White paper: Non-Physician Providers in Maternal Fetal Medicine

The American Congress of Obstetricians and Gynecologists have reported a projected decrease in the workforce over the next two decades.[1] This anticipated change in supply and demand is correlated with the demographic changes among physicians and patients, the aging population, and the relatively stable number of OB/GYN trainees.[1] Women's healthcare services will be in greater demand and certain OB/GYN subspecialties will be greatly affected, including Maternal-Fetal Medicine, gynecologic oncology, and female pelvic medicine. Maternal-Fetal Medicine has seen an increase in services as women are experiencing pregnancy and childbirth at a later age. Advances in medical technology and genetic testing have created a high demand amongst these women for high-risk care and supervision. Tremendous medical advancements have also increased the number of women who survive with significant medical diseases who enter their childbearing years and will require high-risk supervision during pregnancy. In addition, the increasing number of women with diabetes, hypertension, HIV, and obesity require more complex obstetric care to some extent during pregnancy. With this projected increase in demand among women's health providers, certain practice-based strategies have been proposed which include the increased utilization of non-physician providers (NPP).

The Bureau of Labor and Statistics predicts an overall growth of NPPs over the next 20 years, in particular, a 38.4 percent growth for PAs is expected between 2012 and 2022. NPPs include nurse midwives (CNM), physician assistants (PA), clinical nurse specialists (CNS), nurse practitioners (NP), and Certified Genetic Counselors. CNMs and NPs must complete a registered nurse (RN) program prior to attending a CNM or NP program. They are licensed, independent practitioners who practice in ambulatory settings and provide nursing and medical services in accordance with their practice specialties.[2] PAs hold a bachelor's degree with pre-requisite science courses and health care experience prior to attending a PA program. They are educated at the graduate level and are required to pass a national certifying exam and be licensed by the governing board in the state where they practice and must earn continuing education credits to maintain certification

and licensure. Genetic counselors typically hold a Master's of Science or higher degree in Genetic Counseling from a program accredited by the Accreditation Council for Genetic Counseling, after which they must pass a certifying examination administered by the American Board of Genetic Counseling.

NPPs play a significant role in several medical/surgical specialties and subspecialties, including primary care, cardiology, intensive care, orthopedics and emergency medicine. Obstetricians have worked with midwives in managing women's health and pregnancy, while physician assistants and nurse practitioners play a unique and defined role in providing care to obstetric patients in the outpatient or hospital setting. They all provide health care in collaboration with other health care professionals; however physicians have a supervising relationship with PAs. PAs duties are dependent on the scope of their individual supervising physician's practice and the desire of the physician to delegate certain tasks or responsibilities in obstetric care. Both PAs and NPs have a broad foundation of medical knowledge and their range of duties are quite varied as they are able to use their primary care training to manage patient's medical conditions during pregnancy. They are trained to perform physical exams, order and interpret tests, diagnose and treat both acute and chronic illnesses. Counseling and patient education are also important aspects of their care. Recently, the Society for Maternal-Fetal Medicine participated in an Advanced Practitioner Workshop to prepare in assisting physician members learn more about how to collaborate and incorporate advanced practitioners in a Maternal-Fetal Medicine practice. This may be the first step toward educating Maternal-Fetal Medicine specialists about this growing group of non-physician women's health practitioners.

Concerns regarding the scope of practice, physician supervision and reimbursement have limited the full utilization of PAs and NPs in obstetrics. PAs can serve as the first assistant in cesarean sections, perform inpatient rounds on antepartum patients and provide prenatal care, counseling and education in the outpatient setting. Several practice models have been created in maternal fetal medicine to include PAs, CNMs, CNSs or NPs to provide inpatient antepartum and labor/delivery triage. Additional models incorporating midwives and OB hospitalists on labor and delivery to provide care have also been increasing. Variation in state laws and hospital regulations influence the extent to which PAs and other NPPs provide obstetrical care. To date, only four states

(New Jersey, New Mexico, Texas and West Virginia) delineate the specific context of PA participation in obstetrical care.

When determining the role of the NPP in an MFM practice, it is important to distinguish between the services each type of NPPs can provide under their scope of practice vs. how to bill for NPP services. This may be location dependent due to different State regulations. Billing can be particularly complex, due to the Medicare "Incident to" guidelines, and the variation in commercial insurance coverage and billing guidelines for NPP services.
Although "Incident to" is a Medicare concept, many payers follow some version of these guidelines. Under "Incident to", the supervising physician may bill in the office setting as the rendering provider for NPP services. To be considered "Incident to", the NPP service must meet all of the following criteria:

- The NPP represents a direct financial expense to the physician/practice (such as a W-2 or leased employee, or an independent contractor)
- The services must be provided in the office setting ("Incident to" does not apply in the hospital place of service)
- The patient must be an established patient to the practice
- The patient's condition must have previously been diagnosed by the physician and a treatment plan already established
- The billing (supervising) physician must be physically present in the office suite.
- For Medicare purposes, the term non-physician practitioner (NPP) includes Nurse Practitioner or Clinical Nurse Specialist, Certified Nurse-Midwife, and Physician Assistant.

For "Incident to" services, payment is made as if the physician personally rendered the service.

It is important to note that not all insurers follow Medicare "Incident to" or Split/Shared Services guidelines. More and more payers are credentialing non-physician practitioners, and some require that NPP services be billed under the NPPs National Provider Identifier (NPI). In addition, even though an insurer may follow "Incident to" or Split/Shared rules, they may require that the NPP directly bill for his/her services provided in institutional/hospital settings. Generally, the payment for services billed directly by the NPP is reduced by 10-20 percent, depending on the insurer. MFM practices should contact all contracted insurers about credentialing their NPP(s), and determine their coverage and billing requirements for services performed by NPPs.

Understanding the Medicare concept for billing and payment of NPP services is paramount to successful implementation into any practice. For additional information on the "Incident to" and Split/Shared Services guidelines, please see the Medicare Benefit Policy Manual, which is available online at http://www.cms.gov

References

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