Advanced Practice Clinicians

Integrating Advanced Practice Clinicians Into Your Oncology Practice

By Tina Maluso-Bolton, MSN, NP, APRN-BC

The current oncology reimbursement environment challenges practicing oncologists and hematologists at every level. Practices have had to become extremely efficient with little margin for error in resource management. Many practices have added advanced practice oncology clinicians, frequently referred to as midlevel practitioners (MLPs) or by the Medicare-derived term, nonphysician providers (NPPs). Although NPP refers to a variety of specialties, MLP in oncology practice refers specifically to nurse practitioners, physician assistants, and clinical nurse specialists as collaborative partners in providing quality, cost-effective care with demonstrated high levels of patient satisfaction.

Practices that have successfully integrated MLPs usually share common features. These include: (1) a clear, articulated job description; (2) a committed mentor; (3) physician and administrative support; (4) patient and coworker support; (5) feelings of acceptance of the MLP as a valued colleague by all concerned; (6) an atmosphere that supports growth; and (7) physician willingness to delegate. On the other hand, factors that inhibit successful integration include: (1) a lack of appropriate resources for practice, such as a designated computer, examination room, and support staff; (2) unclear or unrealistic role expectations; (3) nursing colleagues feeling threatened; (4) inadequate compensation for role; (5) physician resistance to delegating responsibilities; and (6) lack of understanding of the MLP role function.

Delineate the Role

Role delineation starts with a good job description that defines the role expectations and performance standards, as well as prevents territorial disputes with other NPPs, particularly nursing staff. Be clear about why the MLP was hired and how performance will be measured. It is useful to set measurement criteria such as billable services, patient satisfaction, or contributions to physician efficiency in advance. In addition, a clear contract or employment agreement that defines wages and benefits, overtime, education time, malpractice insurance responsibilities, and paid time off, is useful.

Medicare "Incident-to" Billing Requirements²⁻⁵

Midlevel practitioner (MLP) services will be reimbursed at 100% of the physician rate under Medicare if the service:

- Is furnished "incident to" the professional services of a physician, who initiates the course of treatment and establishes the plan of care
- Is accompanied by subsequent physician services with a frequency that reflects his or her continuing active participation in and management of the course of treatment
- Is furnished under the direct personal supervision of the physician (ie, the physician must be present in the office/suite and available to see the patient if needed when the MLP renders service)
- Is provided by an MLP who is an employee of the physician or clinic
- Is medically necessary
- Is Medicare-covered
- Is commonly provided in a physician's office/clinic
- Is not provided to a new patient or to an existing patient with a new problem
- Is not performed in a hospital setting
- Is billed under the physician's name

Each state has regulations regarding the scope of practice and level of supervision required for each type of practitioner. Both the oncologist and the MLP need to understand these supervision requirements and understand whether an MLP is required to function under standardized protocols. If protocols are necessary, build time into the MLP's initial schedule to write them for the practice, and encourage him or her to collaborate with colleagues to identify best practices. Also, the knowledge of the state drug furnishing or prescribing limitations for MLPs is critical, including their ability to order narcotic pain medications and other Schedule II drugs. Check with the practice's affiliated hospitals regarding privileges for MLPs and become informed about

Oncologist Brings Midlevel Practitioner From Academia to Community Setting

Stephen J. Noga, MD, PhD

While working at the Johns Hopkins Hospital, Stephen J. Noga, MD, PhD, experienced firsthand how valuable nurse practitioners (NPs) are as midlevel practitioners (MLPs) in the academic medicine setting. In 2001 when he joined the Alvin & Lois Lapidus Cancer Institute at Sinai Hospital and Northwest Hospital (Baltimore, Maryland) as its director of medical oncology and hematology, he wanted to introduce NPs to its community-based practice. He was somewhat surprised at the level of resistance he met. The other staff medical oncologists felt the NP would interfere with his patients' care. The nurses wanted to have their questions answered by the oncologists, not by another nurse.

Dr Noga's first challenge was defining the NP's role. He and the NP used guidelines from the professional nursing organizations to create a job description, the plan being to place her in the oncology office. This quickly proved to be a mistake. The nursing staff was already effectively handling the office tasks.

Dr Noga reassigned her to Sinai Hospital's outpatient infusion center. The success has convinced the skeptics.

"In 2001 the infusion center averaged 300 patient visits a month," said Dr Noga. "Today it has more than 1,300."

The Sinai/Northwest Hospital practice now has five NPs (sharing one with a private oncologist) working alongside five medical oncologists. An NP is assigned to each new patient, carries out the initial assessment, and observes the patient throughout treatment. The NPs ensure that chemotherapy orders are carried out, help patients with side effects, coordinate arrangements for related care such as radiology therapy, and act as liaison between physician and patient.

"The NPs have rounded out the practice. Patients often tell them things they won't tell their physician—that they

would like to try some alternative therapies, for example, or that they want to stop chemotherapy and go to hospice."

Defining the NPs' role remains a challenge, however. At one point, both the nurses and NPs were carrying out an assessment on each patient, an unnecessary duplication of effort. The process has been revised; the first professional to see the patient, usually the NP, conducts the initial assessment and logs the results into an electronic medical record.

The NPs meet weekly with the oncologists and discuss the status of each patient. This not only keeps the NPs well-informed about the patients, but also helps reinforce to the nursing staff the NPs' role as direct extensions of the physicians.

The NPs bill for their services, especially for visits involving assessments, examinations, and procedures. Their salaries are easily covered by their billings, which currently match the level of the oncologists.

This, however, has created another challenge.

"Occasionally, patients will ask why they [through their insurance] are being billed for these services," said Dr Noga. "They don't see the difference between the nurse practitioner and the office or infusion center nurses. We have realized that we need to explain up front [to new patients] that the nurse practitioner is a direct extension of the physician and so will be billing for services just as the physician will do."

The NPs are less involved in inpatient care, but that is changing. An outpatient NP accompanies the oncologists on rounds and takes responsibility for the patient's transition to outpatient infusion care. Next year, Dr Noga expects to add a full-time inpatient position.

the supervision requirements and reimbursement implications of having the MLP assist in the management of hospitalized patients.

It is important to commit to establishing the advanced practice clinician as a credible professional with other staff and colleagues. Regular feedback and peer review from a senior staff member is essential to review the MLP's skills in assessment, development of differential diagnoses, interpretation of diagnostic data, diagnosis, and treatment planning. Plan to include the advanced practice clinician in

tumor boards or medical grand rounds. This will not only increase the MLP's knowledge base, but also introduce him or her to the practice's preferred consultants and colleagues, who will need to recognize this person as a valued part of the oncology team.

Mentoring and Supervision

Having a designated mentor, committed to integrating the MLP and assisting in his or her professional development, is essential to successful integration. The MLP is not a medical

A Successful Collaborative Relationship **Alicia Wojchik, RN, MAN, CNP, OCN**

Nurse practitioners (NPs) have been a part of the Minnesota Oncology/Hematology P.A. Minneapolis office since 1997. Currently there are four NPs, both full- and part-time, practicing in collaboration with a total of nine physicians. The true success of this practice integration has been a willingness of the physicians to utilize the NP, to understand the NP scope of practice, and to understand where the value of the role of the NP lies.

Per the Minnesota Board of Nursing guidelines, the NP can perform examinations, diagnose and treat illnesses, order diagnostic tests, and counsel/educate patients. The NP in Minnesota has full prescribing rights with a collaborative written agreement with a physician and DEA number.

In Ms Wojchik's office, patients are seen on a rotational basis. The physician sees the patient initially and then

rotates every other visit with the NP. Patients who are having difficulties with symptom management will be placed on the NP schedule to address their needs, including management of nausea, vomiting, GI disturbances, pain, and possible disease progression. Those patients at high risk for hospitalization are seen on a weekly basis. Ideally the NP schedule is left with available appointments in order to accommodate patients that call with acute symptoms needing evaluation, treatment, and perhaps hospitalization. By acknowledging the capability and knowledge base of the NP to treat and manage systems, the physician schedule is more open to accept new patients.

Successful integration of the NP utilizing respect, trust, and knowledge of the unique roles, scopes of practice, and strengths of the physician and NP has benefited the office and more importantly, our patients.

student or intern, and learning by mistakes is not an appropriate approach. Choose a mentoring style appropriate for this level of practice: Be mindful of what the clinician is able to recognize and treat as they are reviewed for their decision-making capabilities, and mentor for growth. For example, MLPs generally do not need to understand the pathophysiologic basis for many rare diseases, for which collaborative consultation should be sought. MLPs should, however, be able to identify and treat common disorders. Make a conscious effort to include the advanced practice clinician in discussions of pertinent abnormal physical assessment findings to help improve physical assessment skills.

The mentor can also make certain the MLP is on the distribution list for sentinel articles, new treatment guidelines, and other important information. Provide access to teleconferences, CD-ROMs, and educational monographs that come into the practice office. Additionally, use colleagues to assist in the educational process. As the MLP becomes recognized as a credible clinician, many of the barriers to advanced practice role function will begin to remove themselves.

Inexperienced MLPs are often unable to provide succinct, expeditious dictation of progress notes and presentation of new patient cases. If necessary, assist the MLP in developing skills to present only the pertinent treatment history and positive and negative findings, along with the diagnosis, stage of disease, pertinent co-morbidities, current treatment, and response. While knowledge of the whole patient is a reasonable expectation, all providers must be able to succinctly summarize the critical elements of patient presentation as part of safe and efficient practice. Dictation skills are best learned through repeated practice and feedback

from senior staff. Speed will increase as the skill level improves. If the dictation lacks the basic structure you desire, provide a template model.

Interpersonal Relationships

Practices initiating use of an MLP may find interpersonal relationships to be one of the biggest challenges. To lessen conflicts, introduce the MLP to everyone in the practice, including the billing and coding staff, and emphasize the value of learning co-workers' names and job responsibilities. Have the MLP spend a day or two with the nursing staff to get a feel for patient flow and the nursing responsibilities. Orient the MLP to the practice reporting "chain of command."

If the position of MLP is new to the practice, it's important to remember that not everyone "signed on" for this change. Commonly, nurses and even practice and office managers may feel threatened and resentful when an MLP, who is frequently more educated, joins the practice and can assist the physician in ways in which they cannot. The necessarily close relationship between physician and MLP can fuel jealousy, gossip, and resentment. Watch for signs of territorialism and attempts at sabotage and address them at once.

Avoid shifting any current nursing responsibilities to the MLP, at least initially. The higher-level tasks (such as patient education, counseling, and higher level triage) that are frequently shifted are commonly the tasks that provide nursing staff with significant job satisfaction and personal empowerment. Removing these tasks will most likely fuel resentment.

While it is necessary to understand the initial resentment, a show of support for the MLP is critical for success. Ensure

Long-Range Plan Key to Ohio Group's Success With Nurse Practitioners

Timothy Moore, MD

Mid Ohio Oncology/Hematology Inc (Columbus, Ohio) has a 3-year plan for sustainability and financial stability that calls for its four offices to be replaced with one multiservice site. Patients will be able to get radiation therapy, chemotherapy, and medications at a single facility. To prepare for this larger practice, the 11 physicians knew they had to begin expanding their patient volume prior to the changeover. A little over a year ago, they hired an NP to help accomplish that.

Without a history of working with nurse practitioners (NPs), however, the physicians and nurses initially struggled with issues of trust and turf, says Timothy Moore, MD. What exactly could the NP do more effectively than the physicians? What was the best use of the skills of this well-paid, well-trained professional?

"The nurse practitioner is a bridge between the doctor and nurse. It takes a very special kind of person to take on this interface position," says Dr Moore.

At first, the NP was simply carrying out most of the duties of a chemotherapy nurse. While the group is still feeling its way somewhat, the NP has now taken on a number of patient-care responsibilities, freeing physicians to see new patients and care for hospitalized patients. She also added to the revenue stream by carrying out billable tasks once handled by nurses with less effectiveness and without reimbursement.

The NP has been particularly valuable caring for patients undergoing chemotherapy who develop acute problems that may or may not be related to their therapy. For example, the NP assesses patients experiencing side effects of their chemotherapy and, in most instances, devises a

treatment plan. Patients who develop upper respiratory symptoms of influenza but who are otherwise stable on chemotherapy are seen by the NP and receive their cough medicines and other drugs without seeing a physician.

Having a long-range plan, identifying needs from that plan, and then evaluating whether or how an NP or other physician extender can meet those needs is crucial, says Dr Moore.

"These are very well-trained professionals and they need to be treated as such in terms of utilization," he says. "You want to be prepared to utilize them from the start and into the future."

Mid Ohio hired its first NP as a graduate of the local university program. However, the practice's long-range planning meant it had the luxury of time—time that could be invested in helping a staff nurse complete the 2-year program to become an NP. Following her recent graduation, she became the practice's second NP.

"By offering to help finance certification training for one of our nurses, we have an NP who knows us and whom we know from day 1. With the experience we've gained from the first NP and our existing relationship with the second one, we expect to be better able to fully integrate her into the practice at once."

Now that it has two NPs, the practice anticipates expanding their role. Among the likely tasks will be alternating with physicians in seeing patients whose therapy requires frequent office visits, providing pain management for patients on palliative care, and preparing hospitalized patients for physician visits.

that the staff understands that making this person an important part of the team is not optional. As the MLP establishes credibility as a clinician, most of the barriers to nursing trust will dissolve as well.

Billing for Services

Health plans set their own policies for credentialing MLPs and providing reimbursement for their services. Some plans credential MLPs and allow their services to be billed under the MLPs' provider numbers. Other plans instruct practices to bill for services provided by MLPs as if the physician had provided them, using the physician's name and provider number on the claim. Medicare refers to this arrangement as "incident-to" billing and has a set of rules that apply (see sidebar "Medicare 'Incident-to' Billing Requirements").

When these guidelines are met, the practice will be reimbursed for MLP services at 100% of the physician rate.²⁻⁵ In interpreting the requirement of "direct, personal supervision of physician," the Center for Medicare & Medicaid Services requires the physician to be present in the same office suite but not necessarily in the same office, nor does the physician need to see the patient personally.^{3,4} Without the presence of a collaborating physician, MLP professional visits with Medicare patients are billed under the MLP's own provider number, and the evaluation and management service is reimbursed at 85% of the physician fee.

While these rules pertain exclusively to Medicare reimbursement, other payers may reimburse for NPP services

differently. Carefully review the physician participation agreement for the managed care companies with which the practice contracts as well as state laws. This will help determine whether physicians have complete authority, as is often the case, to delegate to NPP services within their scope of practice. Many state laws allow a general delegation of authority with responsibility retained by the physician without requiring on-premises supervision.⁵ When provider agreements recognize this delegation, claims for the MLP's services are generally submitted as if rendered under the Medicare incident-to rules.

Developing the MLP's Schedule

The MLP's schedule should be based on the practice's goals and the tasks he or she will carry out. For example, to maximize billable services, it may be advantageous to schedule a follow-up clinic for the MLP that is run concomitantly and in the same office suite as one or more practice physicians, thus maximizing opportunities for Medicare "incident-to" billing. MLPs frequently see patients undergoing chemotherapy who are experiencing difficulties or need adjustments in antiemetics or provision of RBC or WBC growth factors. However, Medicare will not pay for a "level 1" patient visit on the same day as chemotherapy, so appropriate scheduling is essential. Finally, MLPs who assist in the management of outpatients as well as taking a portion of hospital inpatient rounds, free up the physician to see new patients.

Practice Efficiency: The Business of Oncology

An MLP who is knowledgeable about practice management and finances can contribute tremendously to practice efficiency. Make sure the MLP understands practice basics, such as the primary sources of revenue, payer mix, and important contractual agreements; patient flow; and the need to obtain authorization for chemotherapy, drugs, procedures, and visits. Encourage the MLP to speak and understand the language of reimbursement, including common terms

appropriate for the setting, and to fully understand the International Classification of Disease (ICD) and Common Procedural Terminology (CPT) coding. The practice benefits when the MLP has a clear understanding of the coding process and of the documentation required to support higher levels of care, collaboration, or supervision as needed. If the MLP knows the common formularies from which the practice prescribes, such as practice-specific preferred drugs, hospital inpatient and outpatient formularies, and payer-specific formularies for your most common payer sources, the unnecessary pharmacy telephone calls seeking clarification and calls from unhappy patients hit with costly copayments for prescriptions of nonformulary medications can be avoided.

MLPs can also contribute to practice efficiency by working in collaboration with the practice physicians to develop and implement protocols to manage common time-consuming supportive care problems, such as anemia, neutropenia, and nausea and vomiting. The development and implementation of protocols can assist in the delivery of evidence-based practice, decrease hospitalizations and patient morbidity, decrease physician interruptions, empower the nursing staff, and provide opportunities for collaboration and partnership between the MLP and nursing staff. Additionally, implementation of protocols can assist in providing the necessary documentation to support reimbursement.

Conclusion

As with other significant practice changes, successfully integrating the role of mid-level practitioner into the oncology team will require substantial commitment of time and resources at first. However, the potential payback (in increased revenue and practice efficiency, patient satisfaction, and collegial input) has proven worth the effort in many oncology practices.

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