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Nonphysician Practitioners: A Bridge To The Future In Healthcare

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I. Introduction

In the current debate over reform of the healthcare system, the cost of care has become a major battle ground. An important issue in the battle is how to reduce the cost of care while maintaining quality and access to care for as many people as possible. Many studies of the components of healthcare cost have revealed that the cost of care rendered by physicians is a major contributor to the escalation of the amount of money spent on healthcare. This article will discuss an important, less costly but often overlooked addition or alternative to physician care—the use of nonphysician practitioners (NPPs) to provide care in a less expensive manner.

II. Who Are Nonphysician Practitioners?

There is no generally accepted definition of the term “nonphysician practitioner,” and the term has a fluid meaning that is often applied to other disciplines such as dentists, podiatrists, and chiropractors. The nonphysician practitioners addressed in this article, however, will be those that are listed in the attached chart (click [here](#) to view the chart). The scope of practice, licensure, and credentialing requirements for each NPP are established by the law of the jurisdiction in which the NPP practices. Also, individual payors (state and federal governmental as well as private payors) may set criteria for reimbursement of NPP services, and these may differ from state to state. Therefore, the general descriptions in the attached [chart](#) should be confirmed for each NPP, each applicable jurisdiction, and each payor.

III. The Economics of Including Nonphysician Practitioners in a Hospital or Medical Practice Setting

The cost of healthcare continues to escalate. Yet, the level of reimbursement for healthcare services is expected to decrease because there is no longer enough money in the system to cover costs at current levels. As a result, the use of less costly NPPs has expanded to provide services that patients traditionally received only from more expensive physicians. Consider, for example, the hospital emergency department. In addition to emergency physicians, the hospital or emergency department physicians' group may employ any of the following to supplement the work of physicians: physicians' assistants, nurse practitioners, and social workers. Each of these NPPs is less costly to employ than a physician. While NPPs must be state-licensed and are more limited than physicians in the services they may render, these non-physicians are capable of performing many of the services required in the practice setting. Thus, NPPs expand the availability of physicians to attend to more extreme emergencies and complex medical or surgical problems. Indeed, they also may be more attuned than physicians to providing routine types of services.

Consider the physicians' practice that employs nurse practitioners and physicians' assistants. Many states allow nurse practitioners to perform services that once were provided only by physicians.^[1] The practice hires the NPPs and pays them a salary. (In 2007, the average annual salary for a full-time nurse practitioner in the United States was \$81,397 and for a full-time physician's assistant, \$86, 214.^[2]) Although the physician may see the patient for a few minutes, the nurse practitioner or physician's assistant may continue to provide most of the routine diagnosis and treatment. The physician-employer will be able to bill Medicare for the service, as long as there is compliance with the appropriate reimbursement requirements. The Social Security Act, § 18610(s)(2)(A), provides for Medicare coverage of services performed by NPPs "incident to" the professional services of a physician. Under the "incident to" Medicare rules, as set forth at 42 C.F.R. § 414.34, "Services of nonphysicians that are covered as incident to a physician's service are paid as if the physician had personally furnished the services." To be "covered as incident to a physician's service," the services of a NPP must be: (1) an integral, although incidental, part of the physician's professional service; (2) commonly rendered without charge or included in the physician's bill; (3) of a type [of services] that are commonly furnished in a physician's offices or clinic; and (4) under the physician's direct supervision or by auxiliary personnel under the physician's direct supervision.^[3] If the NPP is an employee of the physicians' medical practice group, the NPP's services could be billed as an NPP service or as a physician service, rather than as an "incident to" service. In these circumstances, assuming all criteria are met, the physician will be fully reimbursed for the services rendered and billed as a physician service. It should be noted

that the Department of Health and Human Services Office of Inspector General (OIG) has expressed concern about the use of NPPs to perform “incident to” services in physicians’ offices. The Fiscal Year (FY) 2009 OIG Work Plan^[4] noted that “these services may be vulnerable to overutilization or put beneficiaries at risk of receiving services that do not meet professionally recognized standards of care.”^[5] In August of 2009, the OIG produced a report based on data from the first three months of 2007, which found that, “Unqualified nonphysicians performed 21 percent of the services that physicians did not perform personally.”^[6] This verifies the OIG’s assertion in its FY 2009 Work Plan that it needs to examine the qualifications of NPPs performing “incident to” services to assure compliance with professionally recognized standards of care.

As an alternative to “incident to” billing, the NPP who has the right to provide the care may bill Medicare directly for services rendered. For example, services performed by CRNAs, physical and occupational therapists, and others may be billed directly by the NPP, as long as the appropriate Medicare and other conditions for reimbursement are met. (See chart above for details.) There may be some circumstances, however, where a hospital employs an NPP (nurse practitioner or physician’s assistant) to perform pre-operative history and physicals, which are not billed to any payor. This may be done to improve services to the patient and to increase pre-op efficiencies for the hospital.

CRNAs provide the majority of anesthesia services in rural communities where physician anesthesiologists are rare. Like other advanced practice nurses, CRNAs do not require a physician to delegate tasks to them (as do PAs). However, CRNAs generally are required to practice “in collaboration and consultation and with the consent of a physician” or under the supervision of a physician. A CRNA may bill Medicare directly for services or have payment made to an employer or other entity with which she has contracted to provide her services. CRNA services are reimbursed by Medicare either directly to the CRNA or as part of the bundled hospital procedure, as the case may be. Under Medicare, if the CRNA’s services are furnished in a hospital, the CRNA must be supervised by a physician who is immediately available, unless the hospital has a state exemption from this supervision requirement.

Under these various arrangements for provision of care and payment, patients are able to receive quality care from licensed and certified providers, NPPs are paid a market wage, and physicians may be compensated for the employment of NPPs to assist in the provision of care and expand the physicians’ availability to patients for services that require a higher level of medical expertise.

IV. Credentialing and Medical Staff Privileges for Nonphysician Practitioners

Before an NPP begins to work, either with a physician practice, with a hospital, or independently, the practitioner must be credentialed in his particular profession and licensed by the states in which he wishes to work. In addition, any NPP who wishes to bill Medicare must meet the program's required qualifications as a provider in that specialty. For example, for a CRNA to qualify to receive payment under Medicare, she must be licensed by the state of practice as a registered nurse, have state authorization to act as a nonphysician anesthetist, have graduated from a nurse anesthesia educational program recognized by the Council on Accreditation of Nurse Anesthesia Programs, and have passed the certification examination of the Council on Certification of Nurse Anesthetists, or the Council on Recertification of Nurse Anesthetists.[\[7\]](#)

Hospital and facility credentialing requirements for NPPs have developed as a reflection of the rules traditionally applicable to physicians. An example is the case of certified registered nurse midwives (CRNMs), practitioners who have often contended with physicians over the issue of clinical privileges within hospitals.[\[8\]](#) In recent years, more institutions have credentialed CRNMs with admitting and/or attending hospital privileges. Where a CRNM has achieved clinical privileges, she frequently may admit her own patients to the hospital and care for them in that institution. However, some hospitals credential CRNMs for "attending" privileges only. With attending privileges, the midwife may care for her patient in the hospital, once that patient has been admitted to the hospital by a physician. By contrast, many hospitals still do not credential nurse midwives for hospital admitting privileges at all.[\[9\]](#) In these cases, the back-up consulting physician becomes of paramount importance in order for the CRNM to care for her patients. Physician back-up is usually provided pursuant to an agreement between the nurse midwife and the back-up physician: the physician admits the patient to the hospital, after which the nurse midwife may continue providing care. In some cases groups of CRNMs may hire the back-up physician, the physician group may hire the CRNM, or both CRNM and back-up physician can be employed by a hospital or larger group. Under Medicare, a nurse midwife may provide services within the scope of her license, in circumstances where the service would be covered if provided by a physician or incident to a physician's service.

The Joint Commission addresses credentialing of all types of NPPs in its Hospital Accreditation Standards Elements of Performance (EP). Specifically, in its chapter on Management of Human Resources, the Joint Commission states at its HR Standard 1.20 ("Staff qualifications are consistent with job responsibilities") that, "EP 13 applies to physician assistants *and APRNs* [advanced practice registered nurses[\[10\]](#)]" (emphasis added). The Joint Commission's EP 13 sets forth in pertinent part that:

The leaders ensure that physician assistants and APRNs who practice within the hospital are credentialed and privileged and reprivileged through the medical staff process or an equivalent process that has been approved by the governing body. An equivalent process at a minimum does the following:

- Values the applicant's credentials
- Evaluates the applicant's current competence
- Includes peer recommendations
- Involves communication with and input from individuals and committees, including the (Medical Staff Executive Committee), in order to make an informed decision regarding the applicant's request for privileges

Thus, NPPs in hospitals must be credentialed by the Medical Staff Executive Committee with the same rigor that applies to physicians in order to satisfy the performance standard set forth by the Joint Commission. This is true whether the credentialing process is the same as the regular medical staff process, or whether NPPs' credentials are reviewed through a separate, equivalent process.

Finally, all NPPs who wish to be compensated for their services by managed care companies, insurance companies, and other payors may first need to be credentialed by the payor, even if the services rendered by the NPP are being billed by another provider or institution. Historically, managed care companies have attempted to exclude the services of some NPPs from coverage. For example, behavioral healthcare providers (clinical psychologists and/or social workers) were often unable to pass the credentialing hurdle in order to be included on the payor's managed care provider list. This may change, however, with the Mental Health Parity and Addiction Equity Act of 2008, which became effective on January 1, 2010, and requires that mental health services be provided to patients on a par with the more traditional health services that are covered.[\[11\]](#)

In sum, the credentialing gauntlet for NPPs is extensive and varied. State licensure requirements might include prior certification from a private practitioner specialty society such as the American College of Nurse Midwives Certification Council or the Council on Certification of Nurse Anesthetists. In turn, most of these society certifications, as well as certification by national professional associations (for example, the American Occupational Therapy Association), require an examination and/or completion of practice criteria. Further, Medicare, private insurers, and managed care companies require separate criteria to participate in and be paid through their programs, and hospitals may require yet another set of criteria for credentialing in order to work through the institution or on its premises. While the requirements to qualify for each of these certifications, licensures, and coverages may overlap, a number of the requirements will be different. Also, the timing of initiation and renewal of each of these certifications and credentialing

applications will be separate. It is for this reason that the Advanced Practice Nursing Consensus Work Group produced its “Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education” on July 7, 2008 to begin the process of standardizing the requirements for advanced practice registered nurses.

V. Interstate Practice: What Happens When an NPP Crosses the State Line?

Many NPPs—especially advanced practice nurses—are gaining expanded responsibility for the care and treatment of patients in more than one state. NPPs who work with large providers that have multiple facilities often cross state borders to carry out their patient-care assignments. This may require the nurse to have numerous state licenses even though he may work for a single provider. Likewise, NPPs working in telehealth, home health, and education and training that perform long-distance monitoring of patients, or do hospital follow-up care by telephone or training in multiple states, ordinarily require a license in each state in which they provide services.^[12] Indeed, an NPP’s failure to be licensed in each jurisdiction in which he provides services, whether in person or electronically, may subject him to a regulatory or criminal prosecution for practicing nursing without a license.

Although registered nurses have gained limited interstate practice authority, the same benefit is not available for advanced practice nursing by an NPP. In order to permit registered nurses to provide services in more than a single jurisdiction, a number of states have entered into the “Nurse Licensure Compact.”^[13] The Nurse Licensure Compact enables a nurse who is licensed in any of the member states to practice nursing in any of the other member states without the necessity of obtaining another license in that state.^[14] However, the Nurse Licensure Compact does *not* provide assistance to nonphysician practitioner nurses—advanced practice nurses. As provided at Article III(d) of the model nurse licensure compact legislation:

This Compact does not affect additional requirements imposed by states for advanced practice registered nursing. However, a multistate licensure privilege to practice registered nursing granted by a party state shall be recognized by other party states as a license to practice registered nursing if one is required by state law as a precondition for qualifying for advanced practice registered nurse authorization. (emphasis added)

Thus, for example, if a nurse in one jurisdiction is a registered nurse with additional certification as a nurse anesthetist, when she travels to an adjoining jurisdiction the Nursing Licensure Compact will authorize her to practice *only* as a registered nurse, but not as a nurse anesthetist.

VI. Antitrust: Interference with NPPs' Access to Payment, Patients, and Facilities

One of the purposes of the antitrust laws as applied to healthcare is to assure competition among providers, thereby reducing the cost of services rendered to patients. As more nonphysician practitioners gain credentials to provide care, they have met competitive opposition from the healthcare providers who had previously enjoyed unchallenged access to patients, facilities, and payment. In antitrust terms, this spawned cases involving refusal to allow NPPs to practice in markets and in facilities essential for their livelihood.

The antitrust law gives nonphysician practitioners the power to enter healthcare provider markets free of unreasonable commercial obstruction; nonetheless, reasonable and lawful obstructions continue to exist that may frustrate the nonphysician practitioner's professional activities. Particularly, a nonphysician practitioner may be excluded upon a showing that her exclusion or limitation resulted in truly increased efficiency, lower cost, and higher quality of care in the particular market in which the practitioner functions.

A fundamental competitive assault on NPPs has been the group boycott or concerted refusal to allow the NPP to practice. Boycotts and refusals to deal with NPPs, if proven, are a violation of the Sherman Antitrust Act, 15 U.S.C. § 1.^[15] If those who refuse to employ NPPs or allow them to practice also have sufficient market power to coerce others to avoid the NPPs, then the boycott usually will be viewed as a per se violation of the Sherman Act^[16] for which no further proof of injury to competition is required. Outside this narrow corridor of per se cases, boycotts and refusals to deal with NPPs are evaluated under the antitrust "rule of reason."^[17] In rule of reason cases, once the plaintiff has presented a prima facie boycott case, the defendant may justify its conduct by showing a procompetitive purpose that outweighs the anticompetitive effect of the boycott or refusal to deal with the NPP. A procompetitive justification that defendants have offered is the "patient care" or "quality medicine" defense. This is based on the notion that the exclusion of NPPs was in furtherance of quality healthcare and for the public good—an end achieved by barring unqualified, dangerous practitioners from the healthcare market. To be successful, this defense must rest upon a showing that the boycott was based on reasonable concern for scientific method and not by the desire for economic advantage.^[18] Thus, for example, in *Wilk v. American Medical Association*, the AMA argued that its boycott of chiropractors was not unlawful because its purpose was good "patient care," a defense that ultimately failed largely because the AMA was unable to prove that its boycott was primarily motivated by a reasonable concern for scientific method.^[19]

Other procompetitive reasons for excluding NPPs from the practice market also have been allowed. In *Bhan v. NME Hospitals, Inc.*,^[20] an exclusion of nurse anesthetists from a hospital was reviewed as a possible group boycott under rule of reason analysis, and the defendant successfully offered evidence of procompetitive offset to the anticompetitive effect of its action.^[21] The *Bhan* court explained that in a rule of reason analysis a hospital may make decisions “about the types of qualifications a practitioner must have to apply for staff privileges in various fields of practice” in order to provide “efficient, higher quality service in order to compete against other hospitals,”^[22] and that “the choice of physician over nonphysician providers may actually sharpen competition by making [the defendant hospital] a more attractive competitor in the patient market.”^[23] On the other hand, the court continued,

a plaintiff may be able to establish . . . that the physicians are conspiring to drive the nurses out of business because their services are just as good but cheaper. The hospital may be shown to be acceding to the doctors’ wishes because of its wish to retain certain of the doctors’ services. In that case, the practice of excluding nonphysician providers as a class would appear to be anti-competitive.^[24]

Exclusion of an NPP from an “essential facility” may also rise to the level of an antitrust violation. This theory was explained in *Registered Physical Therapists, Inc. v. Intermountain Health Care, Inc.*,^[25] in which a hospital’s refusal to lease space in a medical office building to physical therapists was alleged to violate Section 1 of the Sherman Act. The plaintiff therapists’ theory was that the lessor was unlawfully restricting competition by refusing to allow the NPPs access to a resource needed in order for them to practice, thereby curtailing competition for healthcare services in the relevant market. The court defined an “essential facility” as one that could not reasonably be duplicated by would-be competitors and that is necessary if one wishes to compete. Here, the court determined that the office building was not an “essential facility” because the physical therapists could find other clinical space in the geographic market, and therefore the market did not lose competition for physical therapy services. A similar point also was made in *Salem Women’s Clinic, Inc. v. Salem Hospital*,^[26] in which the court observed that the “essential facilities” doctrine imposes on the owner of a facility a duty to make that facility available to its competitors on a nondiscriminatory basis, if the facility is essential to competition in a given market and cannot reasonably be duplicated.

VII. Application of the Stark Law and Anti-Kickback Statute to Nonphysician Practitioners

While compliance with the Stark and Anti-kickback laws has focused on referrals and payments to and from physicians, these statutes and related regulations can have a

dramatic impact on nonphysicians as well. This can occur both directly and indirectly, depending on who submits the bills and how the services are rendered.

The Stark Law

The Stark Law^[27] is technically directed at physicians, with the aim of preventing them from referring patients to medical businesses and other designated health services (DHS) in which they have a financial interest.^[28] Nonetheless, NPPs may be implicated in the application of the regulations to referral schemes involving physicians and/or their families. The Stark Law prohibits a physician from making a referral for a DHS to any entity in which the physician or the physician's immediate family member has a financial relationship (direct or indirect), unless one of the many exceptions is met. The Stark Law also prohibits billing for a service or an item if it is provided as a result of a prohibited referral. Nonetheless, where the referring physician personally provides a DHS, this is not defined as a referral under the Stark Law.

Professional services independently billed by NPPs are not defined in the Stark Law as physician services. Further, referrals by NPPs generally do not involve the Stark Law, as it only applies to physicians' financial arrangements. Nonetheless, the Stark Law could be implicated when referrals are made by a NPP when the NPP is directed or controlled by a physician because the NPP's action may be imputed to the physician who directs or controls the NPP.^[29] Thus, if a referral is made by an NPP that is not in compliance with the Stark regulations, it could be an illegal referral for which the physician will not be paid, and for which penalties could be imposed.

Further, services performed by an NPP pursuant to a physician's referral in violation of the Stark Law may become tainted by the physician's violation, such that the NPP might not receive payment for services rendered at the behest of the physician, and other Stark Law and False Claims Act penalties may come into play. In addition, an NPP who independently submits a claim for payment pursuant to an illegal referral from a physician could violate the Stark law, which could result in a violation of the federal False Claims Act (FCA),^[30] state false claims or fraud prohibitions, or the recently enacted Fraud Enforcement Recovery Act (FERA) amendment to the FCA. The FCA (the federal government's primary litigation tool in the fraud arena) applies to anyone who submits a fraudulent claim to the government. Under FERA, there could be liability for an inadvertent submission of a claim or the making of a material false record or statement in violation of the Stark Law. In other words, FERA expands liability for the making of a false claim, even if no claim for payment is sought. Penalties for Stark Law violations include: (1) nonpayment; (2) payment by the provider of refunds for overpayments; (3) civil monetary penalties of not more than \$15,000 per improper claim; and (4) possible exclusion from the federal or state payment program. Under the FCA, penalties include

statutory treble damages and additional mandatory penalties of \$5,500 to \$11,000 per claim. Thus, an NPP who accepts a referral that is considered illegal, and attempts to receive payment for that service or submits a material false statement to the government, could be prosecuted severely.

The Anti-Kickback Statute

While the changes to the Stark Law have been much in the news recently, the federal Anti-Kickback Statute,[\[31\]](#) could present even greater problems for NPPs. The reach of the Anti-Kickback Statute is wider than that of the Stark Law because it makes it a crime for anyone—not only physicians—to knowingly and willfully, offer to pay, solicit, or receive remuneration, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for any item or service, payable in whole or in part, under a federal healthcare program, or in return for purchasing, leasing, ordering or arranging for any good, facility, service, or item payable under a federal healthcare program.[\[32\]](#) In other words, payments for referrals are prohibited.[\[33\]](#) Because of the Anti-Kickback Statute's expansive reach, any NPP may be caught in the broad web of anti-kickback violations if the practitioner is not careful in the amount of payment that changes hands and for what purpose. In addition to the federal statute, many states have also enacted their own anti-kickback statutes, modeled on the federal law. Thus, NPPs could be found in violation of both state and federal anti-kickback laws for making prohibited payments or offering incentives for referrals.

As part of its oversight of the federal fraud and abuse laws, the OIG issues an annual Work Plan to advise of its priorities for the coming fiscal year. In its FY 2009 Work Plan, the OIG described several activities it planned to review that relate to NPPs. The OIG indicated that it would "examine the qualifications of nonphysician staff that perform 'incident to' services and assess whether these qualifications are consistent with professionally recognized standards of care."[\[34\]](#) In its effort to conform the interpretation of the Stark Law self-referral rules with the Medicare coverage and payment rules, CMS revised the definition of "incident to" services to clarify that both services and supplies provided "incident to" a physician's professional services are included in "incident to" services, as long as they do not have their own independent statutory benefit category. The 2009 OIG Work Plan also singled out for enforcement "incident to" services typically performed by nonphysician staff members in physicians' offices. The Social Security Act § 18610(s)(2)(A) provides for Medicare payment for services performed and supplies "incident to" the professional services of a physician. In its 2009 Work Plan, the OIG expressed concern that there may be overutilization of these "incident to" services that will "put beneficiaries at risk" if the services do not meet professionally recognized standards of care.

In addition, the OIG stated that in 2009 it would review services to inpatients of Medicare participating hospitals performed by clinical social workers in order to determine whether these services were separately (and inappropriately) billed to Medicare. The OIG announced that it also would review outpatient physical therapy services provided by independent therapists to determine whether claims made by these NPPs were “reasonable, medically necessary or properly documented” and properly billed to Medicare. Tying their investigations to the Stark Law, the OIG was going to review services, billing patterns, and provider profiles in geographic areas where there are high concentrations of independent diagnostic testing facilities (IDTFs) and the practitioner performing the services may be a NPP.[\[35\]](#)

VIII. Conclusion

The use of services rendered by nonphysician practitioners presents a viable, less expensive addition and alternative to physician services, and in some cases, to hospital care. The provision of care by NPPs has increased due to the shortage and cost of physicians’ services in some specialties and geographic areas, and due to patients’ preference for NPPs in some medical specialties (nurse midwives, for example.) As NPPs and physicians working with them can be reimbursed for services rendered, the use of NPPs in patient care is likely to continue to increase in almost all healthcare settings.

Counsel advising a nonphysician practitioner must become familiar with the particular state and federal laws applicable to the NPP’s specific practice, as these vary widely by practice area and jurisdiction in which the NPP may render services. These statutes and regulations primarily include licensure requirements, mandates and limitations on practice structure, billing, and conduct. In light of the OIG study noted above,[\[36\]](#) counsel must be watchful that all NPPs are practicing within the standards for professional licensure and credentialing of their specialty. Counsel also should become familiar with the requirements of payment plans and facilities with which the NPP may become affiliated, for these may require more or different credentialing and other criteria than are required for licensure. Representation of an NPP should also entail familiarity with the business environment in which the NPP operates, with a particular eye toward the economic advantages that a NPP may bring to an employer, facility, or health system, as well as any restrictions on business relations and transactions, including those that may be imposed by state and federal antifraud and other laws and regulations. As such, counsel should be attentive to possibly unlawful anticompetitive restrictions encountered by the NPP. Finally, these same issues should be of concern to counsel for healthcare practitioners and others working with NPPs, such as employers or contractors, who want to guard against liability for the actions of unlicensed, improperly credentialed, or unqualified NPPs.

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[1] See David J. Hyman, *An Introduction to Licensed Non-Physician Practitioners* (presented at Am. Health Lawyers Ass'n's Annual Meeting 2008).

[2] Salary in these professions is a function of setting. In 2007, emergency department nurse practitioners made an average of \$95,157; nurse practitioners in neonatal units earned \$93,959; nurse practitioners in other hospital and surgery settings grossed \$86,000; and those in their own family practice settings earned \$79,091. *2007 National Salary Survey of Nurse Practitioners and 2007 Physician Assistant Census Report*.

[3] Medicare Benefits Policy Manual, Ch. 15, §60.

[4] See <http://oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf>.

[5] *Id.* at 14.

[6] Dep't of Health and Human Servs. Office of the Inspector Gen., *Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services (2009)*, available at <http://oig.hhs.gov/oei/reports/oei-09-06-00430.pdf>.

[7] 42 C.F.R. § 410.69(b).

[8] See, e.g., *Nurse Midwifery Assocs., v. B.K. Hibbett, M.D.*, 918 F.2d 605 (6th Cir. 1990), as modified by 927 F.2d 904 (6th Cir. 1991).

[9] *But see* Fla. Stat. § 467.002, which posits that, "The Legislature recognizes the need for a person to have the freedom to choose the manner, cost, and setting for giving birth. The legislature finds that access to prenatal care and delivery services is limited by the inadequate number of providers of such services and that the regulated practice of midwifery may help to reduce this shortage."

[10] Advanced Practice Registered Nurse (APRN) is the licensing title to be used for nurses prepared in advanced, graduate-level nursing to provide direct patient care in four roles: certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist and certified nurse practitioner. APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee, *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*, July 7, 2008, at p. 8.

[11] The official title of the new law is: "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008," passed as part of the Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343.

[12] See Letter from Lesley C. Dinwiddie, MSN, RN, FNP, CNN, President, American Nephrology Nurses Association to Kathy Apple, MSN, RN, Executive Director, National Council of State Boards of Nursing, Inc., Feb. 3, 2005, available at <http://www.annanurse.org...>

[13] States that have enacted the Nurse Licensure Compact as of October 2009 are: Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin.

[14] See Model Nurse Licensure Compact legislation at <https://www.ncsbn.org/1100.htm>.

[15] 15 U.S.C. § 1 provides in pertinent part, "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal."

[16] *Minnesota Ass'n. of Nurse Anesthetists v. Unity Hosp.*, 208 F.3d 655, 659 (8th Cir. 2000). "A 'group boycott' is a narrow category of *per se* violation 'limited to cases in which firms with market power boycott suppliers or customers in order to discourage them from doing business with a competitor.'"

[17] "[T]he rule of reason category includes agreements whose competitive effect can only be evaluated by analyzing the facts peculiar to the business involved, the particular restraint's history, and the reasons it was imposed. The test of legality under the rule of reason is whether the challenged conduct promotes or suppresses competition." *Wilk v. American Med. Ass'n*, 895 F.2d 352 (7th Cir. 1990), *cert. denied*, 111 S. Ct. 513 (1990), citing *Nat'l Society of Prof'l Eng'rs v. United States*, 435 U.S. at 692, 98 S.Ct. at 1365 (1978). *Wilk* involved a rule of reason analysis that arose from the AMA's preventing its members from having any professional dealings with chiropractors.

[18] See *Wilk v. American Med. Ass'n*, 895 F.2d 352 (7th Cir. 1990), *cert. denied*, 111 S. Ct. 513 (1990). The proof required of the AMA to sustain its "patient care" defense is the following: that the defendant AMA and its members genuinely entertained a concern for scientific method in patient care; that this concern is objectively reasonable; that this concern was the dominant motivating factor in the defendants' promulgation of the restriction and in the conduct intended to implement it; and that this concern for scientific method in patient care could not have been adequately satisfied in a manner less restrictive of competition.

[19] *Id.* at nn. 11, 12. See also *Cooper v. Forsyth County Hosp. Auth., Inc.*, 789 F.2d 278 (4th Cir. 1986). The defendant may assert the defense of "patient care motive" and "good faith" to show that the restrictive activity actually allowed the defendant to compete more effectively and to improve the overall market for healthcare services. See also *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980). Absent legitimate business and medical reasons for excluding NPPs from participation in a provider panel, the panel sponsor could not exclude NPPs. The

boycotted NPP's position seems strengthened when his services are necessary and cannot be replaced within the market, as shown in *Oltz v. St. Peter's Community Hosp.*, 861 F.2d 1440 (9th Cir. 1988), in which physician anesthesiologists excluded CRNAs from the only hospital in a town.

[20] 929 F.2d 1404, 1991-1 Trade Cases ¶ 69,395, 19 Fed.R.Serv.3d 644 (4th Cir. 1991).

[21] The defendant's procompetitive justification was, first, that surgeons would be reticent to work at the hospital because they would not want to be responsible for the acts of nurse anesthetists; second, that 24-hour coverage by physicians was necessary for complicated surgeries; and, third, that physician anesthesiologists are better at providing anesthesia services than nurse anesthetists. 929 F.2d at 1408.

[22] *Id.* at 1412 (citing *Jefferson Parish v. Hyde*, 104 S.Ct. at 1551, 1564 (1984)),

[23] *Id.*

[24] *Id.* at 1412. See also *Abraham v. Intermountain Health Care, Inc.*, 461 F.3d 1249, 2006-2 Trade Cases ¶75,403 (10th Cir. 2006), where the court held that a health insurance plan had legitimate procompetitive reasons to exclude optometrists from its plan.

[25] 1988 WL 125788 (D. Utah, 1988), 1988-2 Trade Cases ¶68,233.

[26] Slip Copy, 2008 WL 3245562 (D. Or.), 2008-2 Trade Cases ¶ 76,257.

[27] 42 U.S.C. §1395nn.

[28] Designated health services are defined as: clinical lab services, PT, OT, and speech pathology, radiology and other imaging services, radiation therapy services and supplies, durable medical equipment and supplies, parenteral and enteral nutrition, equipment and supplies, home health services, prosthetics and orthotics, outpatient prescription drugs and inpatient and outpatient hospital services. 42 C.F.R. § 411.351. Effective July 1, 2009, outpatient speech-language pathology services are DHS. (Section 143 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amendment to the Stark statute.)

[29] See Stark Law, Phase I, 66 Fed. Reg. 872; Phase II, 69 Fed. Reg. 16063-16064.

[30] 31 U.S.C. §§ 3729-3733.

[31] 42 U.S.C. §1320a-7b(b).

[32] 42 U.S.C. §1320a-7b(b)(1), (2).

[33] Unlike the Stark law, which is a strict liability statute, violation of the Anti-Kickback Statute requires proof of criminal intent. Violation of the Anti-Kickback Statute constitutes a felony punishable by a maximum fine of \$25,000, imprisonment of up to five years, or both. Conviction will also lead to automatic exclusion from Medicare, Medicaid, and other federally funded healthcare programs. Violations of the Anti-Kickback Statute are also subject to civil monetary penalties of up to \$50,000 and damages of up to three times the amount of the illegal kickback. Due to the government's enforcement authority, an accusation of violations under the Anti-Kickback and related fraud statutes can result in the imposition of heavy fines, a consent order, or a deferred prosecution agreement that may force a provider out of business and/or cause serious harm to that provider's ability to continue to practice or provide services.

[34] 2009 OIG Work Plan, at 15.

[35] *Id.* at 14-15.

[36] *See supra* note 6.

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