

AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 2  
(June 2022)

Introduced by: Timothy G. Abrahamson, MD

Subject: Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Providers

Referred to: OMSS Reference Committee  
(xxxx, MD, Chair)

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1 WHEREAS, Physician extenders and non-physician providers, such as nurse practitioners and  
2 physician assistants have far less training than physicians; and  
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4 WHEREAS, Physician extenders and non-physician providers specifically lack specialty training  
5 as part of their education or maintenance of certification and as such should not be considered  
6 to be meant to be practicing as specialists without appropriate oversight; and  
7  
8 WHEREAS, Despite differences in training relative to physicians, in some states extenders and  
9 non-physician providers are permitted to practice a wide variety of specialty medicine  
10 independently, including intrathecal pain management, fluoroscopy, surgery, biopsies,  
11 endocrinology, dermatology, anesthesiology, ophthalmology, and orthopedics; and  
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13 WHEREAS, Because physician extenders and non-physician providers can change practices  
14 every year, a quality standard for their work cannot be truly established; and  
15  
16 WHEREAS, In some states that allow physician extenders and non-physician providers to  
17 practice independently, their oversight boards have no specific training in overseeing specialty  
18 care in which their members are in practice; and  
19  
20 WHEREAS, Physician assistants, nurse practitioners, and other extenders have been pushing  
21 in several states for greater independence in their practices and, in many cases, seeing that  
22 independence granted while board standards are kept at the lowest level; and  
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24 WHEREAS, Current Medicare reimbursement for physician extenders and non-physician  
25 providers pays 85 percent of the physician rate when practicing beyond primary care, including  
26 specialties like pain management, anesthesiology, orthopedics, ophthalmology, dermatology,  
27 ENT, endocrinology, and urology despite thousands of fewer hours of training, markedly less  
28 academic rigor, and dramatically fewer costs to achieve academic training than all Board  
29 Certified Physicians; and  
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31 WHEREAS, The original goal of physician extenders and non-physician providers was never to  
32 see patients independently but to contribute instead to overall continuity of care; and  
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1 WHEREAS, real world evidence from Hattiesburg Clinic to redesign the clinic's care model over  
2 15 years to expand care teams found that placing non-physician providers in independent  
3 panels was more expensive than care delivered by physicians<sup>1</sup>; therefore be it  
4  
5 RESOLVED, That our American Medical Association urge the Centers for Medicare and  
6 Medicaid Services to reduce reimbursement rates for physician extenders and non-physician  
7 providers to 50 percent of the physician rate, billing independently under their NPI number,  
8 unless a supervising physician has a direct role in the care of the patient visit or procedure, in  
9 which case reimbursement would be set at 100 percent of the physician rate in recognition of  
10 the differential in training and experience (Directive to Take Action); and be it further  
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12 RESOLVED, That our AMA work with state medical boards to improve oversight and  
13 coordination of the work done with physician extenders and non-physician providers (Directive  
14 to Take Action); and be it further  
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16 RESOLVED, That our AMA adopt the position that Boards of Medical Examiners in each state  
17 should have oversight of cases involving specialty care as boards with oversight over physician  
18 extenders and non-physician providers do not have the training to oversee specialty care (New  
19 HOD Policy); and be it further  
20  
21 RESOLVED, That our AMA adopt the position that in each state the Board of Medical  
22 Examiners should have oversight over physician extenders and non-physician providers if billing  
23 independently or in independent practice as their respective oversight boards do not have  
24 experience providing accurate oversight for specialty care (New HOD Policy).

Fiscal Note: Not yet determined

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<sup>1</sup> Batson, B.N, Crosby, S.N., & Fitzpatrick, J.M. (2022). Targeting value-based care with physician-led care teams. *Journal of the Mississippi State Medical Association*. 63, 1. P. 19-21.  
<https://ejournal.msmaonline.com/publication/?m=63060&i=735364&p=22&ver=html5>

## RELEVANT AMA POLICY

### **Physician and Nonphysician Licensure and Scope of Practice (D-160.995)**

1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.
3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation.

Citation: CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19

### **Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners (H-270.958)**

1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities.
2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.

Citation: BOT Action in response to referred for decision Res. 902, I-06; Reaffirmed: BOT Rep. 06, A-16

## **10.2 Physician Employment by a Nonphysician Supervisee**

Physicians' relationships with midlevel practitioners must be based on mutual respect and trust as well as their shared commitment to patient well-being. Health care professionals recognize that clinical tasks should be shared and delegated in keeping with each practitioner's training, expertise, and scope of practice. Given their comprehensive training and broad scope of practice, physicians have a professional responsibility for the quality of overall care that patients receive, even when aspects of that care are delivered by nonphysician clinicians.

Accepting employment to supervise a nonphysician employer's clinical practice can create ethical dilemmas for physicians. If maintaining an employment relationship with a midlevel practitioner contributes significantly to the physician's livelihood, the personal and financial influence that employer status confers creates an inherent conflict for a physician who is simultaneously an employee and a clinical supervisor of his or her employer.

Physicians who are simultaneously employees and clinical supervisors of nonphysician practitioners must:

- (a) Give precedence to their ethical obligation to act in the patient's best interest.
- (b) Exercise independent professional judgment, even if that puts the physician at odds with the employer-supervisee.

### **AMA Principles of Medical Ethics: II,VI,VIII**

*The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.*

Citation: Issued: 2016

## **Scopes of Practice of Physician Extenders (H-35.973)**

Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.

Citation: Res. 213, A-02; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: BOT Rep. 7, A-21