Advanced Practice Providers in the Intensive Care Unit

Thomas Farley MS, NP
Assistant Clinical Professor
UCSF School of Nursing

Outline

• Why utilize APPs in the ICU
• Recent publications
• General review of NP practice requirements
• Our NP experience at UCSF and SFGH
• General review of billing for APP critical care services

Why utilize APPs in the ICU?

• Imbalance in the supply of and the demand for intensivists
• Team based approach to care delivery
• It is taking place in the USA, Canada, and the UK already
• The literature shows it is safe, effective, and more human than a robot

### Recently published

- Columbia Presbyterian Medical Center
- Retrospective review of two ICUs
- Patients managed by NP/PA team had no worse outcomes

### NPs in Critical Care or Trauma

- Memorial Sloan Kettering Cancer Center
- Columbia University
- Henry Ford Hospital Detroit
- Cleveland Clinic
- UC Davis
- California Pacific Medical Center
- UCSF/SFGH Medical Centers
- Oregon Health Sciences University

---

### Nurse Practitioners

- RN with Masters or Doctoral degree
- National certification exam required
- CA mandates use of standardized procedures
- Independent licensure
- Eligible for DEA schedule 2-5 prescribing
- NPI for medicare/private billing

### NP Species

- Focus of education and national certification
- Acute Care: generally inpatient care
- Adult and Family: primary care
- Current recommendation by National Council of State Boards of Nursing is to restrict intensive care roles to acute care nurse practitioners
Our experience at UCSF

Evolution of Critical Care Nurse Practitioner Role Within a US Academic Medical Center

Evolution of a NP practice
- At UCSF 76 adult critical care beds
- Limited amount of housestaff
- Goal of providing immediate critical care consultation 24 hours a day
- 4 NPs added in 2005
- Currently 15 NPs covering 4 ICUs
- At times no residents on team

Evolution of a NP practice
- At SFGH level 1 trauma center
- Recognized need for quality control and improvement
- Added 4 NPs to service in 2001
- Current environment of limited housestaff and work hour reductions
- Now 12 NPs in trauma/general surgery
- At times no interns on teams

Experience at UCSF and SFGH
- Employed by hospital not by MD group
- Medicare part A not part B
- No independent billing performed
- Close contact with the UCSF SON
NP responsibilities

- Follow and teach standard ICU practices and protocols
- Quality standards and improvement
- Intervene and direct or provide appropriate initial therapy
- First call at UCSF and SFGH
- Overnight shifts at UCSF and SFGH
<table>
<thead>
<tr>
<th>Critical Care NP Duties</th>
<th>Critical Care NP Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>- History taking and physical exams</td>
<td>- Consultative role to admitting services</td>
</tr>
<tr>
<td>- Entering admission histories and physical in to the EMR</td>
<td>- Consultative role to bedside RNs</td>
</tr>
<tr>
<td>- Entering daily progress notes into the EMR</td>
<td>- Guidance of house staff</td>
</tr>
<tr>
<td>- Writing admission orders and routine orders</td>
<td>- Responding to code blue activations</td>
</tr>
<tr>
<td>- Independently performing procedures</td>
<td>- Assisting with rapid response consultations</td>
</tr>
<tr>
<td>- Rounding with the critical care team and presenting patients</td>
<td>- Serving on hospital wide multidisciplinary committees</td>
</tr>
<tr>
<td>- Implementing proven care bundles (sepsis, early mobilization, DVT prophylaxis)</td>
<td>- Precepting acute care nurse practitioner students</td>
</tr>
<tr>
<td></td>
<td>- Attending morning teaching and monthly morbidity and mortality conferences</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NP Procedures</th>
<th>Why it works</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Central venous catheter insertion</td>
<td>- It is essential to have appropriate conduits for collaboration and supervision</td>
</tr>
<tr>
<td>- PICC insertion</td>
<td>- Supportive attending MDs</td>
</tr>
<tr>
<td>- Arterial catheter insertion</td>
<td>- Buy-in from the ICU RNs</td>
</tr>
<tr>
<td>- Chest tube insertion</td>
<td>- NPs have experience as ICU RNs</td>
</tr>
<tr>
<td>- Lumbar puncture</td>
<td>- SON provides excellent job candidates</td>
</tr>
<tr>
<td>- Suture and drain removal</td>
<td>- Dedicated and professional group of NPs</td>
</tr>
<tr>
<td>- Airway intubation</td>
<td></td>
</tr>
<tr>
<td>- RN First Assist for OR role</td>
<td></td>
</tr>
</tbody>
</table>
NPP Billing in Critical Care

- Reference CMS transmittal #1548
- Services may be provided by qualified NPPs and reported for payment
- Unlike outpatients no 'incident to' or 'shared' visits allowed

Billing in surgical critical care

- Trauma and burn patients are unique
- Medicare allows separate payment to surgeon for post op critical care during global period

Billing in Critical Care

- Only one provider per day can bill for CPT 99291 critical care eval and mgt 30-74min
- Follow-up after first 74min of services billable by MD or NPP using CPT 99292 each additional 30min of critical care
- That time must be spent at the bedside or elsewhere on the floor as long as the provider is immediately available

Billing in Critical Care

- May be continuous clock time or intermittent time increments and aggregated
- Only one provider can bill for critical care services within an actual time period even if more than one provider involved
- More than one provider can provide critical care at another time and be paid
NP Billing in Critical Care

- For Medicare NP billing as hospital employees (part A) not allowed
- To bill Medicare NPs must be employed by clinical departments or groups
- For Medicare, reimbursement is 85% of published MD fee schedule
- NPs may be credentialed by private payor
- Private payors may reimburse up to 100%