



# Eyes on the Money

Non-Physician Practitioners Offer  
Practice Benefits but Require  
Attention to Billing



The demand for physician services is high. With an aging and growing population, high use of care, and other factors, the overall demand for health care services has also grown significantly in recent years. As a reflection of this growing demand, health care spending in the United States reached \$5.3 trillion in 2024, marked by an increase of over 7% in 2024.<sup>1</sup>

Unfortunately, the supply of available physicians has not kept pace with the growing demand for services. This trend is also expected to continue for the foreseeable future. The projected total shortage of physicians could be as high as 86,000 by the year 2036, according to the Association of American Medical Colleges.<sup>2</sup> This includes an expected shortfall of between 20,200 and 40,400 primary care physicians over the next decade.<sup>2</sup>

In response, the number of non-physician practitioners (NPPs) working in the health system is on the rise. These include nurse practitioners, physician assistants, clinical nurse specialists, and other practitioners. In fact, advanced practice practitioners now constitute over 40% of the U.S. health care provider workforce.<sup>3</sup> This growth is largely found in primary care and surgical settings, but includes many specialties and areas of care.

Notably, NPPs are also often referred to as advanced practice providers (APPs). While the terms are generally synonymous, NPP tends to be used more in reference to billing or administrative matters, while APP refers more to the clinical practice or setting. The Centers for Medicare & Medicaid Services (CMS) describes NPPs as advanced practice non-physician practitioners.<sup>4</sup>

## Check on Teams

For many medical practices, the use of NPPs (or APPs) as a practice resource is an increasingly attractive option, both financially and as a means to enhance patient access and satisfaction. Notably, a recent Medical

Group Management Association (MGMA) Stat poll found 48% of medical practices added advanced practice providers to their clinical staff in 2025.<sup>5</sup>

Doing so can build on the team-based care approach that defines modern medical practices, observes Anders Gilberg, senior vice president of government affairs for the MGMA in Washington, D.C. “Advanced practice nurses and other practitioners are absolutely critical to that team-based setting,” says Gilberg. “In this country, there are challenges now because of physician shortages. There are limits on graduate medical education slots for training physicians. There are shortages as well in some of the primary care specialties. Many medical practices leverage advanced practice providers in a way that is critical for patient access and for the bottom line of the practice. It depends on the physician specialty or whether it’s a multispecialty practice, but advanced practice providers play a critical role in health care delivery in our country today.”

Of course, the expanded use of nurse practitioners, physician assistants, and other NPPs in clinical care requires that medical practices clearly understand the billing responsibilities associated with their use. This is a key challenge for medical groups to avoid claims denials and potential Medicare or private payer audits.

Under Medicare, an NPP must be enrolled in the program under their own National Provider Identifier, or NPI.<sup>4</sup> In turn, when an NPP directly bills for medical services using their NPI, they can expect to be compensated at 85% of the Medicare physician fee schedule. However, two other billing options are available when NPPs and physicians collaborate in patient care. These are known as “incident to” services and “split/shared” services.<sup>6</sup>

## Invest in a Better Understanding

When an NPP provides office-based services under the supervision of a physician (e.g., MD or DO), the supervising provider can bill for those services under Medicare’s incident-to rules. Using the supervising physician’s NPI allows for the NPP to then be reimbursed at 100% of the Medicare physician fee schedule.<sup>6</sup> However, there are some important caveats that come with incident-to services. First, the billed medical service must be initiated by the supervising physician, who is responsible for the initial diagnosis and treatment plan. In turn, the NPP is required to follow that treatment plan in subsequent patient visits. Incident-to rules also require the supervising physician to be physically present in the practice when the NPP treats the patient.<sup>7</sup>

Despite the lower NPP compensation rate associated with billing directly, doing so is likely perceived by many medical practices as less of a compliance risk, finds Gilberg. “In my conversations over the years with administrators and executives of physician practices, that is the predominant way most practices handle it,” he notes. “The other way is incident-to billing, but that comes with a lot of strings attached in terms of regulatory requirements, as well as contractual requirements if we’re talking about a health insurance contract. The regulatory requirements where a physician has to initiate the course of services and then be in the office suite to supervise the care tends to be somewhat more limiting. We find a lot of our medical practices will bill the advanced practice providers at the 85% fee schedule because that allows them to not only have more autonomy, but they can also initiate new diagnoses. You can’t do that under incident-to rules. Although they get paid a little less, the lessened liability risk for the compliance issues that could

occur, as well as the autonomy within the practice to work as part of the team without direct physician supervision, is what most medical practices will do.”

Notably, the 2025–2026 work plan of the Office of Inspector General continues to prioritize audits to ensure compliance with Medicare incident-to services.<sup>8</sup> “The

## The Fundamentals of NPPs

Under Medicare, several types of practitioners are defined as advanced practice non-physician practitioners (NPPs). They include four categories of advanced practice registered nurses: certified registered nurse anesthetists, nurse practitioners, clinical nurse specialists, and certified nurse-midwives. Other NPP categories include physician assistants and anesthesiologist assistants.<sup>6</sup>

[Office of Inspector General] has had incident-to billing on its work plan for many years and is constantly keeping a close eye on this issue,” cautions Gilberg. “On the regulatory side with the federal payers, I would just be very careful and really understand the requirements necessary for incident-to billing. I would advise practices to try to keep that part of the practice as simple as possible.”

## Know the Costs

Admittedly, the billing landscape is a complex one to navigate and likely a source of confusion or uncertainty for many medical practices. While Medicare has consistent rules for billing NPP services, commercial insurance payers may apply different coverage policies. These may be similar to Medicare rules but can also differ in important ways.

Adding to these challenges, medical practices can conceivably work with many contracted private insurance payers. For this reason, practice leadership must establish clear billing policies and processes that enable staff to stay informed, up to date, and compliant with multiple payer requirements.

If a medical practice has plans to introduce or expand its use of NPPs, managers should anticipate and prepare for the multiple contractual obligations this could entail. “Every insurance company has [its] own rules and how they want things submitted,” notes David J. Zetter, PHR, SHRM-CP, CHCC, president of Zetter Healthcare Management Consultants in Mechanicsburg, Pennsylvania. “If you’re working with 10 different insurance companies, the first thing you should do when hiring any type of provider—whether it’s a physician assistant, nurse practitioner, or other provider—is to go to the payer websites and find out what the requirements are for that provider to be credentialed in your state and what they’re

## Bank on Each Other

“The more complex the payer regulations get, the more we have to lean on the rest of our team. Usually, medical groups will have the billing manager go through the updates and newsletters from every single payer. It’s [their] job to stay on top of all of the policy updates. And that’s often just not feasible, particularly if you have a working manager in billing or in practice administration. But if you have a billing team, even three people, you can delegate some of that work. It doesn’t have to be one person who’s responsible. A manager can say, ‘Jennifer, your job is to stay on top of the Blue Cross policy updates’ and, ‘Khalil, it’s your job to look at the United Healthcare updates. If there’s anything that applies to this clinic, you need to escalate it up to me so that we can talk about it at the next billing meeting.’ But what I often find is groups will just say they try to read through all the updates. That’s not efficient. Or, ‘it’s everyone’s job in billing.’ If it’s everyone’s job, it’s no one’s job. That drives zero accountability.

“It’s the same reason when you’re taught CPR, they tell you to point at someone specific and tell that person to dial 911. It’s because everyone will just assume somebody else did it. But when you have that kind of [delegated] accountability and have a regular cadence for your meetings or even just staff huddles, then your staff is encouraged to raise those billing issues. There are just so many rules and payer regulations, you can’t default to one person or just say it’s this department’s job. You really have to get granular and assign accountability to a specific human.”

—Shawntea “Taya” Gordon, MBA, FACMPE

allowed to do to be eligible for reimbursement. Whether it’s Blue Cross Blue Shield, Cigna, or Medicare, you’ve got to know all the rules on how they are allowed to bill, what the supervision requirements are, and more. This should all be figured out before you even hire someone. You’ll know that they need to be credentialed. You’ll know how long it’s going to take. You’ll know whether a physician assistant is going to be allowed to do an ultrasound or [whether] they need an interpretation by a physician to bill that procedure. Everything should be set up so the practice can bill properly and legally and get paid appropriately.”

Given the complexity of NPP services, billing clarity should always be paramount, agrees billing expert Farida Chowdhury, CEO of FC Billing in Lansdowne, Virginia. “I get questions on these issues all the time from [physicians],” says Chowdhury. “I find there’s a lot of confusion among medical practices about

these rules. Unfortunately, [physicians] are often relying on hearsay. They’ll say, ‘Well, I talked to my friend and [they do] it this way.’ Or they learned something in a Facebook or LinkedIn group. My advice is always to go directly to the source and ask, ‘What’s the rule?’ Do not go by what other people are telling you. Don’t talk to your friend; talk to the payer directly. I see thousands and thousands of dollars being taken back every year from one practice or another for relying on this type of hearsay.”

Whether it involves Medicare or private payers, payment and claims audits are a fact of life for medical practices today, emphasizes Chowdhury. “Medical practices need to know the rules because no matter who they are, no matter how big or small the practice, they can expect to be audited at some point,” she says. “In some instances, I have seen practices where a Medicare audit caught that physician assistants and nurse practitioners were continuously billing under a physician’s name, which is considered incident-to billing. In the audits, Medicare actually asked for the [physician’s] schedule. They then saw that most of the days these practitioners were billing, the [physician] wasn’t even on-site as required.”

While incident-to billing rules require careful adherence, they are not unmanageable for those who make the effort to understand them, explains Chowdhury: “If we’re talking about dermatology, let’s say the patient has a skin rash. The MD or DO will see the patient for the first visit and for that particular diagnosis and then set the treatment plan. They might also say the patient should return in six weeks to see the nurse practitioner. The nurse practitioner will then follow that treatment

plan for the subsequent visits. Now, if they intend to bill a claim under the [physician], they will need to exactly follow that plan and also keep the [physician] updated on the patient's progress. If the nurse practitioner were billing on their own, they would get paid 85% of what the [physician] would get from Medicare. By billing under the MD or DO, they are getting 100% of the allowable fee. But that also means the medical [physician] is responsible for managing that particular diagnosis."

As such, this should be a clear, straightforward arrangement. But Chowdhury raises an interesting question: What if, in the course of the treatment, the patient develops a new dermatological condition? How would this affect the billing arrangement?

"In [the example] case, we know the patient is being treated for [a] skin rash," she says. "But what if this patient also develops a severe acne issue on the back? The acne issue is a separate problem. If the nurse practitioner is initiating treatment for the acne, they will need to bill on [their] own NPI, not the [physician's] NPI. That's because they are initiating treatment for a new diagnosis that the [physician] has not addressed or planned for. However, if they want to do incident-to billing, they will have to send the patient back to the MD or DO for the new diagnosis."

"This is what's often misunderstood by medical practices," says Chowdhury. "That's why I generally recommend [billing] under the provider who's actually doing the treatment. But if they do choose to use incident to billing, they will have to stick to the exact plan of the [physician]. They cannot sidestep the plan."

## Organizational Change

As medical practices add NPPs to their groups, experts agree that it is necessary to develop

a consistent approach toward how the practice manages and implements these staffing changes. Doing so requires managerial leadership, perspective, and informed input from staff at every level of the practice.

"For supervisors and managers, one of the critical things to understand is that adding an NPP to your practice means you're changing your care delivery model," says Shawntea "Taya" Gordon, MBA, FACMPE, an MGMA consultant and CEO of Atlas & Perpetua Healthcare LLC in Omaha, Nebraska. "Most groups think [that] if they understand the rules, they're fine, but most of the time when people get into trouble, it's because they didn't operationalize on those rules in a consistent way. They're missing those workflows or the documentation—the standardization in general—that really keeps them safe."

For instance, with incident-to services, Gordon cites an instructive example of the type of complication that could arise. "I worked with a medical group that has several locations, with four physicians and eight NPPs. Ratio-wise, supervisory-wise,

that's fine, except there was one day a week when there was no physician at one of the locations. Yet that involved the designated supervising physician for the NPPs at that location on that day. So, it's a bit of a mismatch, right? Nobody had caught that there wasn't a physician there one day a week to provide direct supervision or to step into a room if there was a new problem or an emergency. It's issues like this that can happen when you don't have a consistent guideline or workflow around changes to your care model. What does that mean across every spectrum of the practice? What does it mean for new patients, established patients, and the workflow? That's really when I start to see people get tripped up."

Gordon also wants medical practices to understand that they should never view incident-to arrangements as a kind of "billing hack"—a way to obtain 100% of the revenue without meeting the credentialing or supervisory rules. "If you have to defend your practice in an audit or in court, you really want to make sure you are in a solid, secure

place with that, which means your documentation isn't just copy and paste," she cautions. "This means you have a true policy for supervision and for escalation of a claim."

## "Split/Shared" Services

The other allowable exception to Medicare's NPP direct billing rules is "split/shared" billing. This is a billing arrangement that is strictly limited to facility-based settings, such as hospitals (both in-patient and outpatient services), emergency rooms, and nursing facilities. These are settings where incident-to billing is prohibited. Since 2021, split/shared services are also defined under the American Medical Association's *Current Procedure Terminology (CPT)* coding system. Accordingly, the place of service (POS) code is needed to understand a facility setting's eligibility

## Small Change

"I think the smaller clinics do a better job of managing billing responsibilities. If you're a small clinic with one to four [physicians] and you have a small administrative team, they're working collaboratively already out of necessity. They really need to focus on every dollar that gets denied. They need to make sure that they are collaborating with the front desk for any coordination of benefits issue. So, they are working pretty interconnectedly.

"At the other end of the spectrum, ... large health systems ... have systems in place. They're big enough that they've built in the standardization and the protocols to drive that sort of efficiency.

"But in between these examples, there is this place where people haven't quite gotten to a point where they need systems as structured as the large systems. They're also not communicating or as interconnected as the small groups. Because you might not see half of the people that are employed at your peer level in a larger group, whereas in a small group you're working right next to them. As soon as you hang up the phone with a payer, you're going to say, 'You're never going [to] believe what I just heard from Blue Cross.' And you tell the person sitting next to you, and now the whole department is informed. So, there is something that gets lost when you grow beyond a certain size and you don't build those SOPs [standard operating procedures] into place."

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for split/shared services.<sup>9</sup>

Essentially, split/shared services are an arrangement in which a physician and an NPP in the same group practice each perform portions of a patient visit in the same facility. As an evaluation and management (E/M) visit, split/shared billing can involve both new or established patients, initial or subsequent visits, and prolonged services.<sup>10</sup> Both the physician and the NPP must document their respective work in the clinical record to support the claim, which is identified with the modifier FS.<sup>11</sup>

Notably, the practitioner whose time constitutes the “substantive portion” of the visit will determine the billing provider eligible for reimbursement. The substantive portion is defined as more than half of the total time spent on the visit by either the physician or non-physician practitioner. This can include the time involved for core medical decision-making.<sup>11</sup>

“With split and shared visits, ... the challenge is that often people are not looking at who the substantive provider was,” notes Gordon. “In my experience, they tend to default to the higher billing provider as the substantive provider. But the actual regulations say that if there are two providers that helped deliver the care, whichever one spent more time or had the more substantive visit is the one who should be billing.”

Gordon illustrates her point with an instructive example. “If you have a physician assistant who is seeing a patient for an established visit, they can do the entire review of systems and history of present illness and go through the majority of the visit,” she says. “Then later in the visit, the physician sees the patient because [the physician assistant] needs [the physician’s] opinion on something. Maybe the physician spends 10 or 15 minutes with the patient in an hour visit. In this case, the person who did the substantive portion of the visit will be the physician assistant, not the physician.

“This is where people can get confused,” remarks Gordon. “They may automatically default to billing the physician because that’s the higher reimbursement. But to do it compliantly, it has to be the person who did the substantive time for the visit.

## Resources

### Medical Group Management Association (MGMA)

<https://www.mgma.com>

### Medicare Learning Network

<https://www.cms.gov/training-education/medicare-learning-network/mln/resources-training>

And not only that. The documentation for the visit has to clearly outline which provider did what and how much total time they spent. The documentation needs to state [that] this [physician] is the one who did the physical review. This [physician] is the one who did the medication list review. It has to be really clear.”

Accordingly, Gordon believes documentation is a responsibility that deserves more attention from medical practices. “In my experience, as a legal record, most groups are not giving the sort of weight, intentionality, and respect to the documentation that it deserves,” she remarks. “They’re using it as just a means to an end, as just the receipt of how they get paid. Or the documentation is their reminder for the patient’s next visit. But this document can get them into a lot of trouble. I’m usually banging that drum pretty loud, especially with split and shared visits where they will often default to the higher licensed provider.”

## Adding Up Benefits

In today’s administrative environment, NPPs certainly can offer medical practices many potential advantages. “Advanced practice providers can be incredibly valuable to the practice,” concludes Gilberg. “They add value both as clinicians, the revenue they generate, and their ability to provide greater access for patients. There are so many different and important ways that a practice can leverage that additional clinical support.”

As an experienced medical assistant, April Jones, CMA (AAMA), of South St. Paul, Minnesota, shares an appreciation for the benefits these practitioners can bring to a medical practice. “I think the advanced

practice practitioners have tremendous value,” she says. “I worked at an OB/GYN practice where advanced practice practitioners were quite prevalent and a major part of the practice. For instance, they were often the providers [who] could take the add-on patients—the ones that needed help right now.”

With a background that includes experience as a surgery scheduler, clinic and operations manager, externship coordinator, and in other specialty areas, Jones says working with nurse practitioners and other NPPs has been quite positive: “In my experience, they tend to be highly personable and explain things well, and that helps me to do my job better. Some of the advanced practitioners bring so much more to patient care. I believe they can play an amazing role in a practice.”

All the more reason, perhaps, for medical practices to ensure NPP services are billed accurately and appropriately. “In health care, billing responsibilities are definitely challenging,” concludes Jones. “Basically, it’s about always dotting your i’s, and there’s very little wiggle room. Knowing the parameters NPPs as providers need to work in is so important to documentation. With Medicare audits too, the amount of charts they may want to review can be a big challenge. It’s all a big deal actually. If it isn’t documented, it didn’t happen.”

To support the essential role of advanced practice NPPs in medical practices, it is fundamental to avoid falling into loose or improper habits or interpretations of billing rules and requirements. Despite the challenges, the good news is that compliance with regulatory and industry payer rules as they apply to these practitioners is an entirely manageable responsibility.

“If you are in a medical group where you’re comfortable putting together new processes and protocols, having conversations and working collaboratively with staff to make sure that everything’s in alignment, the rules are pretty clear, especially in CMS,” concludes Gordon. “In most cases, what we hope for is that a practice has clear guidelines on care delivery, on how patients access and schedule care. We want to know they have all of the scheduling and document tem-

plates in place. If the practice is comfortable working with that level of consistency and standardization, then there's no reason they can't do it the right way and bill incident-to services. They just have to make sure that it's not a default billing just to capture the extra 15% of billing. They have to be willing and all in to really change their entire delivery model and curate a model to include the NPPs and expand access to care."

The use of NPPs represents a growing model of health care, both in primary care as well as in specialty areas such as dermatology, cardiology, and elsewhere. As the health care system continues to grow and evolve, it is incumbent upon medical practices and their billing teams to ensure they remain compliant with the regulatory and commercial requirements necessary to the system's continued integrity and smooth functioning. ✨

The CE test for this article can be found on page 26.



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# MARWeek Materials on the Horizon

Get ready to celebrate **Medical Assistants Recognition Week (MARWeek)**, October 19-23, 2026!

Mark your calendars for **MARDay** on **October 21** and celebrate the vital role medical assistants play as partners in patient care.

MARWeek celebration materials and NEW gifting items will be available soon--visit the AAMA store later this summer to explore what's new!\*

\*You may also download the MARWeek logo and materials from the "MARWeek" webpage, which is found within the "Education and Events" tab or via the QR code below.

