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**SECURING PAYMENT FOR SERVICES PROVIDED BY ADVANCED PRACTICE
NURSES: FRAMEWORK FOR ORGANIZATIONS**

by

Lisa Fournace, MSN

A DNP PROJECT

**Submitted in partial fulfillment of the requirements for the
Degree of Doctor of Nursing Practice**

to

The School of Graduate Studies

of

The University of Alabama in Huntsville

HUNTSVILLE, ALABAMA

2020

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Lisa Farnace

Student Signature

030420

Date

DNP PROJECT APPROVAL FORM

Submitted by Lisa Fournace in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice and accepted on behalf of the Faculty of the School of Graduate Studies by the DNP project committee.

We, the undersigned members of the Graduate Faculty of The University of Alabama in Huntsville, certify that we have advised and/or supervised the candidate on the work described in this DNP project. We further certify that we have reviewed the DNP project manuscript and approve it in partial fulfillment of the requirements for the degree of Doctor of Nursing Practice.

Susan Alexander

030420

Committee Chair

(Date)

C. Borum vsgd

030420

Elaine D Adams

DNP Program Coordinator

Karen Frith

College of Nursing, Associate Dean

Mark H. Adams

College of Nursing, Dean

David
Berkowitz

Digitally signed by David Berkowitz
DN: cn=David Berkowitz, o=University of
Alabama in Huntsville, ou=Graduate Dean,
email=DavidBerkowitz@uah.edu, c=US
Date: 2020.04.20 14:22:45 -0500

Graduate Dean

ABSTRACT
The School of Graduate Studies
The University of Alabama in Huntsville

Degree: Doctor of Nursing Practice

College: Nursing

Name of Candidate: Lisa Fournace

Title: Securing Payment for Services Provided by Advanced Practice Nurses:
Framework for Organizations

Advanced Practice Registered Nurses (APRN) who practice in inpatient facilities are subject to reimbursement guidelines that can create difficulties in billing for services. The purpose of this project was to develop a billing framework to allow for hospital-based APRNs to bill inpatient professional services. A billing framework and billing tool was developed utilizing best evidence and presented to the steering committee work group. Feedback from the work group led to revisions of the framework, billing tool and the development of a billing guideline before being accepted into a larger billing initiative to be reviewed by senior leadership. The development of a billing framework is an important first step in implementing billing for hospital-based APRNs. The groundwork has been laid for the organization to build upon the framework for a successful implementation of billing for hospital-based APRNs in the future.

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Section I
DNP Project

Securing Payment for Services Provided by Advanced Practice Nurses:

Framework for Organizations

Background

As the demand for health care increases due to a growing and aging population, so does the demand for health care providers. According to the Association of American Medical Colleges (AAMC), the supply of physicians is decreasing. The AAMC (2019) predicts the United States will experience a shortage of up to nearly 122,000 physicians by 2032, which includes a shortage of primary care physicians (PCP) estimated to be between 21,100 and 55,200. Concurrently, the number of advanced practice registered nurses (APRN) is increasing, and it is forecasted to increase by 31% by 2026 (Bureau of Labor Statistics, 2019). With the physician shortage and the supply of APRNs increasing, APRNs are poised to help fill the health care gap.

Not only is the United States facing a shortage of physicians, but the cost of health care is skyrocketing. In the United States (US), health care spending is more than twice that of other developed nations such as the United Kingdom, France, and Sweden, accounting for 17.7% of the gross domestic product in the US (Kane, 2012; Centers for Medicare and Medicaid Services [CMS], 2019a). Evidence has shown APRNs can reduce health care costs, especially when barriers are removed, allowing them to practice to the top of their license (Bauer, 2010).

According to studies conducted by the Institute of Medicine (IOM) (2010), APRNs are well educated and trained to provide safe, effective, and quality patient care. APRNs are registered nurses who hold a master's degree or higher and have the training required to evaluate and treat patient medical issues. Their education prepares them to work in a variety of inpatient and outpatient settings, where they can examine patients, diagnose illnesses, provide treatment and prescribe medication, much like physicians do. APRNs are a group comprised of Certified

Nurse Practitioners, Certified Nurse Specialists, Certified Nurse-Midwives, and Certified Registered Nurse Anesthetists (National Council of State Boards of Nursing [NCSBN], 2019). However, APRNs are a unique group of providers because they do not fit into a definitive category of medicine or nursing (Metzger, 2014). While APRNs are not physicians, their education, training, and job responsibilities create different professional roles than those of registered nurses, thereby requiring a different organizational structure to serve more effectively in expanding organizations (Metzger, 2014; Anen & McElroy, 2015). The Center for Advancing Provider Practices (CAP2) recommends six areas of focus to improve the organizational structure for APRNs. The focus areas include “leadership, human resources, credentialing and privileging, competency assessment, billing and reimbursement, and measurement/impact” (Anen & McElroy, 2015, p. 51).

Implementing a health care infrastructure that supports and empowers APRNs requires cooperating leadership from various departments to define the organizational needs and goals to ensure success. APRNs are frequently hired to help fill the health care gaps surrounding national initiatives. This environment allows APRNs to demonstrate their full abilities (Kapu, 2014). A sound APRN-centered infrastructure can facilitate engagement, utilization, and optimization of APRNs, which results in improved patient outcomes in a cost-effective manner (Anen, & McElroy, 2015).

Identification of Problem

Billing and reimbursement for APRNs have been identified by CAP2 as an opportunity to improve organizational infrastructure (Anen & McElroy, 2015). Previously, hospitals were reimbursed under a cost-based system, allowing hospitals to submit the cost of patient care for a percentage of reimbursement. Due to rising costs, the government changed the reimbursement

system (Buppert, 2005). Today, the Prospective Payment System (PPS) is used as a fixed payment system to reimburse for services and care provided in the inpatient setting. The amount is determined by the diagnosis related group (DRG). This is a weighted payment for the specific diagnosis, determined by the resources used to care for the patient (CMS, 2020). In addition to PPS structured reimbursements, hospitals are incentivized to improve quality of care using a value-based payment model. The model has three performance measures for hospitals: Hospital Value-Based Purchasing (VBP) Program, Hospital Readmission Reduction Program, and the Hospital Acquired Conditions Reduction Program. The performance measures programs focus on improving the quality of patient care, reducing hospital 30-day readmission rates, and decreasing infections acquired in the hospital (CMS, 2019b).

To meet the performance measures for the PPS and VBP programs, hospitals and or organizations would benefit from maximizing the integration of APRN services in care-delivery models. However, APRN practice infrastructure must include a billing program for APRNs. Developing and instituting a billing and reimbursement program for services provided by APRNs as part of the organizational practice and infrastructure can help to improve quality, cost-effective care (Kapu, Kleinpell, & Pilon, 2014). Empowering APRNs to practice to the top of their license has been shown to improve job satisfaction (Athey, 2016). Failure to implement a practice infrastructure that promotes and empowers APRNs practice can lead to decreased job satisfaction and increased turnover amongst APRNs (Kapu & Steaban, 2016).

Local Problem

In 2016, two surveys were conducted across the enterprise within a large health care system headquartered in Nashville, Tennessee to understand the roles and utilization of services provided by hospital-based APRNs. Within this organization, hospital-based APRNs work in the

hospital; however, they are employees of the corporation and not the hospital (Figure 1). The first survey was sent to the Chief Nursing Officer (CNO) of each hospital. The second survey was sent to all of the hospital-based APRNs. A work group was developed to review data from the surveys and financial data specific to the services provided by hospital-based APRNs. The surveys revealed APRNs were thought to be valuable to the organization, however, current structures and guidelines were preventing full utilization of skills resulting in hospital-based APRNs not practicing to the top of their license. The work group identified opportunities surrounding hospital-based APRNs that could enhance patient care, reduce costs, increase APRN utilization, and improve job satisfaction (Englebright, 2017).

With the continued growth of APRNs in the hospital workforce and regulatory changes offering new opportunities for services provided by the APRNs, the work group identified the need to assess APRN billing practices and opportunities for organizational changes to promote APRN billing (C. Borum, personal communication, June 18, 2019). The Assistant Vice President (AVP) for Advanced Practice Nursing was tasked to investigate the feasibility of instituting a billing program for hospital-based APRNs and now chairs a work group tasked to explore implementing said billing system. The work group was comprised of business and clinical professionals selected for their knowledge and experience with business systems and clinical services.

Today, within the surveyed health care system, hospital-based APRNs do not bill for services using their own National Provider Identifier (NPI), the ten-digit number used to identify a provider, due to the lack of an APRN billing structure within the organization (CMS 2018). Physicians and out-patient-based APRNs who submit professional fees for inpatient services submit charges to their outpatient clinic to be processed for billing. The hospital-based APRNs

currently are not submitting charges for professional services due to a lack of guidelines or tools in place to foster billing. Without the ability for hospital-based APRNs to bill inpatient services, tracking APRNs' productivity is proving to be difficult as their visibility is decreased. The limitations include tracking financial viability, patient quality care, and costs related to care. Improving the visibility of APRNs recently has been discussed with the Medicare Payment Advisory Commission (MEDPAC), as a recent recommendation was made to Medicare to eliminate incident-to billing to increase APRN visibility (MEDPAC, 2019). With the current shift toward VBP reimbursement models, tracking the activity of health care providers and patients is essential.

PICO Question

The focus of this project was to determine how hospital-based APRNs can bill inpatient professional services. To guide the review of evidence for the proposed project, a clinical question was developed using the population (P), intervention (I), comparison (C), and outcome (O) (Stillwell, Fineout-Overholt, Melnyk, & Williamson, 2010). The PICO was as follows: P = hospital based APRN, I = billing, C = no comparison O = components of hospital billing. The PICO search question was: What are billing guidelines and best practices for hospital-based APRNs?

Purpose

The purpose of the Doctor of Nursing Practice (DNP) project was to develop a billing framework for inpatient care and services provided by hospital-based APRNs. The objectives of the DNP project are 1) Develop a framework to implement billing for hospital-based APRNs; 2) Present the framework to the work group committee by December 13, 2019; 3) Obtain objective feedback from the work group committee; 4) Revise the plan for billing guidelines by

December 20, 2019; and, 5) Develop a billing policy for hospital-based APRNs. Topics to be considered in meeting project objectives include barriers to this new billing structure, code selection for a pilot study, and review of reimbursements for these selected services.

Conceptual Framework

Kanter's *Theory of Structural Empowerment* was the basis for the DNP project. Kanter's theory describes the influences of organizational structure upon the empowerment of employees. Kanter (1993) defines power as "the ability to get things done, to mobilize resources, to get and use whatever it is that person needs for the goals he or she is attempting to meet" (pg. 166). When power is confined to only a few, then effectiveness is diminished. However, when the power is spread among many, the result is increased productivity. Empowerment gives a person the authority over circumstances to promote their actions to accomplish goals (Kanter, 1993).

The four organizational structures that promote empowerment include access to support, opportunity, resources, and information. Access to support involves evaluation, constructive criticism, advice, and guidance from supervisors, colleagues, and subordinates. Access to opportunity for growth and mobility calls for access to skill development, challenges, and professional development. Access to resources involves the permission to utilize necessary resources, such as equipment, money, or supplies to accomplish tasks and meet goals. Access to information involves communication to promote knowledge regarding policies, decisions, and organizational goals (Kanter, 1993; Laschinger, Leiter, Day, & Gilin, 2009). Structural empowerment has been linked to improved job satisfaction, productivity, and autonomy (Clavelle, O'Grady, & Drenkard, 2013; Laschinger et al., 2009; Orgambidez-Ramos, & Borrego-Alés, 2014). Therefore, Kanter's model serves as an excellent guide in developing a billing program for APRNs to promote structural empowerment (Figure 2).

An organization's effectiveness depends on its ability to recognize the values, contributions, and achievements of its employees (Rutherford, Leigh, Monk, & Murray, 2005). An organizational framework that fosters structural empowerment of APRNs can have a beneficial impact on patient care, positive financial implications, and promote job retention. Developing structures such as implementing an APRN billing program can result in increased visibility of APRNs, which may contribute to a sense of empowerment that increases job effectiveness, improves job satisfaction, and ultimately enhances patient care (Stewart, McNulty, Griffin, & Fitzpatrick, 2010).

Review of the Evidence

Search Strategy

A search of the literature describing the processes and plans for billing practices of facility-employed APRNs was conducted in databases including PubMed, Medline, OVID, Cochrane Review, and CINAHL. Keywords searched were: advanced practice registered nurse /nurse practitioner billing, inpatient billing, hospital billing, billing physician services, reimbursement of advanced practice registered nurses, nurse practitioner inpatient quality of care, risks of nurse practitioner billing, and benefits of nurse practitioner billing. The search was limited to English articles describing works conducted in the United States. Initially, a 10-year limit was used for the search; however, there was a limited amount of information regarding APRN billing for inpatient physician services. Therefore, the search was expanded, and no time limitation was used. The references found included billing guidelines and procedures. The search produced 667 articles. A total of seven articles, from peer reviewed journals, were found to be specific to APRN hospital billing and included in the evidence.

Billing Guidelines for APRNs Providing Inpatient Services

Guidelines describing APRNs billing for professional services are complicated and difficult to decipher due to documentation in various locations of federal and state law (Buppert, 2005). Third-party-payers may have largely differing policies regarding APRN billing and reimbursement. Although many payers will adhere to CMS-based guidelines, not all payers, including state Medicaid agencies follow these guidelines. Organizations in individual states need to investigate the rules surrounding Medicaid and commercial payers for billing inpatient care services (Wound, Ostomy, and Continence Nurses Society [WOCN], 2012). Given that the rules vary for each payer, the only definitive guidelines that can be evaluated are those from federal sources such as CMS.

Professional services include consultation, diagnosis, oversight for plans of care, treatments, and surgeries documented using Current Procedural Terminology (CPT) (American Medical Association, 2019). These services can be performed in an institution, such as a hospital, or an outpatient setting such as a clinic or home setting (CMS, 2019c). An APRN can bill for professional services according to specific requirements. CMS requires that scope of practice be followed according to state law, the professional service must be within the APRN scope of practice, and the APRN must have a collaborating physician and a collaborative agreement (CMS, 2019c). Finally, only one bill for evaluation and management (E&M), per day, per specialty will be covered (CMS, 2019d).

Benefits of Billing for Inpatient Services Provided by Hospital-Based APRNs

In a study by Kapu, Kleinpell, and Pilon (2014), APRNs were added to five inpatient teams as billing providers. Adding the APRNs decreased the length of stay in the hospital across all the units. The shortened hospitalization resulted in cost savings of approximately \$28 million in

hospital charges, and each APRN increased gross collections due to the added revenue.

Additionally, nurses and physicians completed 3-month satisfaction surveys regarding adding the APRNs, with the majority responding favorably to this team structure. The nurses, with over 80% response, strongly agreed using the APRNs improved patient care, including improved pain control and better communication with the patient and families. The physicians, with over 75% response, strongly agreed APRNs improved the physician workflow, improved patient care, and, overall, were very satisfied with the clinical decision making of the APRN. Of note, 100% of the physicians strongly agreed using the APRN improved patient throughput.

Brooks and Fulton (2019) implemented a billing algorithm, following Medicare guidelines, across a large academic medical center for inpatient and outpatient APRNs. The data was not separately analyzed for inpatient and outpatient; however, global benefits were noted. The billing algorithm increased APRN visibility by capturing data related to productivity. Before the billing algorithm, physician relative value units (RVU), units used to calculate physician payments, were inflated secondary to APRNs billing under the physicians' NPI. As anticipated, APRN RVU increased as APRNs initiated billing utilizing their own NPI. However, the unanticipated benefit noted was the increase in the physicians' RVUs. The billing algorithm improved work flow through improved utilization of the patient care team.

Moote et al. (2011) conducted a study to evaluate the use of APRNs and physician assistants (PA) in academic health centers. The study consisted of a 3-part survey examining the perceived organizational value of APRNs and PAs, integration of APRNs and PAs into the organization, and deployment strategies of APRNs and PAs. The primary reason noted for employing APRNs and PAs was to fill the gap created by the restrictions on resident hours. Secondary reasons noted include improving patient quality, safety, and throughput, increasing patient access to care,

and decreasing length of stay. Additionally, ease of accessibility of non-physician providers to other care providers to discuss patient care was ranked high with strongly agree. Despite APRNs and PAs proving to be valuable assets to the organizations, 69% of the responders admitted that the financial impact of APRNs or PAs had not been successfully documented. Twenty-three percent of responders reported that hospital-based APRNs and PAs were not billing professional services. In 40% of medical centers tracking RVUs of APRNs and PAs, RVUs were not captured for hospital-based advanced practice providers but limited to the outpatient setting. This study highlights the missed opportunity to bill for services and capture data specific to APRNs.

Kapu and Steaban (2016) recognized the need for a business case to support implementing an inpatient APRN team, and developed an 8-step standardized framework for adding to inpatient teams to improve quality and revenue while providing cost-effective health care. The process included identification of the problem as it related to the program or organization, a statement of the problem, proposed intervention, recommendations on staffing, an overview of the APRN program, APRN quality targets, plan for practice support, and anticipated challenges. This framework has provided a uniform process for strategic planning, implementation, and evaluation. Since implementing the framework, the institution has hired and trained additional APRNs who have utilized the process for developing new programs.

APRN job satisfaction in relation to autonomy and work setting were evaluated in a survey by Athey et al (2015). The study evaluated how job satisfaction was affected by physician relationships, billing practices, and skill utilization. The survey revealed that 30% of APRNs perceived that their skills were underutilized in the hospital setting. Fifty-nine percent of clinic-employed APRNs felt strongly that their skills were utilized. The survey found that across all

settings, only 39% of APRNs were billing under their own NPI. In the hospital setting, 32% of APRNs were billing in the medical setting. The survey determined that the highest job satisfaction reported was among APRNs with the highest reported autonomy and utilization of skills.

Billing Procedures for Hospital-Based APRNs

With the research demonstrating clear evidence that APRNs can bill Medicare for inpatient professional services, the challenge now becomes identifying best practices for billing strategies in facilities. To obtain Medicare credentialing, the APRN must meet Medicare qualifications. The qualifications include licensure as an APRN in the state of practice. If billing privileges were obtained before January 1, 2001, the above is the only requirement. Billing privileges sought between January 1, 2001 and December 31, 2002, require the above and certification from a nationally recognized certifying body. Certifying bodies include: American Academy of Nurse Practitioners, American Nurses Credentialing Center, National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties, Pediatric Nursing Certification Board, Oncology Nurses Certification Corporation, American Association of Critical Care Nurses Certification Corporation, and the National Board on Certification of Hospice and Palliative Nurses. Billing privileges sought after January 1, 2003, must meet the above requirements and the individual must hold a master's or doctoral degree in nursing (CMS, 2016 and CMS 2019d).

Billing guidelines require the APRN to obtain an NPI number for submitting claims to Medicare (CMS 2019d). Split/shared billing occurs when a physician and an APRN submit one claim for combined work. Shared billing is a permissible form of billing for inpatient professional services if both parties have an employment or similar contractual relationship.

Incident-to billing occurs when the claim is submitted under the physician's NPI for APRN work. However, this is not allowed for billing inpatient professional services (Buppert, 2005, CMS, 2016 & CMS, 2019c).

Another guideline is to ensure that a service is medically necessary. Proper documentation supporting the procedure or the E&M code is essential to prove medical necessity. The E&M consists of history, physical exam, and medical decision making (CMS, 2017). APRNs may manage acute and chronic illnesses according to the state scope of practice laws. However, APRNs may not solely assume the care of hospitalized patients, even in states with full practice authority. Federal laws mandate that hospitalized patients have a physician assigned to their care (Electronic Code of Federal Regulations [e-CFR], 2019). These guidelines lay out the steps for billing inpatient professional services. Additional guidelines may be required, depending on individual state laws, organizational by-laws, and policies surrounding privileging and credentialing.

Implementation

Setting

Within a large health care system headquartered in Nashville, Tennessee, hospital-based APRNs do not bill for professional services using their own NPI due to the infrastructure of the organization. The organization operates 185 hospitals in 21 states and the United Kingdom, employing 249,000 individuals, including 87,000 nurses, and 38,000 physicians resulting in over 28 million patient encounters each year. There are 112 hospitals in the United States, with 564 hospital-based APRNs providing professional services to inpatients. The services include performing procedures and providing medical care that supports E&M billing. The APRNs are

in place and performing the billable work; however, due to corporate policies and structure, they cannot submit billing for these services.

At the corporate headquarters, a steering committee work group was developed to evaluate the need for implementing a billing system for hospital-based APRNs. The AVP of Advanced Practice Nursing chaired the work group. The group was comprised of seven members, of which six were women. The members, consisting of business and clinical professionals, were invited to participate in the work group due to their knowledge and experience in leadership, clinical, government issues, human resources, and communication.

Interventions

The first phase of the project developed a basic framework to include the following components: a problem statement, background information, proposed solution, deployment strategy, project scope, project dependencies, operational and process impact, communication approach, key benefits, and project risks and issues. To help guide the framework, a driver diagram (Figure 3) was developed to create a visual display of the components that could affect the outcome. The aim was first identified, and then primary and secondary drivers were identified that had significant potential to impact the aim. Another tool used to assist in the development of the framework was an analysis of strengths, weaknesses, opportunities, and threats (SWOT) (Figure 4). This tool was developed to identify internal and external components that may have influenced the project outcome.

A charge pass form (Figure 5) was developed as a billing tool to be included in the framework. The AVP of advanced practice nursing communicated the decision by the work group for the initial billing tool to only include procedures. The work group identified the procedures to be incorporated into the billing tool.

Finally, a survey was developed to obtain feedback from the workgroup for the proposed framework. The survey included eight closed-ended questions and one open-ended question. The closed-end questions used a 5-point scale to measure the responses.

Phase two of the project was a presentation of the plan to the steering committee work group for review. The 20-minute presentation was presented virtually to the work group. The presentation discussed the importance of and need for billing among hospital-based APRNs. The requirements for APRN billing were explained and the charge pass form was introduced. After the presentation, the work group members were invited to ask questions. At the conclusion of the questions, the work group was invited to complete a survey (Appendix D), via SurveyMonkey, designed to capture feedback regarding their analysis of the plan and suggestions for further consideration. The survey link was emailed to the work group participants and the surveys were collected over the course of one week.

The final phase of the project was the revision of the framework (Appendix F) and the development of the billing guideline (Appendix G). The framework format followed the institution's template for business cases. A billing guideline was provided to outline the requirements for hospital-based APRN billing. Both were submitted to the AVP for review and consideration to be included in the larger advanced practice billing initiative for review by the senior leadership team.

Evaluation

The project was initiated following exemption status from The University of Alabama, Huntsville, Institutional Review Board (IRB). The proposed framework was evaluated by the AVP and the steering committee work group after a presentation was given that included all components of the plan and introduction of a billing tool. The group interacted by asking

clarifying questions and completed a survey to measure the effectiveness of the framework. The survey included closed and open-ended questions to allow for all feedback to be expressed. Revisions to the framework were not required based on feedback received from the survey. Minor revisions requested from the AVP were completed and submitted. The framework was used to develop the billing guideline which was submitted with the final framework.

Analysis

Both quantitative and narrative feedback were collected to evaluate the APRN billing framework. A 5-point scale survey was administered online through SurveyMonkey, which collected the responses. To measure the intervention, the mean was determined for each question. If the aggregated mean exceeded 3, this indicated that the project met acceptable criteria for progression to the next phase. If the mean for any individual question was below 3, it indicated revisions were needed. Narrative feedback was requested from the participants in the form of comments following each question and at the end of the survey. A statistical analysis of the survey was performed using descriptive statistics. SurveyMonkey software and Excel data analysis ToolPak were used to tabulate and analyze the data for each question. Quantitative and narrative survey results are available in Tables 1 and 2.

Results

Phase I developed the APRN billing framework. It involved researching the current evidence regarding APRN billing to help guide the framework. The development of the driver diagram and SWOT analysis helped to identify deficits and allowed for adjustments to be made to the framework.

A charge pass form was developed as the billing tool to be included in the framework. The work group identified and shared the top six procedures performed by the APRNs: arterial line

placement, chest tube placement, endotracheal tube intubation, lumbar puncture, central venous access, and peripherally inserted central catheter. This information was utilized to develop a charge pass form that can be completed and submitted for billing. The form included patient demographics, procedure codes and definitions, and a field to include the diagnosis code (Figure 5). The design of the form was one page to promote ease of use.

Phase II was the presentation of the framework to the work group and completion of the survey. Seven members of the work group attended the presentation and were asked to complete a survey administered online through SurveyMonkey. A total of five surveys were completed from the seven work group attendees. One survey was not completed due to conflict of interest, and one survey was lost to follow-up. The mean aggregate score for all questions was 4.7. The mean for the individual questions was between 4.6 and 4.8. All of the mean scores were greater than 3, which indicated acceptance of the billing framework (Table 1).

The narrative comments were then evaluated. No recommendations for changes to the framework were noted; however, suggestions for future considerations were included. Comments included: “Nothing to necessarily add to the presentation, but there are additional training and billing considerations required for E/M services, particularly in the hospital space. That said, understanding that this presentation was not intended to go into that level of detail. It was very informative and well put together.” and, “I think the only caveat to this is based on how the APRN currently documents and is there an electronic tool in place to support this.” This information will be shared with the AVP to be included for future planning due to the continuation of the project.

The phase III of the project included minor revisions to the framework and the development of the billing guideline. Both were accepted to be submitted to senior leadership for review (Appendices F and G).

Conclusion

Developing an APRN billing framework is an important first step in implementing billing for hospital-based APRNs. Having a thorough understanding of billing regulations and guidelines, as well as federal and state laws, is essential. The project set out to develop the initial APRN billing framework, and it was successfully accepted into the larger advanced practice billing initiative. The groundwork has been laid for the organization to build upon the framework of a successful implementation of billing for hospital-based APRNs. This paradigm shift has the potential to position the organization as a leader in the advancement of APRN billing.

Application to Practice

Implementing a billing program can promote APRNs practicing to the top of license and increase APRN visibility, improving the ability to track metrics specific to APRNs. Additionally, charge capture can improve patient care due to improved utilization and work-flow of the patient care team; thereby increasing practice sustainability by enhancing cost-effective care and foster cost-avoidance. Financial opportunities also exist with the potential to participate in reimbursement with the PPS and the VBP program. Full utilization of APRNs may have far-reaching positive implications.

The greatest barrier to the framework is resistance to change. The framework must first be approved by senior leadership before the process of implementation begins. If approved, organizational guidelines must be revised to allow for the policy implementation. Additionally, the APRNs may be resistant to the change as it is a new process. Resistance to change can be

mitigated with appropriate training. A final barrier is a risk for duplicate billing, specifically with E&M codes. With appropriate training of the billing and coding specialists as well as the physicians and APRNs, this risk can be minimized.

REFERENCES

- Association of American Medical Colleges (2016). The complexities of physician supply and demand: Projections from 2017 to 2032. Retrieved July 7, 2019, from https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf
- American Association of Nurse Practitioners (2019). NP fact sheet. Retrieved June 12, 2019, from <https://www.aanp.org/about/all-about-nps/np-fact-sheet>
- American Association of Nurse Practitioners (2018). 2017 National nurse practitioner sample survey results. Retrieved July 14, 2019, from <https://www.aanp.org/news-feed/2017-national-nurse-practitioner-sample-survey-results>
- Anen, T., & McElroy, D. (2015). Infrastructure to optimize APRN practice. *Nurse Leader*, 13(2), 50-56.
- Athey, E., Leslie, M., Briggs, L., Park, J., Falk, N., Pericak, A., ... & Greene, J. (2016). How important are autonomy and work setting to nurse practitioners' job satisfaction? *Journal of the American Association of Nurse Practitioners*, 28(6), 320-326.
- Bauer, J. C. (2010). Nurse practitioners as an underutilized resource for health reform: Evidence-based demonstrations of cost-effectiveness. *Journal of the American Academy of Nurse Practitioners*, 22(4), 228-231.
- Brassard, A., (2015). APRN policy and payment. *Nurse Leader*, 13(2), 36-38

- Brooks, P. B., & Fulton, M. E. (2019). Demonstrating advanced practice provider value: Implementing a new advanced practice provider billing algorithm. *Journal of the American Association of Nurse Practitioners*, 31(2), 93-103.
- Buppert, C. (2002). Billing for nurse practitioner services: Guidelines for NPs, physicians, employers, and insurers. *Medscape Nurses*, 4(1).
- Buppert, C. (2005). Capturing reimbursement for advanced practice nurse services in acute and critical care: Legal and business considerations. *AACN Advanced Critical Care*, 16(1), 23-35.
- Bureau of Labor Statistics (2019). Occupational outlook handbook. Retrieved July 7, 2019, from <https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm>
- Centers for Medicare and Medicaid Services (2016). Advanced practice registered nurses, anesthesiologist assistants, and physician assistants. Retrieved July 31, 2019, from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244981.html>
- Centers for Medicare and Medicaid Services (2017). Evaluation and management services. Retrieved August 23, 2019, from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243514.html>
- Centers for Medicare and Medicaid Services (2018). National provider identification standard (NPI). Retrieved November 9, 2019, from <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/>

Centers for Medicare and Medicaid Services (2019a). National health expenditure data.

Retrieved March 8, 2020, from [https://www.cms.gov/Research-Statistics-Data-and-](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical)

[Systems/Statistics-Trends-and-](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical)

[Reports/NationalHealthExpendData/NationalHealthAccountsHistorical](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical)

Centers for Medicare and Medicaid Services (2019b). Value based programs. Retrieved August

3, 2019, from [https://www.cms.gov/medicare/quality-initiatives-patient-assessment-](https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html)

[instruments/value-based-programs/value-based-programs.html](https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html)

Centers for Medicare and Medicaid Services (2019c). Medicare benefit policy manual

(Publication No. 100-02). Retrieved August 18, 2019, from

[https://www.cms.gov/Regulations-and-](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)

[Guidance/Guidance/Manuals/Downloads/bp102c15.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)

Centers for Medicare and Medicaid Services (2019d). Medicare claims processing manual

(Publication No. 100-04). Retrieved August 18, 2019, from

[https://www.cms.gov/Regulations-and-](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf)

[Guidance/Guidance/Manuals/Downloads/clm104c12.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf)

Centers for Medicare & Medicaid Services (2020). Acute inpatient prospective payment system.

Retrieved February 28, 2020, from [https://www.cms.gov/Medicare/Medicare-Fee-for-](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS)

[Service-Payment/AcuteInpatientPPS](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS)

Clavelle, J. T., O'Grady, T. P., & Drenkard, K. (2013). Structural empowerment and the nursing

practice environment in Magnet® organizations. *Journal of Nursing Administration*,

43(11), 566-573.

- Cronenwett, L., Sherwood, G., Pohl, J., Barnsteiner, J., Moore, S., Sullivan, D. T., ... & Warren, J. (2009). Quality and safety education for advanced nursing practice. *Nursing Outlook*, 57(6), 338-348.
- De Milt, D. G., Fitzpatrick, J. J., & McNulty, S. R. (2011). Nurse practitioners' job satisfaction and intent to leave current positions, the nursing profession, and the nurse practitioner role as a direct care provider. *Journal of the American Academy of Nurse Practitioners*, 23(1), 42-50.
- Dubree, M., Jones, P., Kapu, A., & Parmley, C. L. (2015). APRN practice: Challenges, empowerment, and outcomes. *Nurse Leader*, 13(2), 43-49.
- Electronic Code of Federal Regulations (2019). Title 42 – Public health. Retried September 29, 2019, from https://www.ecfr.gov/cgi-bin/text-idx?SID=898ca29b98a754fd0883bcced6a68c8e&mc=true&node=se42.5.482_112&rgn=div8
- Englebright, J. (2017). The emerging role of APRNs in hospital nursing practice: Perspectives from a survey of chief nursing officers. *Nurse Leader*, 15(6), 387-391.
- Grisham, S. (2017). Medscape physician compensation report 2017. Retrieved July 14, 2019, from <https://www.medscape.com/slideshow/compensation-2017-overview-6008547#2>
- Horner, D. K. (2017). Mentoring: Positively Influencing Job Satisfaction and Retention of New Hire Nurse Practitioners. *Plastic Surgical Nursing*, 37(1), 7-22.
- Kane, J. (2012). Health costs: How the US compares with other countries. *PBS Newshour*, 22.
- Kapu, A., Kleinpell, R., & Pilon, B. (2014). Quality and financial impact of adding nurse practitioners to inpatient care teams. *Journal of Nursing Administration*, 44(2), 87-96.

- Kapu, A., & Steaban, R. (2016). Adding nurse practitioners to inpatient teams: Making the financial case for success. *Nurse Leader*, 14(3), 198-202.
- Laschinger, H. K. S. (2008). Effect of empowerment on professional practice environments, work satisfaction, and patient care quality: Further testing the nursing work life model. *Journal of Nursing Care Quality*, 23(4), 322-330.
- Laschinger, H. K. S., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: Impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management*, 17(3), 302-311.
- The Medicare Payment Advisory Commission (2019). Issues in Medicare beneficiaries' access to primary care. Retrieved July 8, 2019, from http://www.medpac.gov/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0
- Metzger, R., & Rivers, C. (2014). Advanced practice nursing organizational leadership model. *The Journal for Nurse Practitioners*, 10(5), 337-343.
- Moote, M., Krsek, C., Kleinpell, R., & Todd, B. (2011). Physician assistant and nurse practitioner utilization in academic medical centers. *American Journal of Medical Quality*, 26(6), 452-460.
- National Council of State Boards of Nursing (2019). APRNs in the U.S. Retrieved September 5, 2019, from <https://www.ncsbn.org/aprn.htm>
- Orgambidez-Ramos, A., & Borrego-Alés, Y. (2014). Empowering employees: Structural empowerment as antecedent of job satisfaction in university settings. *Psychological Thought*, 7(1), 28-36.
- Pasarón, R. (2013). Nurse practitioner job satisfaction: Looking for successful outcomes. *Journal of Clinical Nursing*, 22(17-18), 2593-2604.

- Rutherford, J., Leigh, J., Monk, J., & Murray, C. (2005). Creating an organizational infrastructure to develop and support new nursing roles—a framework for debate. *Journal of Nursing Management*, 13(2), 97-105.
- Social Security Administration (2019). Compilation of the social security laws: Part E – miscellaneous provisions (§1861(s)(K)(i). Retrieved August 27, 2019, from https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- Stillwell, S. B., Fineout-Overholt, E., Melnyk, B. M., & Williamson, K. M. (2010). Evidence-based practice, step by step: Asking the clinical question: A key step in evidence-based practice. *AJN The American Journal of Nursing*, 110(3), 58-61.
- Stewart, J. G., McNulty, R., Griffin, M. T. Q., & Fitzpatrick, J. J. (2010). Psychological empowerment and structural empowerment among nurse practitioners. *Journal of the American Academy of Nurse Practitioners*, 22(1), 27-34.
- WOCN Society National Public Policy Committee. (2012). Reimbursement of advanced practice registered nurse services: A fact sheet. *Journal of Wound, Ostomy, and Continence Nursing: Official Publication of The Wound, Ostomy and Continence Nurses Society*, 39(2 Suppl), S7.

TABLES

Table 1: APRN Billing Framework Survey Quantitative Results

<i>Statistics</i>	Discuss importance of APRN billing	Discuss need for APRN billing	Discuss APRN billing requirements	Introduce tool for APRN billing	Journey through a day in the life of an APRN	There is value for business and operations with instituting a billing framework for APRNs.	There is value for clinical practice with instituting billing for APRNs.	The billing framework can be incorporated into the APRN's daily clinical workflow	Aggregate Score
Mean	4.8	4.8	4.8	4.8	4.8	4.6	4.6	4.6	4.7
Range	1	1	1	1	1	1	1	1	
Minimum	4	4	4	4	4	4	4	4	
Maximum	5	5	5	5	5	5	5	5	
Sum	24	24	24	24	24	23	23	23	
N	5	5	5	5	5	5	5	5	

Table 2: APRN Billing Framework Survey Narrative Results

Narrative Results	
Question	Comment
Objectives	No comments
There is value for business and operations with instituting a billing framework for APRNs.	Very informative and a practical approach.
There is value for clinical practice with instituting billing for APRNs.	No comments
The billing framework can be incorporated into the APRN's daily clinical workflow.	I think the only caveat to this is based on how the APRN currently documents and is there an electronic tool in place to support this.
Additional considerations needed to execute the billing framework include:	Nothing to necessarily add to the presentation, but there are additional training and billing considerations required for E/M services, particularly in the hospital space. That said, understanding that this presentation was not intended to go into that level of detail. It was very informative and well put together.

FIGURES

Figure 1: Employment Structure

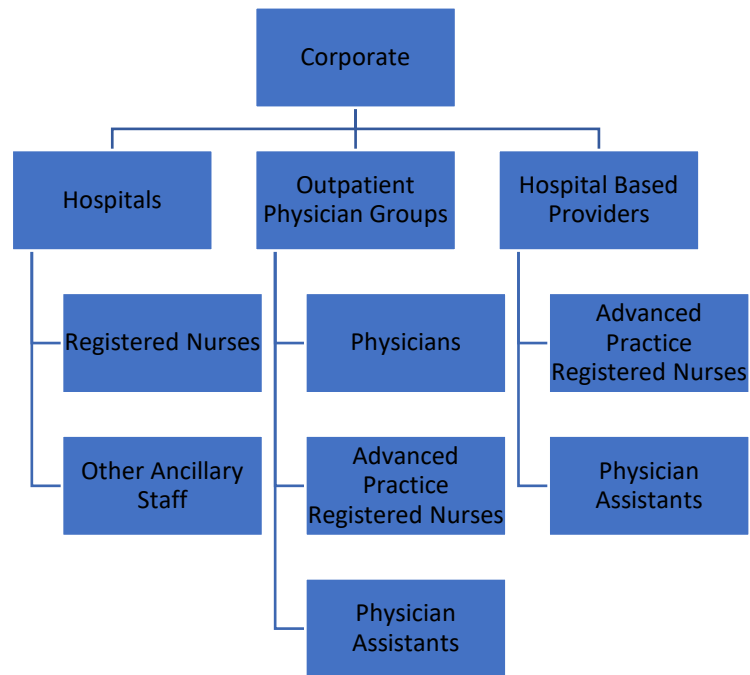


Figure 2: Kanter's Structural Empowerment Model for APRN Billing

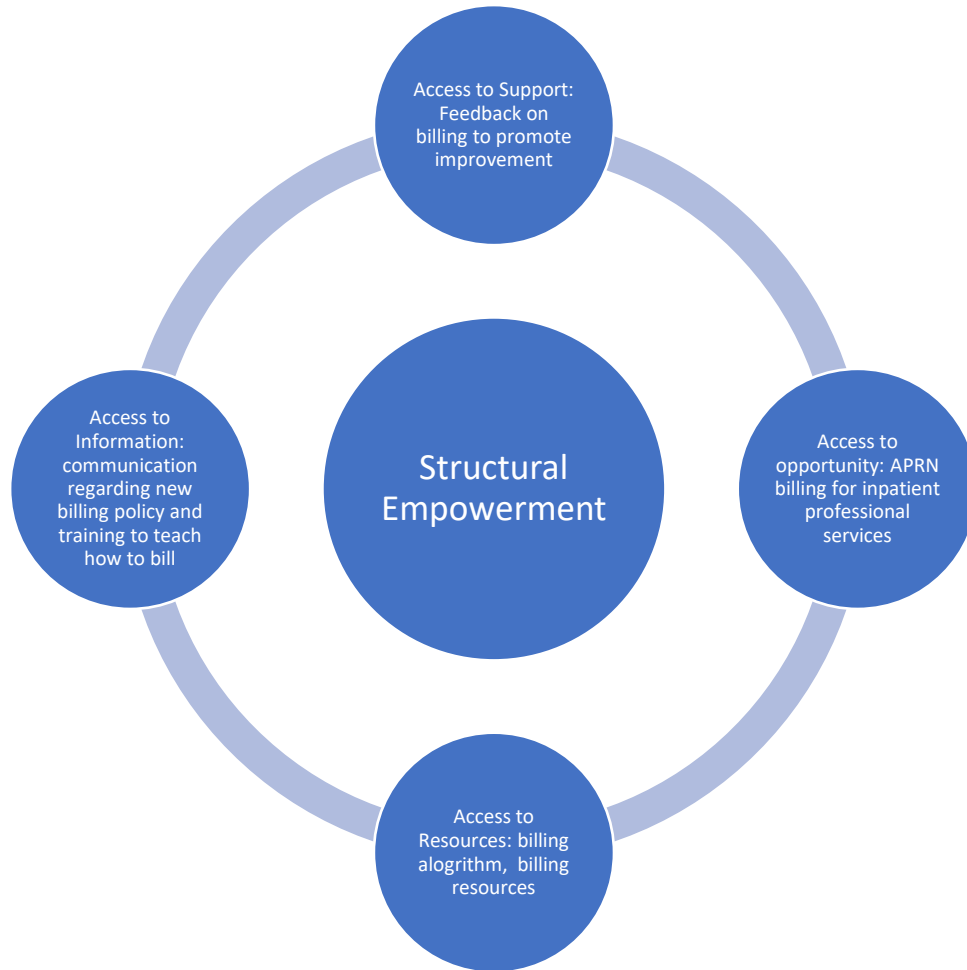


Figure 3: Driver Diagram: Billing for Hospital-Based Nurse Practitioners

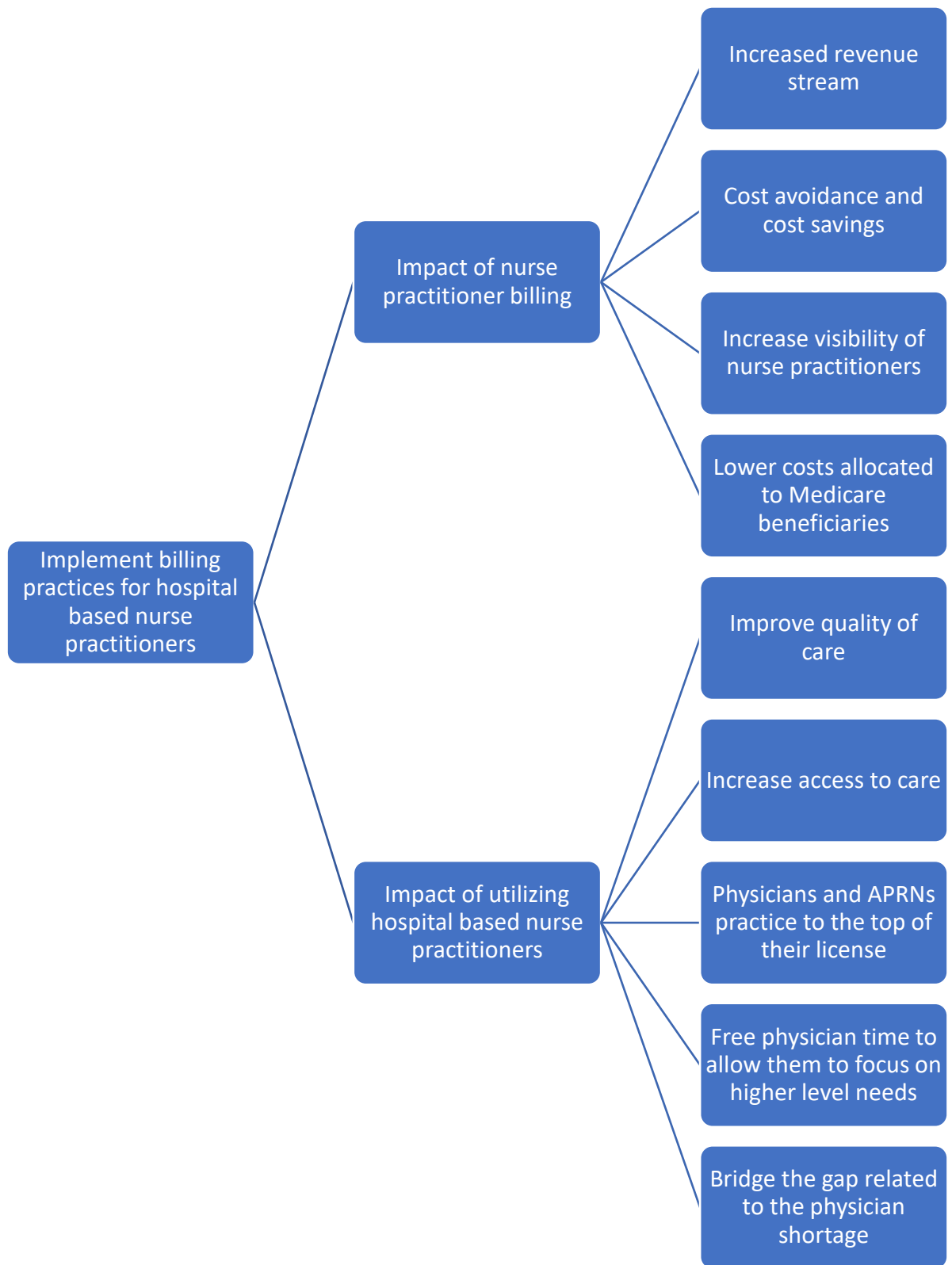


Figure 4: Hospital-Based Nurse Practitioner Billing SWOT Analysis

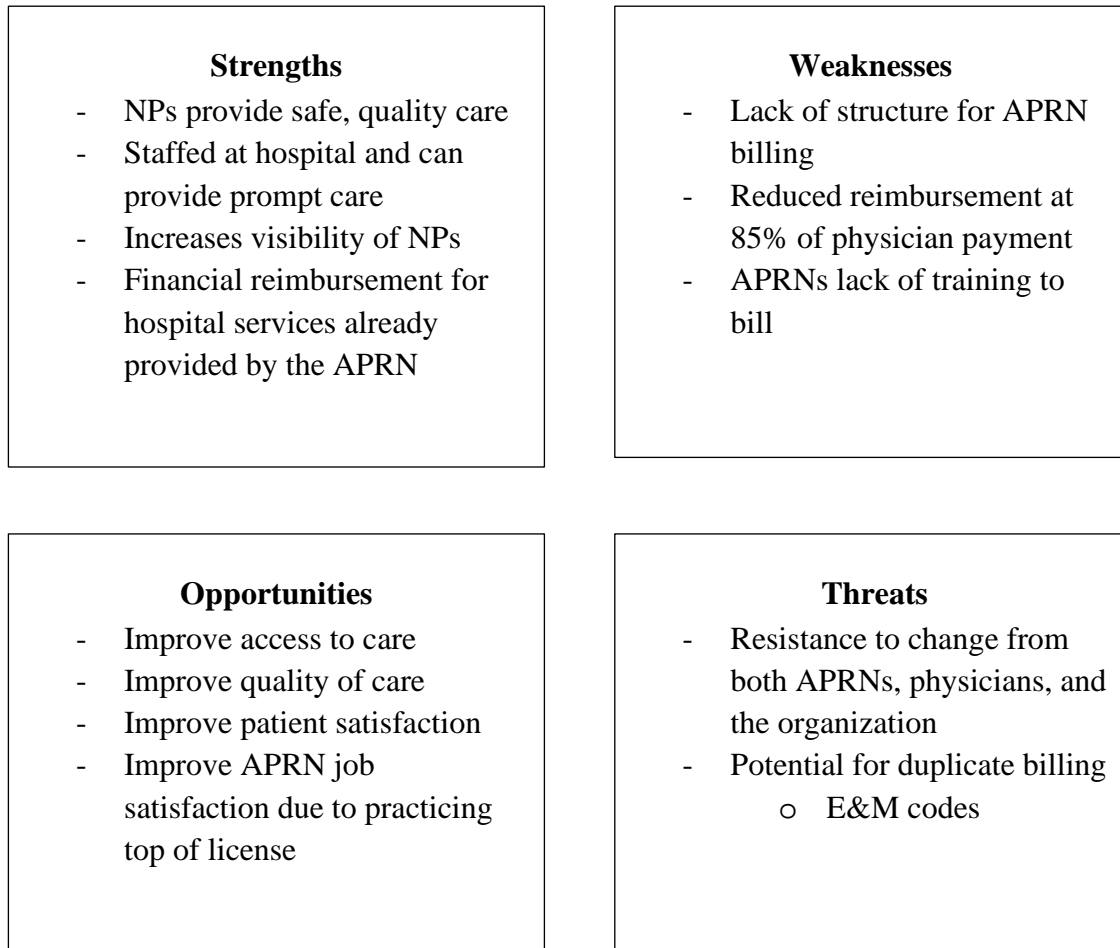


Figure 5: Hospital-Based APRN Charge Pass Form

Date:	MR Number:	Name:	DOB:
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Arterial Line placement			
Procedure	Arterial Catheterization (percutaneous)	Cutdown	Arterial puncture/withdrawal of blood for diagnosis (blood gases)
Billing Code	36620 <input type="checkbox"/>	36625 <input type="checkbox"/>	36600 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:	

Chest Tube placement: Thoracostomy					
Procedure	Tube Thoracostomy Open	Thoracentesis w/o imaging guidance	Thoracentesis with imaging guidance	Percutaneous Pleural drainage, insertion of indwelling cath, w/o imaging	Percutaneous Pleural drainage, insertion of indwelling cath, with imaging
Billing Code	32551 <input type="checkbox"/>	32554 <input type="checkbox"/>	32555 <input type="checkbox"/>	32556 <input type="checkbox"/>	32557 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:			

Endotracheal Tube Intubation		
Procedure	Intubation, endotracheal	Tracheotomy tube change
Billing Code	31500 <input type="checkbox"/>	31502 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:

Lumbar / Spinal Puncture		
Procedure	Spinal puncture, lumbar, diagnostic	Spinal puncture, therapeutic – drainage of CSF via needle or catheter
Billing Code	62270 <input type="checkbox"/>	62272 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:

Central Venous Access			
Procedure	Insertion	Removal	Reposition
Billing Code	36555 (<5yo) <input type="checkbox"/> 36556 (5 or >) <input type="checkbox"/>	Cath: 36589 <input type="checkbox"/> Device: 36590 <input type="checkbox"/>	36597 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:	

Peripherally Inserted Central Catheter				
Procedure	Insertion w/o port (<5 yo)	Insertion w/o port (5 or >)	Insertion w/ port (<5 yo)	Insertion w/ port (5 or >)
Billing Code	36568 <input type="checkbox"/>	36569 <input type="checkbox"/>	35670 <input type="checkbox"/>	36571 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:		

Appendix A: Memorandum of Understanding

APPROVED: _____

Marsha D. Adams
Marsha Howell Adams, PhD, RN, CNE, ANEF, FAAN
Dean, College of Nursing

DATE: 12/15/17

MEMORANDUM OF UNDERSTANDING NURSING ADMINISTRATION EXPERIENCE

THIS MEMORANDUM OF UNDERSTANDING is made and entered into between The Board of Trustees of The University of Alabama, a public educational and constitutional instrumentality of the State of Alabama, incorporated by statute, for and on behalf of The University of Alabama in Huntsville (herein, the "University") and **HCA Healthcare, L.P.**, a Tennessee limited partnership located at One Park Place, Building II, Nashville, Tennessee 37203 (herein, the Agency).

WITNESSETH:

WHEREAS, the University offers through its College of Nursing (herein, the "College") an accredited nursing education program, an important component of which are certain administrative experiences provided for nursing students in cooperation with health care and other appropriate agencies; and

WHEREAS, the Agency is willing to provide the nursing practice setting for such an administrative experience in association with the College; and

WHEREAS, the parties desire to state the terms of their cooperative association in a written agreement.

NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained and other good and sufficient consideration, it is agreed by and between the parties as follows:

1. **Cooperative Program.** The Agency agrees to accept designated College Master of Science in Nursing (MSN) and Doctor of Nursing Practice (DNP) students as participants in a program of nursing administration instruction carried out as a cooperative effort by the University and the Agency. The program shall be designed to supplement and enhance the academic instruction provided in nursing courses by giving student participants administrative experience in health care delivery. Activities shall be selected by mutual agreement of the parties, based on the level of preparation and the educational needs of the student and the availability of appropriate opportunities at the Agency.

Appendix B: Institutional Review Board Letter

IRB Comments

Name: Lisa Fournace

Application Number: EX2019162

Title of Study: *Securing Payment for Services Provided by Advanced Practice Nurses:
Framework for Organizations*

Comments from UAT

The UA Office for Research Compliance has reviewed the above referenced application. **Based on the information provided, this project does not appear to be human subjects research.**

Comments from UAH Chair

UAH IRB supports all review comments.

Please outline how you corrected the concerns addressed above

Appendix C: Author Guidelines from Nursing Economics



Author Guidelines

The purpose of *Nursing Economics* is to advance nursing leadership in health care, with a focus on tomorrow, by providing information and thoughtful analyses of content and emerging best practices in healthcare management, economics, and policymaking.

Writing for *Nursing Economics*

Query letters are welcome, but not required. Material must be original and never published before. Material is submitted for review with the understanding that it is not being submitted to any other journal simultaneously.

Nursing Economics is a refereed journal. All manuscripts submitted undergo review by the editor and blind review by members of the manuscript review panel and/or editorial board members. Each manuscript is reviewed on its timeliness, importance, clarity, accuracy, and applicability.

Upon acceptance of the manuscript, the author will yield copyright to *Nursing Economics*. Acquiring permission to reprint previously published materials is the responsibility of the author. Manuscripts are subject to copy editing. The author will receive proofs via email for review prior to publication.

Reporting Guidelines

Nursing Economics recommends authors incorporate the following reporting guidelines into the development of manuscripts related to randomized controlled trials, systematic reviews and meta-analyses, and quality improvement studies.

- **CONSORT** (Consolidated Standards of Reporting Trials). CONSORT is an evidence-based set of recommendations for reporting randomized controlled trials. The [CONSORT website](#) contains a checklist and flow diagram to guide authors in manuscript preparation.
- **PRISMA** (Preferred Reporting Items for Systematic Reviews and Meta-Analyses). The [PRISMA website](#) includes a checklist for reporting systematic reviews and meta-analyses. A flow diagram is available for use in reporting the review process and studies included at different steps of the review.
- **SQUIRE** (Standards for Quality Improvement Reporting Excellence). The SQUIRE guidelines assist in preparing manuscripts on quality improvement projects. The [SQUIRE website](#) provides a framework for reporting new knowledge about how to improve health care.

Manuscript Preparation

Manuscripts must be typewritten, double-spaced, on a 8.5 x 11 inch document; maximum length is 15 pages (3,750 words). References, photographs, tables, and all other details of style must conform to the *Publication Manual of the American Psychological Association* (APA, 7th ed., 2020).

- **Assembly:** Manuscripts should be submitted as one file (i.e., Title Page, Author Information, Abstract, etc.) unless separate files are absolutely necessary.
- **Title Page:** Include the manuscript title, authors' names, credentials, and a brief biographic statement. Also include an address for correspondence, email address (required), day and evening phone numbers, and a brief abstract of 40 words or less.
- **Text:** Double-space all text, using 1 to 2 inch margins. The manuscript title should be repeated on the first page of the text, but do not include the author's name.
- **Subheadings:** Include subheadings in the manuscript where possible. Type all subheadings flush to the left margin.
- **References:** References in the text should be cited by author and date, for example (Doe & Brown, 2017), with page numbers cited for direct quotations. The reference list at the end of the manuscript should be double-spaced, include only those references cited in the text, and be arranged

alphabetically by author.

Sample references are:

Periodical (up to seven authors):

Doe, J.R., Brown, M.S., Smith, J.R., Jones, M.S., Thomas, J.R., White, M.S., & James, J.R. (2017). Coping with hospitalization. *Nursing Economic\$, 35*(2), 115-120.

Periodical (more than seven authors):

Doe, J.R., Brown, M.S., Smith, J.R., Jones, M.S., Thomas, J.R., White, M.S., ... James, J.R. (2017). Coping with hospitalization. *Nursing Economic\$, 35*(2), 115-120.

Book (up to seven authors):

Doe, J.R., & Brown, M.S. (2017). *Writing for publication*. Academic Press.

Book (more than seven authors):

Doe, J.R., Brown, M.S., Trent, J.R., Michaels, M.S., Bradley, J.R., Willis, M.S., ... Williams, J.R. (2017). *The cost of nursing care*. Academic Press.

Chapter in a Book:

Doe, J.R. (2016). Writing for publication. In M.S. Brown (Ed.), *How to write for a medical journal* (5th ed., pp. 79-86). Elsevier.

Website:

Doe, J.R., & Brown, M.S. (2017). *Writing for publication*. <http://www.writingforpublication.com>

Figures & Photographs

Figures: These include line drawings, diagrams, and graphs. Each figure should be numbered. When using figures adapted from another source, the author must obtain written permission from the original publisher. All figures must be high resolution.

Photographs: Photographs may be digital or hard copy prints. Digital photographs must be of a resolution at least 300 dpi or a minimum of 1280 x 960 pixels. Hard copy prints must be 4" x 5" or larger, of good contrast, and printed on glossy paper.

General: Tables, figures, and graphics should be limited to a total of four per manuscript.

Authorship

Nursing Economic\$ endorses and subscribes to the definition of Authorship by the International Committee of Medical Journal Editors (ICMJE) which states:

The ICMJE recommends that an author should meet all four of the following criteria:

- *Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work.*
- *Drafting the work or revising it critically for important intellectual content.*
- *Final approval of the version to be published.*
- *Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.*

Conflict of Interest

Nursing Economic\$ requires authors, editorial board members, and reviewers to disclose any conflicts of interest related to their submission and involvement with the journal. *Nursing Economic\$* endorses and subscribes to the definition of Conflict of Interest by the International Committee of Medical Journal Editors (2006), "Uniform Requirements for Manuscripts Submitted to Biomedical Journals," which states:

Public trust in the peer review process and the credibility of published articles depend in part on how well conflict of interest is handled during writing, peer review, and editorial decision making. Conflict of interest exists when an author (or the author's institution), reviewer, or editor has financial or personal relationships

that inappropriately influence (bias) his or her actions (such relationships are also known as dual commitments, competing interests, or competing loyalties). These relationships vary from those with negligible potential to those with great potential to influence judgment, and not all relationships represent true conflict of interest. The potential for conflict of interest can exist whether or not an individual believes that the relationship affects his or her scientific judgment. Financial relationships (such as employment, consultancies, stock ownership, honoraria, paid expert testimony) are the most easily identifiable conflicts of interest and the most likely to undermine the credibility of the journal, the authors, and of science itself. However, conflicts can occur for other reasons, such as personal relationships, academic competition, and intellectual passion. Authors should identify individuals who provide writing assistance and disclose the funding source for this assistance.

Informed Consent

Nursing Economic\$ requires authors to assure patients' and subjects' privacy, if applicable, related to their research and manuscript. *Nursing Economic\$* endorses and subscribes to the definition of Human and Animal Rights by the International Committee of Medical Journal Editors (2006), "Uniform Requirements for Manuscripts Submitted to Biomedical Journals," which states:

Patients have a right to privacy that should not be infringed without informed consent. Identifying information, including patients' names, initials, or hospital numbers, should not be published in written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication. Informed consent for this purpose requires that a patient who is identifiable be shown the manuscript to be published. Identifying details should be omitted if they are not essential. Complete anonymity is difficult to achieve, however, and informed consent should be obtained if there is any doubt. For example, masking the eye region in photographs of patients is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic pedigrees, authors should provide assurance that alterations do not distort scientific meaning and editors should so note. When informed consent has been obtained it should be indicated in the published article.

Human and Animal Rights:

Nursing Economic\$ requires authors to disclose Institutional Review Board consent, if applicable, related to their research and manuscript. *Nursing Economic\$* endorses and subscribes to the definition of Human and Animal Rights by the International Committee of Medical Journal Editors (2006), "Uniform Requirements for Manuscripts Submitted to Biomedical Journals," which states:

When reporting experiments on human subjects, authors should indicate whether the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000. If doubt exists whether the research was conducted in accordance with the Helsinki Declaration, the authors must explain the rationale for their approach, and demonstrate that the institutional review body explicitly approved the doubtful aspects of the study. When reporting experiments on animals, authors should be asked to indicate whether the institutional and national guide for the care and use of laboratory animals was followed.

Submission and Publication:

Publication: The primary author will be notified of a publication decision within 12 weeks of the manuscript's receipt. Authors may purchase reprints of their articles at the time of publication at a special discount rate. If contact information (address, email address), or biographical information changes during time of acceptance to publication, please contact the journal office to update your information.

Submission: One electronic copy of the manuscript (MS Word format only) should be submitted to the editorial office. Hard copies are no longer required. Manuscripts should be submitted as one file (i.e., Title Page, Author Information, Abstract, etc.) unless separate files are absolutely necessary. The manuscript can be emailed to the journal editorial coordinator at nejrn1@ajj.com.

Manuscripts should be submitted to:

Donna M. Nickitas, PhD, RN, NEA-BC, CNE, FAAN, Editor
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Any questions or comments regarding this site should be directed to the **webmaster**.

Appendix D: Advanced Practice Nurses Billing Framework for Organizations

Advanced Practice Nurses Billing Framework for Organizations

Number	Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	The objectives for the presentation were met	5	4	3	2	1
Objective 1	Discuss importance of APRN billing	5	4	3	2	1
Objective 2	Discuss need for APRN billing	5	4	3	2	1
Objective 3	Discuss APRN billing requirements	5	4	3	2	1
Objective 4	Introduce tool for APRN billing	5	4	3	2	1
Objective 5	Journey through a day in the life of an APRN	5	4	3	2	1
2	There is value for business and operations with instituting billing for APRNs	5	4	3	2	1
3	There is value for clinical practice with instituting billing for APRNs?	5	4	3	2	1
4	The billing framework can be incorporated into the APRN's clinical workflow?	5	4	3	2	1

5. Additional considerations needed to execute the billing framework include:

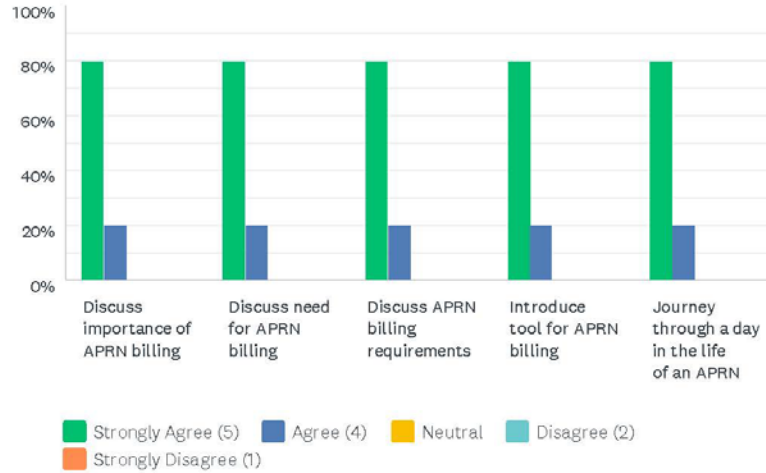
Appendix E: Survey Results

Advanced Practice Nurses Billing Framework for Organizations

SurveyMonkey

Q1 The objectives for the presentation were met

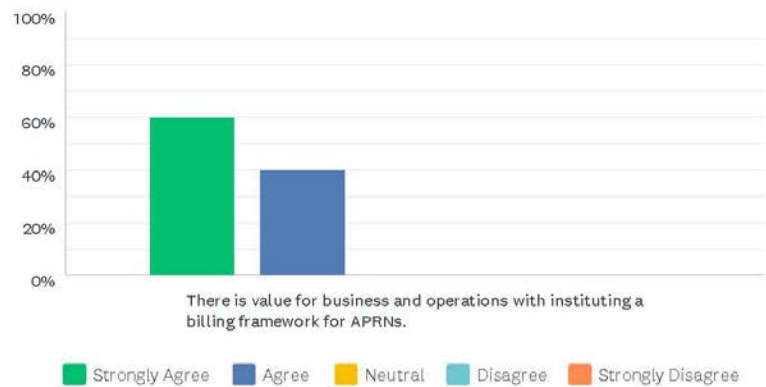
Answered: 5 Skipped: 0



	STRONGLY AGREE (5)	AGREE (4)	NEUTRAL	DISAGREE (2)	STRONGLY DISAGREE (1)	TOTAL	WEIGHTED AVERAGE
Discuss importance of APRN billing	80.00% 4	20.00% 1	0.00% 0	0.00% 0	0.00% 0	5	4.80
Discuss need for APRN billing	80.00% 4	20.00% 1	0.00% 0	0.00% 0	0.00% 0	5	4.80
Discuss APRN billing requirements	80.00% 4	20.00% 1	0.00% 0	0.00% 0	0.00% 0	5	4.80
Introduce tool for APRN billing	80.00% 4	20.00% 1	0.00% 0	0.00% 0	0.00% 0	5	4.80
Journey through a day in the life of an APRN	80.00% 4	20.00% 1	0.00% 0	0.00% 0	0.00% 0	5	4.80

Q2 Question 2

Answered: 5 Skipped: 0

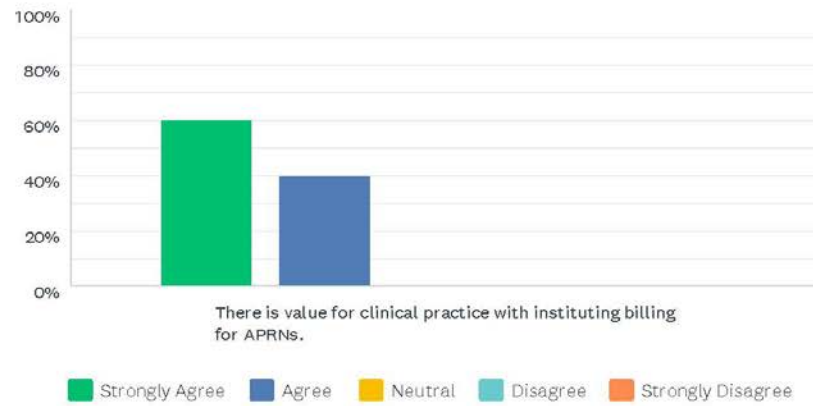


	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
There is value for business and operations with instituting a billing framework for APRNs.	60.00% 3	40.00% 2	0.00% 0	0.00% 0	0.00% 0	5	4.60

#	COMMENT:	DATE
1	Very informative and a practical approach.	1/10/2020 2:24 PM

Q3 Question 3

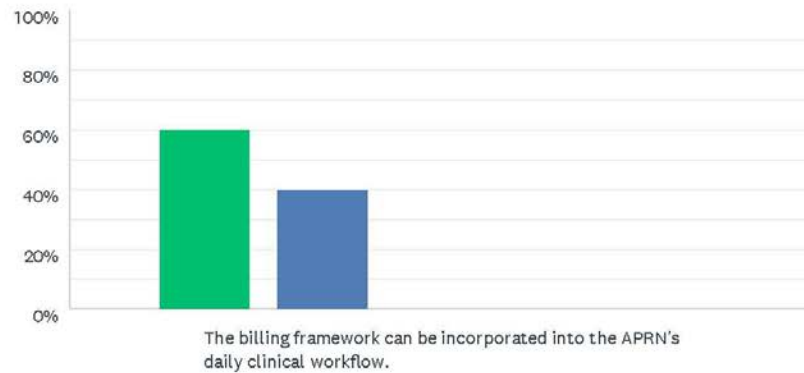
Answered: 5 Skipped: 0



	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
There is value for clinical practice with instituting billing for APRNs.	60.00% 3	40.00% 2	0.00% 0	0.00% 0	0.00% 0	5	4.60

Q4 Question 4

Answered: 5 Skipped: 0



Strongly Agree Agree Neutral Disagree Strongly Disagree

	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
The billing framework can be incorporated into the APRN's daily clinical workflow.	60.00% 3	40.00% 2	0.00% 0	0.00% 0	0.00% 0	5	4.60

#	COMMENT:	DATE
1	I think the only caveat to this is based on how the APRN currently documents and is there an electronic tool in place to support this.	1/13/2020 12:53 PM

Q5 Additional considerations needed to execute the billing framework include:

Answered: 3 Skipped: 2

#	RESPONSES	DATE
1	Great job. Good luck on doctorate.	1/13/2020 12:53 PM
2	Nothing to necessarily add to the presentation, but there are additional training and billing considerations required for E/M services, particularly in the hospital space. That said, understanding that this presentation was not intended to go into that level of detail. It was very informative and well put together.	1/10/2020 2:24 PM
3	Nicely done!	1/10/2020 2:11 PM

Appendix F: APRN Billing Framework Business Case

Problem Statement:

There is currently a forecasted physician shortage, decreasing patient access to care. Additionally, the cost of health care is increasing, accounting for 17.6% of the gross domestic product.

At the same time, the number of APRNs is increasing. Research shows that APRNs provide safe, cost effective, quality care with high patient satisfaction scores. APRNs can be used to help fill the health care gap, increasing patient access to care.

Currently there are no structures in place to support APRN billing of hospital professional services.

Proposed Solution:

Develop a framework regarding billing of hospital-based care provided by APRNs.

- Most hospitals are not set up to support professional billing services for procedures and E&M codes.
- The goal of the proposal is to provide information to senior leadership to aid in making a business decision

Key Benefits:

Hospitals can benefit from implementing APRN billing

- Participate in reimbursement with Prospective Payment System and the Value-Based purchasing program
- Improve quality care
- Empower APRNs
- Improve job satisfaction
- Provide cost-effective care
- Increase patient access to care through improved workflow
- Increase APRN visibility and ability to track productivity
- Increase ability of APRNs to practice to the top of their license

Financial Estimate:

- Budget Neutral

Scope:

- **In Scope:**
 - Enterprise wide initiative.
 - Hospital-based Advanced Practice Registered Nurses, Certified Nurse Specialists
- **Out of Scope:**
 - Certified Registered Nurse Anesthetists, Midwives, and Physician Assistants

Deployment Strategy:

- **Procedure**
 - The project includes the development of a charge pass form to allow for submission of charges.
 - The APRNs will be trained on how to properly complete and submit the charge pass form.
- **Phase I**
 - Billing to start with procedures only
 - Billing to start at one hospital
- **Phase II**
 - E&M charges will be phased in after successful implementation of procedure billing.
 - Billing to be rolled out to additional hospitals in phases to allow for adjustments to be made as needed

Operational & Process Impact:

- The current organizational structure will need to be adapted to allow for hospital-based APRN billing using the charge pass form
- A billing guideline will need to be developed to structure the billing.
- All eligible APRNs will need to be trained on use and submission of the charge pass form.
- All eligible APRNs will need to be trained on billing of procedures initially and future training to include E/M billing
- The billing department will need to be educated regarding the new billing structure and the billing tool for APRNs.

Communication Approach:

- The billing/coding specialists and the education team will work together to develop training material and rollout a training schedule.
- The APRN billing tool will be handed off to the coding and education teams to develop training.

Project Risks:

Risk	Mitigation
Potential for resistance from the physicians and APRNs.	Can be managed by human resources with education for both groups to the rationale regarding APRN billing
Potential for duplicate billing between the physician and APRN	Can be managed by the coding and billing department through training sessions for the physicians and APRNs on how to bill and document appropriately. Additional training will occur with the billing coders to monitor for duplicate charges before submitting the charges.
Potential for a violation of hospital, state, and/or CMS rules.	Should be managed by multiple departments including legal, compliance, credentialing, and senior leadership working collectively to develop a clear guideline for APRNs, that can be adjusted for each hospital and state.

Project Dependencies:

- Support and approval from senior leadership including the Chief Nursing Officer.
- Hospital bylaws and policies changed to allow for the charge pass form and guideline to be adopted and implemented at each facility.

Appendix G: Guideline for APRN Billing

- Licensed as an Advanced Practice Registered Nurse in state of practice
- Certification from a nationally recognized certifying body: American Academy of Nurse Practitioners, American Nurses Credentialing Center, National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties, Pediatric Nursing Certification Board, Oncology Nurses Certification Corporation, American Association of Critical Care Nurses Certification Corporation, and the National Board on Certification of Hospice and Palliative Nurses
- Hold a master's or doctorate degree in nursing
- Obtain a National Provider Identification Number (NPI)
- Credentialed with insurance companies
- Work within the scope of practice according to state law
- Have a collaborative practice agreement in place with a physician
- Must not be hospital employed, only hospital based
- Provide correct documentation to support billing
- APRNs trained to complete and submit the charge pass form

Date:	MR Number:	Name:	DOB:
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Arterial Line placement			
Procedure	Arterial Catheterization (percutaneous)	Cutdown	Arterial puncture/withdrawal of blood for diagnosis (blood gases)
Billing Code	36620 <input type="checkbox"/>	36625 <input type="checkbox"/>	36600 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:	

Chest Tube placement: Thoracostomy					
Procedure	Tube Thoracostomy Open	Thoracentesis w/o imaging guidance	Thoracentesis with imaging guidance	Percutaneous Pleural drainage, insertion of indwelling cath, w/o imaging	Percutaneous Pleural drainage, insertion of indwelling cath, with imaging
Billing Code	32551 <input type="checkbox"/>	32554 <input type="checkbox"/>	32555 <input type="checkbox"/>	32556 <input type="checkbox"/>	32557 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:			

Endotracheal Tube Intubation		
Procedure	Intubation, endotracheal	Tracheotomy tube change
Billing Code	31500 <input type="checkbox"/>	31502 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:

Lumbar / Spinal Puncture		
Procedure	Spinal puncture, lumbar, diagnostic	Spinal puncture, therapeutic – drainage of CSF via needle or catheter
Billing Code	62270 <input type="checkbox"/>	62272 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:

Central Venous Access			
Procedure	Insertion	Removal	Reposition
Billing Code	36555 (<5yo) <input type="checkbox"/> 36556 (5 or >) <input type="checkbox"/>	Cath: 36589 <input type="checkbox"/> Device: 36590 <input type="checkbox"/>	36597 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:	

Peripherally Inserted Central Catheter				
Procedure	Insertion w/o port (<5 yo)	Insertion w/o port (5 or >)	Insertion w/ port (<5 yo)	Insertion w/ port (5 or >)
Billing Code	36568 <input type="checkbox"/>	36569 <input type="checkbox"/>	36570 <input type="checkbox"/>	36571 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:		

Section II

DNP Project Product

I. Nursing Economics: The Journal for Health Care Leaders

A. Journal Scope

Manuscripts focused on nursing leadership, policy changes, innovations in leadership, best practices, economics, and health care management

B. Journal Aims

Advances nursing leadership in health care, with a focus on tomorrow, by providing information and thoughtful analyses of current and emerging best practices in health care management, economics, and policymaking

Title: Securing Payment for Services Provided by Advanced Practice Nurses:
Framework for Organizations

**Securing Payment for Services Provided by Advanced Practice Nurses:
Framework for Organizations**

Lisa Fournace, DNP

Susan Alexander, DNP

Cindy Borum, DNP

Biography

Lisa Fournace is an Advanced Practice Registered Nurse in Nashville, TN. She received her doctorate of nursing from The University of Alabama, Huntsville. Recent publications include “A blueprint for establishing an APRN clinic practice” (2017) and “The Impact of Genitourinary Syndrome of Menopause on Quality of Life” (2017).

Correspondence

Lisa Fournace - 444 Whitley Way - Mt. Juliet, TN 37122

Email: lcfwhnp@gmail.com

Phone: (615) 308-9301

Abstract:

APRNs practicing in inpatient facilities are subject to reimbursement guidelines that can create difficulties in billing for services. The purpose of this project was to develop a framework regarding billing of hospital professional services provided by hospital-based APRNs.

Securing Payment for Services Provided by Advanced Practice Nurses: Framework for Organizations

As the demand for health care increases due to a growing and aging population, so does the demand for health care providers. According to the Association of American Medical Colleges (AAMC), the supply of physicians is decreasing. The AAMC (2019) predicts the United States will experience a shortage of up to nearly 122,000 physicians by 2032. Concurrently, the number of advanced practice registered nurses (APRN) is increasing, and it is forecasted to increase by 31% by 2026 (Bureau of Labor Statistics, 2019). With the physician shortage and the supply of APRNs increasing, APRNs are poised to help fill the health care gap.

Meanwhile, the cost of health care is skyrocketing. In the United States, health care spending is more than twice that of other developed nations such as the United Kingdom, France, and Sweden; accounting for 17.7% of the gross domestic product in the US (Kane, 2012; Centers for Medicare and Medicaid Services [CMS], 2019a). Evidence has shown APRNs can reduce health care costs, especially when barriers are removed allowing them to practice to the top of their license (Bauer, 2010).

According to studies conducted by the Institute of Medicine (IOM) (2010), APRNs are well educated and trained to provide safe, effective, and quality patient care. APRNs are a unique group of providers because they do not fit into a definitive category of medicine or nursing (Metzger, 2014). While APRNs are not physicians, their education, training, and job responsibilities create different professional roles than those of registered nurses, thereby requiring a different organizational structure to serve more effectively in expanding organizations (Metzger, 2014; Anen, & McElroy, 2015). The Center for

Advancing Provider Practices (CAP2) recommends six areas of focus to improve the organizational structure for APRNs. The focus areas include “leadership, human resources, credentialing and privileging, competency assessment, billing and reimbursement, and measurement/impact” (Anen & McElroy, 2015, p. 51).

Implementing a health care infrastructure that supports and empowers APRNs requires cooperating leadership from various departments to define the organizational needs and goals to ensure success. APRNs are frequently hired to help fill the health care gaps surrounding national initiatives. This environment allows APRNs to demonstrate their full abilities (Kapu, Kleinpell, & Pilon, 2014). A sound APRN-centered infrastructure can facilitate engagement, utilization, and optimization of APRNs, which results in improved patient outcomes in a cost-effective manner (Anen, & McElroy, 2015).

Identification of Problem

Billing and reimbursement for APRNs has been identified by CAP2 as an opportunity to improve organizational infrastructure (Anen & McElroy, 2015). Previously, hospitals were reimbursed under a cost-based system, allowing hospitals to submit the cost of patient care for a percentage of reimbursement. Due to rising costs, the government changed the reimbursement system (Buppert, 2005). Today, the Prospective Payment System (PPS) is used as a fixed payment system to reimburse for services and care provided in the inpatient setting. The amount is determined by the diagnosis related group (DRG). This is a weighted payment for the specific diagnosis, determined by the resources used to care for the patient (CMS, 2020). In addition to PPS structured reimbursements, hospitals are incentivized to improve quality of care using a value-based payment model. The model has three performance measures for hospitals: Hospital Value-Based Purchasing Program

(VBP), Hospital Readmission Reduction Program, and the Hospital Acquired Conditions Reduction Program. The performance measures programs focus on improving the quality of patient care, reducing hospital 30-day readmission rates, and decreasing infections acquired in the hospital (CMS, 2019a).

To meet the performance measures for the PPS and VBP programs, hospitals and or organizations would benefit from maximizing integration of APRN services in care delivery models. However, APRN infrastructure must include a billing program for APRNs. Developing and instituting a billing and reimbursement program for hospital-based APRNs as part of the organizational infrastructure can help to improve quality, cost-effective care (Kapu, et al 2014). Empowering APRNs to practice to the top of their license has been shown to improve job satisfaction (Athey, 2016). Failure to implement a practice infrastructure that promotes and empowers APRNs practice can lead to decreased job satisfaction and increased turnover amongst APRNs (Kapu, & Steaban, 2016).

Local Problem

In 2016, within a large health care system headquartered in Nashville, Tennessee, two surveys were conducted across the enterprise to understand the roles and utilization of hospital-based APRNs. Within this organization, hospital-based APRNs work in the hospital; however, they are employees of the corporation and not the hospital. The first survey was sent to the Chief Nursing Officer (CNO) of each hospital. The second survey was sent to all the hospital-based APRNs. The surveys revealed APRNs were thought to be valuable to the organization, however, current structures and guidelines were preventing full utilization of skills resulting in hospital-based APRNs not practicing to the top of their license. Opportunities were identified surrounding APRNs that could enhance patient care,

reduce costs, increase APRN utilization, and improve job satisfaction (Englebright, 2017). Additionally, with the continued growth of APRNs and regulatory changes, a need was identified to assess APRN billing practices and opportunities for organizational changes to promote APRN billing (C. Borum, personal communication, June 18, 2019).

Today, within this health care system, hospital-based APRNs do not bill for services using their own National Provider Identifier (NPI), a ten-digit number used to identify a provider, due to the lack of an APRN billing structure within the organization (CMS 2018). Physicians and out-patient-based APRNs who submit professional fees for inpatient services submit charges to their outpatient clinic to be processed for billing. The hospital-based APRNs currently are not submitting charges for professional services due to a lack of guidelines or tools in place to foster billing. Without the ability for hospital-based APRNs to bill inpatient services, tracking APRNs is proving to be difficult as their visibility is decreased. The limitations include tracking financial viability, patient quality care, and costs related to care. Improving the visibility of APRNs recently has been a discussion with the Medicare Payment Advisory Commission (MEDPAC), as a recent recommendation was made to Medicare to eliminate incident-to billing to increase APRN visibility (MEDPAC, 2019). With the current shift toward VBP reimbursement models, tracking the activity of health care providers and patients is essential.

Literature Review

Billing Guidelines for APRNs Providing Inpatient Services

Guidelines describing APRNs billing for physician services are complicated and difficult to decipher due to documentation in various locations of federal and state law (Buppert, 2005). Third-party-payers may have largely differing policies regarding APRN billing and reimbursement. Although many payers will follow Medicare guidelines, not all payers, including Medicaid, follow their guidelines. Organizations in individual states need to investigate the rules surrounding Medicaid and commercial payers for billing inpatient care services (Wound, Ostomy, and Continence Nurses Society [WOCN], 2012). Given that the rules vary for each payer, the only definitive guidelines that can be evaluated are those pertaining to federally-based reimbursements from CMS.

CMS requires that scope of practice be followed according to state law, the professional service must be within the APRN scope of practice, and the APRN must have a collaborative agreement with a physician (CMS, 2019c). Finally, only one bill for evaluation and management, per day, per specialty will be covered by CMS (CMS, 2019c).

Benefits of Billing for Inpatient Services Provided by Hospital-Based APRNs

In a study by Kapu, Kleinpell, and Pilon (2014), APRNs were added to five inpatient teams as billing providers. Adding the APRNs decreased the length of stay in the hospital across all the units. The shortened hospitalization resulted in cost savings of approximately \$28 million in hospital charges; and each APRN increased gross collections due to the added revenue. Additionally, nurses and physicians completed 3-month satisfaction surveys regarding adding the APRNs, with the majority responding favorably to this team structure. The nurses, with over 80% response, strongly agreed that using the APRNs

improved patient care, including improved pain control and better communication with the patient and families. The physicians, with over 75% response, strongly agreed APRNs improved the physician workflow, improved patient care and overall were very satisfied with the clinical decision making of the APRN. Of note, 100% of the physicians strongly agreed that using the APRN improved patient throughput.

Brooks and Fulton (2019) implemented a billing algorithm, following Medicare guidelines, across a large academic medical center for inpatient and outpatient APRNs. The data was not separately analyzed for inpatient and outpatient; however, global benefits were noted. The billing algorithm increased APRN visibility by capturing data related to productivity. Before the billing algorithm, physician relative value units (RVU), units used to calculate physician payments, were inflated secondary to APRNs billing under the physicians' NPI. As anticipated, APRN RVU increased as APRNs initiated billing utilizing their own NPI. However, the unanticipated benefit noted was the increase in the physicians' RVUs. The billing algorithm improved work flow through improved utilization of the patient care team.

Moote et al. (2011) conducted a study to evaluate the use of APRNs and physician assistants (PA) in academic health centers. The study consisted of a 3-part survey examining the perceived organizational value of APRNs and PA, integration of APRNs and PAs into the organization, and deployment strategies of APRNs and PAs. The primary reason noted for employing APRNs and PAs was to fill the gap created by the restrictions on resident hours. Secondary reasons noted include improving patient quality, safety, and throughput, increasing patient access to care, and decreasing length of stay. Additionally, ease of accessibility of non-physician providers to other care providers to discuss patient

care was ranked high with strongly agree. Despite APRNs and PAs proving to be valuable assets to the organizations, 69% of the responders admitted the financial impact of APRNs or PAs had not been successfully documented. Twenty-three percent reported hospital-based APRNs and PAs were not billing professional services. In 40% of medical centers tracking RVUs of APRNs and PAs, RVUs were not captured for hospital-based advanced practice providers but limited to the outpatient setting. This study highlights the missed opportunity to bill for services and capture data specific to APRNs.

Kapu and Steaban (2016) recognized the need [for](#) a business case to support implementing an inpatient APRN team, developing an 8-step standardized framework for adding to inpatient teams to improve quality and revenue while providing cost-effective health care (2016). The process included identification of the problem as it related to the program or organization, a statement of the problem, proposed intervention, recommendations on staffing, an overview of the APRN pro forma, APRN quality targets, plan for practice support, and anticipated challenges. This framework has provided a uniform process for strategic planning, implementation, and evaluation. Since implementing the framework, the institution has hired and trained additional APRNs who have utilized the process for developing new programs.

APRN job satisfaction in relation to autonomy and work setting were evaluated in a survey by Athey et al (2015). The study evaluated how job satisfaction was affected by physician relationships, billing practices, and skill utilization. The survey revealed 30% of APRNs perceived their skills were underutilized in the hospital setting. Fifty-nine percent of clinic-employed APRNs felt strongly their skills were utilized. The survey found across all settings, only 39% of APRNs were billing under their own NPI. In the hospital setting,

32% of APRNs were billing in the medical setting. The survey determined the highest job satisfaction reported was among APRNs with the highest reported autonomy and utilization of skills.

Billing Guidelines for Hospital-Based APRNs

With the research demonstrating clear evidence that APRNs can bill Medicare for inpatient professional services, the challenge now becomes identifying best practices for billing strategies in facilities. To obtain Medicare credentialing, the APRN must meet Medicare qualifications. The qualifications include licensure as an APRN in the state of practice. Billing guidelines require the APRN to obtain an NPI number for submitting claims to Medicare (CMS 2019c). Split/shared billing occurs when a physician and an APRN submit one claim for combined work. Shared billing is a permissible form of billing for in-patient professional services if both parties have an employment or similar contractual relationship. Incident to billing occurs when the claim is submitted under the physician's NPI for APRN work. However, this is not allowed for billing inpatient professional services (Buppert, 2005, CMS, 2016 & CMS, 2019b).

Another guideline is to ensure a service is medically necessary. Proper documentation supporting the procedure or the evaluation and management (E&M) code is essential to prove medical necessity. The E&M consists of the history, physical exam and medical decision making (CMS, 2017). APRNs may manage acute and chronic illnesses according to the state scope of practice laws. However, APRNs may not solely assume the care of hospitalized patients, even in states with full practice authority. Federal laws mandate that hospitalized patients have a physician assigned to their care (Electronic Code of Federal Regulations [e-CFR], 2019). These guidelines layout the steps for billing inpatient

professional services. Additional guidelines may be required, depending on individual state laws, organizational by-laws, and policies surrounding privileging and credentialing.

Theoretical Framework

Kanter's *Theory of Structural Empowerment* will be a basis for the DNP project.

Kanter's theory describes the influences of organizational structure upon empowerment of employees. Kanter (1993) defines power as "the ability to get things done, to mobilize resources, to get and use whatever it is that person needs for the goals he or she is attempting to meet" (pg. 166). When power is confined to only a few then effectiveness is diminished. However, when the power is spread among many, the result is increased productivity. Empowerment gives a person the authority over circumstances to promote their actions to accomplish goals (Kanter, 1993).

The four organizational structures that promote empowerment include access to support, opportunity, resources, and information. Structural empowerment has been linked to improved job satisfaction, productivity, and autonomy (Clavelle, O'Grady, & Drenkard, 2013; Laschinger et al, 2009; Orgambidez-Ramos, & Borrego-Alés, 2014). Kanter's model serves an excellent guide in developing a billing program for APRNs to promote structural empowerment (Fig 1).

An organization's effectiveness depends on the ability to recognize the values, contributions, and achievements of its employees (Rutherford, Leigh, Monk, & Murray, 2005). Organizational infrastructure fostering structural empowerment of APRNs can have a beneficial impact on patient care, positive financial implications, and promote job retention. By developing structures such as implementing an APRN billing program, the increased visibility of APRNs may contribute to a sense of empowerment that can increase

job effectiveness, improve job satisfaction and ultimately enhance patient care (Stewart, McNulty, Griffin, & Fitzpatrick, 2010).

Specific Aims

The purpose of this project was to develop a framework regarding billing of hospital professional services provided by hospital-based APRNs. The aims of the project were: 1) Develop a framework to implement billing for hospital-based APRNs; 2) Presentation of the framework to the steering committee work group; 3) Obtain objective feedback from the steering committee and revise the framework based off the feedback; 4) Develop a billing policy for hospital-based APRNs.

Methods

Context

Within a large health care system headquartered in Nashville, Tennessee, hospital-based APRNs do not bill for professional services using their own NPI due to the infrastructure of the organization. The services include performing procedures and providing medical care that supports E&M billing. The APRNs are in place and performing the billable work; however, due to lack of organizational structure, they cannot submit billing for these services.

At the corporate headquarters, a steering committee work group was developed to evaluate the need for implementing a billing system for hospital-based APRNs. The Assistant Vice President (AVP) of Advanced Practice Nursing chaired the work group. The group was comprised of seven members, of which six were women. The members, consisting of business and clinical professionals, were invited to participate in the work group due to their knowledge

and experience in leadership, clinical, government issues, human resources, and communication.

This project is a part of a larger initiative evaluating all advanced practice provider billing.

Interventions

The first phase of the project developed a basic framework to include the following components: a problem statement, background information, proposed solution, deployment strategy, project scope, project dependencies, operational and process impact, communication approach, key benefits, and project risks and issues. To help guide the framework, a driver diagram was developed to create a visual display of the components that could affect the outcome. The aim was defined, and then primary and secondary drivers were identified to achieve the aim. A strengths, weaknesses, opportunities, and threats (SWOT) analysis was performed to identify internal and external factors to aid in the strategic planning of the framework.

A charge pass form (Figure 1) was developed as a billing tool to be included in the framework. The billing tool focused on procedures for this project. The work group identified the procedures to be incorporated into the billing tool.

Finally, a survey was developed to obtain feedback from the workgroup for the proposed framework. The survey included eight closed-ended questions and one open-ended question. The closed-end questions used a 5-point scale to measure the responses.

Phase two of the project was a presentation of the plan to the steering committee work group for review. The 20-minute presentation was presented virtually to the work group. The presentation discussed the importance of and need for billing among hospital-based APRNs. The requirements for APRN billing were explained and the charge pass form was introduced. After the presentation, the work group members were invited to ask questions. At the conclusion of the

questions, the work group was invited to complete a survey (Appendix D), via SurveyMonkey, designed to capture feedback regarding their analysis of the plan and suggestions for further consideration. The survey link was emailed to the work group participants and the surveys were collected over the course of one week.

The final phase of the project was the revision of the framework and the development of the billing guideline. The framework format followed the institution's template for business cases. A billing guideline was provided to outline the requirements for hospital-based APRN billing. Both were submitted to the AVP for review and consideration to be included in the larger advanced practice billing initiative for review by the senior leadership team.

Analysis

Both quantitative and narrative feedback were collected to evaluate the APRN billing framework. A 5-point survey was administered online through SurveyMonkey, which collected the responses. To measure the intervention, the mean was determined for each question. An aggregated mean of 3 or more, indicated the project met acceptable criteria for progression to the next phase. A mean for any individual question below 3, indicated revisions were needed. Narrative feedback was requested from the participants in the form of comments following each question and at the end of the survey. A statistical analysis of the survey was performed using descriptive statistics. SurveyMonkey software and Excel data analysis ToolPak were used to tabulate and analyze the data for each question.

Results

Phase I developed the APRN billing framework. It involved researching the current evidence regarding APRN billing to help guide the framework. The development of the driver diagram

and SWOT analysis helped to identify deficits and allowed for adjustments to be made to the framework.

A charge pass form was developed as the billing tool to be included in the framework. The work group identified and shared the top six procedures performed by the APRNs within the hospital: arterial line placement, chest tube placement, endotracheal tube intubation, lumbar puncture, central venous access, and peripherally inserted central catheter. The form included patient demographics, procedure codes and definitions, and a field to include the diagnosis code (Figure 1). The design of the form was one page to promote ease of use.

Phase II was the presentation of the framework and completion of the survey. Seven members of the work group attended the presentation and were asked to complete a survey administered online through SurveyMonkey. In total, five surveys were completed. One survey was not completed due to conflict of interest and one survey was lost to follow-up. The mean aggregate score for all questions was 4.7. The mean for the individual questions was between 4.6 and 4.8. All of the mean scores were greater than 3, therefore indicating acceptance of the billing framework (Table 1). The narrative comments were evaluated last. There were no recommendations for changes to the framework, however suggestions for future considerations were included (Table 2).

Phase III of the project included minor revisions to the framework and the development of the billing guideline (Table 3). Both were accepted to be submitted to senior leadership for review.

Discussion

Developing a billing framework for hospital-based APRNs is a complex and tedious project. Having a thorough understanding of billing regulations and guidelines, as well as

federal and state laws is essential. The project set out to develop the initial APRN billing framework and it was successfully accepted into the larger advanced practice billing plan. The groundwork has been laid for the organization to continue to build upon the framework to work toward successful implementation of billing for hospital-based APRNs.

Limitations

The greatest barrier to the framework is resistance to change. The framework must first be approved by senior leadership before the process of implementation begins. If approved, organizational guidelines will need to be revised to allow for the policy to be implemented. Additionally, the APRNs may be resistant to the change as it is a new process. This can be mitigated with appropriate training. A final barrier is the risk for duplicate billing, specifically with E&M codes. With appropriate training of the billing and coding specialists as well as the physicians and APRNs, this risk can be minimized.

Conclusion

Developing a APRN billing framework is an important first step in implementing billing for hospital-based APRNs. A billing program can promote APRNs practicing to the top of license and increase visibility, improving the ability to track metrics specific to APRNs. Additionally, charge capture can improve patient care due to improved utilization and work-flow of the patient care team. This can increase practice sustainability by enhancing cost-effective care and foster cost-avoidance. Financial opportunities exist with the potential to participate in reimbursement with PPS and the VBP program. Full utilization of APRNs can have far reaching positive implications. The design and development of the framework laid the groundwork to implement an organizational change. This paradigm shift has the potential to position the organization to be a leader in the advancement of APRN billing.

REFERENCES

- Association of American Medical Colleges (2016). The complexities of physician supply and demand: Projections from 2017 to 2032. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf
- American Association of Nurse Practitioners (2019). NP fact sheet. <https://www.aanp.org/about/all-about-nps/np-fact-sheet>
- American Association of Nurse Practitioners (2018). 2017 National nurse practitioner sample survey results. <https://www.aanp.org/news-feed/2017-national-nurse-practitioner-sample-survey-results>
- Anen, T., & McElroy, D. (2015). Infrastructure to optimize APRN practice. *Nurse Leader*, 13(2), 50-56.
- Athey, E., Leslie, M., Briggs, L., Park, J., Falk, N., Pericak, A., ... & Greene, J. (2016). How important are autonomy and work setting to nurse practitioners' job satisfaction? *Journal of the American Association of Nurse Practitioners*, 28(6), 320-326.
- Bauer, J. C. (2010). Nurse practitioners as an underutilized resource for health reform: Evidence-based demonstrations of cost-effectiveness. *Journal of the American Academy of Nurse Practitioners*, 22(4), 228-231.
- Brassard, A., (2015). APRN policy and payment. *Nurse Leader*, 13(2), 36-38

Brooks, P. B., & Fulton, M. E. (2019). Demonstrating advanced practice provider value:

Implementing a new advanced practice provider billing algorithm. *Journal of the American Association of Nurse Practitioners*, 31(2), 93-103.

Buppert, C. (2002). Billing for nurse practitioner services: Guidelines for NPs, physicians, employers, and insurers. *Medscape Nurses*, 4(1).

Buppert, C. (2005). Capturing reimbursement for advanced practice nurse services in acute and critical care: Legal and business considerations. *AACN Advanced Critical Care*, 16(1), 23-35.

Bureau of Labor Statistics (2019). Occupational outlook handbook.

<https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm>

Centers for Medicare & Medicaid Services (2016). Advanced practice registered nurses, anesthesiologist assistants, and physician assistants.

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244981.html>

Centers for Medicare & Medicaid Services (2017). Evaluation and management services.

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243514.html>

Centers for Medicare & Medicaid Services (2018). National provider identification

standard (NPI). <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/>

Centers for Medicare & Medicaid Services (2019a). Value based programs.

<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html>

Centers for Medicare & Medicaid Services (2019b). Medicare benefit policy manual

(Publication No. 100-02). <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>

Centers for Medicare & Medicaid Services (2019c). Medicare claims processing manual

(Publication No. 100-04). <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>

Centers for Medicare & Medicaid Services (2020). Acute inpatient prospective payment system.

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS>

Clavelle, J. T., O'Grady, T. P., & Drenkard, K. (2013). Structural empowerment and the nursing practice environment in Magnet® organizations. *Journal of Nursing Administration*, 43(11), 566-573.

Cronenwett, L., Sherwood, G., Pohl, J., Barnsteiner, J., Moore, S., Sullivan, D. T., ... & Warren, J. (2009). Quality and safety education for advanced nursing practice. *Nursing Outlook*, 57(6), 338-348.

De Milt, D. G., Fitzpatrick, J. J., & McNulty, S. R. (2011). Nurse practitioners' job satisfaction and intent to leave current positions, the nursing profession, and the nurse practitioner role as a direct care provider. *Journal of the American Academy of Nurse Practitioners*, 23(1), 42-50.

Dubree, M., Jones, P., Kapu, A., & Parmley, C. L. (2015). APRN practice: Challenges, empowerment, and outcomes. *Nurse Leader*, 13(2), 43-49.

Electronic Code of Federal Regulations (2019). Title 42 – Public health. Retried September

29, 2019, from [https://www.ecfr.gov/cgi-bin/text-](https://www.ecfr.gov/cgi-bin/text-idx?SID=898ca29b98a754fd0883bcced6a68c8e&mc=true&node=se42.5.482_112&rgn=div8)

[idx?SID=898ca29b98a754fd0883bcced6a68c8e&mc=true&node=se42.5.482_112](https://www.ecfr.gov/cgi-bin/text-idx?SID=898ca29b98a754fd0883bcced6a68c8e&mc=true&node=se42.5.482_112&rgn=div8)

[&rgn=div8](https://www.ecfr.gov/cgi-bin/text-idx?SID=898ca29b98a754fd0883bcced6a68c8e&mc=true&node=se42.5.482_112&rgn=div8)

Englebright, J. (2017). The emerging role of APRNs in hospital nursing practice:

Perspectives from a survey of chief nursing officers. *Nurse Leader*, 15(6), 387-391.

Fournace, L., & Borum, C., (2017) A blueprint for establishing an APRN clinic practice.

Tennessee Nurse, 80 (3), 9.

Grisham, S. (2017). Medscape physician compensation report 2017.

<https://www.medscape.com/slideshow/compensation-2017-overview-6008547#2>

Horner, D. K. (2017). Mentoring: Positively Influencing Job Satisfaction and Retention of

New Hire Nurse Practitioners. *Plastic Surgical Nursing*, 37(1), 7-22.

Hull, A., & Fournace, L. (2017). The Impact of Genitourinary Syndrome of Menopause On

Quality of Life. *Urol Nurs November/December*, 37, 310-315.

Kane, J. (2012). Health costs: How the US compares with other countries. *PBS Newshour*,

22.

Kapu, A., Kleinpell, R., & Pilon, B. (2014). Quality and financial impact of adding nurse

practitioners to inpatient care teams. *Journal of Nursing Administration*, 44(2), 87-

96.

Kapu, A., & Steaban, R. (2016). Adding nurse practitioners to inpatient teams: Making the

financial case for success. *Nurse Leader*, 14(3), 198-202.

- Laschinger, H. K. S. (2008). Effect of empowerment on professional practice environments, work satisfaction, and patient care quality: Further testing the nursing work life model. *Journal of Nursing Care Quality*, 23(4), 322-330.
- Laschinger, H., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: Impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management*, 17(3), 302-311.
- The Medicare Payment Advisory Commission (2019). Issues in Medicare beneficiaries' access to primary care. http://www.medpac.gov/docs/default-source/reports/jun19_ch5_medpac_reporttocongress_sec.pdf?sfvrsn=0
- Metzger, R., & Rivers, C. (2014). Advanced practice nursing organizational leadership model. *The Journal for Nurse Practitioners*, 10(5), 337-343.
- Moote, M., Krsek, C., Kleinpell, R., & Todd, B. (2011). Physician assistant and nurse practitioner utilization in academic medical centers. *American Journal of Medical Quality*, 26(6), 452-460.
- National Council of State Boards of Nursing (2019). APRNs in the U.S. <https://www.ncsbn.org/aprn.htm>
- Orgambídez-Ramos, A., & Borrego-Alés, Y. (2014). Empowering employees: Structural empowerment as antecedent of job satisfaction in university settings. *Psychological Thought*, 7(1), 28-36.
- Pasarón, R. (2013). Nurse practitioner job satisfaction: Looking for successful outcomes. *Journal of Clinical Nursing*, 22(17-18), 2593-2604.

- Rutherford, J., Leigh, J., Monk, J., & Murray, C. (2005). Creating an organizational infrastructure to develop and support new nursing roles—a framework for debate. *Journal of Nursing Management*, 13(2), 97-105.
- Social Security Administration (2019). Compilation of the social security laws: Part E – miscellaneous provisions (§1861(s)(K)(i).
https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- Stillwell, S. B., Fineout-Overholt, E., Melnyk, B. M., & Williamson, K. M. (2010). Evidence-based practice, step by step: Asking the clinical question: A key step in evidence-based practice. *AJN The American Journal of Nursing*, 110(3), 58-61.
- Stewart, J. G., McNulty, R., Griffin, M. T. Q., & Fitzpatrick, J. J. (2010). Psychological empowerment and structural empowerment among nurse practitioners. *Journal of the American Academy of Nurse Practitioners*, 22(1), 27-34.
- WOCN Society National Public Policy Committee. (2012). Reimbursement of advanced practice registered nurse services: A fact sheet. *Journal of Wound, Ostomy, and Continence Nursing: Official Publication of The Wound, Ostomy and Continence Nurses Society*, 39(2 Suppl), S7.

Figure 1: Hospital-Based APRN Charge Pass Form

Date:	MR Number:	Name:	DOB:
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Arterial Line placement			
Procedure	Arterial Catheterization (percutaneous)	Cutdown	Arterial puncture/withdrawal of blood for diagnosis (blood gases)
Billing Code	36620 <input type="checkbox"/>	36625 <input type="checkbox"/>	36600 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:	

Chest Tube placement: Thoracostomy					
Procedure	Tube Thoracostomy Open	Thoracentesis w/o imaging guidance	Thoracentesis with imaging guidance	Percutaneous Pleural drainage, insertion of indwelling cath, w/o imaging	Percutaneous Pleural drainage, insertion of indwelling cath, with imaging
Billing Code	32551 <input type="checkbox"/>	32554 <input type="checkbox"/>	32555 <input type="checkbox"/>	32556 <input type="checkbox"/>	32557 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:			

Endotracheal Tube Intubation		
Procedure	Intubation, endotracheal	Tracheotomy tube change
Billing Code	31500 <input type="checkbox"/>	31502 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:

Lumbar / Spinal Puncture		
Procedure	Spinal puncture, lumbar, diagnostic	Spinal puncture, therapeutic – drainage of CSF via needle or catheter
Billing Code	62270 <input type="checkbox"/>	62272 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:

Central Venous Access			
Procedure	Insertion	Removal	Reposition
Billing Code	36555 (<5yo) <input type="checkbox"/> 36556 (5 or >) <input type="checkbox"/>	Cath: 36589 <input type="checkbox"/> Device: 36590 <input type="checkbox"/>	36597 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:	

Peripherally Inserted Central Catheter				
Procedure	Insertion w/o port (<5 yo)	Insertion w/o port (5 or >)	Insertion w/ port (<5 yo)	Insertion w/ port (5 or >)
Billing Code	36568 <input type="checkbox"/>	36569 <input type="checkbox"/>	35670 <input type="checkbox"/>	36571 <input type="checkbox"/>
Diagnosis	Description:	ICD-10:		

[illegible]

Table 2 - APRN Billing Framework Survey Narrative Comments

Narrative Comments	
Question	Comment
Objectives	No comments
There is value for business and operations with instituting a billing framework for APRNs.	Very informative and a practical approach.
There is value for clinical practice with instituting billing for APRNs.	No comments
The billing framework can be incorporated into the APRN's daily clinical workflow.	I think the only caveat to this is based on how the APRN currently documents and is there an electronic tool in place to support this.
Additional considerations needed to execute the billing framework include:	Nothing to necessarily add to the presentation, but there are additional training and billing considerations required for E/M services, particularly in the hospital space. That said, understanding that this presentation was not intended to go into that level of detail. It was very informative and well put together.

Table 3 – Guideline for APRN Billing

- Licensed as an Advanced Practice Registered Nurse in state of practice
- Certification from a nationally recognized certifying body: American Academy of Nurse Practitioners, American Nurses Credentialing Center, National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties, Pediatric Nursing Certification Board, Oncology Nurses Certification Corporation, American Association of Critical Care Nurses Certification Corporation, and the National Board on Certification of Hospice and Palliative Nurses
- Hold a master's or doctorate degree in nursing
- Obtain a National Provider Identification Number (NPI)
- Credentialed with insurance companies
- Work within the scope of practice according to state law
- Have a collaborative practice agreement in place with a physician
- Must not be hospital employed, only hospital based
- Provide correct documentation to support billing
- APRNs trained to complete and submit the charge pass form