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Eli's Rehab Report

Optimize Reimbursement for Nurse-only Visits

Nugget: Practices can schedule, bill and expect reimbursement for nurse-only visits, even though they are for minor services and last for only five minutes.

Following our article on billing for incident-to services, several subscribers asked whether their practices could schedule evaluations between the nurse and a patient for routine follow-up visits or other minor services. The answer is yes. Usually, the most accurate way to bill for a nurse-only (RN or LPN) visit is to use evaluation and management (E/M) code 99211 (office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician).

The Typical Five-minute Nurses E/M

Typically, for a nurse-only visit, the presenting problems are minimal, and the normal visit time is five minutes, says **Mary Mulholland, BSN, RN, CPC**, reimbursement analyst in the department of medicine at the Hospital of the University of Pennsylvania in Philadelphia. The time spent with the patient may vary with the needs of the patient.

The nurse might render any range of services, including, but not limited to, vital sign checks, uncomplicated suture removal, dressings changes, diet instructions, or review of self-medication administration, including a discussion of possible medication side effects, says Mulholland. In a physical medicine practice, where patients with conditions such as multiple sclerosis (340) or a pinched nerve (**ICD-9 355.9**) may be in pain and have limited range of motion and diminished strength, the nurse might review energy conservation methods to perform activities of daily living.

Until recently, we had a nurse on staff, and we billed the 99211 incident-to any time the nurse saw a patient for an E/M visit, says **Terri Cronise**, office supervisor at Physical Medicine Specialists, a three-physician physical medicine and rehabilitation (PM&R) practice in Hagerstown, Md. Our nurse did the usual services like blood pressure checks, but she also did a lot of patient education on things like teaching patients about the side effects of medications and giving them exercises that might help improve their conditions or keep them more comfortable. She was a pain management nurse, so she would actually do some follow-ups for injections. For example, if our doctors performed a lumbar epidural (62282), the nurse often would do the follow-up to make sure there were no adverse effects, and for that we would bill the 99211.

Of course, if the doctor directed the nurse to administer an injection, we normally wouldnt bill the 99211, says Cronise. For that, we would bill the correct injection administration code, (usually 20550, 20600, 20605 or 20610) with the J code for the medication.

When the Nurse Notices a Change In Condition

Mulholland says that the 99211 shouldnt extend too far beyond the suggested five minutes. She explains, There are no prolonged service codes or modifiers for extra time for the 99211 because anything that takes much longer than the normal five minutes is more complex than a registered nurse should be performing.

If, for example, a fibromyalgia (729.1) patient meets with the nurse to discuss how she is handling a new pain medication but, during the course of the visit, the nurse discovers that the patients blood pressure has risen dramatically, the nurse should bring in the doctor. When the nurse, in the course of evaluating the patient, discovers an abnormality, a new problem or an exacerbation of an existing problem, he or she must notify the supervising physician, says Mulholland. Its not within the nurses scope of practice to prescribe a medication or give the patient an injection that hasnt been ordered by the physician.
As soon as the nurse alerts the physician to the patients new symptoms, the physician most likely will want to see the

patient right away. If the physician subsequently provides an E/M service for this patient on the same date of service, only the physicians service would be reported, says Mulholland. The claim form must contain the medical necessity for the physicians services as demonstrated by the use of the appropriate ICD-9 diagnosis. No modifiers are necessary, as the ICD-9 codes will identify the conditions treated during the visit.

For example, the doctor would report the visit with the fibromyalgia patient described above by using an established patient E/M code (99212-99215) with the diagnosis codes for fibromyalgia (729.1) and high blood pressure (796.2, elevated blood pressure reading without diagnosis of hypertension). The 99211 would not be billed.

Incident-to Guidelines Apply

Nurses who bill 99211 should follow the incident-to guidelines set forth by the patients insurance carrier. Medicare specifies that practices billing incident-to must meet their requirements, which state that the physician must be on-site at the time of treatment, the physician must have originally seen the patient for the first visit to the office or clinic, and the physician must see the practices established patients for any new medical problems. (See the March Physical Medicine & Rehab Coding Alert, Correctly Bill for Incident To and Optimize pay Up on page 19.)

When billing the 99211, the nurse should document the date of the visit, a brief description of the reason for the visit, and the services provided, says Mulholland. The name of the supervising physician also needs to be identified in the notes. Something like, April 5, patient came in for blood pressure check to ensure hes doing OK on his new pain medication. Performed review of systems; no adverse effects found. Dr. Jones on-site. That way, if an auditor checked, they would know the physician was available to the nurse. In the absence of the declaration about the doctor being on-site, the physicians signature and date (and comments, as appropriate), also could justify the physicians supervision of the service.

Of course, the guidelines for billing 99211 apply to all services that may not require the presence of a physician, which include evaluations performed by physicians assistants (PA) and nurse practitioners, who also may bill incident-to the doctors services. The difference between a PA or nurse practitioner and an RN is that PAs and nurse practitioners have their own billing numbers, and therefore use the same guidelines as a physician, says Mulholland. RNs are not billing independently. The services the RN provides will depend on his or her scope of practice, and will vary on a state-to-state basis. Therefore, PAs or nurse practitioners can bill either using their own billing numbers, or incident-to the doctors services using the physicians billing number.