Strategy 24

Promote RN billing in primary care

Strategy 24.1 The North Carolina Area Health Education Centers (NC AHEC) should develop and disseminate a course related to inclusion of RNs on primary care practice care teams, with information about scope of practice, patient outcomes, and revenue generation.

Desired Result

More primary care practices in North Carolina will employ the services of registered nurses (RNs) to provide care that is within their standard scope of practice and billable to insurance payers.

Why does the task force recommend this strategy?

Integrating RNs into more primary care settings can improve access to care and care quality for patients. Barriers to increasing the use of nursing services in primary care may include a lack of awareness of RN scope of practice and related opportunities to bill for services. The task force seeks to encourage primary care practices to capitalize on the full scope of practice that RNs are capable of providing. In addition, billing for RN services can generate additional revenue for their practice. This financial compensation recognizes RNs' expertise and contributions and elevates the status of nursing within the health care team. NC AHEC is a natural partner in this work as it currently engages in a variety of practice supports.

Role of RNs in Primary Care

"BSN-RNs represent an untapped resource in primary care, and the holistic approach that nursing practice provides can contribute to improved patient outcomes. For example, BSN-RNs use critical clinical judgement skills to help the medical team address patient-centered health goals, identify and address social determinants of health, ameliorate health literacy issues, and support the medical treatment plan. In addition, they perform patient education, population health data analytics, telephone triage, quality improvement, patient coaching, care coordination, and advocacy to support client self-management and care management. One of the most valuable ways in which the role can support practice viability and outcomes is through Medicare Annual Wellness Visits, which are within the RN scope of practice. BSN-RNs also contribute to behavioral health integration using health assessments and other interventions, and they serve as leaders to promote teamwork and collaboration via relational and communication skills that guide the team in coordinated care delivery."

-Dolansky MA & Livsey KR. Preparing RNs for emerging roles in primary care. American Nurse Journal. October 2021. https://www.myamericannurse.com/wp-content/uploads/2021/10/an10-Primary-Care-4-924.pdf

Context

Fee-for-service is the primary payment mechanism for primary care practices, with only 6.7% of total revenue in primary care practices coming from value-based contracts in 2021.[57] Much of the payment for services is centered on care provided by a physician or other qualified health provider (QHP) who can independently diagnose, treat, and bill. For purposes of billing, RNs, LPNs, and other licensed and non-licensed staff are considered clinical or auxiliary staff.[57] Under this model, licensed nurses have not been specifically identified as qualified providers of services, and instead are considered support staff. There are a variety of opportunities for ambulatory practices to bill for services that fall within the independent scope of practice for RNs.

A Business Case for RNs in Primary Care

"An expanded role for RNs in primary care may require more RN staff. The business case question is whether the additional costs of staffing can be offset either with higher revenues or cost reductions in other areas. The answer to these questions will differ depending on whether the practice is operating under a FFS revenue model, a capitated model, or other value-based purchasing model. Practices increasingly operate under multiple models of payment and may tailor services provided depending on the financial incentives. For example, they may offer case management services to all patients, but aggressively promote these for patients seen under risk contracts. Similarly, they may focus hospital transition services intended to reduce readmissions on patients under capitation or shared savings contracts such as ACO agreements."

Source: Preparing Registered Nurses for Enhanced Roles in Primary Care - Expanding The Role Of Registered Nurses In Primary Care: A Business Case Analysis. Jack Needleman, PhD. June 2016. Pages 113-139. https://macyfoundation.org/assets/reports/publications/macy_monograph_nurses_2016_webpdf.pdf

BASICS OF BILLING IN PRIMARY CARE

There are detailed specifications for how services are billed in primary care and who can bill for different types of services.[d] Some basics of these billing details include:

- Healthcare Common Procedure Coding System (HCPCS) codes are used in conjunction with Current Procedural Terminology (CPT) codes to describe and report medical procedures and some other medical services.
- Evaluation and Management (E/M) codes are used to bill for services in outpatient or ambulatory care settings.
- Coding based on number and complexity of patient issues assessed during a visit, medical decision-making, or total time required for the service.
- Distinctions are made between new and established patients.
- There are requirements that must be met for nurses and other clinical staff to provide billable E/M services.[57]

[d] *For a useful resource about billing specifications, access: Witwer SG, Mattson A, Jessie AT. Registered Nurse Billing in Primary Care. Nursing Economics. July/August 2023. 41(4):200-207. https://www.aaacn.org/sites/default/files/documents/RNBilling.pdf*

EXAMPLES OF BILLABLE NURSING SERVICES IN PRIMARY CARE

CPT and/or HCPCS codes commonly billed by nurses in primary care include:[57]

- **Code 99211** – The only CPT code "that allows RNs and clinical staff to bill for direct services without the presence of a QHP" and can be used for evaluation or management of established patients; this code includes a requirement for assessment, which would be appropriate for an RN but not for other non-licensed staff. Practices should consult CMS guidance on requirements for billing under this code.
- **Minor Procedures** – Procedural codes can be used for minor procedures like injections, ear washes, and catheterizations that "occur either as part of a QHP visit or at a separate nurse visit".
- **Care Management Services** – These services can 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". Because of the holistic approach and broad education that nurses possess, they are well suited to lead care management teams to support patients between clinic visits.
- **Chronic Care Management** – Clinical staff may use CPT code 99487, 99489, or 99490 to bill for services related to care for patients with "two or more chronic conditions expected to last at least 12 months or the lifespan of the patient".
- **Principal Care Management** – Clinical staff may use CPT code 99426, 99427, or 99439 for services lasting at least 30 minutes that are "for patients with a single chronic condition or when services are focused on one high-risk condition".
- **Behavioral Health Integration** – Clinical staff may use CPT code 99492, 99493, 99494, or HCPCS code G2214 when providing services "for patients who continue to be treated by their primary provider, but their behavioral health diagnosis would benefit from a team approach".
- **Transitional Care Management** – Clinical staff may use CPT code 99495 or 99496 (depending on the complexity of service) to help address issues around transitions of care and prevention of unnecessary readmission.
- **Initial Preventive Physical Examination** – Clinical staff may use code G0402, G0403, G0404, or G0405 for the "Welcome to Medicare Preventive Visit"; visits "cannot be billed by RNs without a face-to-face component from the QHP".
- **Annual Wellness Visit** – Clinical staff may use codes G0438 or G0439 for the Medicare beneficiary wellness visits. Other than ordering of medical tests, the screening and education included in these visits fall within the scope of the RN's practice.

Cost-Effectiveness of RN-Led Annual Wellness Visits

With the exception of ordering tests or specialty referrals, the assessment, patient education, and development of a health promotion plan involved in an Annual Wellness Visit (AWV) all fall within the licensed scope of an RN. Under current Medicare rules, all billing is submitted incident to the provider.

For each AWV completed (and correctly billed), the practice is reimbursed roughly $227 per visit. Based on 28 AWVs completed each month, a practice would receive around $6,356 in reimbursement with a net additional revenue of $5,222 per month after RN costs:

- **Estimated RN time spent (including pre-visit planning) of 1.5 hours per AWV**
- **Estimated RN salary of $27 per hour**
- **RN costs for AWVs = $1,134 per month**

Effort cost for a physician to conduct an AWV is substantially higher, thus reducing net revenue gained. Additionally, RN-led AWVs can provide enhanced access for walk-in or other appointments by eliminating the provider time that would be spent for a 40- to 60-minute AWV.

Medical providers at rural health clinics and federally qualified health centers are required to have some time spent in a face-to-face encounter with the patient due to billing rules.

Source: Personal communication with task force member.

KEY RESOURCE NEEDS

NC AHEC and its affiliated program sites will need financial resources to expand programming around practice supports for primary care.

Nursing students would benefit from more preparation to serve in primary care settings. In addition, nurses need better education about billing and payment models in primary care and other settings to effectively advocate and educate about the value they can bring to these settings.

Trade associations serving physicians and administrators in primary care settings can help to advocate for opportunities to integrate nurses into private practice and connect providers to AHEC supports.