

RN BILLING & CODING FAQ: CLINIC FLOW, CODES, & LEVELS OF SERVICE

Historically, many clinics providing STD services have relied on registered nurses (RN) to provide quick, follow-up, and “worried-well” visits. As more of these clinics bill third-party payers, questions about billing for visits when a patient is seen only by a RN are common. Insurance reimbursement for medical services is based on a model of care with the physician as the provider.¹ The following frequently asked questions (FAQ) explain the current state of billing and coding for the services of a RN and other clinical staff.

FREQUENTLY ASKED QUESTIONS REGARDING RN BILLING

Can an RN bill third-party payers for his/her time?

Yes, but with restrictions. An RN (or medical/clinic assistant) can only bill for time with an established patient, and only with one particular code.

What codes can an RN bill for?

Insurance reimbursement coding is based on the American Medical Association CPT² coding system. Under that system, the only Evaluation and Management (E/M) code that a registered nurse can bill to is 99211. CPT defines this code as an “office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician performing or supervising these services.”³ Common uses for the 99211 code in a STD site are: asymptomatic urine STD screening, stand-alone HIV counseling and testing, chlamydia treatment with a previously written order, or retesting after treatment for chlamydia or gonorrhea.

What documentation is needed?

Unlike other office visit E/M codes, a 99211 office visit does not have any specific key documentation component requirements. Rather, the documentation needs to include the date of services and identity of the person providing care, along with sufficient information to support the reason for the encounter and E/M service and any relevant history, physical assessment, and plan of care. Any interaction with a supervising provider should also be documented.

What about an LPN/LVN?

The presence of an RN is not required. A 99211 should not be billed for incidental interactions such as picking up a routine prescription. However, the CPT manual includes the example of using a 99211 for an “office visit for a 45-year old female, established patient, for a blood pressure check.” There is no requirement for a particular staff member to take the blood pressure.

Can an RN bill for a new patient?

No. Code 99211 cannot be reported for services provided to patients who are new to the practice. A new patient is expected to be seen by an MD/NP-level provider. According to CPT, an established patient is one who has received professional services from the physician [sic] or another physician of the same specialty in the same group practice within the past three years.⁴

Does an RN get the same reimbursement as an MD/NP?

Reimbursement for 99211 is the same regardless of which staff saw the patient; however, an MD/NP/PA can bill for a full range of codes, but the RN can only bill for a 99211. Reimbursement varies from carrier to carrier, but typically ranges from \$13.00 to \$25.00. The other codes that MD/NP can bill for reimburse at significantly higher rates.

What role does the MD/NP play when an RN bills for care?

To bill for any E/M service, even a Level One (99211), an E/M service must be provided. Generally, this means that the patient's history is reviewed, a limited physical assessment is performed, or some degree of decision making occurs. A 99211 should not be used for RN services provided during the course of a more complex visit with a provider. The service must be separate from other services performed on the same day. For example, if a nurse takes a patient's vital signs and provides counseling and education to a patient prior to or after an encounter with the physician, 99211 should not be reported because these services are considered part of the E/M service already being provided and will be billed as a more complex service code. A 99211 should not be used if there is a more specific code for a given service—for instance, a simple blood draw should be reported with the code for a blood draw (e.g., 36415).

The 99211 code provides a mechanism to report services provided by a nurse or other clinical staff member. According to the CPT manual, the staff member may communicate with the provider, but direct intervention or interaction with the provider is not required.⁵ Check with the state Medicaid rules or other third-party payer to clarify specific requirements for physician supervision.

Can we bill a 99211 for telephone counseling?

No. The provider-patient encounter must be face-to-face; telephone calls with patients do not meet the billing requirements for a 99211.

How can we make this financially viable in our clinic?

If your clinic has both MD/NPs and RNs and plans to begin billing insurance companies, consider changing your clinic flow. Instead of relying on a RN for quick or follow-up visits and the MD/NP for more complex visits, consider a more integrated model of care. In this model, the MD/NPs provide more visits overall, obtaining higher reimbursement rates available to them. The RN and MD/NP work in partnership, with the RN in a significant supporting role while the MD/NP is the provider on record.⁶

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- 1 CPT uses "Physician" but under most circumstances a practicing nurse practitioner, certified nurse midwife, or physician assistant can report E/M codes as a provider, under the supervision of a physician.
 - 2 The Current Procedural Terminology (CPT) code set is a medical code set maintained by the American Medical Association through the CPT Editorial Panel.
 - 3 American Medical Association. <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page>.
 - 4 AMA CPT Standard Edition. E/M Services Guidelines, 2011 version.
 - 5 American Academy of Family Physicians. <http://www.aafp.org/journals/fpm.html>.
 - 6 Moss Healthcare Consulting.