

Reimbursement for Nurse Practitioner Services

Securing fair and equitable reimbursement for nurse practitioners (NPs) is a unique challenge to the profession. NPs continuously are called upon to validate their expertise and worth in a health care delivery system driven by the medical model principles. The National Association of Pediatric Nurse Practitioners (NAPNAP) understands the unique contribution NPs make to the nation's health care system and believes that NPs should be reimbursed directly and on par with physicians for the health care services they provide. This country will not realize the quality and economic efficiencies of an interdisciplinary delivery system until payers for health care services acknowledge the value of services furnished by all health care providers other than physicians and ensure patient access to their services through fair reimbursement.

Reimbursement options for nurse practitioners are restrictive (Maliszewski, 2003). While the US Balanced Budget Act of 1997 authorized reimbursement for NPs in all sites of service, it set the payment rates for NPs at only 85 percent of the physician rate. State Medicaid programs and many third-party payers, such as commercial indemnity insurers, commercially managed care organizations/health maintenance organizations, and businesses or schools, also frequently pay NPs less than physicians for the provision of the same services (Buppert, 1998). In addition, the various third-party entities have different rules on coverage of NP services or may not recognize and credential NPs at all. These various limitations on coverage and payment impede the ability of NPs to establish their own practices or caseloads (McCloskey, 2003).

NPs' ability to demonstrate the clinical and financial outcomes related to the care provided is critical to support changes in coverage and reimbursement rules, yet efforts to document these measures are hindered by a number of issues. The primary problem is that NP services are often billed under

a physician-colleague's name and provider number, not the NPs', so that services are paid at the physician reimbursement rate. Medicare permits this type of billing under the "incident-to" rule, provided certain criteria are met. Some Medicaid programs have similar provisions. Private insurers, on the other hand, more typically advise NPs to bill under a physician's or group's name and provider number because they do not credential NPs. As a consequence, administrative and clinical data regarding NP services is folded into the physicians' information and makes it difficult to document the exact services rendered by the NP or the revenue generated by them.

In order for NPs to skillfully negotiate with managed care organizations, NPs must invest in learning about new systems and marketing aspects of their practice. NPs must be familiar with state regulations and policies pertaining to managed care, monitor the status of Medicaid waiver applications in their state of practice, and lobby lawmakers and managed care officials to be designated as primary care providers (Cohen & Juszcak, 1997). Direct billing allows an NP's care and revenue generation to be linked directly to the NP (McCloskey, 2003) and should be a priority for all NPs. Whenever possible, NPs should apply for their own provider numbers and use them. It is imperative that NPs are reimbursed directly and equitably for the health care services they are able to provide.

NAPNAP advocates for:

- All NPs to obtain their own unique health care provider number.
- Legislation and policies that requires state programs to reimburse nurse practitioners on par with

physicians.

- NPs to apply for direct reimbursement from insurance companies and to bill under their own names, not under a collaborating physician's name, to allow for full recognition of NPs and services provided and to promote truth in billing practices.
- Legislation mandating insurance companies to include NPs, to credential NPs, and to cover NP services.
- An amendment to the Social Security Act authorizing NPs to provide health care to those eligible to receive health care covered in this act.
- Continued research to demonstrate the cost-effectiveness, competency, and patient acceptance of NPs.

NPs make unique contributions to our health care delivery system, but the full clinical and financial benefits of NP services will not be realized until coverage and reimbursement rules become more competitive and equitable. Reimbursement parity for NPs within the competitive health care industry is the key to survival. NPs offer enormous value for the dollar (Mundinger et al., 2000) and must assert that and expect to be reimbursed for it. NAPNAP urges that NPs be reimbursed equally with all other health care providers when performing the same services.

ACKNOWLEDGMENTS

The National Association of Pediatric Nurse Practitioners would like to acknowledge the contribution of the following individuals from the NAPNAP Professional Issues Committee: Linda Carlson, MS, CPNP, Chair; Dolores C. Jones, EdD, RN, CPNP, CAE; Margaret Brady, PhD, RN, CPNP; Colleen Kochman, MSN, CPNP; Judy Raymond, MNSc, CPNP; Ann Sheehan, MA, CPNP; Michelle Widecan, CPNP.

Reprint requests: NAPNAP National Office, 20 Brace Rd, Suite 200, Cherry Hill, NJ 08034-2633.

J Pediatr Health Care. (2004). 18, 27A-28A.

0891-5245/\$30.00

Copyright © 2004 by the National Association of Pediatric Nurse Practitioners. No part of this statement may be reproduced in any form or by any means without prior written permission from the National Association of Pediatric Nurse Practitioners except for one copy for personal use.

doi:10.1016/j.pedhc.2004.07.006

REFERENCES

Buppert, C. (1998). Reimbursement for nurse practitioner services. *Nurse Practitioner, 28*(2), 67, 70, 72-6, 81-2

Cohen, S., Juszczak, L. (1997). Promoting the nurse practitioner role in managed care. *Journal of Pediatric Health Care, 11*, 3-11.

Maliszewski, S. C. (2003). Getting paid: An overview of the reimbursement process. *Advance for Nurse Practitioners, 11* (8), 50-2.

McCloskey, B., Grey, M., Deshefy-Longhi, T., & Grey, L. J. (2003). APRN practice patterns in primary care. *The Nurse Practitioner, 28* (4), 39-44.

Mundinger, M. O., Kane, R. L., Lenz, E. R., Totten, A. M., Tsai, W., Cleary, P. D., & Friedewald, W. T. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians: A randomized trial. *Journal of the American Medical Association, 283*, 59-68.

Adopted by the National Association of Pediatric Nurse Practitioners' Executive Board on July 22, 2004.