee from getting in their cars and driving to a local coffee shop.

Fortunately, the OIG limited the scope of this statement and concluded that the arrangement was not problematic, citing factors such as the reasonable expectation that the arrangement would improve patient care; the lack of billing for the nurse practitioner services; safeguards such as the required daily rounding and the prohibition against physician reliance on nurse practitioner patient assessments or documentation in submitting billings; the arrangement being uniformly offered to physicians without regard to the volume or value of a physician's referrals; and the arrangement being limited to general care medical units.

On the one hand, the decision to "approve" the proposed arrangement is reassuring and appears to be reasonable considering the noted facts and safeguards. However, several aspects of this Advisory Opinion are concerning and signal that hospitals should be cautious in implementing programs through which hospital-employed nurse practitioners relieve treating physicians of burdens historically borne by the treating physicians.

First, the OIG seemed to conceptualize remuneration very broadly, apparently extending the concept to the relief of burdens historically borne by the treating physicians even without explicit Medicare program guidance that such efforts were part of the applicable CPT code billed by the treating physician.

Second, while it is not fully clear that the OIG would have reached a different result had the hospital billed for certain services of the nurse practitioners, the OIG specifically noted that the hospital perceived the need not to bill for the patient care services actually provided by the NPs. In our experience, hospitals commonly bill for certain hospitalist services not only for unassigned patients, but also where a hospitalist supplements the services of the treating physician and the supplemental services are separately billable; recognizing that safeguards are appropriate to avoid duplicative billings, it is unclear why the services of the nurse practitioners should uniformly remain unbilled.

Finally, raising some concern and ambiguity, the OIG indicated that "we might reach a different conclusion if, for instance, the arrangement was offered on surgical or specialty units where specialist physicians typically make more lucrative referrals." Recognizing the enhanced potential for abuse in such settings, one would still expect—to the extent the arrangement truly constituted remuneration to the physicians at all—that the types of safeguards implemented by the requesting hospital, together with the potential significant patient benefits, would ultimately lead to a conclusion that such an arrangement is appropriate, regardless of the particular setting and/or the specialty of the participating physicians. In other words, "the statute is the statute and the analysis is the analysis."

Given the issues raised by this favorable advisory opinion, providers should approach the structuring of these arrangements carefully and with the assistance of experienced health care compliance counsel. To the extent that a hospital implements a program under which hospital-employed practitioners relieve treating physicians of burdens historically borne by the treating physicians, hospitals should thoroughly document the exact scope of the arrangement and the anticipated patient care benefits, i.e., the "why" underlying the arrangement. Moreover, hospitals may wish to consider structuring the arrangement under the relatively new care coordination safe harbor.

If you have questions about this alert, please contact Sandford V. Teplitzky, Joseph Keillor, or a member of Baker Donelson's Health Law Group.