USE OF NON-PHYSICIAN PRACTITIONERS

A Roundtable Discussion

In the field of oncology, non-physician practitioners (also known as physician extenders and mid-level providers) typically refer to nurse practitioners (NPs) and physician assistants (PAs). In recent years oncology practices, freestanding cancer centers, and hospital-based cancer programs have increased their use of nurse practitioners and physician assistants. Why? First, adding non-physician practitioners is less expensive than adding physicians. These professionals can increase patient capacity and overall patient volume for less than what it would cost to add new physician(s). Additionally, non-physician practitioners can see patients for many of their visits, giving physicians more time to see new patients and carry out consultations. Non-physician practitioners can also:

- Provide patient care when physicians are out of the office when allowed by state law
- Serve as clinical resources for oncology nurses, other cancer program staff, and cancer patients
- Reduce patient wait times
- Spend increased time with cancer patients.

Before adding these professionals to your staff, however, you must consider a variety of factors, starting with the scope of practice as outlined in your state's laws. Consider how the responsibilities and credentials of these professionals differ from other providers; determine how your institution can or should be reimbursed for services provided by these staff members; and ensure that employment or other service contracts are structured correctly.[1] In addition, be sure to read the following roundtable discussion on non-physician practitioners from ACCC's 32nd Annual National Meeting.

—Elaine Towle, CMPE
Director of Consulting Services
Oncology Metric, LLC

SCOPE OF PRACTICE AND STAFFING MODELS

Moderator: Let's start with a couple of statistics. Oncology Metrics just completed a not-yet-pulished survey of group practices. We asked practices to report how many doctors and non-physician practitioners are in their group. Although there was a wide range in group size, most respondents were three- or four-doctor practices. About half of the 110 practices that answered our survey use non-physician practitioners. In larger practices, use of non-physician practitioners is very prevalent now, and it's becoming increasingly prevalent in smaller practices. The 50th percentile is currently .5 non-physician practitioner per one physician.

At my former practice, we employed both physician assistants and nurse practitioners, but they all worked under what I call a "physician assistant mode," meaning they worked under physician supervision and as an adjunct to the physician.

Participant: Nurse practitioners in our program frequently work that way as well, but NPs, in general, are trained to function independently. Their training model is such that it leads to a mindset of functioning more independently. When we hired NPs into our practice, we made it clear that independence was in the job description.

Participant: We didn't have any trouble hiring nurse practitioners, because they came into a sub-specialty practice and expected to be working under the direction of the physician directly. When making decisions about nurse practitioner versus physician assistant, you must also be conscious about your state laws.

Moderator: Generally, nurse practitioners are governed by the state's Board of Nursing, and physician assistants are governed by the state's medical board. The rules can be very different for each discipline, so you must look at both sets of regulations.

Three big issues may sway your decision about whether to hire a nurse practitioner or a physician assistant. First is state scope of practice, which may be very different for NPs

ILLUSTRATION/STOCK ILLUSTRATION SOURCE

and PAs. You need to understand your state's scope of practice as you write a job description and prepare to hire.

Second, you need to understand prescriptive authority and the differences between the two disciplines. Laws vary dramatically from state to state. In some states, one discipline may have unlimited prescriptive authority and the other may have restrictions for writing narcotic prescriptions or even chemotherapy orders. Be sure you understand your state's laws about prescriptive authority.

Third is the issue of supervision and collaboration, because there can be some issues, particularly on the physician assistant side. The most restrictive state I know of is Missouri, where PAs cannot see patients and cannot function clinically without a physician immediately onsite. In most other states, the law says the supervising physicians must be telephonically or electronically available.

Participant: Can we talk about staffing models. For example, do physician assistants and nurse practitioners require the same staff support as physicians? And should NPs function exactly like PAs?

Moderator: For cancer programs that are thinking about bringing on nurse practitioners and physician assistants, it's critically important to get buy-in from the physicians and staff and to decide what your model is going to look like. In some models the NPs and PAs see all patients and have different roles each day. For example, one NP or PA is in clinic all day and someone else is the back-up for walk-ins and emergencies and assists the nurses with phone triage. In other practices, NPs and PAs work one-on-one with an individual physician. I find that staff support is generally about the same as for physicians.

Participant: I know practices that use their nurse practitioners or physician assistants almost like nurses. PAs make expensive nurses.

Participant: In my practice there are two secretaries, five physicians, and me. So what I don't do, my physician does. So yes, I am an "expensive nurse," but I am also a "cheap physician." I can return phone calls, fill out order sheets that set people up who need to come back for visits, fill out CMNs (certificates of medical necessity) and paperwork, and complete disability forms. Yes, it's expensive, but I'm saving work that my physician would have to do. Our budget is to the bone. Secretaries can't fill out the disability forms, so I sign them, and I send them. And I do anything and everything on the physician's desk that I can do, which frees him up to see patients. That's the way I see my role. I do anything administrative.

Moderator: In today's environment, everyone is interested in enhancing practice efficiency. Adding non-physician providers to your staff is a huge practice efficiency tool. If you want to try and increase the number of

new patients that are coming into your practice—which is the revenue driver for everything else that you do—this is a tool you can use: hire a nurse practitioner or a physician assistant and have them see the patients that your practice decides are appropriate. This move will free up your physicians to see new patients and do the other activities that keep an oncology practice thriving and viable.

Participant: Non-physician practitioners are much like physicians in that they have their own interests and abilities. Some like to spend a lot of time in palliative care. Others are sort of latent surgeons. Some like to do emergency work, while others like to do counseling. I think cancer programs have to be flexible.

Participant: I don't think you can force a non-physician practitioner to do something that he or she doesn't like to do any more than you can force a physician.

Moderator: I absolutely agree. As my practice developed its model, we had one job description. Then we hired a nurse practitioner who had come from an oncology nursing background. She clearly had more nursing-oriented interests, including education and training, so we carved out a niche to allow her to use those skills and abilities.

Participant: You still have to show an increase in productivity for the practice or program. I don't care what the job role is as long as the non-physician providers are making my physicians more productive.

Participant: Both of my nurse practitioners came from oncology nursing backgrounds. I looked for that skill set because I was going to use them on the treatment side, and they do increase our revenue because they handle all of our Coumadin assessments, treatment reactions, and walk-ins. So, my NPs are generating revenue, and they also have an understanding of what they're looking at because they have been in oncology nursing; for example they understand the particular problems with people who are neutropenic. The model has worked out very well.

Participant: How full does a physician's practice have to be in order to make the use of an extender acceptable and allow for expansion?

Moderator: Look at the number of new patients that an oncologist is seeing. Three hundred new patients a year per full time equivalent (FTE) physician has been a consistent number for several years and generally indicates a busy medical oncology oncologist. At that level, physicians are usually pretty amenable to thinking about some help. If

you are looking to add new services or add new staff, new patients per doctor is a good denominator for most of those calculations.

Participant: So I'm a very busy physician, a medical oncologist, who tends to hang on to his patients and turn them into internal medicine patients, developing strong relationships, expanding my practice size exponentially, and creating need for more and more support. I would best benefit from a nurse practitioner.

Participant: But that's the hardest physician to get to use a nurse practitioner.

Participant: Bingo.

Participant: I started out as a RN in a physician practice. I approached the physician and said, "What do you think if I go back to school to become a nurse practitioner?" I convinced him…and we've been together now for 11 years. We work together so well, I think sometimes it helps the practice to use somebody you know.

Participant: In essence, it's a control issue. We found that it's really the physician who bonds with the patients and continues to care for them for internal medicine. We've also found that when physicians are given a mid-level or a non-physician practitioner, they will typically use that non-physician practitioner to see emergencies and walk-ins, while they continue to follow-up those stable patients in the long-term. It's a very difficult practice model to break.

"INCIDENT TO" AND OTHER BILLING ISSUES

Moderator: Let's talk about the difference between billing independently and billing "incident to." "Incident to" is a Medicare term that allows someone other than the physician to provide services if he or she is employed by (or is a leased employee of) the physician. The physician must be physically present in the office and immediately available to respond and take care of the patient if there are issues. There also needs to be a demonstrated active involvement by the physician in the patient's care that includes the physician seeing the patient in consultation initially, establishing a treatment plan, and demonstrating active involvement. If you meet all those criteria—and for chemotherapy patients, that's pretty easy to do—then an nurse practitioner or physician assistant can see the patient, bill as though the physi-

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cian provided the service, and get paid at the same rate then as if the physician provided the service.

Physician assistants and nurse practitioners should also have their own NPI (national provider identifier) number with Medicare. This allows them to bill under their own number if there are times when you cannot meet the "incident to" requirements. When they bill independently for Medicare patients, they are paid at 85 percent of the physician fee schedule for all professional services. Drugs are not impacted. Drugs are paid the same—no matter who is treating the patient. But NPs and PAs are reimbursed 85 percent for E&M (evaluation and management) services and 85 percent for drug administration.

Most commercial payers do not use the term "incident to," although they may follow a similar reimbursement practice. In my experience, most private payers want you to bill under the physician, similar to Medicare's "incident to." Many payers recognize both physician assistants and nurse practitioners, although that practice is hugely variable among third-party payers. So here's another consideration when bringing on non-physician providers: You want to make sure you understand your payer policies.

Participant: The requirements for nurse practitioners to bill independently vary from state to state. In Virginia, for example, the state scope of practice does not allow nurse practitioners to bill independently in oncology. They're restricted to OB/GYN, primary care, and primary care specialists. Nurse practitioners and physician assistants can bill "incident to," but they can't function independently.

Participant: In the state of Arizona, I do the credentialing for the physicians and the nurse practitioners. Certain insurance companies fully credential both, while others do not recognize the NP.

Moderator: I've found that oncology practices have had pretty good success sitting down with payers to describe Medicare's policy and the methods of billing, and encouraging them to recognize physician assistants and nurse practitioners. It's less frequent now to run into a payer that won't recognize one or the other, because the physician assistant and nurse practitioner are so prevalent in many specialties.

Participant: Here in Maryland our biggest payer has been CareFirst BlueCross BlueShield. They recognize and pay for nurse practitioners, but they don't for physician assistants.

Participant: Another billing issue can be a physician's perception that the non-physician provider is "taking away" some of the oncology practice's revenue.

Moderator: That scenario depends on your practice's compensation model: base salary or salary plus bonus, for example. In my experience, the majority of PAs and NPs are paid salary. It's generally straight salary and not based on production. But many physicians are paid on production, so your practice will need to decide how to include nurse practitioner/physician assistant production in that formula.

Participant: In our model, the nurse practitioners and physician assistants are paid a base salary. Our physicians are incentivized by RVU production, and they get credited with the team's RVU production.

Participant: Are you suggesting a practice model that pairs them up, in other words assigning a nurse practitioner or physician assistant to each team?

Moderator: Yes. So production is based on the whole team. That's one solution.

Participant: Are there benchmarks out there by team?

Participant: There are benchmarks for RVUs per physician; that's what we used.

Participant: We also RVUs, but we geared it down a little bit, recognizing the physician had help, so we compromised on a little bit lower RVU level.

OFFICE VISIT LEVELS

Participant: Can I change the topic to discuss level of visits? When I looked at my office stats, and we're billing "incident to," the doctors who have nurse practitioners have a lot more level three visits than the physicians who do not have nurse practitioners. When I look at the NPs stats, the notes support a higher level visit. One NP came to me the other day and said, "I just billed my first level five and I'm terrified." And I said, "What you are billing for is every bit worth a level five." Are the audit police out there looking for NPs to stay more in the level three range? Are they looking at under-coding?

Moderator: Medicare does not restrict billing levels for nurse practitioners and physician assistants. If the nature of the visit and the documentation supports a level five, NPs or PAs can bill anything that's medically appropriate—with the caveat that under Medicare rules, nurse practitioners and physician assistants should not be seeing new illnesses.

I've recently heard of practices where nurse practitioners and physician assistants become the primary provider for routine hematology consults. Medicare regulations say

that NPs and PAs can do consultations if it is allowed in state scope of practice. But be cautious because if a nurse practitioner or physician assistant does a consult, that patient can never be billed as an "incident to" patient. The patient must always be billed under the nurse practitioner or physician assistant, because the physician didn't see the patient initially and provide the treatment plan. In my experience, this practice becomes very difficult for office staff to manage.

Participant: I have a question about billing for teaching visits. Say a non-physician practitioner spends an hour with a patient doing some kind of teaching about chemotherapy, would that be a bill based on counseling?

Moderator: Yes. Many cancer programs use oncology nurses to do chemotherapy teaching and, as you know, nurses can only bill a level one visit. Other practices have their nurse practitioners do the teaching. If NPs spend an hour educating a patient, they can bill based on time just like a physician can for a counseling visit. In other words, they would document a 60- or 45-minute visit, prepare a bill based on time, and generate a larger billable charge.

PATIENT/PHYSICIAN INTERACTION

Moderator: What happens when a patient comes in and says, "But I wanted to see the oncologist?"

Participant: The key is that when the patient presents to the practice, that patient should be introduced to the entire cancer care team.

Moderator: During the new patient visit, the physicians should talk about the nurse practitioners and physician assistants and try to introduce the patient if possible. The patient needs to understand from the beginning that the NP or PA is part of the cancer care team.

Participant: For chemotherapy patients, some practices have the physician see the patient once per chemotherapy cycle. The NPs and PAs then see them for other visits during their chemotherapy cycle. Patients should understand this staffing model. They should also know that a physician is always available and that the non-physician practitioners can always consult with the physician. Patients appreciate that kind of message. If something comes up emergently, if patients have a problem, they really appreciate these non-physician providers because they can generally get in much quicker to see the NP or PA than the physician.

THE PATIENT NEEDS TO UNDERSTAND FROM THE BEGINNING THAT THE NURSE PRACTITIONER OR PHYSICIAN ASSISTANT IS PART OF THE CANCER CARE TEAM.

Moderator: We had challenges bringing new physicians into the practice. Sometimes new physicians are a little hesitant to work with nurse practitioners and physician assistants, if they haven't worked under the specific staffing model. Yet when they see the competency demonstrated by our nurse practitioners and physician assistants, their perspectives change.

Participant: Our patients want consistency. The more you can align the nurse practitioner and the physician assistant with your physicians, the more cohesive your cancer care team becomes. The consistency is there; patients and providers appreciate that consistency.

Moderator: I think that's true. Our nurse practitioners and physician assistants were scheduled the same days in clinic. Because chemotherapy patients generally come in the same day each week, they ended up seeing many of the same clinic practitioners and the patients appreciated that consistency.

EDUCATION AND TRAINING

Moderator: How does your practice train new nurse practitioners and physician assistants? How do you teach them oncology, if you're hiring someone with an internal medicine background, for example.

Participant: It's a big investment of time, but well worth the effort. If we can't find someone with oncology experience, we try to hire nurse practitioners and physician assistants with a strong internal medicine background, because a lot of what they are doing is general medicine related.

We also hired a couple of new graduates. That's a big investment of time. Our physicians were very committed. We established a complete training curriculum, and our doctors volunteered for specific topics. I think you have to plan for this commitment to training in order to get the nurse practitioner or physician assistant up to speed as quickly as possible. If they don't have an oncology background, you are probably talking six to nine months before your physicians are going to feel really confident letting them practice solo.

REFERENCES

[1]Berson SW. Employment contracts for ancillary professionals. *Oncol Issues.* 18(6):19; 2003.