COOPERATIVE OF
AMERICAN PHYSICIANS

Physicians, Nurse Practitioners, and Physician Assistants Working Together Under One Roof

Presented by:

Stewart Shanfield, MD
Chair and President, CAP and Chair MPT
Dona Constantine, RN, BS
Deborah Kichler, RN, MSHCA
Andie Tena, BA

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Disclosure

No planner, faculty, or presenter for this activity has any relevant financial relationships with ineligible companies.

OBJECTIVES

Review the duties and responsibilities of a physician when supervising Nurse Practitioners and Physician Assistants.

Analyze contributing factors involving advanced practice providers that jeopardize patient safety and increase liability risk.

Apply appropriate coding and billing of services provided by advanced practice providers.

Demonstrate risk management and patient safety strategies that will improve patient outcomes when care is shared by a Nurse Practitioner and/or Physician Assistant and Physician.

Adapt awareness of cultural linguistic competency and implicit bias when interacting with the patient, their families, and healthcare team.

Growth in Advanced Practice Professionals

- Increase patients accessing care
- Fewer physicians
- Aging population
- Chronic care management
- Expanding workforce

Physicians to consider:

Benefits:

Increase access to care.

Allows physician to focus on more complex, high-risk patients.

Patients have more time with providers.

Shorter appointment wait times.

Improved patient outcomes.

Increased patient satisfaction with medical practice.

Liability:

Hiring based on licensure.

Unaware of education, training, scope of practice or patient practice interactions.

No written procedures or protocols.

Uninformed of supervisory role.

False sense of assurance when a NP or PA has their own liability coverage.

Nurse Practitioner Scope of Practice

Registered Nurse	Nurse Practitioner	103 NP/ 104 NP
Direct Supervision and Under Patient-Specific Physician Orders	**Diagnose/Prescribe Under Written Protocols**	**Independent Practice**

Hiring and Onboarding

- Evaluate credentials
- Perform background checks, including criminal and professional board actions.
- Verify professional liability coverage.
- Investigate malpractice claims.
- Contact all references.
- On-the-job orientation.
- Utilize a checklist.
- Orientation of expectations and practice standards.

Written Protocols

Define Scope of Practice.
Standardized Procedures and Protocols
Define role in written job descriptions.
Requirements for consultation with physician and referral to a specialist.

Physician Supervision

Understand State Laws and Regulations.
Supervise no more than 4 total NP's, if they furnish drugs, at one time.
Be available by phone.
Conduct frequent meetings.
No requirement to countersign medical records.

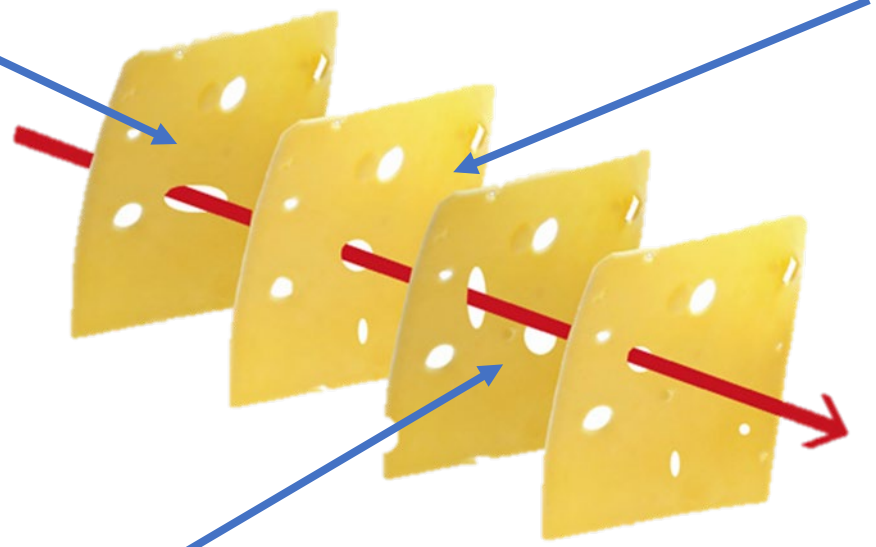
Closed Case

- 39-year-old pregnant female, G1, with diabetes, followed by the Nurse Practitioner during her entire prenatal course.
- Patient was never seen by the Obstetrician.
- First trimester ultrasound was performed.
- No order for a third trimester ultrasound to determine fetal size.
- During delivery, shoulder dystocia was encountered. The infant was 11 lb. 2 oz.
- Unfortunately, the infant suffered severe nerve damage to the right arm.

What went wrong?

No Policy and Procedures:
No "Standardized Procedure" defining NP's Scope of Practice.

Poor Clinical Judgement:
Infant at increased risk for Macrosomia; No late term ultrasound or scheduled C-Section.



Lack of Supervision:
No MD involvement in prenatal course.

What are the most common causes of medical professional liability claims?

COMMUNICATION FAILURE

LACK OF SUPERVISION

LACK OF CLINICAL JUDGEMENT

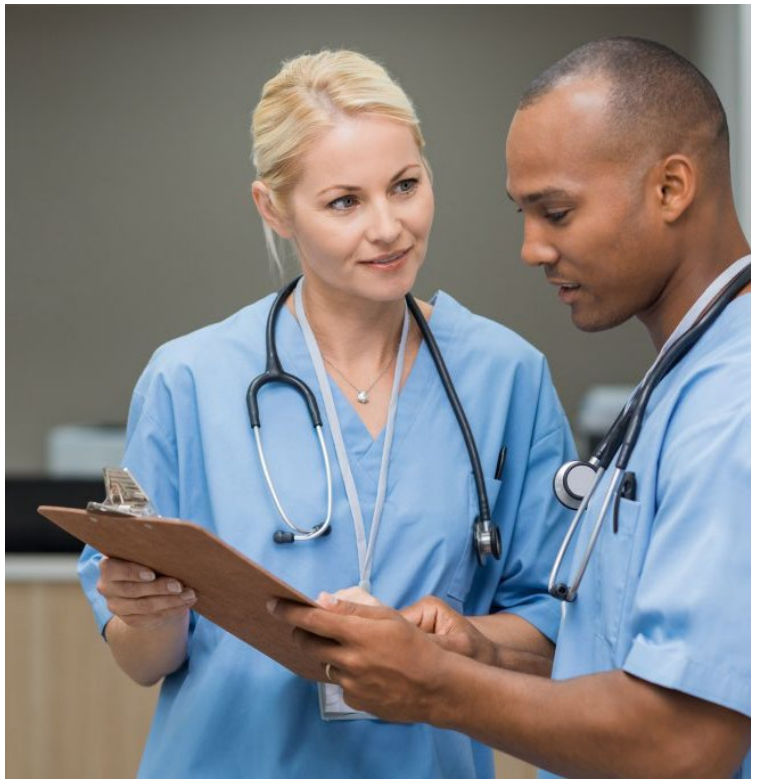
DEFICIENT DOCUMENTATION

TIMELY REFERRAL

Bias in Healthcare

Take an introspective look at your feelings and behaviors.

- **Ask yourself:**
  - Do I use a condescending tone of voice when speaking to patients of a particular group?
  - Do I avoid offering certain alternatives to treatment to patients of a race or culture because of assumptions about their capability to adhere to a treatment regimen?
- **How to help reduce bias in healthcare:**
  - Provide more education on health disparities.
  - Increase an awareness of the additional needs of patients with disabilities.
  - Provide patients with a list of questions to ask regarding their condition, which can lead to more in-depth conversations with their healthcare providers.



History of a Physician Assistant

- **The PA Law** (statutes of 1970, Chapter 1327)
  - Certified by: The National Commission on Certification of Physician Assistants (NCCPA)
    - Must pass a National License Exam
  - In CA Physician Assistants are Regulated by:
    - The CA Medical Board

Physician Assistant: Who am I?

- **A Physician Assistant (PA) is a licensed and skilled health care professional, trained to provide patient evaluation, education and health care services under the supervision of a physician.**

- **CA Physician's Legal Handbook, Document #3007, p. 1, January 2022**


Education and Training
Determine areas of competency and deficiencies.
Provide on-the-job training.
Support professional growth and need for continuing education.

FAQ

- **PA may cover multiple physicians.**
- **Physician may supervise up to four PAs.**
- ***Independent practice not permitted.***

Scope of Practice

A physician assistant (PA) practices medicine under the direction of a physician as a member of a healthcare team.

A PA performs many of the same diagnostic, preventative, and health maintenance services as a physician.

A PA practice foundation is on the Four Pillars of Care:

- **Physical Health,**
- **Social Health,**
- **Financial Health, and**
- **Spiritual Health**

Practice Agreement Addresses

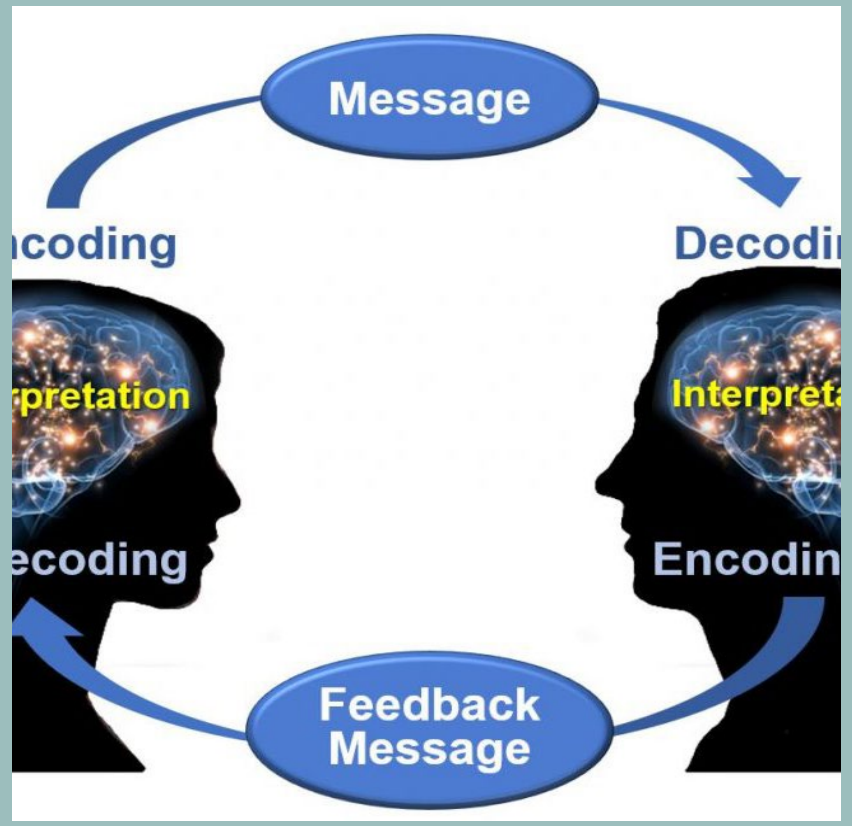
- **Types of Medical Services PA is authorized to perform.**
- **P/P to ensure adequate Supervision & Evaluation.**
- **Additional provisions agreed to by the practice.**
- **Signed by both PA and a physician authorized to sign for the practice.**

Risk Issues

- Lack of hiring the best fit
- Lack of understanding of their roles & responsibilities within the practice
- False assurance –PA has own coverage
- Lack of adequate supervision

Contributing Risk Factors

- Lack of Clinical Knowledge
- Lack of Communication Skills
- Deficient Documentation



Case Summary

22 year old Spanish speaking male presented to the FM/WC clinic with work-related back, left knee and thigh pain and egg-sized mid-thigh lump.

X-ray “normal”.

Treated with Ibuprofen, Vicodin, PT, and activity/work restrictions.

Over 4 months, patient saw 3 PA’s and 5 MDs, including physician locum tenens.

Patient transferred care to another physician after no relief.

Your patients' lives depend on teamwork!

NPP Billing Guidelines

NPP DIRECT BILLING: NPP personally provides services to the patient, independently documents the service and bills under their own NPI. Payment received is based on the physician fee schedule. Medicare will reimburse 85% of the Medicare Physician Fee Schedule reimbursed amount.

INCIDENT-TO BILLING: Medicare requires that practices bill services under the provider number of the individual clinician performing the service. However, Medicare rules allow "incident-to" billing, in which services provided by a supervised employee, under certain circumstances, can be submitted under a physician's provider number. If billing an NP's services "incident to" a physician's service, practices may be reimbursed at 100% of the Physician Fee Schedule rate. If the physician and NPP collaborate on care of the patient, the visit can be billed under the physician’s NPI if certain conditions are met.

These conditions include:

- The services are typically provided in a physician's office or clinic (POS 11) or in some cases, the patient's home.
- The services are an integral, although an incidental part of the service.
- **Direct supervision**: The services are rendered under the direct personal supervision of the physician or an employee or independent contractor of the physician. The physician must either be present in the office suite (not necessarily in the treatment room) to render assistance while the NPP provides the service, if necessary. CMS will also permits and has extended direct supervision to the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through December 31, 2024. Another physician in the group who did not establish care may fulfill this requirement.
- The physician must first see the patient to establish care for the initial visit and must remain actively involved in the treatment course with periodic review and oversight of the plan of care. The physician must perform "the initial service and subsequent services of a frequency which reflect his or her active participation in the management of the course of treatment."
- New or Worsening Problems: If an established patient presents with a new or worsening problem, then incident-to billing does not apply. The visit would again require the direct participation of the Physician (i.e. pull into visit). NPP may see the patient alone for the new problem but would need to bill under their own NPI.

DOCUMENTATION OF INCIDENT TOO: NPP documentation should reference a supervising physician was present in the office or that direct supervision was provided and that they are providing follow-up care to the physician's established plan of care

- The rules on incident-to billing can be found in the Medicare Claims Processing Manual (cms.gov)

SPLIT-SHARED BILLING FOR EVALUATION AND MANAGEMENT (E/M) SERVICES:

Split Shared Billing is not allowed in Physician Offices (POS 11): (Effective January 1, 2022)

1. A split-shared visit is a medically necessary E/M visit in the facility setting that is hospital based(POS 19,21,22,23) and is performed in part by both a physician and an NPP who are in the same group. One of the practitioners (not necessarily the one who bills) must have seen the patient face-to-face. Whomever provides the substantive portion of the services bills with Modifier FS under their NPI. Medicare will reimburse 100% of the fee schedule amount when billed by the physician, and 85% of the fee schedule amount when billed by the NPP.
2. In 2024, CMS is implementing an E/M add-on code G2211 and defines the "substantive portion" of a split (or shared) E/M visit to mean more than half of the total time spent by the physician or nonphysician practitioner or a substantive part of the medical decision making.

In Summary:

- Hire appropriately.
- Implement written supervision/collaboration agreements.
- Improve diagnostic accuracy and communication processes.
- NEVER misrepresent Advanced Practice Professionals.
- PROPER ONGOING SUPERVISION.

Questions?

References

- **Board of Registered Nursing**
- **AB 890**
- **Physician Assistant Board: A Brief History of the Physician Assistant**
- **SB 697 Regulations**
- **MBC FAQ: Supervising Physician Assistants**