

Registered Nurse Billing in Primary Care

Stephanie G. Witwer

Angela Mattson

Anne T. Jessie

Payment for primary care remains predominantly fee-for-service. Billing regulations are complex and often not a part of nursing curriculum. This leads to confusion and a lack of understanding. When nurses are employed by primary care practices, their nursing services that contribute to context, as well as the systems they serve and impact the RN's billable services, are not clearly identified. This article describes frequently used codes, regulatory requirements for use, and opportunities for future payment models.

Debate about primary care payment reform and movement to value-based payment models is gaining momentum as payors seek higher quality at a lower cost. In 2021, only 6.74% of total revenue in primary care practices came from value-based contracts, with fee-for-service (FFS) continuing as the predominant payment model (Medical Group Management Association [MGMA], 2022). Though value-based models continue to evolve, it is likely that without conversion mandates, many primary care practices will persist in FFS models due to perceived financial risk, as well as cost and complexity associated with conversion to value-based care models.

Billing and payment models for care are rarely part of nursing education curricula at the undergraduate or graduate level; thus, when nurses are employed by primary care practices, there is a lack of understanding regarding the intersection of scope of practice and the ability to bill for services. Health care systems, including primary care, provide inconsistent, non-standardized education regarding billing and payment as part of orientation to practice or even as part of transition to leadership roles.

This article provides a brief overview of FFS billing processes for free-standing clinics in the United States, specifically selected billing codes commonly used by nurses, and the context in which nurses may bill in primary care practice. The systems of care are complex. Although this article

emphasizes free-standing clinic billing, it is important to note that variation occurs in different billing systems, such as those used for hospital-based, Rural Health Clinics, Federally Qualified Health Centers, Veteran's Affairs, Indian Health Service, military, and other governmental entities. Although some codes are more typically used in primary care, billing principles apply across ambulatory care practices. This article is not meant to provide the breadth of information needed to implement outpatient billing processes, but is intended to provide a basic understanding, inform, and add to the debate about billing opportunities within current and future reimbursement models.

Professional Payment in Ambulatory Care Settings

Outpatient care includes a wide array of services provided in the health care landscape, including clinician offices, hospital-based settings, ambulatory care surgery centers, skilled nursing facilities, hospice, post-acute settings, dialysis facilities, clinical laboratories, and homes. These services are classified utilizing the Healthcare Common Procedure Coding System (HCPCS) (Centers for Medicare and Medicaid Systems [CMS], 2023a). This system is large and complex, containing codes for over 8,000 distinct surgical and non-surgical services. HCPCS codes, are used in conjunction with Current Procedural Terminology (CPT) codes to further describe and

report medical procedures and select non-physician services, such as ambulance transport, durable medical equipment, drug injections, and other medical services (CMS, 2023b; Healy, 2019; Medpac, 2022). These codes have three levels.

- Level I codes are identical to the CPT code. This category includes many codes commonly billed by physicians, advanced practice providers, and others (Nurok & Gewertz, 2019).
- Level II codes include non-physician services, supplies, and treatments not included in CPT codes, such as ambulance transport, durable medical equipment, and drugs. In ambulatory care, these codes are used in conjunction with select Care Management Services.
- Level III codes are temporary codes often used with emerging technologies.

CMS works in conjunction with the American Medical Association (AMA) to update codes and calculate payments. Through the use of CPT codes, procedural language has been standardized, facilitating claims processing and providing a standard platform for quality review and research. In 2000, CPT codes were designated by the U.S. Department of Health and Human Services (HHS) as the national coding standard for physician and other health care professional services and procedures under the Health Insurance Portability and Accountability Act (AMA, 2021). This means electronic billing for all financial and administrative health care transactions must utilize CPT codes. Application of CPT codes is primarily intended to guide coding and billing for physicians and Qualified Health Providers (QHPs), including clinicians able to independently diagnose, treat, and bill. The CPT manual provides a comprehensive review of current coding guidelines. It describes instances in which non-QHPs, such as nurses or other clinical staff, can submit codes for payment, but the primary purpose of the manual is guidance for QHPs. There are limited billable codes available for use by non-QHPs.

Fee-for-Service Billing Context

In addition to the establishment of standard nomenclature and claims processing, CPT guidelines provide additional guidance for allowable billing practices. Evaluation and

Management (E/M) codes describe services provided in an outpatient or ambulatory care setting. The following definitions help provide a context for FFS billing under the E/M CPT codes:

- **QHP.** A QHP includes physicians and other professionals who, by training, license, certification, scope of practice, and facility privilege, can exercise independent medical decision-making, including diagnosis and treatment. In the ambulatory care setting, QHPs often include physicians, advanced practice registered nurses (APRNs), therapists, and physician assistants. Only QHPs are qualified to directly bill services.
- **Clinical or auxiliary staff.** Registered nurses (RNs), licensed practical nurses (LPNs), and other licensed and non-licensed staff fall under the broad category of clinical or auxiliary staff. An RN is not considered a QHP because their scope of practice does not permit independent medical diagnosis and treatment. Billing guidelines do not specify qualifications of clinical staff who can bill, only that they are “allowed by law, regulation, and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service” (AMA, 2021, p. 6). This article is primarily focused on RNs; however, it should be noted that there are no billing provisions specifically for RNs, only for clinical or auxiliary staff.
- **Scope of practice and billing.** Scope of practice and billing are not the same but are related. An RN or other licensed provider can perform a wide range of services for which they are competent and able to perform by law, regulation, or institutional policy, but they may be unable to bill for them because their scope does not allow independent diagnosis and treatment, or the service does not meet other billing requirements. All services are provided under the direction of and billed by a QHP. With differing state regulations, education, and institutional permissions, this opens the door for variation across states and practice settings.
- **Incident to services.** Section 1861(s)(2)(A) of the Social Security Act authorizes payment for services and supplies that are “of kinds which are commonly furnished in physician’s offices

and are commonly either rendered without charge or included in physicians' bills" (Social Security Administration, n.d.). These are often called "incident-to" services.

Turner (2016) describes additional requirements to bill incident to a QHP, including that the service must be:

- Furnished in a non-institutional setting.
- An integral, though incidental, part of the service provided by the QHP as part of diagnosis or treatment.
- Furnished under the direct supervision of a physician or other QHP.

Of note, incident to billing under a QHP does not occur in hospital-based outpatient departments. These settings utilize similar codes, but billing occurs under the facility rather than the QHP.

Evaluation and Management

In outpatient practice, care is billed under the category of E/M services. CPT codes are selected based on the number and complexity of problems addressed at a visit, required medical decision-making, or the total time required for the service. In addition, CPT makes a distinction of billing for *new* or *established* patients. This is important to keep in mind because these definitions impact nurse billing.

- **New patient.** A new patient is "one who has not received any professional services from the physician or QHP, of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years" (AMA, 2021, p. 6).
- **Established patient.** An established patient is "one who has received professional services from the physician/QHP of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years" (AMA, 2021, p. 6).

There are five levels of medical decision-making identified in the CPT guidelines that drive CPT code choice. They range from one code (99211) in which no medical decision-making is identified, to straightforward/minimal, low, moderate, and high. The code 99211 is the only E/M code that can be used by RNs because it does not require medical decision-making.

For nurses and other clinical staff to provide billable E/M services under a QHP, several requirements must be met including:

- The patient must be established with the practice. Nurses are not able to diagnose; therefore, they must refer to the established plan of care and diagnoses. Thus, E/M codes may not be used by clinical staff caring for new patients or new diagnoses.
- Services billed under CPT 99211 may be provided face to face or through telehealth visits. Leniency extended during the public health emergency (PHE) has allowed billing of virtual visits by clinical staff that would have normally been face to face. This leniency has been extended through the end of 2024 (CMS, 2023a). Permanent rule change is unclear.
- Level of supervision must be appropriate for the code and the type of outpatient setting. For example, in a free-standing practice, the RN providing services to be billed under the 99211 CPT code must have direct supervision. This type of supervision requires physical presence and ready accessibility of a QHP. During the PHE, leniency was granted, which allowed virtual supervision. Virtual supervision still requires a readily accessible QHP; however, access to the QHP can be provided through telehealth. CMS has clarified they will return to the direct supervision requirement at the end of 2023 (CMS, 2023a).
- Services billed under the umbrella of Care Management Services, specialized types of E/M codes, can be provided through telehealth and require only general supervision. General supervision requires that clinical staff consult regularly with the billing provider regarding patient status, but physical presence during the care is not required. Examples of this include chronic care management (CCM), principal care management (PCM), and collaborative care management (CoCM). These are time-based codes. There are additional behavioral health integration (BHI) codes that can be used by team members.
- Multiple E/M codes cannot be billed on the same day; thus, if an RN provides a service on the same day as a QHP who bills an E/M code, the nurse is not able to bill for additional

services even if they are provided. It is possible to bill other non-E/M services provided by clinical staff on the same day, such as immunizations, screenings, or other procedures. These are billed under different types of codes.

- Documentation must support the need for the encounter, the services provided, and any other specific code requirements.
- Clinical staff must have the education and competence to provide the service.

CPT E/M codes underwent major change in 2021. This revision focuses less on the components of the history and physical examination, and relies on either time spent in or preparing for/following up on the visit or the required level of medical decision-making (Tenpas & Dietrich, 2022). New codes were added, and some related to telehealth, remote patient monitoring, and applications of artificial intelligence, such as use of ChatGPT to assist with medical diagnosis, are being considered as a CPT. While changes were made to many CPT codes, the most frequently billed E/M code used by nurses and other non-QHP's, 99211, was left untouched. This code is rarely used by QHPs; thus, it was likely not a focus for the E/M updates.

Payment

In 1991, the Relative Value Scale Update Committee (RUC) was created by the AMA to make recommendations about the economic value for medical care. These recommendations are based on an estimate of the cost of providing a service and a combination of the physician's (or QHP's) work, practice expenses, and professional liability. They are called Relative Value Units (RVUs). CMS adjusts the RVUs to account for geographic variation in cost and other factors (HHS, 2022b). The physician's or QHP's work accounts for roughly 50% of the RVU reimbursement value, with the other 50% from practice expenses and professional liability. RVUs are reviewed every five years at a minimum. Although not part of the RUC's initial intention, RVUs are often used to measure physician productivity and set compensation (Nurok & Gewertz, 2019). The RVU assigned to CPT code 99211 is very low because the medical decision making ('QHP

work') is expected to be minimal – approximately 5 minutes or less. Since 50% of the RVU reimbursement is derived from medical decision-making or time, the reimbursement is much lower for 99211 than other CPT codes that require higher levels of decision-making. CMS sets a provider fee schedule through a complex formula that considers factors, such as RVUs, geography, and the service provider's credentials, to set reimbursement.

Codes Commonly Billed by RNs and Other Clinical Staff in Primary Care

This section provides examples of CPT and/or HCPCS codes commonly billed by nurses in primary care. Again, please note, this article is not intended to advise on billing but to provide an overview of commonly used codes and general rules surrounding their use.

CPT Code 99211

The code 99211 is the only E/M CPT code that allows RNs and clinical staff to bill for direct services without the presence of a QHP. This code is defined 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" (AMA, 2021, p. 19). Even though a physical presence is not required, there is still a requirement for direct supervision; thus, a billable provider must always be accessible. This code was developed for use when presenting problems of patients are minimal, requiring 5 minutes or less of medical care or QHP supervision. This code is considered "not applicable" with respect to medical decision-making. It should not be used for new patients or problems. The estimated physician time for this code is extremely low; thus, the economic value, as established by the RVU, is also low. Recall that CPT codes were developed to reflect the time required by the physician, and do not reflect time spent by the RN or clinical staff. Even though license, skills, and abilities allow an RN to safely provide a service, they may not be able to bill for it unless all billing requirements are met. Thus, the service can be provided but not billed. An example of this would be a telephone triage RN utilizing a protocol for treatment of urinary tract infection in women. The institution may have an

approved protocol, the RN competency established, and the state Board of Nursing sanctions use of protocols. However, billing cannot occur because a) it is not in-person, and b) it is a new problem.

Minor Procedures

Minor procedures that occur either as part of a QHP visit or at a separate nurse visit are billed through procedural codes rather than the 99211 E/M code. If they occur at a time separate from the QHP visit, evidence that the service is part of the plan of care should be present in the health record. Examples of these services include injections, ear wash, and catheterization.

Care Management Services

Care management services were developed to provide additional support for complex patients receiving care in both primary and specialty services. These services are under the broad umbrella of E/M codes, and were developed to improve care quality and safety for patients with chronic conditions (AMA, 2021). Care management services are provided outside of an in-person visit by clinical staff under the general direction of a QHP. Services are provided to patients residing at home or other residential locations, excluding institutional settings, such as skilled nursing facilities. They commonly include communication, coordination of care with community or other specialty care, assessment, education, counseling, brief intervention, management of care transitions, and development, evaluation, and review of a comprehensive plan of care. There are specific requirements for each code set, but in general, all care management services must meet the following conditions:

- Patients must have diagnosed chronic condition(s) expected to last for a significant time (varies between code types) or the lifespan of the patient, and put the patient at risk of further health issues if not well managed.
- Only general supervision by the QHP is required.
- The patient must have an initiating visit if they are new to the practice or have not been seen by the billing practitioner within one year.

- The patient must consent to the service.
- Billing codes are time-based, and billing occurs monthly.
- Additional regulations regarding concurrent billing and documentation apply.

Chronic Care Management (CCM)

CCM services are intended for patients who have multiple serious chronic conditions (HHS, 2022a).

- To bill these codes, patients must have two or more chronic conditions expected to last at least 12 months or the lifespan of the patient. These chronic conditions place the patient at significant risk of death due to exacerbation or worsening of symptoms.
- Service time must span at least 20 minutes; additional billing options are available for longer service times.
- CPT codes typically used by clinical staff include 99487, 99489, and 99490. Other codes are available to billing providers.
- Requirements are extensive to bill these codes, including availability of:
 - Comprehensive electronic care plans.
 - Managing transitions of care.
 - 24/7 access to care and information.
 - Preventive care.
 - Comprehensive care management and coordination.
 - Engagement with patients and caregivers.

Principal Care Management (PCM)

PCM services are intended for patients with a single chronic condition or when services are focused on one high-risk condition (HHS, 2022a). They are often billed in specialty ambulatory care services.

- PCM services may be expected to last 3 months to one year or until the patient's death.
- At least 30 minutes of service must be provided before billing.
- CPT codes commonly used include 99426, 99427, and 99439.

Behavioral Health Integration (BHI)

BHI services are intended for patients who continue to be treated by their primary provider,

but their behavioral health diagnosis would benefit from a team approach (HHS, 2023a).

- Psychiatric CoCM services are provided under the BHI umbrella and provide support for patients receiving behavioral health treatment.
- The patient must have a qualifying behavioral health diagnosis.
- CPT codes commonly used include 99492, 99493, 99494, HCPCS code G2214.
- Services are provided by a treatment team consisting of the primary care provider (or other primary treating practitioner), behavioral health care manager, and a supervising psychiatrist.
- Behavioral health care managers must have specialized training (can be an RN).
- Regular psychiatric inter-specialty consultation is required.
- Billing occurs under the treating practitioner.

Transitional Care Management

Transitional care management (TCM) services were implemented to address concerns that arise during transitions of care and prevent unnecessary readmission (HHS, 2022c). TCM services may be provided to new or established patients transitioning from the following settings: inpatient (acute, rehabilitation, long-term acute), partial hospitalization, hospital-based observation, or skilled nursing facility to a community residence, such as their home, an assisted living facility, or group home. To qualify for this service, patients must have medical and/or psychosocial problems that require moderate or high complexity decision-making as determined by the QHP. TCM services require:

- Initial contact (or at least two attempts at contact) with patient or caregiver within two business days of discharge. The purpose of this contact is to ensure the patient and/or caregivers understand and can manage their plan of care at home, that appropriate resources are available, and how to access additional care, if needed. Clinical staff often perform this portion of the TCM service.
- Contact can be made through telephone or web-based outreach.
- Reasonable services based on patient needs, such as education, referrals, clarification of

medications, and treatment plan, must be provided.

- TCM must include an in-person visit by a QHP, within established timeframes based on medical and psychosocial complexity.
- To bill TCM, both the contact and the in-person visit must be provided within appropriate timeframes.
- CPT codes include 99495 for moderate complexity decision-making and 99496 for high complexity decision-making as determined by the QHP. These codes are billed by the QHP.
- CMS maintains a list of other codes that can be billed concurrently with TCM.
- TCM is not billable if the patient is within a global surgery payment period.

Initial Preventive Physical Examination (IPPE)

Medicare beneficiaries qualify for this visit if they have Medicare Part B coverage and are within their first year of Medicare eligibility. This visit type is often referred to as the “Welcome to Medicare Preventive Visit.” The goals of this visit are health promotion and disease prevention and detection (HHS, 2023b). This visit includes a review of the medical and social history, use of standardized assessment tools to identify risk factors, review of the patient’s functional ability and level of safety, select physical examination elements, and end-of-life planning. It culminates in a review of findings, education and counseling, and potential referral for additional services. Although this visit cannot be billed by RNs without a face-to-face component from the QHP, many elements of the assessment can be performed by RNs, with a QHP reviewing the information and developing the plan of care with the patient. To qualify:

- Patients must be in their first year of Medicare eligibility.
- Patients must have Part B coverage.
- Codes billed include:
- G0402 – new Medicare beneficiary in first 12 months
- G0403, G0404, G0405 – billed if EKG is included as part of the screening
- An additional E/M code can be billed on the same day, if the patient’s condition indicates a need using a Modifier 25.

Annual Wellness Visit (AWV) – Initial and Subsequent

Medicare beneficiaries qualify for an AWV if they have Medicare Part B coverage and either have not received an IPPE or AWV within the past 12 months (HHS, 2023b). Required elements for this visit are like those required by the IPPE; however, this visit can be completely performed by clinical staff and billed incident to a QHP. Clinical staff must perform this visit face to face. The initial and subsequent AWV have slightly different required elements, but in general, include performing a health risk assessment, updating history, updating provider and supply lists, cognitive screening, reviewing/updating preventive services, lifestyle education and counseling, review of risk factors, advance care planning, assessing mental health and substance use, and providing referrals or counseling, if needed. Patients may be confused about the purpose of the AWV and how it differs from a physical examination, or a visit related to chronic or acute conditions. This visit is focused on prevention; however, if the patient needs a chronic or acute condition visit, it can be provided on the same day.

- There must be a 12-month interval between AWV services.
- Codes billed include G0438 for initial AWV and G0439 for subsequent AWVs.
- If an additional visit is needed, it can be provided on the same day with the addition of a Modifier 25.

Discussion

Information about billing and payment systems currently available to nurses in primary care, with some applications to specialty practice. Billing information provides foundational knowledge about the current FFS model that continues to be the principal source of primary care reimbursement. The current FFS system continues to focus on acute episodic care with inadequate support for health education, chronic condition education, and care coordination without demonstrating value-based performance and quality outcome improvement.

Primary care is the backbone of an increasingly fragmented health care system. Traditional FFS models have not delivered on patient-centered, high-quality outcomes, but rather, reward acute, episodic, and specialty care. Although more advanced practice providers are graduating, their practice options have expanded significantly beyond primary care. Looming physician shortages and fewer medical residents are choosing primary care specialties, contributing to access problems, particularly for patients with lower reimbursing health plans or no insurance. Without significant change, the current FFS model in primary care will not be able to deliver the access and quality outcomes needed.

Care management services have been a welcome addition; however, these codes have complex tracking requirements. Software solutions are not yet available to make billing simple. RNs and other team members perform most of the chronic care services, but with the “incident-to” model, their significant contributions to access, quality, and value remain invisible. As the country moves toward value-based models, without an opportunity to directly quantify both the contributions and outcomes of RNs in primary care, it is likely their contributions will continue to be invisible to payers, health care system leaders, providers, and patients. As is the case in inpatient care, primary care RNs will be considered a labor expense rather than recognized and rewarded for their contributions toward health, wellness, and CCM, and the revenue they generate.

There are monumental barriers to overcome for RNs to be able to move to direct billing. However, opportunities could be adopted to better position RNs. For example, a common language of billable services is needed. Recall that AMA built CPT codes to enable a common platform and language that could be used for billing, quality, and research. This is exactly what nursing needs. The AMA is not going to build this system, nor should it. Development of ‘nursing CPT codes’ and working on systems to implement standard language within the electronic health record will illuminate RN contributions to quality and outcomes. Nursing needs to do this.

Second, adoption and use of National Provider Indicator (NPI/NURSYS) will be key to connecting

services provided by individual RNs to billing and payment. These two critical moves would help build the foundation needed to describe and document RN contributions. While advocacy for change requires significant work by many people and on many fronts, positioning nursing to bill directly is within our reach. \$

Stephanie G. Witwer, Ph.D., RN, NEA-BC, FAAN

Emeritus Nurse Administrator
Mayo Clinic
Rochester, MN
President-Elect
American Academy of Ambulatory Care Nursing

Angela Mattson, DNP, RN, NE-BC

Nurse Administrator
Primary Care, Department of Nursing
Mayo Clinic
Rochester, MN

Anne T. Jessie, DNP, RN

Nurse Consultant
Fenix Health Care Population Health

NOTE: The “Perspectives in Ambulatory Care” column makes sense of today’s changing ambulatory care market. It is written by members of the American Academy of Ambulatory Care Nursing (AAACN) and edited by Mary Jo Vetter, DNP, RN, AGPCNP-BC, FAANP. For more information about AAACN, please visit www.aaacn.org; email aaacn@aaacn.org; or call (800) AMB-NURS.

References

- American Medical Association. (2021). *CPT 2021 professional edition*. Author.
- Centers for Medicare & Medicaid Services. (2023a). *HCPCS coding questions*. https://www.cms.gov/medicare/coding/medhcpcsgeninfo/hcpcs_coding_questions
- Centers for Medicare & Medicaid Services. (2023b). *Physicians and other clinicians: CMS flexibilities to fight COVID-19*. <https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf>
- Healy, H. (2019). Health care fiscal management. In C.B. Laughlin, & S.G. Witwer (Eds.). *Core curriculum for ambulatory care nursing* (4th ed., pp. 57-69). American Academy of Ambulatory Care Nursing.
- Medical Group Management Association. (2022). *Data report: Patient access and value-based outcomes amid the great attrition*. <https://www.mgma.com/data/landing-pages/2022-mgma-data-divide-practice-ops-report>
- Medpac. (2022). *Physician and other health professional payment system*. https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_physician_final_sec.pdf
- Nurok, M., & Gewertz, B. (2019). Relative value units and the measurement of physician performance. *JAMA*, 322(12), 1139-1140. <https://doi.org/10.1001/jama.2019.11163>
- Social Security Administration. (n.d.). *Social Security Act §1861*. https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
- Tenpas, A., & Dietrich, E. (2022). Simplifying medical decision-making for pharmacists. *Research in Social and Administrative Pharmacy*, 18(6), 3072-3075. <https://doi.org/10.1016/j.sapharm.2021.07.026>
- Turner, S. (2016). Medicare issues clarifications to “incident to” billing rules. *Geriatric Nursing*, 37(1), 63-64. <https://doi.org/10.1016/j.gerinurse.2015.12.007>
- U.S. Department of Health & Human Services (2022a). *Chronic care management services*. <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf>
- U.S. Department of Health & Human Services. (2022b). *How to use the MPFS look-up tool*. <https://www.cms.gov/files/document/physician-fee-schedule-guide.pdf>
- U.S. Department of Health & Human Services. (2022c). *Transitional care management services*. <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf>
- U.S. Department of Health & Human Services. (2023a). *Behavioral health integration services*. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegrationPrint-Friendly.pdf>
- U.S. Department of Health & Human Services. (2023b). *Medicare wellness visits*. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNProducts/preventive-services/medicare-wellness-visits.html>
-