Non-Physician Providers’ Scope of Practice and Regulations Applicable to Them

Presenter Information
• Cora Butler, RN JD CHC
• This information is presented for educational purposes only, as well as to give you general information and a general understanding of the relevant law, not to provide specific legal advice. The information presented here should not be construed as or used as a substitute for competent legal advice from a licensed professional attorney in your state.

Initial Office Visit Exercise
Circle the health professionals you think may perform the tasks indicated
• Chief Complaint
  - Receptionist/Non-Medical Staff, Medical Assistant, Licensed Practical Nurse, Registered Nurse, Physician’s Assistant, Advanced Practice Nurse, Physician
• Past, Family and/or Social History
  - Receptionist/Non-Medical Staff, Medical Assistant, Licensed Practical Nurse, Registered Nurse, Physician’s Assistant, Advanced Practice Nurse, Physician
• History of Present Illness
  - Receptionist/Non-Medical Staff, Medical Assistant, Licensed Practical Nurse, Registered Nurse, Physician’s Assistant, Advanced Practice Nurse, Physician
• Physical Examinations
  - Receptionist/Non-Medical Staff, Medical Assistant, Licensed Practical Nurse, Registered Nurse, Physician’s Assistant, Advanced Practice Nurse, Physician
• Prescribe controlled substances
  - Receptionist/Non-Medical Staff, Medical Assistant, Licensed Practical Nurse, Registered Nurse, Physician’s Assistant, Advanced Practice Nurse, Physician
What are Scope of Practice Laws and Regulations?

• Scope of Practice Laws and regulations determine what tasks certain types of non-physician professionals (NPPs) and other medical professionals may legally do.

• There are several different sources of Scope of Practice Laws.
  – Notably, the regulations surrounding Medicare payment for NPP and other medical professional services.

Where do Scope of Practice Laws come from?

• State Statutes
  – Statutes are laws that are voted on by state legislatures and signed into law by governors.

• State Regulations
  – Regulations are rules enacted by the executive agencies of states.

• United States Code (USC)
  – Federal statutes.

• Code of Federal Regulations (CFR)
  – Similar to USC, but enacted by federal agencies. In particular, the regulations surrounding Medicare payments.

• Case law
  – Judicial interpretations of laws. Can be federal or state.

• CMS Rules
  – CMS, as the body empowered to enforce Medicare’s regulations, the Centers for Medicare and Medicaid Services (CMS) have considerable leeway in interpreting Medicare regulations.
  – CMS “transmittals” are clarifications of existing regulations that can diverge considerably from the original regulations.
  – CMS Manuals can also contain rules that must be followed for reimbursement.

What are the Consequences of Violating Scope of Practice?

• State Criminal Charge, for practice without a license

• Federal Criminal Charge, for Medicare Fraud (if rules for Medicare reimbursement were violated)

• Loss of License and/or Certification

• Civil Lawsuit (malpractice)

• Medicare Payment Recoupment
Medical Assistants (MAs)

- No Missouri Law specifically governing MAs
- CMS likewise does not address MAs, rather they use the terms "auxiliary" or "ancillary" personnel or staff.
- One exception: Only "credentialed medical assistants" are permitted to enter information in EHR for EHR Meaningful Use purposes.
  - This applies to both Stage 1 and Stage 2, and will apply to Stage 3.
  - CMS FAQ 7693.
  - Because the language used is "licensed healthcare professional," CMS has determined that MAs must have a licensure component beyond their degree or certificate to count as "licensed.
  - Note that the "licensed healthcare professional" likewise excludes medical scribes.
  - No particular credentialing agency mentioned other than it must be a third party agency other than the employer.
  - American Association of Medical Assistants certification recognized, but probably not the only qualifying certification.

Licensed Practical Nurses (LPNs)

- RSMo 335.016(9)
- The performance for compensation of selected acts for the promotion of health and the prevention of disease to persons who are ill, injured, or experiencing alterations in normal health processes. Such performance requires substantial specialized skill, judgment and knowledge. All such nursing care shall be given under the direction of a person licensed by a state regulatory board to prescribe medications and treatments or under the direction of a registered professional nurse. For the purposes of this chapter, "direction" shall mean guidance or supervision provided by a person licensed by a state regulatory board to prescribe medications and treatments, a registered professional nurse, including, but not limited to, written, oral, or otherwise communicated orders or directives for patient care. When practical nursing care is delivered pursuant to the direction of a person licensed by a state regulatory board to prescribe medications and treatments, such care may be delivered without direct physical oversight.

Registered Nurses (RNs)

- RSMo 335.016(15)
- "Professional nursing", the performance for compensation of any act which requires substantial specialized education, judgment and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences, including, but not limited to:
  - Responsibility for the teaching of health care and the prevention of illness to the patient and his or her family;
  - Assessment, nursing diagnosis, nursing care, and counsel of persons who are ill, injured or experiencing alterations in normal health processes;
  - The administration of medications and treatments as prescribed by a person licensed by a state regulatory board to prescribe them;
  - The coordination and assistance in the delivery of a plan of health care with all members of the health team;
  - The teaching and supervision of other persons in the performance of any of the foregoing.
Physician Assistants (PAs)

- RSMo 334.735(3)
- The scope of practice for a physician assistant shall consist of only the following:
  - Taking patient histories;
  - Performing or assisting in the performance of audiometric and patient screening procedures;
  - Performing routine therapeutic procedures;
  - Performing routine office laboratory and patient screening procedures;
  - Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by a licensed physician;
  - Assisting the supervising physician in institutional settings, including reviewing of treatment plans, ordering of diagnostic and therapeutic laboratory and radiological services, and reviewing of medical records;
  - Physician Assistants shall not perform or prescribe abortions.

- Additionally, PAs must practice under the supervision of a physician pursuant to a mandatory written supervision agreement.

Physician Assistant Supervision Agreements

- “Physician assistant supervision agreement” means a written agreement, jointly agreed upon by a supervising physician and a physician assistant, which provides for the delegation of health care services from a supervising physician to a physician assistant and the review of such services.

- Such agreements must contain:
  - Complete names, home and business addresses, and telephone numbers of both the physician and the PA.
  - A list of locations the physician typically provides care, and which of them the PA is authorized to provide care in.
  - All specialty or board certifications of the supervising physician.
  - The manner of supervision, including:
    - An attestation on a form provided by the board that the physician shall provide supervision appropriate to the PA's training and experience and that the PA shall not practice beyond the scope of his or her training and experience nor the supervising physician's capabilities and training;
    - Provide coverage during absence, incapacity, infirmity, or emergency by the supervising physician;
  - The duration of the supervision agreement between the supervising physician and PA; and
  - A description of the time and manner of the supervising physician's review of the PA's delivery of health care services. Such description shall include provisions that the supervising physician, or a designated supervising physician listed in the supervision agreement review a minimum of ten percent of the charts of the physician assistant's delivery of health care services every fourteen days.

Advanced Practice Registered Nurse (APRN)

- RSMO 335.016(2)
  - “Advanced practice registered nurse”, a nurse who has education beyond the basic nursing education and is certified by a nationally recognized professional organization as a certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or a certified clinical nurse specialist.

- 20 CSR 2200-4.100(5)
  - Advanced practice nurses shall function clinically within the professional scope and standards of their advanced practice nursing clinical specialty area and consistent with their formal advanced/nursing education and national certification, if applicable, or within their education, training, knowledge, judgment, skill, and competence as a registered professional nurse.
Collaborative Practices

- Physicians may enter into collaborative practice agreements with APRNs which delegate to them the authority to administer or dispense drugs and provide treatment.
  - RSMo 334.104
  - A physician may have up to but no more than 3 such collaborative agreements.
- Note that, unlike PA supervision agreements, collaborative practice agreements are optional and NPs and other APRNs may have independent practices under Missouri law.
  - However, Medicare will only cover NP services when the NP has a collaborative practice with a physician. Medicare Part B covers nurse practitioners' services...[42 CFR 410.75(c)(3)]
- Available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/...
- Missouri law requires collaborative practice agreements that stipulate prescriptive authority before NPs may prescribe medications.

Collaborative Practices Continued

- Written collaborative practice agreement must include:
  - Complete names, phone numbers and home and business addresses of the physician and nurse(s).
  - List of any other locations where the APRN may practice.
  - A provision requiring notice to patients that they may be seen by an APRN in a physician's practice.
  - All specialty or board certifications of the physician and nurse.
  - A description of the APRN's prescribing authority, if any.
  - A provision that the physician will review a minimum of 20% of charts where the APRN prescribed controlled substances (which may count towards the 10% overall requirement).
CMS and State Scope of Practice Law

• “To ensure that the practitioners and other personnel providing hospital outpatient therapeutic services to Medicare beneficiaries incident to a physician’s or non-physician practitioner’s service do so in accordance with the requirements of the State in which the services are furnished, and to ensure that Medicare payments can be recovered when such services are not furnished in compliance with the State law…” 78 FR 75059.

– In short, CMS has no distinct scope of practice laws, but rather incorporates the relevant state laws by reference.

– It also a requirement that NPPs practice within their states’ scope of practice to bill incident to physician services under Medicare.

  – E.g. – To bill for PA services under Medicare, the PA must be “legally authorized to perform the services in the State in which the services are performed.” 42 CFR 410.74(a)(2)

CMS and Medicare Considerations

• Services provided by NPPs can be included in Medicare payments.

  – Section 2050 of the Medicare Carrier’s Manual states that incidental services must be “part of the physician’s personal services in the course of diagnosis or treatment of an injury or illness.”

• To bill for NPP services under Medicare, CMS’ regulations on supervision and qualifications must be followed.

  – The level of supervision required is determined by the type of facility, which in turn is determined by the Provider-Based Rule, 42 CFR §413.65.

Provider Based Rule

• An extremely long and complex rule, for purposes of this presentation we are primarily concerned with if a facility can be consider a Free Standing Clinic (FSC) or a “provider-based entity,” both of which have distinct supervision and Incident-To billing requirements.

  – FSC

    – “[A]n entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, a remote location of a hospital, a satellite facility, or a provider-based entity.” 42 CFR 413.65(a)(2).
Provider-Based Rule Continued

- Provider-Based Entity
  - “[A] provider of health care services […] that is created by […] a main provider for the purpose of furnishing health care services of different type of the main provider under the ownership and administrative and financial control of the main provider.”

- Main Provider
  - “[A] provider that either creates or acquires ownership of another entity to deliver additional health care services under its name, ownership, and financial and administrative control.”

Levels of Supervision

- CMS defines three distinct levels of supervision.
  - Personal Supervision, the strictest level.
  - Direct Supervision, the medium and presumed “default” level of supervision.
  - General Supervision, the most lenient.

- The level of supervision required is determined by the nature of the procedure as well as the supervisor.
  - Namely, the minimum supervision level for a NPP as a supervisor is Direct Supervision, regardless of the procedure.

Personal Supervision

- The highest level of supervision.
- The physician (or non-physician supervisor) must remain in the same room throughout the entire procedure.
- Generally reserved for diagnostic services and services supervised by non-physicians.
Direct Supervision

- The “default” supervision level, the physician or NPP supervisor must be available and interruptible to take over procedure if needed. Need not be in same room.
  - No specific time limit or distance given to determine availability.
  - Same buildings certainly satisfies availability, same campus probably does, no guidance otherwise.
  - “Interruptible” means the supervisor is not engaging in tasks that cannot be halted immediately.
    - E.g. surgery, emergencies.
  - Note that the supervisor must be interruptible and available throughout the ENTIRE direct supervision period.

General Supervision

- Most lenient, physician must be available for consultation (availability by phone is acceptable).
  - Regardless of setting or type of procedure, all NPPs must be at least “generally” supervised by a physician to bill under Medicare.
  - Procedures considered “non-surgical extended duration therapeutic services” (also called “extended duration services” or “NSEDTS”) may use general supervision after an initiation period of direct supervision.
  - A list of procedures which may be conducted by non-physicians under a physician’s General Supervision and procedures deemed to be NSEDTS is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/OPPS-General-Supervision.pdf

General Supervision and NSEDTS Chart Example
Supervision by Setting

- CAHs and Rural Health Clinics
  - Though CMS has foregone enforcing supervision requirements for these facilities in previous years, it announced that the non-enforcement provision will not be extended through 2014.

- Off-Campus Locations
  - For an off-campus department or satellite that is part of a provider-based entity, the supervising physician must be present at premises of the services.
    - Unfortunately, no guidance yet on just how far may be to be determined “off-campus.”

Incident-To

- To bill for most NPP or medical professional services under Medicare, the services must be “incident-to” a physician’s services.
- However, services and supplies (including drugs and biologicals that cannot be self-administered) incident to a PA’s or NP’s service can also be billed under Medicare provided they are rendered pursuant to a written supervision agreement (for PAs) or written collaborative practice agreement (for NPs).
  - In such situations, the supervising PA or NP must always maintain at least direct supervision, no general supervision is allowed in any setting or circumstance.

- Services incident to a physician or NPP service must be:
  - An integral although incidental part of the physician/NPP’s professional service
  - Commonly rendered without charge or included in the physician’s bill
  - Of a type that are commonly furnished in a physician’s office
  - Furnished by the physician or by auxiliary personnel under the physician’s direct supervision unless for a procedure with an otherwise specified supervision level (such as in the General Supervision and NSEDTS chart earlier).

Incident-To Billing by Setting

- Two types of “Incident-To” payments based on facility type:
  - They sound almost identical but operate under very different billing guidelines.

- Free Standing Clinic
  - 42 U.S.C. 1395(s)(2)(A) – “Incident-To Billing”
    - Must be direct supervision
    - Physician bills NPP services as his or her own.
    - See also Medicare Benefit Policy Manual, Chapter 15, Section 60A

- Hospital
  - 42 U.S.C. 1395(s)(2)(B) – Payment for “Incident-To Services”
    - Physician can bill for NPP services, only the hospital can.
    - See also Medicare Benefit Policy Manual, Chapter 15, Section 60B
Diagnostic Service Supervision

- “A service is “diagnostic” if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury.”

- Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1

- Diagnostic services each have a supervision level predetermined by CMS and set out in the Medicare Physician Fee Schedule Database.

- Direct supervision for diagnostic services has two slightly different meanings depending on the facility:
  - Hospital (On or off campus facility) – “[T]he physician must be immediately available to furnish assistance and direction throughout the performance of the procedure.” – 42 CFR 410.28(e)(1)
  - Nonhospital – “[T]he physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure.” – 42 CFR 410.32(b)(3)(ii), incorporated by reference through 42 CFR 410.28(e)(2)

- Narrower definition for nonhospitals – physician must physically remain within just the office suite rather than “immediately available” which includes at least the entire hospital main building and likely the hospital campus.

Therapeutic Service Supervision

- Most NPP and other staff services will fall under therapeutic services.

- Therapeutic services have a default direct supervision level, with general supervision available for specific procedures in the list cited earlier.

- “CMS requires direct supervision [...] by an appropriate physician or non-physician practitioner in the provision of all therapeutic services to hospital outpatients, including CAH outpatients. CMS may assign certain hospital outpatient therapeutic services either general supervision or personal supervision.”

- Transmittal 169 to Publication 100-02.

NPP Supervision

- Certain NPPs can provide supervision services in therapeutic services

- “Non physician practitioners who are specified under §410.27 of the final regulations as clinical psychologists, licensed clinical social workers, physician assistants, nurses practitioners, clinical nurse specialists, and certified nurse midwives, may directly supervise the work of appropriate NPPs who perform services within their state scope of practice and hospital- granted privileges, provided that they meet all additional requirements as specified in §§ 410.71 (clinical psychologists), 410.72 (clinical social workers), 410.74 (PAs), 410.75 (NPs), 410.76 (临床 nurse specialists), and 410.77 (certified nurse midwives).”

- 74 FR 60591.
NPP Supervision

- However, NPPs can NOT supervise others in Diagnostic services.
  - Even if a NPP can perform a diagnostic service themselves, they may not supervise another non-physician in providing diagnostic service.
- "Thus, while physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives only require physician supervision in any collaboration or supervision requirement particular to that type of practitioner when they personally perform a diagnostic test, these practitioners are not permitted to function as supervisory "physicians" for the purpose of other hospitals staff performing diagnostic tests." Transmittal 128 to Publication 100-02.

Pulmonary and Cardiac Rehabilitation

- "For pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services, direct supervision must be furnished by a doctor of medicine or osteopathy as specified in §§410.47 and 410.49, respectively." Transmittal 169 to Publication 100-02.
- NPPs excluded from supervising these procedures as well.

Documenting Supervision

- In the event of an audit, a provider must be able to affirmatively demonstrate that a qualified physician or practitioner was on campus for supervisory purposes.
  - At minimum: Identity of the supervisor, documentation that supervisor met the requirements of availability and interruptibility (e.g. timesheets, logs or clinical documents that affirmatively state where the supervisor was at certain points in time)
Office Visit Walkthrough

• CMS regulations on which individuals can perform which elements of an office visit are much stricter than Missouri’s.
• The following walkthrough reflects CMS regulations as stated in the Evaluation and Management Services Guide initially published by CMS in December 2010 and confirmed as current as of July 16, 2014.
  – Available at http://www.cms.gov/Outreach-and-Education/Medicare-
    Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-
    ICN006764.pdf
  – The Guide uses the term “ancillary staff,” which includes medical assistants and any other non-physician staff.

Office Visit Walkthrough

• Chief Complaint
  – The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s own words.
  – Any ancillary staff can record the Chief Complaint.
  – Including front desk staff, receptionists, and any others that might not even be considered medical professionals. They simply record and pass along the information to the physician or NPP.

Office Visit Walkthrough

• Review of Systems (ROS)
  – A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.
  – A ROS may be completed by ancillary staff or by the patient on a provided form.
  – To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
Office Visit Walkthrough

- Past, Family and/or Social History (PFSH)
  - The PFSH consists of a review of three areas:
    - Past History – the patient’s past experiences with illnesses, operations, injuries and treatments;
    - Family History – a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk;
    - Social History – an age-appropriate review of past and current activities.
  - A PFSH may be completed by ancillary staff or by the patient on a provided form.
  - To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

History of Present Illness

- The HPI is a chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements: location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms.
- Only HPIs performed by PAs, NPs, and physicians may be reimbursed under Medicare.

Physical Examinations

- There are four broad levels of physical examinations which cover one or more body areas or organ systems:
  - Problem Focused – a limited examination of the affected body area or organ system.
  - Expanded Problem Focused – a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s).
  - Detailed – an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).
  - Comprehensive – a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).
- Only PAs, NPs and physicians may perform physical examinations, regardless of level.
Prescriptive Authority

• Physicians have broad authority to prescribe controlled substances.

• Mid-level practitioners may prescribe controlled medication if they meet certain qualification requirements and a physician has delegated to them the authority to do so.
  – Note that improperly prescribing drugs can lead to criminal charges. The following information is relevant to Missouri mid-level practitioners only.

Prescriptive Authority: Physician Assistants

• PAs may only be granted prescriptive authority by delegation by their supervising physician through their written supervision agreement, and must also obtain a certificate of controlled substance prescriptive authority.

  – Note that improperly prescribing drugs can lead to criminal charges. The following information is relevant to Missouri mid-level practitioners only.

  • Such certificate is obtained from the state’s Board of Healing Arts and shall be issued upon showing:
    – Successful completion of an advanced pharmacology course that includes clinical training in the prescription of drugs, medicines, and therapeutic devices.
    – Completion of a minimum of three hundred clock hours of clinical training by the supervising physician in the prescription of drugs, medicines, and therapeutic devices.
    – Completion of a minimum of one year of supervised clinical practice or supervised clinical experience. The one thousand hours of practice shall be obtained in a program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency, which includes pharmacotherapeutics as a component of its curriculum, and meet any other requirements, in the opinion of the Department of Health and Senior Services.

      – A PA from another state may obtain a certificate of prescriptive authority upon a supervising physician attesting that the other prerequisites had been previously met.

Prescriptive Authority: Nurse Practitioners

• The Board of Nursing may grant a certificate of controlled substance prescriptive authority to an advanced practice registered nurse who:
  – Submits proof of successful completion of an advanced pharmacology course that shall include preceptorial experience in the prescription of drugs, medicines and therapeutic devices, and
  – Provides evidence of a minimum of one thousand hours of practice in an advanced practice registered nurse practice setting education program, and
  – Provides evidence of a minimum of three hundred clock hours preceptorial experience in the prescription of drugs, medicines, and therapeutic devices with a qualified prescriber; and
  – Provides evidence of a minimum of one thousand hours of practice in an advanced practice registered nurse practice setting education program, and
  – Has a controlled substance prescribing authority delegated in the collaborative practice arrangement under section 334.104 with a physician who has an unrestricted federal Drug Enforcement Administration registration number and who is actively engaged in practice comparable in scope, specialty, or expertise to that in which the advanced practice registered nurse regularly practices.
Illinois Distinctions

- Illinois scope of practice laws, including those surrounding prescriptive authority and collaborative agreements, are similar to Missouri’s.
- Notable exception: Physicians and nurses have broad authority to delegate to medical assistants and other ancillary staff.
  - Illinois law states that a registered professional nurse may delegate to registered professional nurses, licensed practical nurses, and other persons.
  - “A registered professional nurse shall not delegate any nursing activity requiring the specialized knowledge, judgment, and skill of a registered nurse to an advanced practice registered nurse, licensed practical nurse, or others persons.”
- Illinois law allows an advanced practice nurse to delegate to registered professional nurses, licensed practical nurses, and others.
  - “[W]e shall not delegate any nursing activity requiring the specialized knowledge, judgment, and skill of a registered nurse to an advanced practice registered nurse, licensed practical nurse, or others persons.”
- Illinois law allows registered professional nurses to delegate to registered professional nurses.
  - “Nothing in this Section shall be construed to limit the delegation of tasks or duties by a physician licensed to practice medicine in all its branches to a licensed practical nurse, a registered professional nurse, or other personnel including, but not limited to, certified nursing assistants or medical assistants.”
- Illinois law is silent on delegation by physician assistants.

Quick Scope of Practice Checklist

- Is the activity permitted by the Missouri Nurse Practice Act (which includes PA scope of practice laws), if relevant?
- If not expressly permitted, are you certain that the activity is not prohibited by any other law or regulation?
- Has the individual completed special education if needed?
- Does the individual possess the appropriate knowledge?
- Is there documented evidence of competency and skill (credentialing)?
- Would a reasonable & prudent individual of the same profession do the act?
- Is the individual prepared to accept the consequences of the action?
- If you answered “no” to any of the above, consider having someone else perform the activity.

Using Complementary Professionals in Practice

- Patient-centered practices use teams to provide efficient and cost-effective health care.
- To accomplish this goal, non-physician professionals are invaluable as “physician extenders,” freeing up a physician’s time by performing part of the health care process.
  - For this to work, non-physician professionals should be working at the top of their license, that is, doing everything they legally may do in order to maximize efficiency.
  - Establishing Policies & Procedures around complementary scope of work can go a long way in ensuring that staff works effectively while also mitigating the risk of legal or compliance issues.
  - Likewise, enumerating qualifications and duties in a job description can reduce staff confusion regarding what is expected of them.
Audits & Monitoring

- The rules surrounding scopes of practice are incredibly complex and constantly changing.
- Regular audits and monitoring can help keep your practice up-to-date with current laws and regulations.
  - Remember, even seemingly minor issues can have major legal and/or financial consequences!

For More Information:

- Name: Cora Butler
- Company: Primaris
- Contact Information: cbutler@primaris.org

Sources

- CMS FAQ 7693
- August 23, 2012, CMS final rule for Stage 2 of the EHR Incentive Programs:
  - 42 CFR 170.177
  - 42 CFR 170.57
  - 21 CFR 804.1 (2013)
- CMS 1500 Claim Form:
  - CMS 1500 Instruction Manual
- Mansfield & Associates:
  - CMS 1500 Instruction Manual
  - 42 CFR 170.013
- Transmittal 543 in Publication 100-02:
  - Medicare Benefit Policy Manual, Chapter 1, Section 415.1
  - 42 CFR 1500 508.23
- 42 USC 1395w-3:
  - Transmittal 543 in Publication 100-02
- Evaluation and Management Services Guide:
  - 225 USC Section 1395w-3
  - 42 USC 1395w-3