Position Statement on Reimbursement for Nurse Practitioner Services

Nurse practitioners (NPs) provide comprehensive, cost-effective, high-quality health care services in diverse settings across the care and age continuum (Institute of Medicine, 2010; Newhouse et al., 2011). The National Association of Pediatric Nurse Practitioners (NAPNAP) believes that NPs must receive equitable reimbursement from all payers in order to provide the communities they serve with the full scope of health care services. NAPNAP understands the unique contribution that NPs make to the U.S. health care system and recognizes that NPs are important members of the health care delivery team who increase patient access to care and deliver safe, patient-centered care (Kuo, Loresto, Rounds, & Goodwin, 2013; Manion & Odiaga, 2014; Newhouse et al., 2011; Stange, 2014). NPs are recognized as independently licensed providers of primary and acute care, have demonstrated the ability to provide high-quality health care, and incur the same overhead costs as physicians who provide care to patients and therefore must be reimbursed commensurate with physicians for the services they deliver.

Adopted by the National Association of Pediatric Nurse Practitioners' Executive Board on January 13, 2016. This document replaces the 2009 NAPNAP Position Statement on Reimbursement for Nurse Practitioner Services.

All regular position statements from the National Association of Pediatric Nurse Practitioners automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

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Although the U.S. Balanced Budget Act of 1997 authorized Medicare reimbursement for NPs in all sites of service, it set the payment rates for NPs at only 85% of the physician rate. State Medicaid programs and many third-party payers, such as commercial indemnity insurers, commercially managed care or health maintenance organizations, and businesses or schools, also frequently pay NPs less than physicians for the provision of the same services (Hansen-Turton, Ritter, & Torgan, 2008; Kaiser Family Foundation, 2015; Yee, Boukus, Cross, & Samuel, 2013). In addition, third-party entities have reimbursement policies for NP care that are often more restrictive than state scope-of-practice regulations and provide unnecessary limitations on NP care delivery (Yee et al., 2013).

The ability of NPs to demonstrate clinical and financial outcomes related to the care they provide is critical to support changes in coverage and reimbursement rules, yet efforts to document these measures are hindered because third-party payers often require that NP services be billed under a physician-colleague's name and provider number. This requirement renders the care provided by NPs *invisible*. As a consequence, administrative and clinical data regarding NP care delivery is subsumed under physician documentation, which makes it difficult to account for NP care delivery outcomes or revenue generation (American Academy of Nursing, 2010; Yee et al., 2013).

NPs who co-manage inpatients with physician-members of the same practice face an additional challenge when both the NP and physician evaluate a patient on the same day. Only one claim for the patient evaluation may be submitted from that specialty team. Because the physician rate of reimbursement typically is greater than that of the NP, the physician's service is generally reflected on the claim. Shared/split billing can resolve this problem by both professionals to document their role in the evaluation and management of the patient with varying compensation models (Stantz, 2013). Inpatient reimbursement can further be complicated by bundled codes, when many critical

care and surgical service charges are bundled into one charge for the patient, making it challenging to decipher the care provided by the NP (Stantz, 2013).

NAPNAP advocates for:

- All NPs obtaining their own National Provider Identifier (NPI) number.
- All NPs obtaining their own Drug Enforcement Agency (DEA) number.
- Direct reimbursement for NP services from insurance companies billed under the NP's name and National Provider Identifier (NPI) number.
- Comprehensive documentation of NP care delivery to support reimbursement for and measurement of NP contributions to care (Craig, 2014).
- The same reimbursement for NPs, physicians, and other health care providers when they perform the same service.
- Legislation and policies that require state programs to reimburse NPs commensurate with physicians and other health care providers.
- Enforcement of nondiscrimination regulations established in the Patient Protection and Affordable Care Act mandating that insurance companies credential and empanel NPs and reimburse NP services.
- Development of partnerships between NPs and state insurance commissioners to support increased NP payment and recognition as credentialed providers.
- Inclusion of NPs on commercial and other payers' advisory and credentialing committees.
- Recognition of the ability of NPs to lead a Health Care/Medical Home (NAPNAP, 2016) or Accountable Care Organization.
- Continuing research to demonstrate the cost-effectiveness, competency, and quality outcomes of NP practice.

NAPNAP, an organization whose mission is to empower pediatric-focused advanced practice registered nurses and their interprofessional partners to enhance child and family health through leadership, advocacy, professional practice, education and research, believes that NPs should apply for and use their own provider numbers and that it is imperative that NPs be reimbursed directly and equitably for the health care services they are able to provide.

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