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David Hyman, Special Counsel
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Dear Sir,

I read an article last week in the May 2003 issue of Nurse Practitioner World News encouraging nurse practitioners to contact your office with comments about anti-competition practices. I would like to take this opportunity to do so.

Personal Background

I am a Board Certified Family/Pediatric Nurse Practitioner (NP) in rural Alabama. We have a continual shortage of qualified physicians for primary care. This is certainly not unique to our geographic area. In my area, I have been fortunate to become employed in a multi-specialty physician owned practice. The physicians with whom I work have been completely supportive of my role. They are comfortable with my level of clinical expertise and that when appropriate I will seek physician involvement in the patient's care. Nonetheless, eighty to ninety percent of the time, the level of acuity of my patient population can be managed without direct physician involvement. I provide wellness care, perform minor office surgeries, episodic acute care, as well as manage chronic health conditions such as congestive heart failure, hypertension, diabetes, hyperlipidemia, arthritis, asthma, emphysema and a host of other conditions.

The impact medical licensing laws and regulations have on nurse practitioner practice

In Alabama, the oversight authority for advanced nursing practice is the Joint Committee of the Boards of Nursing and Medicine. Three physicians and three advanced practice nurses sit on this Board. Of the physician members, two have never worked with an advanced practice nurse; one of those two is a radiologist, not even involved in clinical care but dedicated to limiting its access. For example, he stated in one directive that NPs

may not be credentialed to perform joint injection, aspiration, etc. His opinion is that "the psychomotor domain required to master this skill requires years to perfect. Something not possible in a NP's training." He further stated that with appropriate didactic training an NP may be credentialed to place a "subclavian vein catheter for venous access, but only if the collaborating physician is in the facility as well." NP's may not be credentialed to place chest tubes in the event a pneumothrorax develops during insertion of the central (SC) line. This physician is also the incoming president of the State Medical Association and thus exerts undue influence on his peers without the experience with which to make reasonable recommendations.

In regards to supervision, in Alabama Nurse practitioners must have a collaborating physician in order to practice within the state. If a NP does not have a collaborating physician a NP simply cannot practice within the state. Nurse practitioners provide an integral link in delivery of healthcare across many settings. NPs are not in competition with physicians, we are a complement to physicians. Valuable, irreplaceable primary care, low acuity episodic care, and delivery of chronic care can easily and effectively be delivered by NPs especially in rural areas where the recruitment of primary care physicians is next to impossible. I feel that removing unnecessary restrictions to practice and decreasing duplication of effort can save healthcare dollars. These include but are not limited to the following:

- Cosigning of medical charts within the hospital setting. In Alabama each entry within a patients chart must be co-signed by a collaborating physician. In my specific case the hospital reviews and tags each page of each patient chart and then places these charts in the appropriate physicians medical chart basket for his/her signature. This back log of charting not only makes for a nightmare for the physician but also wastes valuable resources for the hospital that could be better allocated to nursing and other medical care (which in the rural setting is major problem).
- Limiting health care provision in the "swing bed", nursing home and home health setting. NPs cannot initially certify care (and thus not bill for it), nor can NPs sign initial orders in these settings though the collaborating physician may never have seen these patients. These are perhaps the lowest acuity settings and one of the arenas of greatest need for continuity of care.
- Inability to prescribe certain controlled medications, even antidiarrheals(Lomotil),antianxiety agents, sleeping pills, and pain medications. Many patients cannot be given non-narcotic pain relief because of GI tract pathology (ulcer disease, chronic gastritis) or chronic renal disease associated with diabetes or hypertension. Every time a patient needs one of these agents I must seek out a physician to sign the order.

Coding and billing problems

In my practice I average between 300 to 350 patients per month depending on the season, exclusive of hospital visits. Given the number of patients that I see on an average day one must assume that the coding and billing of each visit is very important part of what I

do each day. This is especially true when fifty percent of my patient population is covered by Blue Cross and Blue shield of Alabama (other issues with BCBS of Alabama will be addressed later). These patients have the misfortune of being covered by an entity that requires me to bring in a physician to "re-examine the patient" so that BCBS may be billed in the physician's name or I would be unable to bill the visit. This causes a scheduling nightmare for the staff as well as for my patients. I must wait to see these patients later in the morning and in the early part of the afternoon in order for there to be a physician available for the duplication of work which BCBS requires. I can think of no other industry that must alter their business practices let alone require their customers to jump through the hoops that we require of 50% of my patient population because of this unfair business practice. I could increase the number of patients that I can serve by 5 or 6 daily if I didn't have to stand and wait for a physician to bestow blessing on the work I have already done in order to satisfy a third party payer. This may not seem like a big increase but given our current physician shortage and the need for care in rural areas the increase in just 5 patients a day means an additional 100 patients per month could be cared for.

Not only are the NPs within our state limited in how we see patients covered by BCBS, we are also limited on how we should code for our services. While higher level visits are reimbursed under Medicare (99214,99215, 99204, 99205) we recently received an unusual written directive from BCBS (unusual because they put something in writing outside of a provider manual) noting that an NPs should never bill for a level of care higher than a 99213 or 99203. Be assured, providing chronic care for the diabetic, hypertensive, cardiac patient who also has atrial fibrillation on chronic Coumadin anticoagulation, COPD, and chronic renal insufficiency; overseeing and monitoring the medications to treat these conditions, observing for changes in condition, monitoring for adverse drug interactions, providing patient/family education; coordinating diagnostic testing when appropriate; aiding the patient in procuring medications he cannot care for and any other chore which arises. In delivering this care is NEVER a 99213 or lower visit. At one "town meeting" where the BCBS rep meets with staff to answer particular questions, our current rep informed me that as far as BCBS was concerned, NPs had no business seeing patients and BCBS would probably never empanel, or credential NPs as providers. This is confusing considering I have a BCBS provider number and BCBS has published a limited fee schedule to include the higher-level visit codes, complements of the "Pilot Project.".

I'd like to comment briefly about Medicaid. I reluctantly accept the 15% discount imposed on reimbursement to NPs under Medicare. I cannot afford to provide healthcare that is discounted any greater than that. For seeing the Medicaid patient, and providing the same level of care as a physician provider, I am discounted 25%. Many tests, and treatments are not paid for unless ordered by a physician. The Medicaid program does not reimburse NPs for the patient seen in the ER or Acute Care setting (hospitalization). These are generally the most educationally and socioeconomically disadvantaged patients who require a disproportionate amount of time for care. Because of the low level of reimbursement and the associated limitations in providing care, I no longer see Medicaid patients, nor am I likely to in the future without major program revisions.

Credentialing and privileging issues

For 15-20% of my patients, the bill must be submitted in the collaborating physician's name because advanced practice nurses are not credentialed as panel providers for those insurers though they do not require that the physician physically see the patient. On still others, I may bill for the visit, but any diagnostic studies, injections, x-rays must be ordered and billed by the physician or they are not reimbursed. Not only does this cause undue confusion for my patients when they receive their Explanation of Benefits (EOB) for their visit it also causes problems for staff when routing diagnostic studies to the appropriate provider. All of this causes more cost of work for the entire practice.

The insurance industry should follow Medicare's lead in opening up the marketplace to NPs. Although we are paid 15% less for providing the same care that a physician would to a Medicare recipient, it is probably worth the trade off to have the freedom to deal with nearly every aspect of the patient's care without involving the collaborating physician unless he/she needs involved. The three gaps with Medicare that I cannot bill for are oversight of Home Health Care, Swing Bed,and Nursing Home Visits. Hopefully these will be addressed at a later date, allowing for continuity of care with this huge segment of the population.

With respect to credentialing and privileging for admitting privileges to hospitals, another layer of bureaucracy is added. Although most of my hospital admissions are for Medicare recipients, and thus no requirement for direct physician supervision exists, the hospital (pursuant to State of Alabama Board of Nursing Regulations) requires that every entry I make into the chart (history and physical, progress notes, discharge summary, and every treatment order) be cosigned by the collaborating physician. This is never accomplished during the hospital stay. Rather, after discharge, a medical records clerk double checks and manually flags each entry in the chart, sends it to the respective physician's delinquent stack where he must labor through each entry and co sign them---most of the time on patients he has never seen. This is a laborious, needless, duplication of effort that I presume to be based on JCAHO standard. One more hidden cost of providing care.

The problems with Blue Cross/Blue Shield panel placement

The single greatest obstacle that I encounter on a daily basis is the monopoly of BCBS of Alabama. Of the estimated 4 million people within the state of Alabama 3.4 million are covered by BCBS. By using this massive market leverage BCBS dictates what every health care consumer and every health care provider has access to whether or not BCBS insures that particular patient. I have previously addressed the majority of the problems NPs face in the state of Alabama. In this time of healthcare crisis with costs rising and access dwindling, no entity should be able to monopolize the marketplace for their financial gain as BCBS has done. Why a non-profit organization is allowed to mandate the majority of the medical insurance policies within the state while yet not having to answer to the state insurance commission is not only confusing but wrong. Why I have been given provider number and only allowed to bill for certain groups and only then am I allowed to order certain test for my patients is nothing but discriminatory in nature and limits my ability to make a living.

My patients that have BCBS coverage chose me as their primary care provider because I provide them with a level of care that meets or exceeds their expectations. The fact that I am a nonphysician provider is a non-issue to my patients. Nonetheless, they are subjected to a special set of rules with regards to scheduling and how they are seen. A "sick" visit may have to be provided at no charge (by me) if no physician coverage is available, or alternatively put off until a later date when physician coverage is available. The latter is a totally unacceptable option if you are the sick patient.

In summary, the cycle that we see over and over is that the local hospital, in conjunction with select physician practices, recruit physicians who are generally J-1 Visa status. They locate here with a salary guaranteed by the hospital for their initial year of practice, plus whatever other incentives may be offered, and they stay for 3 years. They apply for citizenship, become naturalized citizens, and then move out of the community that supported them initially. This happens time and time again, the exception being the retention of a qualified provider familiar with the language, people and cultural differences in the rural South. Yet, with virtually no questions asked, these physicians are empanelled as providers by any insurer. I request the same privilege to provide care, and I expect the same right to be gainfully employed in my profession as any other licensed health care provider regardless of class

I appreciate that these agencies are interested in looking at the antitrust issues involved in healthcare. I would be delighted to discuss my personal experiences in these areas and to present testimony if you should so desire.

Respectfully,

Melissa English CRNP

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Cc: Winifred Carson, Esq.