The Role of Advanced Practice Providers in Urology

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KEYWORDS

• Advanced practice providers • Nurse practitioners • Physician assistant

KEY POINTS

- Population growth, particularly in the Medicare population, has greatly increased the need for urologic care in the United States—these needs cannot be met by urology as a specialty.
- Advanced practice providers (APPs) are unique providers of health care services who are practicing at the highest level of their certification and should be identified as such.
- Licensure and scope of practice requirements for nurse practitioners and physician assistants are governed at the state level and vary greatly by location.
- Billing regulations for practices that utilize APPs are complex; these must be understood and scrupulously followed.
- It is incumbent on urology as a specialty to recognize and address potential deficits in care and develop mechanisms to properly utilize APP resources to address these deficits.

INTRODUCTION

The undersupply of urologists relative to need for urologic was anticipated in literature from early in the last decade.[1] More recently, the American Urological Association (AUA) annual census[2] identified 13,044 "practicing urologists" in the United States in 2019, an increase of 384 over the 12,660 reported in the 2018 report.[3] Of note, 85.6% (11,167) and 84.5% (10,693) were identified as active practicing urologists in 2019 and 2018, respectively. Consequently, the AUA census report suggests that the per capita ratio of urologists to the general population has improved from 3.72 to 3.99 urologists per 100,000 population in 2015 and 2019, respectively. Despite this increase, 62.4% of counties in the United States had no urologists in 2019.

Although on the surface, the AUA census data may provide some reassurance that the tide on urology manpower issues is beginning to be turned, this does not capture the extent of the problem, because the expansion of the Medicare population has exacerbated the shortage of urologists in the United States. The baby boom generation (born between 1946 and 1964) began to age into Medicare in 2011, when those born in 1946 turned age 65. This resulted in an immediate and dramatic increase in Medicare enrollment—daily Medicare enrollment increased by 16.6% in 2011 compared with 2010 (**Fig. 1**).[4] This trend has continued; since 2011, average new daily Medicare enrollment has increased by 21.4% compared with the 3 prior years. Even given disenrollment due to death and other causes, from 2008 to 2019, the Medicare rolls grew by more than 16 million beneficiaries, an increase of more than 29%.

Given the impact of Medicare expansion, a more appropriate analysis than total urologists per capita may be the number of urologists who treat Medicare beneficiaries, because this number is substantially lower than the number of urologists reported to be in active practice in the AUA census. As illustrated in **Fig. 2**, Medicare data

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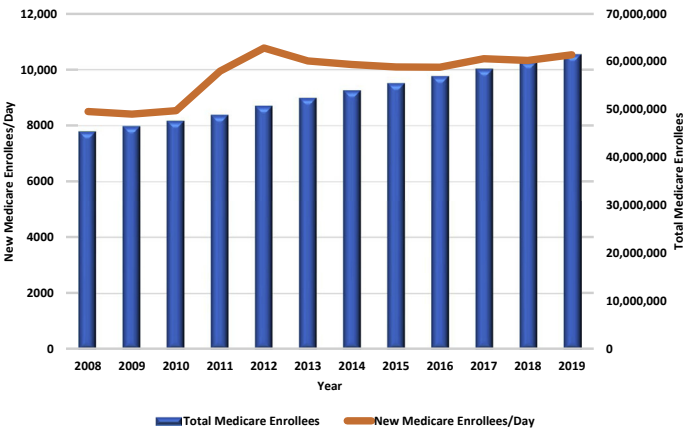

Fig. 1. New Medicare enrollees per day and total Medicare enrollees, 2008 to 2019.

suggest that the number of urologists that billed Medicare for any service from 2012 to 2018 increased by just over 0.5%, from 8792 to 8838, respectively.[5] Given the increase in Medicare beneficiaries, the per capita number of urologists was 17.3 to 14.7 per 100,000 Medicare beneficiaries in 2012 and 2018, respectively, a decrease in 14.9%. As illustrated in **Table 1**, when comparing the overall number of urologists, access for Medicare beneficiaries is worse; in 2018, 67.6% of the nation's 3144 counties had no urologists providing Medicare services compared with 62.4% of counties with no urologists at all ($P<.01$).[6] This is ominous particularly when considering that outcomes for the 3 most common genitourinary cancers is significantly worse in counties without urologic care.[7]

This article focuses on the role that advanced practice providers (APPs) can play to supplement the nation's urologic resources to expand access to services in a cost-effective manner.

HISTORY AND TYPES OF ADVANCED PRACTICE PROVIDERS

Historically, APPs were characterized by the terms, *physician extenders* and *midlevel providers*. These terms should be discarded for several reasons. First, and most importantly, these terms are inaccurate—attempts to define individuals in these professions using these criteria tend to emphasize their role as appurtenant to a physician rather than as unique providers of service who are practicing at the highest level of their certification. As an extension, these definitions focus on what these professionals cannot or should not do rather than what they can do as part of their appropriate scope of practice. Second, these terms are inconsistent with the collaborative team approach to health care that is necessary to improve access, enhance outcomes, and reduce cost. Third, these historical definitions detract from the training and certification required to

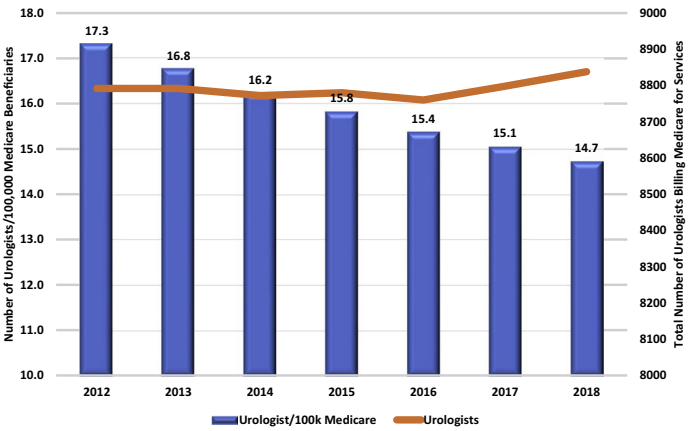

Fig. 2. Number of urologists billing for Medicare services and urologists/100,000 Medicare beneficiaries, 2012 to 2018.

Table 1
Number of urologists per United States county, all urologists, and urologists billing Medicare

Number of Urologists in County	All Urologists, N (%)	Urologists Billing Medicare, N (%)
0	1961 (62.4)	2125 (67.6)
1	294 (9.4)	270 (8.6)
2–3	299 (9.5)	273 (8.7)
4–8	263 (8.4)	243 (7.7)
9 or more	327 (10.4)	233 (7.4)
Total	3144 (100.0)	3144 (100.0)

enter these professions, and many nurse practitioners (NPs) and physician assistants (PAs) find their use demeaning.[8]

Unquestionably, the earliest APPs were midwives; descriptions of midwifery as an independent profession date back millennium.[9] More recently, individuals without what would be considered formal medical education at the time continued to engage in the diagnosis and treatment of disease, both with and without formal physician supervision.[10] In the modern era, although any number of different professions can be considered APPs, this article focuses on NPs and PAs, because these are the predominant APPs involved in urologic care in the United States. The first formal training programs for both NPs and PAs were introduced in 1965, when Dr Loretta Ford and Dr Henry Silver developed the NP program at the University of Colorado and Dr Eugene A. Stead Jr created the first physician PA class at Duke University Medical Center. Over the subsequent years, the training and certification requirements for these fields have become codified. Although both serve important roles, there are important differences in training and scope of service between these professions.

To become a PA in the United States, it is necessary to be a graduate of an accredited PA program; as of January 2021, there were 315 such programs nationwide.[11] In general, these programs require 2 years to 3 years of study and usually result in a master of science (MS) degree. Certification requires evidence of degree status and between 1000 hours and 2000 hours of clinical practice as well as passing the Physician Assistant National Certifying Exam. Certification is required for licensure in all 50 states. Once certified, PAs use the designations, *PA-C* or *RPA-C*, where *C* connotes certified, and *R* is registered. These designations vary by state. More recently, doctoral programs for PAs that result in a doctor of medical science (DMSc) degree are being offered, but this degree is not required for practice.

There are a variety of NP designations, all categorized under the broad definition of advanced practice registered nurse (APRN). It is a prerequisite of APRN training to be a registered nurse, with subsequent 18 months to 36 months of post-baccalaureate training. It is not necessary to have clinical nursing experience to pursue APRN training. Although there are many types of APRNs, there are 4 broad categories of practice: (1) certified NP; (2) certified nurse midwife; (3) clinical nurse specialist; and (4) certified registered nurse anesthetist. Importantly, APRNs cannot be licensed only in a specialty area. Degrees commonly associated with APRNs are MS, MS in nursing, and doctor of nursing practice (DNP). Certification requires evidence of degree status as well as 500 hours to 1000 hours of clinical practice. As with the DMSc for PAs, the DNP degree is not required to practice.

SCOPE OF PRACTICE

Scope of practice for both PAs and NPs varies according to state of practice and is a source of both confusion and controversy. In general, professional medical societies (led by the American Medical Association) contend that expansions of scope of practice will result in danger to patients due to the different levels of training of physicians and APPs.[12,13] As expected, societies representing APPs (American Academy of Physician Assistants and American Association of Nurse Practitioners) contend that expanding scope of practice for APPs will result in greater access, improve outcomes, and reduce costs—the global public health emergency (PHE) has provided momentum to these efforts.[14] Although exploration of this controversy is beyond the scope of this article, as with most circumstances with starkly opposing views from highly invested stakeholders, the truth likely is in the middle. Recent literature suggests that for most routine health care encounters, there is little evidence that quality of care

rendered by APPs differs from physicians; simultaneously, diagnosis and management of more complex illnesses or patients with comorbidities are enhanced by physician supervision of care.[15]

For PAs, scope of practice laws are less complex than for NPs, because, by definition, PAs must function under the supervision of a physician. Scope of practice laws for PAs largely govern the mechanism by which physician supervision is provided as well as prescriptive authority for medications. At present, 47 states allow the supervising/collaborating physician at the practice site, 2 require a signed collaborative agreement between the PA and supervising physician, and 1 requires PAs to be directly supervised by a participating physician.[16] As with supervision requirements, prescribing rights in most states (44) is left to the discretion of the supervising physician, with only 6 states restricting the ability for PAs to prescribe Schedule II medication.[17]

For NPs, scope of practice is determined by the state in which the professional is licensed. There are 3 general categories that define scope of practice:

- Full practice: state practice and licensure laws permit all NPs to evaluate patients; diagnose, order, and interpret diagnostic tests; and initiate and manage treatments, including prescribing medications and controlled substances, under the exclusive licensure authority of the state board of nursing.
- Reduced practice: state practice and licensure laws reduce the ability of NPs to engage in at least 1 element of NP practice and require a signed collaborative agreement with a physician for the NP to provide patient care, or it limits the setting of 1 or more elements of NP practice.
- Restricted practice: state requires supervision, delegation, or team management of NPs by physicians.

As of January 2021, 26 states or territories allow NPs full practice authority and 19 allow for reduced practice, whereas 11 restrict practice.[18]

An important exception to scope of practice regulations is for government employees. APPs employed by the federal government are not under jurisdiction of state scope of practice regulations, except with respect to the ability to prescribe and administer controlled substances. Importantly, in 2016 the US Department of Veterans Affairs (VA) amended provider regulations to permit full practice authority to 3 roles of VA APRNs to practice to the full extent of their education, training, and certification, regardless of state restrictions that limit such full practice authority, again, except for certain prescribing restrictions.[19]

Finally, during the PHE, waivers have been granted on the state level (which has jurisdiction over APP licensure) that ease supervisory requirements and scope of practice regulations for a variety of APPs. For PAs, 8 states have eased supervision requirements by executive order of their respective governor and 13 have suspended and/or waived all or partial supervision requirements by existing statute or regulation whereas 26 have suspended and/or waived select practice requirements (eg, licensure, ratios, and telemedicine)—only 3 states (Arkansas, Kentucky, and Alaska) have not taken waiver actions for PAs during the PHE.[20] NPs practicing in states or territories that do not permit full practice authority also have seen regulatory relief. Six states or territories have temporarily suspended all practice agreement requirements and 12 have issued temporary waiver of select practice agreement requirements, whereas 10 have taken no action on this issue.[21] In addition to state waivers, the federal government has issued several waivers to Medicare billing restrictions governing physician supervision at long term care facilities, provision of telemedicine, and the ability for hospitals to hire and utilize APPs to provide services.[22]

BILLING CONSIDERATIONS FOR ADVANCED PRACTICE PROVIDERS

Historically, physicians have had disquiet about incorporating APPs into their practice due to concerns regarding financial liability. More recently, data suggest that in general, APPs can be incorporated into practices in a manner that is profitable,[23] with additional studies documenting this specifically for the specialty of urology.[24,25]

One issue that faces practitioners that incorporate APPs into their practice is the consideration of billing for services. Depending on the insurance company and the site of service, APPs may bill for services in 1 of 3 distinct methodologies: (1) incident-to billing, (2) direct billing, or (3) split/shared billing. The billing rules for each of these modalities are very specific, and although Medicare guidelines are national (albeit affected by state licensure rules), these rules may not apply to private payors. Further complicating the issue is that billing for APPs has been subject to an increase in the number of third party and Office of Inspector General (OIG) audits to ensure adherence to billing policies.

When permitted by scope of practice laws, APPs may bill carriers for their services directly. For Medicare, when this approach is utilized, the

reimbursement is 85% of the rate listed in the Medicare Physician Fee Schedule. Private carriers each establish their own rate schedule for services directly billed by APPs, and although most follow Medicare policy, insurers are free to set fees that might be higher or lower than the percent used by Medicare. Although in some cases, fees paid to APPs may approach or equal physician fees, in no cases do they exceed physician payments. Other than overall reduced revenue from lesser reimbursement, there are 2 important considerations for when contemplating direct billing for APP services. The first is that if an APP is administering Part B drug payments, practices must ensure that these services are not subject to a contractual reduction in payment, because any such reductions may result in payments that are below acquisition costs. The second is that overhead costs for procedures, especially the costs of implants or disposables, must be factored when considering margins for procedures that are performed by an APP.

To avoid reimbursement and supervisory pitfalls, the most common approach to billing for APP services is "incident-to" billing. Services billed incident-to a physician service are reimbursed at 100% of the fee schedule for the physician provider. Although private payors can define this differently, the Medicare definition of incident-to billing covers services or supplies that are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. These services are performed in the physician's office or in the patient's home and, during the PHE, may include telemedicine visits. Regulations vary by state regarding the scope and level of supervision required, but general requirements for the APP to qualify to bill for incident-to services include (1) a state license/registration; (2) a National Provider Identification (NPI) number; (3) being an employee of a physician or a physician-directed clinic as either a W-2 employee or a 1099 contracted/leased employee; (4) being under the control of the physician; and (5) presenting an expense to the physician, group practice, or legal entity. Qualifying incident-to service must be provided by a caregiver who is supervised directly, and, although private payors may have different payment rules, these services are reimbursed by Medicare at 100% of the applicable fee schedule.

An important caveat to billing for incident-to services is that the physician must perform the initial service, face to face with the patient, and document the plan of care which the APP will be following. As such, APP billing is incident-to the plan of care outlined by the physician billing provider at the initial visit with the patient. As such, 2 fundamental rules always must be observed for incident-to billing: (1) new patient visits performed by an APP are not considered incident-to physician services unless very strict documentation requirements are met, and any subsequent visits for the same diagnosis never can be billed as an incident-to visit; and (2) if an established patient being followed in accordance with incident-to regulations presents with a new problem, the APP may not bill as incident-to if the visit addresses the new problem, unless the physician documents participation in the visit and creates the new care plan. For example, a patient with advanced prostate cancer is placed on hormone deprivation therapy with an Luteinizing-hormone releasing hormone-antagonist, administered monthly by an APP. Administration of the medication and any services associated with the management of the advanced prostate cancer (as delineated in the physician care plan) are considered incident-to and may be billed at 100% of the applicable fee schedule. If, during a visit, however, the patients indicate another problem (such as urinary incontinence or erectile dysfunction), services referable to the new diagnosis may not be billed as incident-to unless the patient is evaluated for that specific issue by the physician and the physician issues a care plan for that problem.

There are additional provisions for APPs to bill for their services incident-to physician services. Although the billing physician does not have to be in the treatment room, he or she must be present within the suite of offices while the APP is performing the incident-to service. And although the billing provider does not have to be the physician who documented the plan of care, the billing/supervising provider must be present within the suite of offices and available to supervise/assist the APP who is performing the service. Importantly, the supervising physician cannot be performing a procedure while the incident-to services are being performed by the APP—in an audit, the OIG is looking to see where and what the supervising physician was doing at the time of the incident-to service; this information is readily available from the metadata incorporated into all certified electronic health records. As an aside, for multispecialty practices, the supervising physician does not have to be of the same specialty as the physician who performed the initial visit and created the patient plan of care. Finally, to qualify as an incident-to service, the APP must sign the medical record. Importantly, there is no incident-to billing in a hospital setting—these services must be billed under the APP as an independent service. Any services

that are performed by APPs within a hospital setting are not paid if the licensing state and/or the insurance carrier does not allow for independent billing.

For split or shared billing, both the APP and the physician work for the same entity (ie, same practice or same hospital) and the service performed is an evaluation and management (E&M) service and not a consult or a procedure. The physician must provide the face-to-face portion of the E&M service with the patient (simply reviewing and agreeing with the APP's description on the patient's chart is not satisfactory to meet the requirement for split/shared billing). The APP and the physician see the patient on the same calendar day; if all criteria are met, then it is permissible to bill under the supervising physician's Medicare number, with payment at 100% of the fee schedule, but if not met, then the service must be bill under the APP's NPI with payment at 85% of the fee schedule. In split/shared visits, both the physician and the APP (PA or NP) must participate, each performing and documenting at least 1 required component of the E&M encounter. Split/shared visits may be performed for either initial or subsequent encounters at all levels of coding but not for consultative services, and this concept does not apply to critical care codes. It is important that each provider document their contribution to the service. Importantly, an addendum by the physician is not applicable; both physician and APP must contribute to the service being billed and the documentation must support distinct services for each provider. Again, if such an independent service is not permissible due to state regulations, then no payment for these services is made.

A final consideration when examining services performed by APPs are with respect to designated health services (DHSs). Payments for DHSs are subject to certain self-referral restrictions as delineated in federal Stark law. Guidelines regarding distribution of proceeds for DHSs performed by APPs billed by any of the methods described are arcane and complex—unfortunately, Stark law is a strict liability statute, and even unintentional technical violations can result in massive penalties. As such, practices must take great care that their income distribution formula with respect to DHSs performed by APPs is Stark compliant.

SERVICES PERFORMED BY ADVANCED PRACTICE PROVIDERS

Over the past decade, both the number of APPs providing urologic services and the volume and nature of these services have increased. The 2019 AUA census reports that 71.4% of urologists incorporate APPs into their practice, an increase of 13.9% over the 2015 report.[2] Of the subset of urologists who utilize APP services, more than 79% interact with 2 or more APPs on a routine basis, suggesting that once the barrier to entry is overcome, physicians embrace the addition of APPs into their practice.

The most common services provided by APPs are E&M visits performed—due to the financial advantages, most of these are performed as incident-to visits. Depending on state of licensure and degree of training, however, APPs also may perform a variety of procedures as well as serve as surgical assistants. Because services performed by an APP incident-to a physician visit are billed under the physician's NPI number, ascertaining precisely how many procedures are performed by APPs is challenging. A review of service performed by APPs and directly billed, however, may provide insight into the general types of service performed. As illustrated in **Table 2**, a review of the Medicare billing data from 2012 to 2018 for Healthcare Common Procedural Coding System (HCPCS) codes referable to the most common urologic procedures (HCPCS 50000–55899) 20 HCPCS codes comprise nearly 99% of all APP direct billing for this period, with a single code (HCPCS code 51798, determination of post-void residual urine) accounting for more than 55% of total services.[5]

As summarized in **Fig. 3**, the total number of APPs who directly billed for Medicare services increased from 1412 to 2557 in 2012 and 2018, respectively, an increase of 81.1%. Simultaneously, the total number of procedures directly billed to Medicare by APPs increased by 93.4%, from 186,673 in 2012 to 361,118 in 2018. During this interval, the ratio of urology procedures billed by APPs to Medicare compared with urology procedures billed by all providers to Medicare grew from 3.5% in 2012 to 6.8% in 2018, an increase of 95.7%.[5] The rate of expansion in number of services was significantly higher ($P = .04$) than the pace of expansion in the number of APPs providing these services, suggesting that these providers became progressively busier, particularly over the latter part of the last decade.[26]

Erickson and colleagues[27] found that most services provided by APPs could be considered an extension of routine urologic care. They concluded that these services, which can be learned relatively quickly but may be time consuming and disruptive to perform, could improve a practice's efficiency. At that time, more technical services (eg, cystourethroscopy, stent removal, and prostate biopsy) constituted a much smaller percent of APP direct

Table 2
Top 20 Healthcare Common Procedural Coding System codes direct billed to Medicare by advance practice providers by year

Healthcare Common Procedural Coding System Code	Healthcare Common Procedural Coding System Description	2012 (%)	2013 (%)	2014 (%)	2015 (%)	2016 (%)	2017 (%)	2018 (%)	Grand Total (%)
51798	Ultrasound measurement of bladder capacity after voiding	56.4	51.9	52.3	54.8	55.7	56.4	56.3	55.1
51702	Insertion of indwelling bladder catheter	5.8	6.7	6.9	6.9	6.8	7.0	6.9	6.8
51701	Insertion of temporary bladder catheter	5.4	6.0	5.9	5.8	6.1	5.8	6.	5.9
51741	Complex uroflowmetry	6.0	6.7	6.4	6.0	5.8	5.2	5.0	5.8
51700	Bladder irrigation and/or instillation	4.5	4.6	5.7	5.8	6.1	6.1	6.0	5.7
51720	Bladder instillation of cancer preventive, inhibiting, or suppressive agent	2.5	3.7	3.6	3.5	3.7	3.9	3.9	3.6
51784	Non-needle measurement and recording of electrical activity of muscles at bladder and bowel openings	5.2	5.5	4.2	3.1	2.7	2.6	2.4	3.4
51705	Removal of skin suture with change of bladder tube	2.0	2.7	3.2	3.0	3.4	3.5	3.9	3.2
51797	Insertion of device into the abdomen with measurement of pressure and urine flow rate	2.3	2.5	2.4	2.1	2.0	1.9	1.9	2.1
52000	Diagnostic examination of the bladder and bladder canal (urethra) using an endoscope	1.2	1.3	1.4	1.4	1.4	1.6	1.6	1.4

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Table 2
(*continued*)

Healthcare Common Procedural Coding System Code	Healthcare Common Procedural Coding System Description	2012 (%)	2013 (%)	2014 (%)	2015 (%)	2016 (%)	2017 (%)	2018 (%)	Grand Total (%)
51728	Insertion of electronic device into bladder with voiding pressure studies	1.7	1.8	1.6	1.3	1.3	1.3	1.3	1.4
51729	Insertion of electronic device into bladder with voiding and bladder canal (urethra) pressure studies	1.0	1.1	1.1	0.9	0.8	0.8	0.8	0.9
55866	Surgical removal of prostate and surrounding lymph nodes using an endoscope	0.9	0.8	0.7	0.6	0.7	0.7	0.7	0.7
51703	Insertion of indwelling bladder catheter	0.4	0.6	0.9	0.9	0.8	0.7	0.6	0.7
53661	Dilation of bladder canal (urethra), female	0.8	0.8	0.7	0.6	0.3	0.2	0.2	0.4
51725	Insertion of device into bladder to measure pressure of urine flow	0.9	0.4	0.4	0.3	0.3	0.3	0.3	0.4
52310	Removal of foreign body, stone, or stent from bladder canal (urethra) or bladder using an endoscope	0.3	0.3	0.3	0.4	0.3	0.3	0.4	0.3
55700	Biopsy of prostate gland	0.5	0.4	0.4	0.4	0.3	0.3	0.2	0.3
54235	Injection procedure to induce erection	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.2
51792	Assessment of muscle signal of pelvic nerves	0.3	0.4	0.2%	0.1	0.1	0.1	0.1	0.2

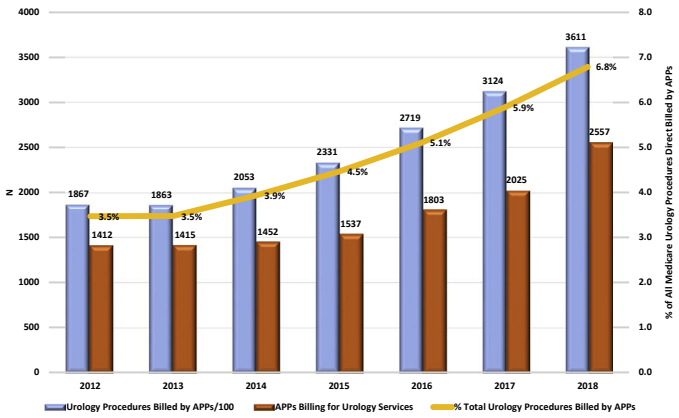

Fig. 3. Number of NPIs direct billing for Medicare services, total number of Medicare procedures/100 direct billed by APPs and percent of urologic and urologists/100,000 Medicare beneficiaries, 2012 to 2018.

billed services. Expanding the analysis, as described previously, suggests that although service volume expanded greatly, the nature of services provided did vary substantially; although there was a slight increase for both diagnostic cystourethroscopy and endoscopic stent removal (HCPCS codes 52000 and 52310, respectively), this was offset by a decrease in prostate biopsies (HCPCS code 55700) billed directly to Medicare by APPs.

OPPORTUNITIES AND RISKS

The expanding shortage in access to urologic services provides ample opportunity for APPs to fill potential gaps in care. An immediate benefit to ramp up staffing on a national level is the duration of training required for an APP versus a physician to be able to practice to the full level of their certification; urologic education involves a minimum of 9 years of postgraduate education, not including fellowship, whereas an APP, can be licensed in approximately one-third that time. Increased staffing should enable faster patient access to care and potentially decrease burnout for overworked physicians (burnout has been identified as problematic particularly in the urologic community)[28]; burnout may be further reduced through enhanced after-hours on-call coverage. Because most services provided by APPs in an incident-to fashion involve managing cases according to a physician care plan as well as office procedures that should be mastered easily, physicians should be able to focus on more complex diagnostic, surgical, and patient management problems, improving quality of care and patient satisfaction. Clearly, practices that utilize APPs for other services, including office visits assisting in surgery, and seeing patients in a facility setting (eg, postoperative follow-ups, hospital consults, and emergency room visits) may well experience lower operating overhead and other economic benefits by allowing physicians to continue to work in the more profitable office environment rather than spend time traveling between sites. Additionally, the advent of telemedicine services and the easing of billing and supervisory restrictions resulting from the PHE has opened additional opportunities to expand access to the many areas that either are without or are underserved from the perspective of urologic care. It remains to be seen if the temporary easing of restrictions will remain over the intermediate term to long term; if so, it can be anticipated that APPs will be an important component of care outreach to currently underserved communities. Finally, APPs are an opportunity for improve diversity in urologic caregivers. In its 2017 report on health care, 67.8 of PAs and 85.1% of APRNs were female[29]; contemporaneously, just 9.9% of the urologic workforce was female[2]; although this does not replace the need to encourage the development of female urologists, it will provide patients the opportunity to experience greater gender diversity in their contacts with urologic care. Regrettably, APPs do not provide a road to racial diversity; the same HHS report indicates that 84.0% of APRNs and 72.7% of PAs are white compared with 84.7% of practicing urologists[2,29]

Besides issues of regarding scope of practice and billing complexities identified previously, physicians grapple with issues of quality in APPs. Urologic training is not a core focus of training for APPs; as such, newly graduated APPs may need significant supervision and/or a specific urology training program prior to physicians having comfort in the care the APP may render. Although not linked directly to training, another issue of concern for supervising physicians is that of medical liability. Depending on the type of certification, APPs are between 12 times and 24 times less likely to

be sued than physicians; that said, financial liability for claims still may be substantial.[30] In malpractice actions, the provider (physician or APP) may be held directly liable for their own acts or omissions, and the practice employing them may be subject to vicarious liability for failing to implement or enforce standard of care protocols. Liability actions involving APPs can be complicated by supervisory requirements, which may implicate the common law doctrine of *respondeat superior*, meaning "let the master answer." Using this doctrine, a physician can be held liable for liability claims occurring as a part of the APPs employment. This theory often is used to hold physicians liable for the acts or omissions of an APP. This situation can occur even when the physician did not treat the patient personally. Liability could arise because the physician employs the APP or because it is the physician's responsibility to supervise or oversee the APP. Because the definition of what constitutes appropriate collaboration or supervision of an APP varies greatly by type of PA and state of licensure, it is vital that physicians and practices familiarize themselves thoroughly with their then extant regulatory requirements regarding APP supervision.

SUMMARY

Existing resources are inadequate to meet the nation's urologic health care needs. These access to care issues are exacerbated by the changing demographics of the population as well as the distributions of urologists nationwide; evidence suggests that this may be a greater problem for the Medicare population. Although utilization of APPs has increased recently, due to both an increase in number of caregivers and an apparent increase in services per APP, the nature of the services provided has not changed materially, focusing largely on E&M services and simple procedures. The shorter training period and demographics of the APP population have the potential to both address staffing issues and assist with gender diversity among urologic providers, but at least at present, increasing the number of APPs does not address racial diversity concerns. Expanding the role of APPs is complicated by the patchwork nature of licensure and supervision regulations that varies between states, payors, and type of APP. Practices that consider incorporating APPs must address issues of training, supervision, billing, and liability as well as ensuring compliance with Stark regulations should the APP perform DHSs. The current PHE has eased restrictions on APP services, loosened supervision requirements and expanded the availability of telehealth services—it remains to be seen if some or all these changes become permanent. Despite these challenges, APPs are an important resource whose role in providing urologic care is likely to continue to expand. As the principal caregivers of the genitourinary tract, it is imperative that the urologic community ensure the nation's access to urologic care, which includes actively engaging in ensuring quality of care by APPs by developing both training modules and possibly certification standards.

DISCLOSURE

No disclosures.

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