Session 49 PD, Physician Efficiency Strategies

Moderator:
Sara Corrough Teppema, FSA, MAAA

Presenters:
Tracy Cardin, ACNP-BC, FHM
Theresa Jones, RN, FNP-BC
Advanced Practice Providers: a hospitalist perspective

• Tracy E. Cardin, ACNP, FHM
  • University of Chicago
What did you call me?
Language is powerful

Appropriate terms:

1. Nurse Practitioner (NP)
2. Physician Assistant (PA)
3. Advanced practice nurse (APN)
4. Advanced practice provider (APP)
Avoid

- Physician extender
- Non-physician provider
- Mid level provider
- Nurse
- Physician’s assistant
Hospitalists-what are they

• Fastest growing medical specialty
• Total of at least 40,000 providers who identify themselves as “hospitalists”-likely more out there
• Society of Hospital Medicine has 14,000 members
• NP/PA members doubled in the last 3 years
• 65% of HMG have NP/PA providers in their practice
Hospitalists

• Expanding beyond general medicine inpatients to sub specialty co-management
• Also becoming more active in post acute care
• Can be hospital employed or in a private practice group contracting with the hospital
• Usually given some financial support from hospital
• Does hospital’s institutional by-laws permit NP/PA practice?
• Organizational Privileges
• Core privileges
• Privileges specific to work areas
<table>
<thead>
<tr>
<th>Philosophy</th>
<th>Nurse Practitioner</th>
<th>Physician Assistants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nursing model (patient-centered, health education, assessment)</td>
<td>Medical model (disease-centered, biology, pathology, diagnosis, treatment)</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Training</th>
</tr>
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<tbody>
<tr>
<td>-Pre-requisites</td>
</tr>
<tr>
<td>-courses</td>
</tr>
<tr>
<td>-Clinical time</td>
</tr>
<tr>
<td>Degree</td>
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</tbody>
</table>
3 Common Scenarios

1. Getting overwhelmed with admissions late in the day
2. Need help and need a lower cost option or NP/PA only available option
3. Problem-specific
   - Readmissions
   - Census Surges
   - Consult services
Some Models…
MD/APP Team Option 1

- 16 patients
  - APP = 8
  - MD = 8 + 0 to 8 = 8 to 16
- See patients independently
- Can increase MD and APP satisfaction
  - Autonomy, decreased work load
- But, again, coverage and collaboration
Team approach

– Pros
  • increased MD satisfaction
  • Increased billing, patient encounters
  • More eyes on patients

– Cons
  • APPs often work different hours than MDs
  • Resentment
  • How will you cover when APP not there?
  • Duplication of work
MD/APP Team: Option 2

- MD and APP round on all patients together in am
- Split patients equally for note-writing, calling consults, care coordination, billing
- Pros: both team members intimately know patient
- Cons: time waste
MD/APP Team: Option 3

• MD sees patients every third day
• Pros
  – MD knows patients better for when APP away
  – Distributes patients by acuity
  – Continuity with APP
• Cons
  – Typically lower acuity patients
  – Check bylaws!
APP Owns Patients

Short stay, disease-specific

– Pros
  • Great autonomy
  • MDs can focus on higher acuity patients
  • Great APP satisfaction
  • Lower cost

– Cons
  • Coverage when APP away
  • Hard for MD to jump in/out when APP needs input
• Will take a year to get to steady state.
• Plan for:
  – Training
  – Ramp up of productivity
  – Physician oversight
### NP/PA Productivity

<table>
<thead>
<tr>
<th>Months</th>
<th>New Grad Productivity</th>
<th>Old Hand Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>&lt; 20%</td>
<td>60%</td>
</tr>
<tr>
<td>3-6</td>
<td>40%</td>
<td>80%</td>
</tr>
<tr>
<td>6-8</td>
<td>60%</td>
<td>100%</td>
</tr>
<tr>
<td>8-12</td>
<td>80% plus</td>
<td>100%</td>
</tr>
</tbody>
</table>
Physician oversight: No free lunch

• Need to recognize oversight as valued work:
  – Direct pay for role
  – Decrease physician census
  – Attribute some portion of work generated by NP/PA to physician
<table>
<thead>
<tr>
<th></th>
<th>5-10%</th>
<th>10-15%</th>
<th>15-20%</th>
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</thead>
<tbody>
<tr>
<td><strong>Uncomplicated patient</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Complex</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Experienced NP/PA</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>New Grad NP/PA</strong></td>
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</table>
Optimization

• Occurs when skill set is match for clinical need=less supervision, less cost

• How to approach-
  a. Increase complexity of patients on the physician side
  b. Decrease supervision
Optimization cont

- Utilize NP/PA in a specific and limited role ie Observation Unit
- NP/PA would see same volume as a physician, but cost less. Don’t need to pay for physician oversight
- BUT-there are start up inefficiencies to NP/PA that are not there with physician
Compensation

- Salary alone
- Salary plus shared savings program
- Salary plus productivity incentive
  - Patient encounters, RVU, patient satisfaction
Question 25: What percentage of your total compensation is comprised of productivity incentives?

- 90% for 0-10%
- 10% for 11-20%
- 5% for 21-30%
- 3% for 31-40%
- 2% for 41-50%
- 0% for More than 50%
Survey

Question 28: Current base salary is

- $40-$49,000/year: 15%
- $50-$59,000/year: 2%
- $60-$69,000/year: 6%
- $70-$79,000/year: 1%
- $80-$89,000/year: 10%
- $90-$99,000/year: 8%
- $100,000-$119,000/year: 24%
- $120,000-$129,000/year: 34%
- More than $130,000/year: 2%
Cost: What is cost of NP/PA?

- Compensation + fringe (know your fringe rate)
- Hiring
- Training
- Malpractice
- Physician oversight - more later
## Costs

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>NP</th>
<th>Internist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median compensation</td>
<td>$87,649</td>
<td>$80,365</td>
<td>$191,198</td>
</tr>
<tr>
<td>Median gross charges</td>
<td>$352,596</td>
<td>$315,907</td>
<td>$554,476</td>
</tr>
<tr>
<td>Median Collections</td>
<td>$246,001</td>
<td>$204,442</td>
<td>$346,070</td>
</tr>
<tr>
<td>Median compensation/collection ratio</td>
<td>.349</td>
<td>.376</td>
<td>.567</td>
</tr>
</tbody>
</table>

Revenue: Hospital funds transfer

• Volume
• Quality
• Safety
• Experience
• Efficiency
Is this a good ROI?  
From whose perspective?

- Hospital funds flow transfers are usually not done to incentivize greater professional fees
- Can you demonstrate:
  - Lower hospital costs
    - Lower LOS, decreased penalty, etc.
  - Higher hospital revenues
    - Value Based Purchasing
- If your NP/PA is targeting these improvements, measure their effect as best you can
Do NP/PAs positively affect revenue at reduced cost?

- NP/PA FTE lower cost than MD FTE
- Manage the care of patients that don’t need a physician at the bedside
- Coordinate the process of care
- Can augment practice productivity
- Can be used to maximize hospital funds flow
- Services reimbursed by Medicare/Insurers
Conclusion

• NP/PA additions can augment hospitalist practice in a variety of ways

• Consider the problem you are trying to solve before hiring

• Optimize skill set with patient population to reduce MD oversight
Session 49: Physician Efficiency Strategies

Moderator: Sara Teppema, FSA, MAAA
Speakers: Tracy Cardin, ACNP-BC, FHM
Theresa Jones, RN, MS, FNP-BC

October 12, 2015
Today’s Discussion

Goals for today
- Provide “101 level” overview of health care delivery by health care professionals other than physicians
- Provide publicly available data on costs associated with these professionals
- Invite and encourage a “201 level” session next year, adding cost and utilization data

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Sara Teppema, Valence Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care perspective</td>
<td>Terri Jones, RN, MS, FNP-BC</td>
</tr>
<tr>
<td>Have Practitioner in primary care practice</td>
<td>Austin, TX</td>
</tr>
<tr>
<td>Hospitalist perspective</td>
<td>Tracy Cardin, ACNP-BC, FHM</td>
</tr>
<tr>
<td>University of Chicago Hospital</td>
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<tr>
<td>An actuary’s perspective</td>
<td>Sara Teppema</td>
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</table>
Provider Efficiency: Realities

“The train has left the station”

• Risk is shifting away from traditional insurance models and toward providers and provider organizations

Providers need to think like insurers

• Traditional focus on managing their cost per service
• Evolving focus on Total Cost of Care, aka PMPM
• Trading volume increases for declining reimbursement won’t work anymore
Payors are Addressing Rising Costs by Shifting to “Value-based” Payment Systems

“Value-based” systems imply increased provider risk both for total cost of care as well as for quality of care.

Payors bear most accountability for cost of care
- Percentage of charges
- Per-diem
- FFS Negotiated rates

Increased provider accountability for “Total Cost of Care”
- APR DRGs
- Bundling across inpatient & ambulatory services (e.g.: OB)
- Downward pressure on rates + P4P
Non-Physician Professionals Can Significantly Improve the Per-Service Cost of Professional Services

Advance practice nurses and physician assistants can improve both quality and efficiency

• Enable all professionals to “practice at the top of their license”
• Advance practice registered nurses (APRNs), aka Advance Practice Professionals (APPs) including Nurse Practitioners
• Physician Assistants
• Nurse Practitioners vs. Physician Assistants
  • Both require a master’s degree to be certified
  • Median pay is similar
  • NP training is typically in nursing schools, PA training is typically in medical schools

Types of APRNs or APPs:
• Nurse practitioners (NPs)
• Nurse anesthetists
• Nurse-midwives
• Clinical nurse specialists
APPs practice in all care settings…

• Primary care is the most common: 70-80% of APRNs
  • Patient-centered medical homes (PCMHs) are growing
  • Retail clinics are typically staffed by NPs
• Also hospital, in a hospitalist role or other roles
• Specialist practices
• Behavioral health
• Long term care

… And across all demographics and payor types

• Medicare, Medicaid, Commercial
• Geriatric, Pediatric, adult
Nurse Practitioners in the Primary Care Setting
Nurse Practitioners in the Hospitalist Setting
The Actuary’s Perspective
Practice productivity improves with NPs/PAs

• The median NP salary in 2010 was about half of median family practice and internal medicine salaries

• PA/NPs have potential to attend to between 50% and 75% of primary care visits. One study notes the following costs to an integrated health system:

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Cost Per Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic surgeon</td>
<td>$4.00</td>
</tr>
<tr>
<td>Primary care physician</td>
<td>$2.00</td>
</tr>
<tr>
<td>Nurse practitioner or physical therapist</td>
<td>$1.00</td>
</tr>
</tbody>
</table>

• Adding an NP to an existing primary care practice could double the patient panel, adding an increase of $1.28 PMPM in revenue to the practice

• In Tennessee, NPs average care delivery costs were 23% below the average of other PCPs

• Productivity can improve when NPs see patients independently, versus in a complementary manner
Publicly Available Studies Indicate Cost Efficiency of NPs and PAs Without a Compromise in Quality

Other Outcomes

• NP-managed practices may drive lower utilization in ED and inpatient days
  • The use of health risk adjustment in these two studies is not known
• Studies also show no difference in patient satisfaction between visits attended by an MD versus those attended by a NP or PA

System savings

• 2009 RAND recommendations to Massachusetts for reducing health care spending included the following:
  • Encourage greater use of NPs and PAs: system savings of 0.6% to 1.3%
  • Increase availability and use of retail clinics (staffed primarily by NPs): system savings of up to 0.9%

Most publicly available studies of NP/PA cost efficiency are related to primary care.
Adding APPs to Networks Has Benefits and Challenges

Benefits

• Increased productivity within primary care practices
• Nationwide PCP shortfall can be addressed
• Higher quality:
  • Physicians can focus on complicated cases and procedures
  • NPs/PAs can spend additional time on patient focus, engagement and more basic primary care
• Alternative practice philosophies

Challenges

• Payor reimbursement policies and rules may not allow NP/PA reimbursement without physician
• NPs/PAs typically spend additional time with patients, which may not be reimbursed
• Physician review
• Prescribing laws and policies
Resources

American Association of Nurse Practitioners

- AANP Position statements and papers:
- http://www.aanp.org/publications/position-statements-papers

American Academy of Physician Assistants

- https://www.aapa.org/

Society for Hospital Medicine

Health Affairs articles

- Mary D. Naylor and Ellen T. Kurtzman, The Role Of Nurse Practitioners In Reinventing Primary Care, Health Affairs, 29, no.5 (2010):893-899
  http://content.healthaffairs.org/content/29/5/893.full.html
- C. Craig Blackmore, Robert S. Mecklenburg and Gary S. Kaplan; At Virginia Mason, Collaboration Among Providers, Employers, And Health Plans To Transform Care Cut Costs And Improved Quality; Health Affairs, 30, no.9 (2011):1680-1687
  http://content.healthaffairs.org/content/30/9/1680.full.html
- Don’t forget: SOA Health Section members have online access to Health Affairs!

Other studies are cited within the sources listed above.
Welcome to Austin, Texas!
Terri Jones, RN, MS, FNP-BC

- FNP at Family First in Leander, TX
- BSN at University of Evansville
- M.S. and NP degree from University of Illinois at Chicago
- Practices:
  - Large multi specialty practice with predominately HMO patients
  - Small privately owned family practice
  - Corporately owned FP
Agenda

✓ Introduction
✓ What is a Nurse Practitioner?
✓ Scope of Practice
✓ Statistics
✓ Studies
✓ Barriers for NPs
✓ My Practice
What is a Nurse Practitioner?

Nurse practitioners are licensed, independent practitioners who practice in ambulatory, acute and long-term care as primary and/or specialty care providers. They provide nursing and medical services to individuals, families and groups accordant with their practice specialties.

- Diagnosing and managing acute episodic and chronic illnesses
- NPs emphasize health promotion and disease prevention
- Services include ordering and interpreting diagnostic and laboratory tests
- Prescribing pharmacological agents and non-pharmacologic therapies
- Teaching and counseling patients
- Health care researchers, interdisciplinary consultants and patient advocates

**Education & Training**
- Master's or doctoral degree program.
- Advanced clinical training beyond their initial professional registered nurse preparation
- Didactic and clinical courses

**Qualifications**
- NPs undergo national certification ANCC
- Periodic peer review, clinical outcome evaluations, and adhere to a code for ethical practices.
- Self-directed continued learning and professional development is also essential to maintaining clinical competency.
- NPs lead and participate in both professional and lay health care forums, conduct research and apply findings to clinical practice.
Scope of Practice

• Provide a full range of primary, acute and specialty health care services including:
  • Order and interpret diagnostic tests such as lab work and x-rays
  • Diagnosing and treating acute and chronic conditions such as diabetes, high blood pressure, infections, and injuries
  • Prescribing medications and other treatments
  • Managing patients' overall care
  • Counseling
  • Educating patients on disease prevention and positive health and lifestyle choices
Statistics

- There are more than 205,000 nurse practitioners (NPs) licensed in the U.S. ¹
- An estimated 15,000 new NPs completed their academic programs in 2012-2013 ²
  - 95.1% of NPs have graduate degrees ³
  - 96.8% of NPs maintain national certification ³
  - 86.5% of NPs are prepared in primary care ⁴
  - 84.9% of NPs see patients covered by Medicare and 83.9% by Medicaid ³
  - 44.8% of NPs hold hospital privileges; 15.2% have long term care privileges ³
  - 97.2% of NPs prescribe medications, averaging 19 prescriptions per day ³
- In 2015,
  - Average full-time base salary was $97,083
  - Average full-time NP total income at $108,643 ⁵
- Malpractice rates remain low
  - only 2% have been named as primary defendant in a malpractice case ³
- NPs hold prescriptive privilege in all 50 states and D.C., with controlled substances in 49
- In 26 states, NPs have the authority to practice independently
- 69.5% of NPs see 3 or more patients per hour ³
- Nurse Practitioners have been in practice an average of 10 years ⁴

Sources:
¹ AANP National Nurse Practitioner Database, 2014 ² 2013-2014 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing.
<table>
<thead>
<tr>
<th>Population</th>
<th>% of NPs</th>
<th>Yrs of Practice</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>7.5</td>
<td>8</td>
<td>46</td>
</tr>
<tr>
<td>Adult+</td>
<td>19.3</td>
<td>11</td>
<td>50</td>
</tr>
<tr>
<td>Family+</td>
<td>54.5</td>
<td>9</td>
<td>48</td>
</tr>
<tr>
<td>Gerontological+</td>
<td>2.5</td>
<td>13</td>
<td>53</td>
</tr>
<tr>
<td>Neonatal</td>
<td>1.1</td>
<td>16</td>
<td>52</td>
</tr>
<tr>
<td>Oncology</td>
<td>1.2</td>
<td>9</td>
<td>47</td>
</tr>
<tr>
<td>Pediatric+</td>
<td>5.3</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>Psych/Mental Health</td>
<td>3.7</td>
<td>11</td>
<td>54</td>
</tr>
<tr>
<td>Women’s Health+</td>
<td>4.9</td>
<td>17</td>
<td>53</td>
</tr>
</tbody>
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*Distribution, Mean Years of Practice, Mean Age by Main Specialty*
Nurse Practitioner

What my friends think I do.

What my mom thinks I do.

What my patients think I do.

What doctors think I do.

What I think I do.

What I actually do.
Nurse Practitioners Are Not Mid-Level Providers

Do not call nurse practitioners mid-level providers, physician extenders, or non-physicians. If you can’t decide how to address one, I would suggest using “nurse practitioner.” Your next best bet would be, “highly-educated professional providing expert medical care to diverse populations with a steadfast belief in the value of health promotion and patient-centered care.”

Source: Health eCareers By Dr. Melissa DeCapua, DNP, PMHNP On Sep 18, 2015
A meta-analysis in *Nursing Economic* (August 2011) stretching over 18 years compared care provided by advanced practice registered nurses (APRNs) to care provided by physicians. Care was compared in 24 different categories.

- APRNs performed equal to physicians in 13 categories.
- APRNs performed *better than* physicians in 11 categories.
- Physicians performed better than APRNs in zero categories.
- The categories in which APRNs outperformed physicians:
  - For Nurse Practitioners:
    - Lower blood sugar levels
    - Lower serum lipid levels
  - For Certified Nurse Midwives:
    - Lower C-section rates
    - Fewer epidurals
    - Less analgesia
    - Better breastfeeding rates
    - More VBACs (vaginal births after delivery)
    - Fewer NICU admissions
    - Fewer episiotomies
    - Fewer perineal lacerations after delivery
    - Lower rate of labor induction and augmentation
Patients co-managed by APRNs receive much better care than when managed by physicians alone

- Patients co-managed by APRNs receive much better care than when managed by physicians alone
- Patients 75 and over with at least one of the following conditions were treated either by an APRN/physician team, or by a physician alone

Source:
### Effect of Nurse Practitioner Co-management on the Care of Geriatric Conditions

<table>
<thead>
<tr>
<th>Condition treated in 1,084 patients over 75 years of age</th>
<th>Co-managed by APRN and physician team, percentage of recommended care received</th>
<th>Managed by physician alone, percentage of recommended care received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>80%</td>
<td>34%</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>66%</td>
<td>19%</td>
</tr>
<tr>
<td>Dementia</td>
<td>59%</td>
<td>38%</td>
</tr>
<tr>
<td>Depression</td>
<td>63%</td>
<td>60%</td>
</tr>
</tbody>
</table>

**Source:**
Evidence of the equivalence of care provided by NPs and physicians

- Care provided by NPs is as effective as, and no different from, that of physicians in terms of health status, treatment practices, and prescribing behavior.
- NPs achieved consistently better results than their physician colleagues on measures of patient follow-up, consultation time, satisfaction, and the provision of screening, assessment, and counseling.

Source:
Laura Stokowski at Medscape summarizes the study "The Role Of Nurse Practitioners In Reinventing Primary Care" by Mary Naylor & Ellen Kurtzman in Health Affairs (2010;29:893-899)
Primary Care Outcomes- Two year follow up

This study reports results of the 2-year follow-up phase of a randomized study comparing outcomes of patients assigned to a nurse practitioner or a physician primary care practice. In the sample of 406 adults, no differences were found between the groups in health status, disease-specific physiologic measures, satisfaction or use of specialist, emergency room or inpatient services. Physician patients averaged more primary care visits than nurse practitioner patients. The results are consistent with the 6-month findings and with a growing body of evidence that the quality of primary care delivered by nurse practitioners is equivalent to that by physicians.

Source:
Primary care outcomes in patients treated by nurse practitioners or physicians: Two-year follow-up. Medical Care Research and review. 2004 Sep;61(3):332-51  Lenz ER, undinger MO, Kane RL, Hopkins SC, Lin SX, Ohio State University, OH, USA.
Drugs and Devices Delegation

- TMB Rule 193.6:
  - Delegate ordering and prescribing nonprescription drugs, prescription drugs, medical devices and durable medical equipment

- Schedules III-V Controlled Substances subject to four limitations
  1. The duration of the prescription, including refills of the original prescription, may not exceed 90 days
  2. Continued treatment with the same controlled substance beyond 90 days requires consultation with the delegating physician prior to writing another prescription or refilling the original prescription
  3. Treating a child under age two years requires prior consultation with the delegating physician
  4. Consultation with the physician must be noted in the patient’s medical record

- Schedule II Controlled Substances
  1. Treating patients who are terminally ill and cared for through a qualified hospice care provider
  2. Facility-based in a hospital and treating patients in that hospital’s emergency department
  3. Facility-based in a hospital and treating patients admitted for an intended length > 24 hours
Written PAA must include:

- The name, address, and all professional license numbers of the parties to the agreement
- Brief description of the nature of the practice, location or setting
- Either the types or categories of drugs and devices the APRN may order and/or prescribe or the types or categories of drugs and devices the APRN may not order or prescribe
- A general plan for consultation and referral
- A plan for addressing patient emergencies
- The general process for communication and sharing information related to the care and treatment of patients
- A prescriptive authority quality assurance and improvement plan which includes a chart review and monthly meetings, and describes how implementation of the QAI activities will be documented
- Signatures by all parties to the agreement
Medicare Reimbursement

Legislation calling for Medicare reimbursement for nurse practitioners regardless of setting was passed by Congress and signed into law by the president on August 4, 1997. The new legislation became effective January 1, 1998.

Contents of the Bill

- This legislation calls for direct reimbursement to nurse practitioners for providing Medicare Part B services that would normally be provided by physicians. The bill states that these services are not restricted by site or geographic location. Under the previous statute, nurse practitioner reimbursement was restricted to rural areas, long term care facilities and a service labeled "incident to" which is limited to follow-up care (i.e. no new patients and no old patients with new problems) in an office setting with a physician on site. It is the intent of this legislation that the "incident to" bill mechanism will no longer need to be used by nurse practitioners who now will be classified as Part B providers. Under this legislation nurse practitioners may see all new patients and old patients without restriction. There are no limitations on CPT codes as long as visits meet the established Medicare E and M requirements. The legislation also calls for nurse practitioners to be reimbursed for assisting at surgery.

Reimbursement rates

- Under this legislation, nurse practitioners are being reimbursed at the rate of 80% of the lesser of the actual charge or 85% of the fee schedule amount for physicians (Section 1848). In the case of assistant at surgery, the reimbursement is 80% of the lesser of the actual charge or 85% of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery. These rates are the same rates that were previously paid to nurse practitioners in rural settings and nurse practitioners providing services in long term care facilities. Nurse practitioners cannot collect fees if their services have been billed through some other mechanism, i.e. payment twice for the same service is prohibited.
Additional Studies

- Read more: http://www.truthaboutnursing.org/faq/aprn_md.html#ixzz3oAxmIYcy