

Pre-Publication Draft

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HIGHEST AND BEST USE REVISITED

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Highest and Best Use Revisited

“How many times do I have to tell you, the right tool for the right job!”

- Enterprise Chief Engineer, Montgomery “Scotty” Scott

.1 Introduction

Health care business models are shifting. The Baby Boomers are aging, and represent a massive demographic bloc poised to exert unprecedented pressure on a health care system already strained. In the wake of these forces, the traditional approaches to the practice of medicine are changing. New payment models are emerging, alongside new approaches to health care delivery. Moreover, with the passage of the Patient Protection and Affordable Care Act of 2010 (PPACA), it is anticipated that the patient pool will drastically expand. Estimates indicate that another 12 million individuals will have become patients by 2014 alone.¹

At the same time, the physician population is not growing at a rate capable of meeting this increased demand, as Baby-Boomer-generation physicians retire and new physicians fail to enter practice in sufficient numbers to replace them, particularly in primary care. Between 1996 and 2008, the physician population grew approximately 29%; but primary care growth was less than 4%.² Such changes in the health care landscape tax the traditional physician-driven, fee-for-service system and encourage the adoption of innovative business models or changes to existing practices.

One way for physicians to meet the challenges of the future is to rely more heavily on non-physician practitioners (NPPs). In comparison to the anemic growth in the physician sector, the number of NPPs is increasing at a rapid pace, and is projected to continue in the foreseeable future. For example, between 2000 and 2010, the population of physician assistants (PAs) grew by 106%; between 2008 and 2025, the nurse practitioner (NP) population is expected to have grown by 94%.³ Shifting to business models that make substantial use of NPPs can help reduce the burden on physicians and save their efforts for their highest and best use, while deploying NPPs in theirs. Such an approach can also improve quality of care, as well as allow physicians to better engage with the patients who need them most.

It has been over a decade since the Health Law Handbook addressed these issues.⁴ In light of the new "facts on the ground," as well as changing regulatory guidance, this chapter will explore the role of NPPs in the new care delivery and payment environments. The purpose is to provide updated guidance on the different types of NPPs and the contexts in which they are used,

¹ Health Research Institute, Health Insurance Exchanges: Long on Options, Short on Time, Price Waterhouse Cooper, October, 2012, p. 1

² “Nearly half of office-based physicians work with NPs and PAs,” Amednews.com, Sept. 12, 2011. Located at <http://www.ama-assn.org/amednews/2011/09/12/bisb012.htm>.

³ “Sharp increase expected in the number of nurse practitioners,” Amednews.com, July 2, 2012. Located at <http://www.ama-assn.org/amednews/2012/07/02/bisb0702.htm>.

⁴ Downey, Morgan, “Medicare Reimbursement of Nonphysician Health Care Practitioners,” Health Law Handbook, Gosfield, Alice G., ed., West Group Publishing, 1991, pp. 357-371; Gosfield, Alice G., “Highest and Best Use: Nonphysician Practitioners and Physicians Under Medicare,” Health Law Handbook, Gosfield, Alice G., ed., West Group Publishing, 1999, pp.89-133.

with a particular (but not exclusive) focus on Medicare-related rules and policies, including enrollment. This chapter will further examine the potential impact of NPPs on physician practices under current payment and delivery models, as well as how they may be used in newer models.

2 The Lay of the Land

Before discussing how they are used, it is necessary to define who we are talking about when speaking of "NPPs." In a broad sense, the terms "non-physician practitioners" or "NPPs" are self-evident: a non-physician practitioner is any type of health care practitioner other than an allopathic or osteopathic physician. It should be acknowledged that some practitioner societies disapprove of the term "non-physician practitioner," claiming that it presumes the superiority of physicians – and therefore the inferiority of the practitioner who is not a physician. However, such categorization derives from long-standing concepts in health care professional licensure.

Physicians typically hold a plenary license under state law. Other health care practitioners typically have a more restricted scope of practice, and may only perform some of the duties a physician may perform. For this reason, physician scope of practice is the standard against which other health care professions are judged, and the term "non-physician practitioner" is the most accurate to describe the vast swath of other health care professions (when not referring to them by their specific professional title). Legally speaking, everything a non-physician practitioner may do, a physician may also do, but the obverse is not the case.⁵ For this reason, this chapter shall use the term "non-physician practitioner" or "NPP" broadly to describe a range of different clinicians with scopes of practice more restricted than that of physicians.

Much of this chapter will also focus on how this term is used in the Medicare context, given the continuing importance of Medicare as a payor.⁶ Interestingly, Medicare defines the term "physician services" for payment purposes to include services performed not only by both MDs and DOs, but also chiropractors, dentists, and podiatrists.⁷ Non-physician practitioners under Medicare include: physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs). The term also applies to physical therapists (PTs), occupational therapists (OTs), speech language therapists (SLTs), audiologists, certified social workers (CSWs), clinical psychologists (CPs), certified nurse midwives (CNMs), certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs). Of these categories, PAs, NPs, and CNSs are

⁵ However, physicians may not always be permitted to hold themselves out as performing the same services. Pennsylvania's Physical Therapy Practice Act prohibits anyone not licensed to practice physical therapy from holding themselves out as capable of doing so. 63 P.S. § 1304(a). Other licensed professionals may practice within their own scope of practice, but may not advertise that they provide physical therapy services unless they are licensed as physical therapists. 63 P.S. § 1304(b.1). See also, Commonwealth Bureau of Professional and Occupational Affairs v. State Board of Physical Therapy, et al., 728 A.2d 340 (Pa. 1999).

⁶ Medicare alone accounted for 3.7% of the GDP in 2011, and is expected to rise to 5.7% by 2035. Social Security and Medicare Boards of Trustees, "A Summary of the 2012 Annual Reports," <http://www.ssa.gov/oact/trsum/index.html>.

⁷ 42 CFR § 410.20(b). Note that definitions of "physician" and "physician services" can vary, depending on the nature of the Medicare policy. For example, the Medicare opt-out rules define "physician" more broadly to include podiatrists, optometrists and dentists, but do not include chiropractors. See, Medicare Benefit Policy Manual, chapter 15, Section 40.4. On the other hand, all are physicians for Stark purposes. 42 CFR § 411.351.

generally treated as equivalent to physicians for coverage purposes, assuming state licensure laws permit the performance of the service in question. The other NPP types listed above are not treated as equivalent to physicians, generally, but are all permitted to bill in their own name.

Outside of who the Medicare system recognizes, however, there exists an even broader range of NPPs. These include athletic trainers, surgical assistants, medical assistants, respiratory therapists, and a range of technologists. Many, but not all, of these categories are subject to state licensure laws. Practitioners who have no such state license may be certified by national certification bodies for their profession. However, neither state licensure nor national certification, necessarily translates into recognition by Medicare of independent billing status.

With regards to the context in which they work, in general, NPPs chiefly work in primary care. According to the Centers for Disease Control, approximately 49% of physicians across all specialties practice with an NPP. However, 55.4% of all primary care physicians use NPPs, as compared to only 45.9% of surgical specialists, and 40.8% of medical specialists.⁸

..2.1 NPP Types in Detail – Physician Assistants

Under most state laws, physician assistants are generally college-educated professionals, having gone to school specifically for physician assistant training. Their scope of licensure typically involves supervised practice, but with responsibilities similar to those of physicians, such as minor surgeries and venipuncture. Physician assistants are typically required by state law to operate under physician supervision (although not with the physician in the room with them), and are frequently granted limited prescriptive authority. The PA profession grew out of military medics, and were primarily procedurally focused. The training and experience received by PAs in the military setting eventually led to their entering into primary care practice in civilian life.⁹ Today, PAs practice in a variety of settings. Approximately 36% of PAs practice in primary care, with roughly 26% of PAs practicing in family medicine as a specialty, followed by general surgery and surgical subspecialties, emergency medicine, other internal medicine subspecialties, general internal medicine, and dermatology. As of 2010, the Bureau of Labor Statistics found that approximately 54% of PAs work in a solo or group practice in an ambulatory setting, with 24% employed by hospitals, 9% employed by outpatient care centers, 4% employed by the government, and the remainder practicing in colleges, universities, etc.¹⁰

For Medicare enrollment purposes, the PA must have graduated from an accredited PA education program and be certified by national exam, as well as maintain a valid state license for all states in which they practice and treat Medicare patients.¹¹ Under Medicare, covered PA services are the same as those services provided by a physician¹², provided that the PA meets Medicare's qualifications, the services are provided under the general supervision of a physician,

⁸ Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants in Physician Offices, National Center for Health Statistics, Centers for Disease Control and Prevention, www.cdc.gov/nchs/data/databriefs/db69.pdf.

⁹ See, <http://www.nlm.nih.gov/medlineplus/ency/article/001935.htm>.

¹⁰ See, <http://www.bls.gov/ooh/healthcare/physician-assistants.htm#tab-3>.

¹¹ See generally, 42 CFR § 410.74.

¹² Meaning an allopathic or osteopathic physician in this case, not the more expansive Medicare definition.

and are within the PA's scope of practice under state law. The regulations define this to mean that "the supervising physician need not be physically present when the physician assistant is performing the services unless required by State law; however, the supervising physician must be immediately available to the physician assistant for consultation."¹³ These services may include physical exams, minor surgeries, setting casts for simple fractures, and reading x-rays.¹⁴

Physician assistants are permitted to bill in their own name and are typically paid at 85% of the physician fee schedule rate for the service. When functioning as an assistant-at-surgery, they are paid at 75% of the physician rate. Physician assistants are also permitted to bill in their own names for services performed by individuals that the PA supervises, provided they meet the "incident-to" guidelines.¹⁵

One quirk of Medicare's rules regarding PAs is that, while they may enroll using the CMS-855I application and may obtain individual billing privileges, Medicare will only pay their W-2 employer for their services. The employer must be a physician or physician group. Moreover, PAs do not reassign their right to payment to the employer; it is assumed that only the employer itself will bill for the PA's services. The implication of this is that PAs cannot practice independently as 1099 independent contractors and bill under Medicare, even if they would otherwise be permitted to bill alone under state law. This necessarily affects the available practice models for PAs with respect to Medicare.¹⁶

2.2 Nurse Practitioners

Under state law, nurse practitioners are generally registered professional nurses licensed under state law to function at a higher level than that of a licensed professional nurse or a registered nurse. They typically have a masters degree or doctorate in nursing, and are required by state licensure to work in collaboration (usually evidenced by a collaboration agreement) with a licensed physician. The scope of their duties is usually broader than that of PAs, allowing them a measure of independence in their practice. Like PAs, they often are granted prescriptive authority.

According to a member survey conducted by the American Academy of Nurse Practitioners between 2009 and 2010, NPs practice in a variety of settings, including private MD/DO practices (27.9%), hospital outpatient clinics (12.1%), inpatient hospital settings (5.9%), community health centers (5.8%), and retail clinics (2.0%), as well as other settings.¹⁷

¹³ 42 CFR § 410.74(a)(2)(iv)

¹⁴ Medicare Benefit Policy Manual, Chapter 15, Section 190(B)(3). The "incident-to" guidelines are discussed in more detail in section 2.7 of this chapter.

¹⁵ Medicare Benefit Policy Manual, Chapter 15, section 190(B)(2).

¹⁶ Medicare Benefit Policy Manual, Chapter 15, section 190.

¹⁷ For a full list of the practice settings reported, broken down by percentage of respondents, see, 2009-10 AANP National NP Sample Survey: An Overview, American Academy of Nurse Practitioners, August, 2010, http://www.aanp.org/images/documents/research/2009-10_Overview_Compensation.pdf.

To qualify for Medicare enrollment, the NP must be certified by a recognized national certifying body, and must have a masters or doctorate in nursing practice.¹⁸ As with PAs, the NP's services must meet general coverage requirements for physician services. The services must also be performed in collaboration with a physician.¹⁹ This does not necessarily require the in-person presence of the physician, however, as distinct from a PA.

State laws usually define what "collaboration" means. However, where state law does not include such a definition, Medicare defines "collaboration" to mean:

"A process in which a nurse practitioner has a relationship with one or more physicians to deliver health care services. Such collaboration is to be evidenced by nurse practitioners documenting the nurse practitioner's scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. Nurse practitioners must document this collaborative process with physicians."²⁰

For purposes of collaboration in this context, a "physician" means an allopathic or osteopathic physician.²¹

As with PAs, NPs are reimbursed at 85% of the physician fee schedule rate. They may also bill for services rendered "incident-to" their own services, if they meet the "incident-to" requirements and are performed under the direct supervision of the NP. Unlike PAs, however, NPs need not be employed by the physicians with whom they collaborate, giving them considerably more independence and permitting a broader range of business models.

2.3 Clinical Psychologists and Clinical Social Workers

Clinical psychologists (CPs) and clinical social workers are behavioral health care providers licensed to treat patients for a range of psychological maladies. Their practice usually does not include prescriptive authority (unlike a psychiatrist), but does involve measurement and testing of psychological attributes and conditions, as well as therapeutic psychological methods and consulting. Under Medicare's rules, a clinical psychologist must hold a doctoral degree in psychology and hold a state license at the independent practice level to provide diagnostic, assessment, preventive, and therapeutic services directly to individuals. The diagnostic and therapeutic services which they may provide are those which would be otherwise covered if provided by a physician, but must be within the CP's scope of practice under state law. Clinical psychologists may bill for services they render in their own name, and may also bill for services rendered "incident-to" their services, provided the services are those commonly furnished in a CP's office. Clinical psychologists are also required to consult with the patient's primary care physician.²²

¹⁸ 42 CFR § 410.75(b). For a full list of certifying bodies, see Medicare Benefit Policy Manual, Chapter 15, Section 200(A).

¹⁹ Medicare Benefit Policy Manual, Chapter 15, Section 200(B)(1).

²⁰ 42 CFR § 410.75(c)(3)(ii).

²¹ Medicare Benefit Policy Manual, Chapter 15, Section 200(D).

²² "When applying for a Medicare provider number, a CP must submit to the carrier a signed Medicare provider/supplier enrollment form that indicates an agreement to the effect that, contingent upon the patient's

Clinical social workers are behavioral health professionals, but who have a distinct practice which is separate from that of clinical psychologists. For example, Pennsylvania state law defines the practice of clinical social work as “rendering a service in which a special knowledge of social resources, human personality and capabilities and therapeutic techniques is directed at helping people to achieve adequate and productive personal, interpersonal and social adjustments in their individual lives, in their families and in their community.”²³ Under Medicare, clinical social workers must have a masters degree or a doctorate in social work. They must have provided at least two years of supervised clinical social work, and be licensed under state law.²⁴ The types of services CSWs render include services within the scope of their licensure, including the diagnosis and treatment of mental illnesses. They are permitted to bill both in their own names, and may bill the services of others provided “incident-to” their own services. Payment for CSWs is made at 75% of the Medicare Physician Fee Schedule rate.²⁵

2.4. Certified Registered Nurse Anesthetists and Anesthesiology Assistants

Certified registered nurse anesthetists function similarly to NPs, but relative to pain care and anesthesia services. For coverage under Medicare, they must be licensed by state law as registered professional nurses, and must have graduated from a nurse anesthesia educational program meeting the standards of the Council on Accreditation of Nurse Anesthesia Programs. They must also be certified by the Council on Certification of Nurse Anesthetists.²⁶

Anesthesia assistants, by contrast, work under the direct supervision of an anesthesiologist, much like PAs. To bill under Medicare for an AA’s services, the AA must be in compliance with applicable state licensure laws regarding administration of anesthesia, and must have graduated from a medical school-based AA educational program. The program must

consent, the CP will attempt to consult with the patient’s attending or primary care physician in accordance with accepted professional ethical norms, taking into consideration patient confidentiality. If the patient assents to the consultation, the CP must attempt to consult with the patient’s physician within a reasonable time after receiving the consent. If the CP’s attempts to consult directly with the physician are not successful, the CP must notify the physician within a reasonable time that he or she is furnishing services to the patient. Additionally, the CP must document, in the patient’s medical record, the date the patient consented or declined consent to consultations, the date of consultation, or, if attempts to consult did not succeed, that date and manner of notification to the physician. The only exception to the consultation requirement for CPs is in cases where the patient’s primary care or attending physician refers the patient to the CP. Also, neither a CP nor a primary care nor attending physician may bill Medicare or the patient for this required consultation.” Medicare Benefit Policy Manual, Chapter 15, Section 160(E).

²³ 63 P.S. § 1903. The full definition continues, “The term includes person and environment perspectives, systems theory and cognitive/behavioral theory, to the assessment and treatment of psychosocial disability and impairment, including mental and emotional disorders, developmental disabilities and substance abuse. The term includes the application of social work methods and theory. The term includes the practice of social work plus additional concentrated training and study as defined by the board by regulation.”

²⁴ For states which do not have a licensure or certification process for CSWs, this requirement may be satisfied by two years or 3,000 hours of post-masters supervised clinical social work under the supervision of a social worker holding a masters degree, conducted in a setting such as a hospital, skilled nursing facility, or clinic.

²⁵ Medicare Claims Processing Manual, Chapter 12, Section 150.

²⁶ 42 CFR § 410.69(b).

be accredited by the Committee on Allied Health Education and Accreditation, and must include approximately two years of specialized basic science and clinical education.²⁷ The AA must also have completed a six year program, of which two years consists of specialized academic and clinical training in anesthesia.²⁸

2.5 Physical and Occupational Therapists

Physical therapists (PTs) and occupational therapists (OTs) in private practice have identical requirements for services provided in a private practice setting. Each must possess a valid state license to engage in the private practice of physical or occupational therapy, and must be practicing within the scope of such license. Under such circumstances, the PT or OT must be practicing as: (1) an unincorporated solo practitioner, (2) a member of an unincorporated partnership or group practice, (3) a member of a professional corporation or other incorporated physical therapy group, (4) an employee of a physician group, or (5) an employee of a group that is not a professional corporation.²⁹ They may only bill for services provided in their private practice office space, or in a patient's home.³⁰

Interestingly, PTs and OTs are paid at 100% of the Medicare physician fee schedule rate for their services. Accordingly, there is less incentive to bill PTs' or OTs' services as having been rendered incident-to a physician's services; it is not as if the physician or group practice will receive more money. Instead, the reason to do so may be to more directly allocate payments to a physician as the originator of the service.

2.6 Current Medicare Rules

Traditional Medicare is a fee-for-service (FFS) system. Payment under such a system treats health care like any other "widget": each unit of health care provided is paid at an individual rate; if you perform more services, you are usually paid more money. Such a system, however, is now considered unsustainable. With a massive influx of Medicare beneficiaries anticipated as the Baby Boomers continue to retire, coupled with increases in costs for health care services, FFS models will simply place too much burden on the Medicare program. Moreover, such systems incentivize higher utilization without regard to the quality of care delivered. The FFS system, however, is unlikely to completely disappear any time soon. Accordingly, it is important to understand how the FFS impacts NPPs in physician practices, with particular attention to the concepts of "incident-to" billing, "shared visits," and the restrictions of the Stark law.

²⁷ 42 CFR § 410.69(b).

²⁸ Medicare Claims Processing Manual, Chapter 12, Section 140.1.

²⁹ 42 CFR § 410.59(c)(1)(i)-(ii); 42 CFR § 410.60(c)(1)(i)-(ii).

³⁰ 42 CFR § 410.59(c)(1)(iii); 42 CFR § 410.60(c)(1)(iii). However, a therapist's private practice office space is defined as "the location(s) where the practice is operated, in the State(s) where the therapist (and practice, if applicable) is legally authorized to furnish services, during the hours that the therapist engages in practice at that location." The space must be owned, leased, or rented by the practice, and used for the exclusive purpose of operating the practice. Patient homes also do not include SNFs, CAHs, or hospitals. *Id.*

2.7 Incident-To Billing

“Incident-to” billing generally involves a physician or qualified NPP billing for services provided by individuals under their supervision, as if the physician or NPP personally performed the service. The service must be an integral, although incidental, part of the physician’s or NPP’s services. They must be of a type commonly performed without charge or included in the physician or NPP’s bill, and must be commonly furnished in a physician’s or NPP’s office or clinic. “Incident-to” services must be furnished by a NPP or by auxiliary personnel under the physician’s supervision.

To be integral to the physician’s services, the "incident-to" service must relate to a specific physician's service. In practice, the physician/NPP may perform the initial service on a patient, and subsequent services may be performed by the auxiliary personnel. The services must be performed under direct supervision. This supervision requirement must be met at all times, even when the supervised personnel is permitted by state law to perform the service independently. This requires the physician/NPP to be present in the office suite and immediately available to provide assistance and direction while the service is performed, but not necessarily in the same room as the auxiliary personnel during performance of the service.³¹ The concept of an “office suite” is vague, but generally is considered to include a single structure under a single lease where the offices are rented. This would not include, for example, buildings separated by a walkway.³²

In a “clinic” setting (another phrase for a physician-directed group), the “incident-to” rules are similar, but have some subtle differences. First, the physician “clinic” must meet several criteria: (1) a physician must be present to perform medical services at all times that the clinic is open; (2) each patient must be under the care of a clinic physician; and (3) the non-physician services must be provided under medical supervision. In such a setting, Medicare does not require that the physician ordering the services be the one who provides supervision, as long as the other rules for “incident-to” billing are met.³³

When the requirements for "incident-to" services are met, the service is paid at 100% of the rate of the supervising practitioner. Thus, a service performed "incident-to" an M.D.'s services, even when performed by an unlicensed technician, is paid at 100% of the Medicare Physician Fee Schedule rate for the service, as long as the performance of the service is permitted under state law. On the claim form, it is as if the physician him or herself performed the service; the supervised individual is essentially invisible.

Consequently, the "incident-to" rules, when performed in an office setting, represent one of the better ways for physicians to maximize payments. By employing or contracting with a

³¹ Medicare Benefit Policy Manual, Chapter 15, Section 60.1. As an additional quirk of the “incident-to” rules, a physician’s services may be billed “incident-to” the services of another physician.

³² See, U.S. v. Palazzo, 2010 WL 1141644 (C.A.5 2010). In this case, a physician was convicted of Medicare fraud for improper billing, and appealed to the Fifth Circuit Court of Appeals. In addressing the appeal, the Court described how the physician had billed for services rendered by a PA as “incident-to” the physician’s services, even though the physician either was on a different floor of the same physical building, which was leased by a different corporate entity, or was not in the building at all. The Court stated that this would not have been sufficient to meet the “immediately available” standard.

³³ Medicare Benefit Policy Manual, Chapter 15, Section 60.3.

range of NPPs, a physician may increase the range of services which can be performed by his or her practice, all of which may be billed at the full physician rate. However, assuming these requirements can be met, the practice may be able to bill at the physician rate for substantially more services using the "incident-to" rules. It is also worth noting that "incident-to" is a Medicare concept, and may not apply under private insurance programs, or workers' compensation, motor vehicle accident, or personal injury rules. Physician practices should review billing policies of such private payors, rather than assuming that "incident-to" rules will apply.³⁴

Even if the "incident-to" rules cannot be met, however, most NPPs can still be billed under their own billing numbers, and will be paid at 85% of the Medicare Physician Fee Schedule rate (and in some instances at 75% or 100%). The use of NPPs billing in their own name may make more sense for practices which find it harder to meet the incident-to requirements, such as practices which have limited office-based services where both the NPP and the physician will be in the facility at the same time. Instead, NPPs can be used to free physicians to perform more complex procedures, while still allowing the practice to reap the vast majority of what the physician would have been paid.³⁵

2.8 Shared Visits and the Global Surgical Period

By contrast with "incident to" in the office, a similar billing concept – that of "shared visits" – applies to evaluation and management (E/M) services rendered in a hospital setting – inpatient, outpatient, or emergency department. Under the "shared visits" rule, a physician who sees a hospital inpatient, outpatient, or emergency department patient for an E/M encounter, and has face-to-face time with the patient, may "share" the visit with an NPP who also works in the physician's group.³⁶ When these requirements are met, the service may be billed as if performed by the physician (or by the NPP), and will be paid at 100% of the fee schedule rate (or 85% if billed in the NPP's name). Either the physician or the NPP may perform the bulk of the visit, with the other party merely following up on the same day. If the physician does not have a face-to-face encounter with the patient, however, the service must be billed under the NPP's number.³⁷

³⁴ State laws are relevant here, as well. For example, Pennsylvania law permits a physician to delegate any task which the performing individual is qualified and trained to perform. 63 P.S. § 422.17. Under these circumstances, a service which might not be covered under Medicare's rules might still be covered under private insurance, as long as the state delegation laws were met.

³⁵ This financial discrepancy between the physician rate and the NPP rate for services may become problematic in the future. Because many NPPs can bill under their own numbers, there is an argument to be made that there is no reason to permit them to be billed "incident-to" when, but for the physician's presence in the office suite, they would be paid at 15-25% lower rates. Towards this end, CMS might attempt to require practitioners who can bill independently to do so, rather than permit them to be billed at 100% of the physician rate merely because a physician is in the building. In **200X**, CMS attempted to close this "loophole" by publishing a transmittal which did just this. However, the transmittal was subsequently withdrawn. Still, it proves that the issue is on CMS' radar screen.

³⁶ Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.

³⁷ Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.

"Shared visits" free physicians to do more both in and out of a hospital setting, without requiring them to spend as much time rounding. Unlike the more restrictive "incident-to" rules, there is no supervision requirement for "shared visits." The physician may, therefore, be anywhere physically while the NPP is performing the "shared visit" portion. For example, the physician could be performing administrative work at an office off the hospital's campus, while the NPP is meeting with the patient. Thus, in the "shared visit" scenario, the NPP acts as a true "physician extender." Moreover, once the NPP has met with the patient, they too are free to perform other services.

Another opportunity to use NPPs arises in how Medicare addresses services provided in relation to a surgical service. Medicare uses a concept known as the "global surgical package" to reimburse such services. In general, this means that, as part of a single surgical service, Medicare also includes: (1) a pre-operative visit, usually beginning the day before the surgery is scheduled; (2) intra-operative services that are commonly furnished as part of the surgery; (3) services necessary to address any post-surgical complications; (4) post-operative visits; (5) post-surgical pain management; (6) supplies; and (7) miscellaneous services (which include local incision care, removal of sutures, insertion or removal of catheters, etc.).³⁸ Services within the global surgical period are prime examples of services which can be rendered by qualified NPPs. Because these services are not separately reimbursable and are not billed as visits, there is no reason to insist on a physician performing them, if an NPP could legally provide the service.

2.9 Medicare Enrollment Issues

Of course, for NPPs to bill Medicare at all, they must first go through the Medicare enrollment process.³⁹ This requires completion of the CMS-855I enrollment form.⁴⁰ There are, however, some quirks to this process. First, the NPP frequently must also complete the CMS-855R reassignment form, to permit the NPP to reassign benefits to an employer or a company to which the NPP is providing services as an independent contractor. In some instances, the entity to which the NPP reassigns his or her right to payment may need to update a portion of its own CMS-855B group enrollment form. For example, if the group is removing a PA, it must update such information on its CMS-855B, even though there is no requirement to list a PA on the group's enrollment form initially.⁴¹ Most changes to the NPP's enrollment information must be submitted to CMS within 90 days, or the NPP (and any group required to report changes) risks

³⁸ Medicare Claims Processing Manual, Chapter 12, Section 40.1(A). There is also a long list of services which are not included in the global surgical package, such as the initial consultation to determine the need for surgery, diagnostic tests, visits unrelated to the surgical service, etc. See, Medicare Claims Processing Manual, Chapter 12, Section 40.1(B).

³⁹ For a more in-depth examination of the enrollment process, see Shay, Daniel, "Halt! Who Goes There?: Coping with the Continuing Crackdown on Medicare Enrollment", HEALTH LAW HANDBOOK (2011 ed.) West Group; "Enrollment in Medicare: Fraternity Hazing or Keeping Out Bad Actors?", HEALTH LAW HANDBOOK (2009 Ed).

⁴⁰ For a full list of the types of NPPs who may enroll, see the most recent CMS-855I. <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf>.

⁴¹ Interestingly, *adding* a PA is not done using the CMS-855B. It is, instead, handled through the PA's individual enrollment, using the CMS-855I and CMS-855R.

revocation of billing privileges. Other NPP-specific requirements include that CPs submit a document indicating that the CP will attempt to consult with the patient's primary care physician or attending physician (with the patient's consent).⁴²

These requirements do not apply to every type of NPP. For example, Medicare does not recognize medical assistants, surgical first assistants, athletic trainers, acupuncturists, etc. as separate clinicians for enrollment purposes. However, the fact that these NPPs cannot enroll does not mean that their services cannot be billed at all; they may still be billed under the incident-to rules, provided the requirements for incident-to billing are met when they perform services. From a practical perspective, therefore, this may require physicians and physician groups to exercise more forethought when adding and removing NPPs, depending on the NPP practitioner type.

..2.10 Other Considerations

The Stark prohibition on physician self-referrals also plays into how NPPs can be used. The Stark statute prohibits a physician or an immediate family member of the physician from referring a Medicare patient, for “designated health services” to an entity with which the physician or family member has a financial relationship, unless the transaction conforms with an exception. Among those exceptions is one for the provision of “in-office ancillary services,” which can apply to services furnished by individuals directly supervised by a physician “in the group.”⁴³ This, of course, raises the question of whether the group actually meets the Stark definition of a “group.”⁴⁴ However, assuming that the group does indeed meet the definition of a “group practice” for Stark purposes, and assuming the services can qualify for the in-office ancillary services exception, physicians can benefit significantly from delegating tasks to NPPs, which may then be supervised by other physicians in the group. If the practice qualifies as a “group practice” under Stark, then the physicians may be paid productivity bonuses for services both personally performed and services performed incident-to the physician’s services, including physical therapy, infusions, visits, and more.⁴⁵

With the exception of PAs (as discussed above), Medicare does not require that physician practices employ NPPs. Instead, they may be leased as part-time independent contractors on a 1099 basis from other physician practices, hospitals, staffing companies or NPP groups. This may represent a more cost-efficient approach for a practice which does not expect to be able to use a given NPP on a full-time basis. Likewise, for practices or hospitals with a surplus of NPPs, leasing such NPPs to another practice may help to bring in additional revenue for their services and create closer alignment for other purposes. Such leases will need to meet the requirements

⁴² Medicare Claims Processing Manual, Chapter 12, Section 160(E).

⁴³ For a more in-depth discussion of the Stark in-office ancillary services exception, see Gosfield, Alice G., “The Stark Truth About Stark, Part I,” Family Practice Manager, November-December, 2003. <http://www.aafp.org/fpm/2003/1100/p27.html>.

⁴⁴ For more on meeting the definition of a “group practice” under Stark, see Gosfield, Alice G., “Is Your Group A Group? How the Stark Law Applies to You,” Physicians Practice, 2004. <http://www.physicianspractice.com/articles/your-group-group>.

⁴⁵ Note, however, that this excludes diagnostic testing, which can never be billed incident-to.

for the Federal anti-kickback safe harbor and the Stark exception for personal services,⁴⁶ but these are not insurmountable challenges. For NPPs that have their own billing numbers, however, the practice will also need to complete the CMS-855R reassignment form to ensure that the NPP's services can be billed in their own name.⁴⁷ Of course, if the practice to which the NPP is being leased does not intend to bill in the NPP's name, this is less of an issue.

Overall, the use of NPPs represents an attractive option for physician practices participating in Medicare. The current rules offer opportunities to deploy NPPs to achieve greater coverage of patients, and to address patients' issues efficiently. As the health care system changes, such priorities will continue to rise in importance.

..3 The Push Towards Enhanced Value

The health care industry recognizes that traditional FFS is unsustainable as a payment model. It incentivizes the treatment of health care as if it were “widgets” – the more the provider produces, the more the provider is paid. Such a system does not take into account the quality of the care delivered, nor the efficiency with which it is delivered. The ultimate goal is to strike a “golden mean” which incentivizes value – the efficient delivery of high quality care.

Towards this end, the health care system is developing a range of new programs and payment models, as well as health care delivery models. Some of these focus exclusively on quality, while some focus more on the efficiency of care, but all form the fabric of a larger push towards enhanced value of health care. To understand the role that NPPs may ultimately play in the future of health care, it is critical to have some familiarity with these new programs, payment models, and health care delivery models.

..3.1 Quality Reporting and Pay-for-Performance

In recent years, the improvement of quality of care has been a significant focus under Medicare, as well as in the private market.⁴⁸ Patients who receive higher quality medical care will need less of it, and will receive the care most appropriate for them. Several different approaches have arisen which emphasize quality, albeit in different ways. Some approaches merely incentivize the reporting of the performance of certain quality measures, while others actually incentivize clinical outcomes.

In the Medicare system, programs such as the Physician Quality Reporting System (PQRS) and the Inpatient Quality Reporting (IQR) program, the Electronic Prescribing program (E-Rx), and, to a lesser degree, Meaningful Use all incentivize the reporting of quality metrics. Under PQRS and the IQR system, physicians and hospitals alike face the potential for reductions in the payments they receive from Medicare, unless they report the performance (or non-

⁴⁶ 42 CFR § 1001.952(d) and 42 CFR § 411.357(d), respectively.

⁴⁷ The practice should also make certain to terminate the reassignment using the CMS-855R when the NPP ceases providing services to it and/or the lease terminates. Failure to do so can result in revocation of Medicare billing privileges.

⁴⁸ For a more in-depth discussion of Medicare's quality improvement programs, see Shay, Daniel, “PQRS and its Penumbra,” Health Law Handbook, Gosfield, Alice G., ed., 2012, pp. 87-119.

performance) of certain quality measures.⁴⁹ Similarly, the E-Rx program reduces Medicare payments to physicians who fail to effectively report the use of electronic prescribing software.⁵⁰ Meaningful Use also requires the reporting of quality-based measures (some of which overlap with both PQRS and E-Rx), although the program requires the use of electronic health records software, and pays for the adoption of such software. However, no emphasis is placed on actual outcomes; the provider simply reports the performance of the measure itself. The difference, in practice, is that between counseling a patient about the dangers of smoking, and actually showing that the patient stopped or reduced their smoking habit.

In the private sector, there have been a variety of "pay-for-performance" (or "P4P") programs throughout the years. Many of these programs incentivize outcomes, such as reductions in hospital readmissions or hemoglobin A1c in diabetic patients. The Robert Wood Johnson Foundation estimates that over 40 private-sector P4P programs currently exist.⁵¹ However, it also reports that the results of many P4P programs, particularly earlier approaches which narrowly focused on quality without regard to cost of care, saw relatively little long-term improvement in quality. Moreover, quality on its own is insufficient to ultimately providing high value health care. Patients might receive high quality care, but that care could still be expensive or delivered by overqualified personnel. Efficiency, therefore, must also be incentivized.

3.2 Incentivizing Efficiency Through Financial Risk

Traditional FFS medicine usually pays physicians at the highest rate for performing a given service. This creates a perverse set of incentives which drive physicians to try to perform services as often as possible, even if those services could be provided by NPPs with no corresponding loss of quality of care. Such an approach represents an inefficient use of both health care funding and physician time. In response, public and private efforts are underway to change how the health care system functions, so as to incentivize greater efficiency.

The concept of bundled payment, for example, attempts to correct the over-utilization problem inherent in traditional FFS.⁵² Conceptually speaking, bundled payment shares some common designs with capitation (namely that payments are limited instead of made on a per-service basis). However, a key difference between bundled payments and capitation is that true bundled payment programs group more than one type of provider (e.g., a physician practice and a hospital) into a single bundle. The intent is to limit the amount to be paid to a predetermined rate which should motivate the providers to work together to be more efficient. Payments under such a program may be based on specific diagnoses or "episodes of care," or on a specific procedure. There are both government-funded and private examples of bundled payment systems.

⁴⁹ For 2013, PQRS is actually a hybrid system involving incentive payments for proper reporting, and payment reductions for failure to report effectively. This, however, will change in 2015 when the system will become purely punitive.

⁵⁰ As with PQRS, the E-Rx system does pay incentives for reporting, but shifts to a purely punitive system by 2015.

⁵¹ Health Affairs Health Policy Brief, Pay for Performance, October 11, 2012, p. 2.

⁵² For a far more in-depth examination of bundled payments, see chapter ___ of this book. Gosfield, Alice G., "Bundled Payment: Avoiding Surprise Packages," Health Law Handbook, 2013 ed.

In the public sector, CMS has instituted the Centers for Medicare and Medicaid Innovation Bundled Payment for Care Improvement initiative, which involves several models for bundled payment, several of which place providers at varying degrees of financial risk.⁵³ In the private sector, similar models exist which incentivize delivery of quality care and efficiency. For example, under the PROMETHEUS Payment® model, budgets include only a portion of the amount expected to be paid for what the model considers “potentially avoidable complications” (PACs).⁵⁴ This incentivizes the avoidance of PACs, since the provider will only receive a portion of what would otherwise be paid for performing the same service in a traditional FFS system.

In addition, multiple new care delivery models have arisen, which emphasize efficiency, such as Accountable Care Organizations (ACOs). In general terms, an ACO is an organization of “hospitals, primary care providers, specialists, and other providers to align the incentives of these providers to improve health care quality and slow the growth of health care costs. ACOs...reach these goals by promoting more efficient use of treatments, care settings, and providers.”⁵⁵ An ACO has an administrative body that manages patient care, as well as receives and distributes payment to the entity and manages financial risk, which the ACO generally bears to a greater or lesser degree. There have been both private and public efforts to create ACOs.

For example, CMS has instituted the Medicare Shared Savings Program (MSSP), as required under PPACA, which serves as the basis for CMS' ACO programs.⁵⁶ Under the MSSP, ACOs can share in the savings produced through meeting program requirements for care; depending on which version of the program in which the ACO elects to participate, they may also share in the downside risk for failure to meet budget requirements. In the private sector, health insurers have also established shared savings programs and ACOs, with varying degrees of risk.⁵⁷ In both scenarios, physicians and physician practices may ultimately receive a portion of such savings or risk.

While much depends on the nature of the particular program and its compensation model, whether the physician practice is participating in an ACO or some form of bundled payment, and whether the program in question utilizes a downside-risk model, or merely offers participants a

⁵³ <http://innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>.

The initiative bundles payments around episodes of care. The web site for the initiative offers the following example: “Instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a ‘bundled’ payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. Providers will have flexibility to determine which episodes of care and which services would be bundled together.”

⁵⁴ For more about PROMETHEUS Payment®, see http://www.hci3.org/what_is_prometheus.

⁵⁵ American Hospital Association, 2010 Committee on Research, AHA Research Synthesis Report: Accountable Care Organizations, 2010, p. 3. Regulations have been published at 42 CFR part 425.

⁵⁶ Patient Protection and Affordable Care Act of 2010, sec. 3022.

⁵⁷ In a report published in November, 2011, the Urban Institute estimates that there were at the time of writing at least eight private ACOs which involved shared risk – offering physicians a share of any savings earned, but putting them at risk for going over-budget. Berenson, Robert A. and Rachel A. Burton, Accountable Care Organizations in Medicare and the Private Sector: A Status Update, Urban Institute, November, 2011. <http://www.urban.org/uploadedpdf/412438-Accountable-Care-Organizations-in-Medicare-and-the-Private-Sector.pdf>.

potential share of the savings generated by meeting performance requirements, participating practices must remain ruthlessly efficient in their delivery of care. Towards this end, the common theme in each of these models is that participating practices must now ensure that they make the best use of their providers' time, rather than focus on which provider will be paid the most money for performing the service.

3.3 Other Approaches

In addition to purely quality-oriented systems and efficiency-oriented systems, some programs have arisen to address value itself – the marriage of quality performance and efficient delivery of care. One public sector program focusing on such efforts is the Medicare Physician Value Based Purchasing (VBP) program, the creation of which was mandated by PPACA, and which is set to “go live” by 2015.⁵⁸ Its primary focus is on enhancing quality and efficiency in the delivery of care within the Medicare system. In broad strokes, the VBP program measures providers against a baseline of quality of care⁵⁹, with providers who exceed the baseline receiving bonuses, and providers who fall below the baseline having payments reduced. In addition to quality metrics, the VBP will eventually measure efficiency as well. Under such a system, providers have an incentive not only to deliver high quality care, but also to make efficient use of their time.

Another approach which attempts to implement high quality medical care with better efficiency is the concept of the Patient-Centered Medical Home (PCMH). Under PCMH, a patient's care is managed by a primary care physician, who is supervising a team of NPPs, all with a goal of providing coordinated care for the patient, with an eye towards preventive care in particular and keeping patients out of the hospital.⁶⁰ The care teams can include a broad range of NPPs, such as NPs and PAs, but also CSWs, psychologists, audiologists, pharmacists, and more. The team can also be “virtual,” meaning that not every NPP involved in the team need be an employee of the physician practice; instead, the physician practice may develop contractual relationships with independent groups of NPPs, or may lease the services of NPPs from other physician practices where they are employed.

This approach also need not be limited to primary care practices. Cardiology and oncology both represent physician specialties where a patient's care may revolve around a particular diagnosis (usually a chronic condition) which also has implications for a wider, related range of health issues, all of which can be managed by the patient's physician. Although the

⁵⁸ For a more in-depth examination of the VBP Program, see Shay, Daniel, “PQRS and its Penumbra,” Health Law Handbook, 2012 ed., pp. 87-119. See also, 77 Fed. Reg. 69306-69328, November 16, 2012. This is in addition to the Medicare hospital value-based purchasing program which has already increased and decreased payments in 2013 for hospitals based on performance. See “Understanding the Fiscal Year 2013 Actual Percentage Payment Summary Report”, located at www.qualitynet.org/dcs/BlobServer?blobkey=id&blobnocache=true&blobwhere=1228889875140&blobheader=multipart%2Foctet-stream&blobheadername1=Content-Disposition&blobheadervalue1=attachment%3Bfilename%3DFY2013_ActualFactSheetv2.pdf&blobcol=urldata&blobtable=MungoBlobs.

⁵⁹ Derived from reported Physician Quality Reporting System data.

⁶⁰ AHRQ “Ensuring That Patient-Centered Medical Homes Effectively Serve Patients with Complex Health Needs.” The concept can be expanded to other types of practices beyond primary care, however, such as an oncology PCMH.

concept may sound similar the “gatekeeper” model of care (whereby a primary care physician must authorize specialist treatment for patients), the true emphasis is on coordination across multiple, otherwise disparate providers, in an effort to coordinate and improve patient care. The ultimate goal is to keep patients from requiring more expensive care (such as hospitalization) by having a single physician group coordinate and manage their care. If the PCMH can demonstrate to payors that the PCMH can provide value by reducing the patient’s need for more expensive services through the delivery of quality care, the payor will, ideally, pay the PCMH for the management of the patient’s care in addition to however else it compensates the delivery of care itself. The critical issue for PCMH, though, is payment. Models to pay for the changed approach include stipends and per patient per month payments, but these are evolving.⁶¹

The model is not without its issues, however. One potential problem facing the PCMH concept is the tendency for the term “PCMH” to be rendered meaningless by imprecise or overly broad usage.⁶² To combat this, some organizations, such as the National Council for Quality Assurance (NCQA), are attempting to standardize the PCMH concept by certifying PCMH entities.⁶³ The American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association have also come together to jointly define principles behind a primary-care PCMH.⁶⁴ Another potential issue is that physician employment contracts may need to be amended to reflect the change in focus from, for example, a productivity-based model to one which pays the physician for supervision and management duties. If the physician is performing fewer procedures – such as when those procedures have been transferred to NPPs to perform in the interests of efficiency – then the physician’s compensation will need to be changed to reflect the new administrative and managerial duties undertaken. This is not an insurmountable obstacle, of course, but one with which some groups may have to contend.

4 The Impact of NPPs – Where the Rubber Meets the Road

Under traditional FFS payment systems, physician services are typically reimbursed at a higher rate than the same service performed by an NPP. For example, where Medicare reimburses physicians at 100% of the MPFS rate for services, it only reimburses NPs and PAs at 85% of the MPFS rate. This has created a perceived dilemma for physicians and physician practices--should the physician perform the specific task and be paid the higher rate, or delegate

⁶¹ See, Haas, Paula, “Medical Home Model Calls for New Payment Methods – Experimentation Is Name of the Game,” *AAFP News Now, Special Report*, February 17, 2009. Located at <http://www.aafp.org/online/en/home/publications/news/news-now/pcmh/20090217pcmhpayment.html>; [Paying for the Medical Home: Payment Models to Support Patient-Centered Medical Home Transformation in the Safety Net](#), Safety Net Medical Home Initiative, located at <http://www.safetynetmedicalhome.org/sites/default/files/Policy-Brief-1.pdf>; Bailit, Michael, [Payment Rate Brief](#), Patient-Centered Primary Care Collaborative, March, 2011. Located at http://www.pcpcc.net/files/payment_brief_2011.pdf.

⁶² Similar accusations can be leveled at the “bundled payment” concept, where, for example, some have described capitation as being a “bundled payment” model. See, “Bundled Payment,” AHA Research Synthesis Report (May, 2010). http://www.aha.org/research/cor/content/bundled_payment_cp.pdf.

⁶³ <http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx>.

⁶⁴ <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>.

the task to an NPP which, depending on billing rules, might involve “giving up” a percentage of receipts? From this perspective, a physician under Medicare would be “giving up” 15% of the practice’s potential reimbursement for a procedure by delegating the task to an NPP. Although Medicare permits “incident-to” billing and “shared visits,” even if a payor does adopt Medicare’s fee schedule for services, it may not follow all of Medicare’s billing rules.

However, as the health care industry responds to the dual crises of an increasing need for health care services and an increasing shortage of providers, payment and delivery models which are more focused on value are on the rise. This new landscape presents physician practices with opportunities to benefit from using NPPs. In addition, even under traditional FFS, itself unlikely to disappear entirely in the foreseeable future, physician practices can improve their lot through the effective use of NPPs.

4.1 The NPP Impact on Quality

Improved quality of care is a central focus of the new health care environment. For practices participating in value-driven payment systems, particularly those which allocate downside risk to the practice, improving their quality of care will be essential to attaining goals for payment (and avoiding the negative impact of failing to meet such goals). Effective use of NPPs can be critical to success. An NPP cannot fully replace a physician. But NPPs can, in many instances, render care that is equal in quality to physicians, and may even be able to provide higher quality care in some circumstances.

In the primary care setting, a 2008 study of the quality of diabetes care in family medicine practices examined the impact of NPs and PAs.⁶⁵ The study examined 46 family medicine practices from New Jersey and Pennsylvania, and compared their adherence to American Diabetes Association guidelines through chart audits of 846 diabetes patients, comparing practices with and without NPs or PAs.⁶⁶ Compared to practices with physicians only, and even to practices using only PAs, practices with NPs generally performed more monitoring tasks, and yielded better results in patients meeting lipid level targets.⁶⁷

Another primary care study examined four community-based primary care clinics and one primary care clinic at an urban academic medical center, to compare outcomes for patients randomly assigned to a nurse practitioner or a physician for primary care follow-up and ongoing

⁶⁵ Ohman-Strickland, Pamela A., Ph.D.; et al., “Quality of Diabetes Care in Family Medicine Practice: Influence of Nurse-Practitioners and Physician’s Assistants,” Annals of Family Medicine, Vol. 6, No. 1, January/February, 2008, pp. 14-22.

⁶⁶ The study examined 28 practices with neither a PA nor an NP; 9 practices with 1 or more PAs; and 9 practices with 1 or 2 NPs, all functioning as part of small- or solo-physician, single-specialty family medicine practices. Ohman-Strickland, Pamela A., Ph.D.; et al., “Quality of Diabetes Care in Family Medicine Practice: Influence of Nurse-Practitioners and Physician’s Assistants,” Annals of Family Medicine, Vol. 6, No. 1, January/February, 2008, at 15.

⁶⁷ Ohman-Strickland, Pamela A., Ph.D.; et al., “Quality of Diabetes Care in Family Medicine Practice: Influence of Nurse-Practitioners and Physician’s Assistants,” Annals of Family Medicine, Vol. 6, No. 1, January/February, 2008, at 18.

post-emergency-department or urgent care visits.⁶⁸ The study found that, overall, there were no significant differences between patients treated by NPs and patients treated by physicians in satisfaction, self-reported health status, physiologic measures, or utilization.

Within the hospital setting, in 2008, an evidence-based review of then-existing literature on the use of NPs and PAs in the intensive care unit found that, as compared to medical residents or fellows, NPs and PAs were equivalent in some cases to the care provided by the residents or fellows, and in others actually showed better outcomes.⁶⁹ In general, use of NPs and PAs was demonstrated to enhance patient care flow and resident work hours, without altering patient outcomes or direct hospital costs, and patient care outcomes were substantially similar to resident physicians.⁷⁰ One study reviewed noted that outcomes did not differ between the NPPs and the residents with respect to length of stay (LOS), in-hospital mortality, or readmission rates.⁷¹ In fact, in some cases, “the addition of NPs was found to be associated with a decrease in LOS and clinic wait times, and an increase in documentation quality.”⁷² Moreover, with mechanically ventilated patients, clinical and financial outcomes were improved for LOS, mortality, ventilator duration, and cost savings.⁷³ *[Footnotes 70 & 72: Same study in citations?]*

Another institution-focused study, conducted in 2009, compared the use of internal medicine residents against physician assistants, comparing patient outcomes in a community hospital.⁷⁴ For outcomes, the study examined mortality, adverse events, readmissions, patient satisfaction, and documentation, collecting two years of data.⁷⁵ The study found that mortality rates were significantly lower with PAs as opposed to residents, and other measures remained equivalent, even though the PAs had no further formal training than the usual two-year PA education.

⁶⁸ Mundinger, Mary O, Dr.PH; et al., “Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians – A Randomized Trial,” Journal of the American Medical Association, Vol. 283, No. 1, January, 2000, pp. 59-68.

⁶⁹ Kleinpell, Ruth M., Ph.D, RN, ACNP, FCCM; et al., “Nurse Practitioners and Physician Assistants in the Intensive Care Unit: An Evidence-Based Review,” Critical Care Medicine, Vol. 36, No. 10, 2008.

⁷⁰ Kleinpell, Ruth M., Ph.D, RN, ACNP, FCCM; et al., “Nurse Practitioners and Physician Assistants in the Intensive Care Unit: An Evidence-Based Review,” Critical Care Medicine, Vol. 36, No. 10, 2008, at 2894.

⁷¹ Kleinpell, Ruth M., Ph.D, RN, ACNP, FCCM; et al., “Nurse Practitioners and Physician Assistants in the Intensive Care Unit: An Evidence-Based Review,” Critical Care Medicine, Vol. 36, No. 10, 2008, pp. 2890-2893.

⁷² Kleinpell, Ruth M., Ph.D, RN, ACNP, FCCM; et al., “Nurse Practitioners and Physician Assistants in the Intensive Care Unit: An Evidence-Based Review,” Critical Care Medicine, Vol. 36, No. 10, 2008, at 2893.

⁷³ Kleinpell, Ruth M., Ph.D, RN, ACNP, FCCM; et al., “Nurse Practitioners and Physician Assistants in the Intensive Care Unit: An Evidence-Based Review,” Critical Care Medicine, Vol. 36, No. 10, 2008, at 2893.

⁷⁴ Dhuper, Sunil, M.D.; and Sonia Choksi, M.D., “Replacing an Academic Internal Medicine Residency Program with a Physician Assistant-Hospitalist Model: A Comparative Analysis Study,” American Journal of Medical Quality, vol. 24, no. 2, February, 2009, pp. 132-139.

⁷⁵ Dhuper, Sunil, M.D.; and Sonia Choksi, M.D., “Replacing an Academic Internal Medicine Residency Program with a Physician Assistant-Hospitalist Model: A Comparative Analysis Study,” American Journal of Medical Quality, vol. 24, no. 2, February, 2009.

The implication of these studies is that certain NPPs in many cases provide the same quality of care that a physician can, and in some cases may even improve the quality of care delivered. This is significant, in that it eliminates a potential complication of hiring an NPP instead of a physician: the potential decrease in quality of care. Moreover, the fact that NPPs can effectively substitute for physicians in many cases will be even more essential when attempting to improve efficiency of care.

4.2 Improving Efficiency

In the new value-driven environment, it is insufficient to merely deliver quality care, when that delivery is inefficient. Even under traditional FFS, providers need to ensure that they treat a sufficient number of patients to remain profitable. In either scenario – the traditional model or a newer model – physicians should only be spending as much time with patients as is necessary for the patient’s care and to ensure reimbursement. Delegation of tasks to NPPs can allow the physicians to see a higher volume of patients by freeing the physicians from performing the same tasks the NPP would (and thereby losing time that they could spend with other patients to increase throughput).

Under traditional FFS, mechanisms such as Medicare’s “shared visits” and “incident-to” offer opportunities for physicians to maximize their time by billing at higher rates for services rendered by NPPs. Even when billing under the NPP’s own number, and when paid at the NPP’s lower rate (depending on the nature of the NPP), physician practices may find that they are better able to care for patients. For example, in a recent study, researchers ran simulations using estimated times to provide acute, chronic and preventive care services at recommended levels, taking into account whether the service could be delegated to an NPP. The study discovered that physicians who delegated 77% of their preventive care and 47% of chronic care could treat a panel of 1,947 patients, while physicians who delegated only 50% of preventive care and 25% of chronic care could only handle a patient panel of 1,387 patients. The study also noted that while average physician panels are 2,300 patients per physician, a doctor with a 2,500 patient panel trying to perform all of the recommended services without delegation would need to work almost 22 hours per day.⁷⁶

The use of an NPP can be a significant financial boost, too, at a far more cost-effective rate. For example, a 2009 study found that adding an NP or PA to a cardiovascular practice could earn the practice approximately \$300,000 per additional NPP. By comparison, a general cardiologist would earn the practice between \$700,000 and \$870,000. However, a PA would cost the practice only approximately 30% of what a general cardiologist would.⁷⁷ The Bureau of Labor Statistics (BLS) reports that the median PA salary in 2010 was \$86,410.⁷⁸ Average NP salary in 2009, as reported by the American Academy of Nurse Practitioners (AANP), was

⁷⁶ “Study Quantifies Practice Boost from Physicians Delegating Tasks,” [amednews.com](http://ama-assn.org/amednews/2012/11/19/busb1119.htm), November 19, 2012.

⁷⁷ Association of American Medical Colleges & The Lewin Group, *Cardiovascular Workforce Assessment (Final Report)*, 2009, p. 95. Located at <http://content.onlinejacc.org/data/Journals/JAC/23181/1.pdf>. Salary data was based on 2008 BLS information, however.

⁷⁸ <http://www.bls.gov/ooh/healthcare/physician-assistants.htm>.

approximately \$90,200.⁷⁹ The AANP also reports that NPs offer substantial cost-effectiveness, potentially lowering the cost of health care. For example, the AANP reports that NPs practicing in Tennessee’s state-run managed care organization, TennCare, delivered health care at 23% below the average cost of other primary care providers, reduced hospital inpatient rates by 21%, and had 24% lower lab utilization rates as compared to physicians.⁸⁰

The information described above offers a view of the potential for efficiency in a traditional fee-for service model. However, physician practices stand to benefit under newer payment and delivery models, too. Under models driven by budgets, such as bundled payment, physicians face similar pressures to ensure efficiency, particularly when they are “at risk”; they must keep costs low while ensuring the patient receives appropriate care, so as to maximize the moneys retained by the practice. In such a scenario, wasted time equals wasted money. Accordingly, NPPs can be used to free physicians to perform to their “highest and best use.” If the service can be effectively performed by an NPP and is within their scope of licensure, then the physician ought not be performing it. The physicians should only step in when the complexity of the service requires their intervention.

Under the PCMH model, a physician will necessarily play more of a coordinating role with less hands-on time with patients than under a traditional FFS model. The physician will certainly be required to spend some time with the patient, but effective coordination of the patient’s care – the physician’s main responsibility under this approach – will require that the physician spend less time with patients than they have traditionally. Into this gap must step the NPPs, who must provide the hands-on care, as well as care coordination, patient engagement, phone calls, managing patient reminders, etc. As with the bundled payment approach, there is no reason for NPPs not to do this, provided that the service is one which they can legally render under applicable state law. Again, the physician would therefore only interact directly with the patient for those services requiring the physician’s unique skills and scope of licensure.

Interestingly, in the NPP/physician “turf wars” – wherein NPPs seek to gain greater autonomy and be recognized more as independent practitioners – one hopeful sign is that NPPs actually want to be performing those services for which they are qualified. In other words, there may be more alignment of goals than the turf wars suggest – physicians need NPPs to be the “first line of defense” with patients, and the NPPs want more responsibility. “The essential question really should be, ‘what level of education, experience and length of time in training is optimal for providing a given level of care?’”⁸¹

Given the types of services that would be performed by NPPs, under the new payment and delivery models, there may be no reason for a turf war in the first place. Performance of procedures such as taking a history and physical, performance of simple sutures, administration of medications, etc. do not require the expertise of a physician in many instances. Accordingly, if NPPs wish to have more responsibility and importance, the new payment and delivery models may offer an easier avenue towards that than business models oriented around traditional FFS.

⁷⁹ American Academy of Nurse Practitioners, Nurse Practitioner Cost-Effectiveness, p.1. Located at <http://www.aanp.org/images/documents/publications/NPCostEffectiveness.pdf>. The BLS does not report NPs separately from RNs, so current data on NPs specifically is unavailable.

⁸⁰ American Academy of Nurse Practitioners, Nurse Practitioner Cost-Effectiveness, p.1.

⁸¹ “Years of training is wrong focus in NPP vs. MD discussions,” Modernphysician.com, September 26, 2012.

4.3 Patient Satisfaction

Part of the new health care environment is the drive to create more informed and engaged consumers.⁸² Donald M. Berwick, M.D., the former administrator of CMS, among many others, has proposed that the health care industry should endeavor to provide much more “patient-centered” care, and that the concept of “patient-centered” care ought to be a factor in determining whether quality health care had been delivered.⁸³ Moreover, satisfied patients tend to adhere more to treatment recommendations, which can improve outcomes and NPPs have been shown to enhance patient satisfaction.⁸⁴ “Patient centered care” is defined as, “The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one’s person, circumstances, and relationships in health care.” Dr. Berwick’s definition is broader than most. As part of the efforts of the industry towards this end, multiple web sites have developed in recent years, offering ratings of physicians and hospitals. These websites, established both by private and public entities, include Health Grades, the Leapfrog Group, and even CMS with its Hospital Compare and Physician Compare websites.⁸⁵ As informed and engaged consumers become more active in their choices regarding where they get their health care, ensuring patient satisfaction will also become more important for physician practices. The addition of NPPs to the practice can help in this regard.

For example, a 2011 questionnaire commissioned by the U.S. Agency for Healthcare Research and Quality’s Consumer Assessment of Healthcare Providers and Systems randomly sampled 97 low-income NP patients and 99 low-income physician patients, all between the ages of 16 and 62, in Flint, MI.⁸⁶ The results of the questionnaire indicated that, in general, the patients preferred the services of the NPs. In terms of global scoring on a scale of 1 to 10, physicians received an average score of 7.2, while NPs received an average score of 9.8.⁸⁷ In 2010, the American Academy of Physician Assistants (AAPA) and the American College of Physicians (ACP) published a policy monograph discussing the integration of PAs and internists in team-based care, which noted that “When PAs assist with patients with lower acuity, the

⁸² While the term “consumer” often relates to employers who actually pay for health care premiums, in the context of this chapter, the term refers to patients themselves.

⁸³ Berwick, Donald M., M.D., “What ‘Patient-Centered’ Should Mean: Confessions of An Extremist,” Health Affairs, vol. 28, no. 4, May, 2009, pp. w555-w565, at w560.

⁸⁴ Hooker, Roderick S., Ph.D., et al., “Patient Satisfaction with Physician Assistant, Nurse Practitioner, and Physician Care: A National Survey of Medicare Beneficiaries,” Journal of Clinical Outcomes Management, vol. 12, no. 2, February, 2005, pp. 88-92, at 88.

⁸⁵ In fact, CMS’ Hospital Compare and Physician Compare each draw their data at from the IQR and PQRS reporting programs, respectively, and will eventually draw information from the VBP program.

⁸⁶ “Nurse Practitioners Outscore Physicians in Patient Satisfaction Survey,” Clinical Advisor, Jun 24, 2011. Located at: <http://www.clinicaladvisor.com/nurse-practitioners-outscore-physicians-in-patient-satisfaction-survey/article/206090/>.

⁸⁷ “Nurse Practitioners Outscore Physicians in Patient Satisfaction Survey,” Clinical Advisor, Jun 24, 2011. Located at: <http://www.clinicaladvisor.com/nurse-practitioners-outscore-physicians-in-patient-satisfaction-survey/article/206090/>.

practice is able to see more patients faster, reducing wait times and increasing patient satisfaction.”⁸⁸

Even if the use of NPPs does not increase patient satisfaction, there exists data to suggest that there is at least no decrease in patient satisfaction when using an NPP. In 2005, a study of NPs and PAs examined Medicare beneficiaries enrolled in traditional FFS Medicare for a period of six months or longer, who identified a generalist physician, a PA, or NP as their personal health provider.⁸⁹ The study was conducted using a survey, which asked the patients to rate their experiences, addressing questions such as “How often does your health provider listen carefully to you,” and “How often does your provider spend enough time with you,” on a scale of 1 to 5.⁹⁰ Overall, the study found that the distribution of responses to the questions rating patient satisfaction were similar across all three provider types.

In another study, the American Society of Clinical Oncology examined collaborative practice relationships between physicians and NPPs, and found that, in addition to increasing practice productivity, patients were satisfied with the care they received from NPPs. Moreover, the use of NPPs produced high satisfaction for both the physician and the NPP, and physicians reported a greater level of satisfaction with their own workloads.⁹¹

The data discussed above suggests that NPPs can improve patient satisfaction, which can in turn result in better outcomes for patients, and better quality of care delivery in accordance with Dr. Berwick’s notions of “patient-centered” care.

..5 Conclusion

The practice of medicine faces a future full of both certainties and uncertainties. It is certain that new, quality-driven models for both payment and care delivery will be developed and implemented. Likewise, it is certain that traditional FFS will not disappear overnight. Under both old and new payment and care delivery systems, the guiding principle must be “value.” Towards this end, physicians must realize that merely because a physician can render the service in question does not mean that the physician should render the service. Where an NPP can provide the service, they should. Doing so has been shown to result in no loss of quality of care, and in some cases may improve quality. Likewise, it is a far more efficient use of resources than having physicians overextend themselves while trying to maximize the number of services they perform.

⁸⁸ American Academy of Physician Assistants and American College of Physicians, Internists and Physician Assistants: Team-Based Primary Care, 2010, p.5. Located at: http://www.acponline.org/advocacy/where_we_stand/policy/internists_asst.pdf.

⁸⁹ Hooker, Roderick S., Ph.D., et al., “Patient Satisfaction with Physician Assistant, Nurse Practitioner, and Physician Care: A National Survey of Medicare Beneficiaries,” Journal of Clinical Outcomes Management, vol. 12, no. 2, February, 2005, pp. 88-92.

⁹⁰ Hooker, Roderick S., Ph.D., et al., “Patient Satisfaction with Physician Assistant, Nurse Practitioner, and Physician Care: A National Survey of Medicare Beneficiaries,” Journal of Clinical Outcomes Management, vol. 12, no. 2, February, 2005, pp. 88-92, at 89.

⁹¹ Towle, Elaine L, “Results of the ASCO Study of Collaborative Practice Arrangements,” Journal of Oncology Practice, vol. 7, Issue 5, pp. 278-282.

Reliance on physician performance of services will fade as payment and delivery models shift. When practices can reap the rewards of staying below budget, and may even be penalized for failing to stay within budgets, there is less incentive to increase revenues by having physicians perform as many services as possible. In such an environment, NPPs will be essential in efforts to contain costs while simultaneously providing high-quality patient care.

In the end, the guiding principle must be to use the right tool for the right job. Physicians are highly trained, have the broadest scopes of practice, and can address issues of the highest complexity. While also often highly trained, NPPs have more restricted scopes of practice, but are still able to treat patients with a wide range of concerns (albeit of lesser complexity than those a physician can treat).

The key question, therefore, is which practitioner is capable of providing the patient with the services needed. While a helicopter, an ambulance, and a taxi can all transport a patient with a minor abrasion requiring stitches to the hospital, there is no need to use either the helicopter or the ambulance when the patient does not require it. Using either mode of transport would be needlessly expensive, and would tie up those resources so that they could not be used for the patients who genuinely needed them. So too with the services of physicians and NPPs. Just as the helicopter is not “better” as a mode of transport in all circumstances, neither is the physician “better” as a health care provider in all circumstances. By effectively using NPPs, physicians can offer better quality service to patients, have a better quality of life, and treat a wider range of patients, all in a more cost-effective way.