NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

[FACT SHEET]
July 2020

Billing for STI Express Services

Overview

The purpose of this fact sheet is to increase the capacity of clinics to bill for STI express services and other clinical services provided by registered nurses (RNs) and other clinical providers. Note that while this resource includes some general information regarding billing, it is intended for clinics that already bill for services and should not be used to support initial implementation. Moreover, while it provides guidance for billing information relevant to STI clinics, it is recommended that you review insurance plans specific to your state, as there is wide variation.

This resource was developed as part of NACCHO's STI Express Initiative,[1] which aims to explore and support the scale-up of STI express services. The initiative seeks to develop a better understanding of the role of express services for STI prevention and treatment and increasing clinic capacity to implement express services that are responsive to patient, clinic, and community needs. For more resources on STI express services, please visit NACCHO's STI Prevention webpage.

1. The STI Express Initiative is a NACCHO-led initiative funded by and in collaboration with the Centers for Disease Control and Prevention's Division of STD Prevention (CDC/DSTDP).

Billing Basics

Who can bill?

As determined by the Centers for Medicare and Medicaid Services (www.cms.gov), qualified providers (QPs) for the purpose of billing for outpatient clinical services include **doctors of medicine (MDs), doctors of osteopathic medicine (DOs), nurse practitioners, physician assistants, midwives, and some mental health specialists**. RNs are qualified by education and licensure to perform a wide variety of healthcare services including in STI clinics. However, for the purpose of billing, RNs are not considered QPs but rather Allied Health Providers (AHPs) whose services can be billed only under specific circumstances.

What are the types of billing?

- **Provider** (professional billing): QPs as previously defined can obtain a National Provider Number (NPI) and bill for the services they provide using their NPI number on the claim.
- **Clinic** (institutional billing): Health departments can also qualify to receive a separate clinic NPI number, which can be used by STI clinics to submit claims for the services provided by QPs in their institution.
- **Laboratory**: Laboratories bill for lab tests they perform.
- **Pharmacy**: Pharmacies bill for medications they dispense.

To maximize billing for RN services, health department STI clinics should use both **provider billing** and **clinic billing** as described below:

- ***When to use provider billing:*** Each state department of education has a professional nursing division which specifies the types of clinical and prevention

services that can be performed by RNs under non-patient specific orders (formerly referred to as standing orders). Non-patient specific orders are written orders that authorize RNs to provide specified services without a physician's or certified Advanced Practice Provider's (APP) direct involvement with the individual patient at the time of the interaction. Generally, services performed by RNs under non-patient specific orders are billable to Medicaid and other third-party payers. In this case, the RN services are billed using the NPI number of the "ordering provider," who is the MD or APP who signed the non-patient specific orders.

  - *Example:* In New York, STI clinics can use provider billing for the following services provided by RNs: immunizations, HIV testing, Hepatitis C testing, screening for gonorrhea, chlamydia and syphilis, opioid related overdose treatment, and anaphylaxis treatment.

  - *Note:* Non-patient specific orders for RNs vary state to state, so refer to your state's professional nursing division.

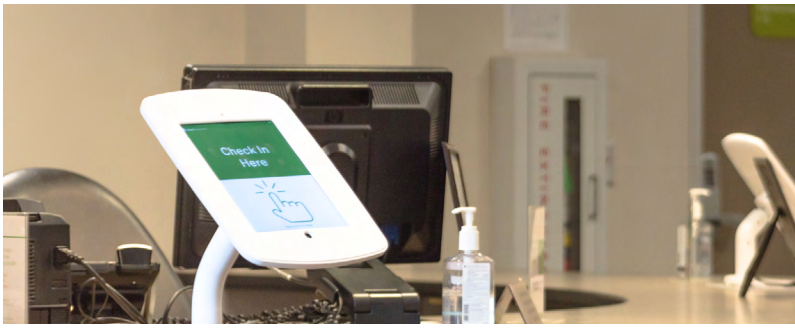
- ***When to use clinic billing:*** Except for RN services covered under non-patient specific orders, STI clinics generally use clinic billing. State Medicaid programs usually pay a significantly higher rate for visits and other services provided by a health department as opposed to other outpatient clinics or private medical practices. State Medicaid programs determine what will be covered under fee-for-service as well as managed care plans, so it is important that you communicate with the insurance plans specific to your state and patient population to understand coverage rates.

Billable Services in STI Clinics

STI clinical services may include a wide range of billable services, such as:

- Clinic visits, including express
- Preventive services
- Procedures such as injections or venipuncture
- Medications or immunizations administered
- Lab tests "sent out" (must be billed by laboratory performing tests)

RNs perform many of these services. The chart in Appendix A indicates which are billable.



E&M Visits and Billing for Express Services

Visits to STI clinics primarily entail Evaluation and Management (E&M) Services to address a specific reason for which a patient sought clinical care. The patient may have symptoms or desire a specific service such as STI/HIV testing. A selective history, physical exam, and testing occurs related to the reason for the visit, also known as the chief complaint. A patient may have several E&M visits with various types of providers in a year.

There are three different sets of guidelines in use for billing for E&M visits. Of these, STI clinics should use the 1997 Guidelines for a Single Organ System Exam consistent with August 2017 Documentation Guidelines for Evaluation and Management Services. This set of guidelines most closely aligns with the selective history and examination performed in STI clinics resulting in the use of higher-level E&M visit coding and reimbursement.

E&M visits are billed using two sets of Current Procedural Technology (CPT) billing codes based on patient type. Patients are identified as either **new** or **established**, depending on previous encounters with the provider/clinical practice.

- **New Patient:** An individual who did NOT receive any professional services from the physician/APP, or another physician of the same specialty who belongs to the same group practice, within the previous three years. CPT billing codes are 99201 – 99205, depending on complexity of the visit.

- **Established Patient:** An individual who received professional services from the physician/NPP, or another physician of the same specialty who belongs to the same group practice, within the previous three years. CPT billing codes are 99211 – 99215, depending on complexity of the visit.

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In general, a QP must see a patient in order to bill for an E&M visit with one exception: a visit by an established patient who is seen by an RN only for a minor problem or a follow-up. These visits, sometimes referred to as a "nurse visit," can be billed using the CPT code 99211, which applies to an office or other outpatient E&M visit of an established patient that may not require the presence of a QP. In these cases, problems are minimal, and typically 5-10 minutes are spent performing these services. See Appendix B for charts showing the CPT billing codes and documentation requirements for E&M visits for new and established patients.

Express visits, pre-exposure prophylaxis (PrEP) follow-up visits, and STI follow-up visits can be billed using code 99211.

Rules for Using Code 99211

1. Patient must be established (not new), which means seen at your clinic within the previous three years. Note that this may have implications for express eligibility.
2. Must be a face-to-face encounter. Telephone calls do not count.
3. E&M service must be provided:
    a) Selective history is reviewed ***OR***
    b) Limited physical assessment is performed ***OR***
    c) Procedure, tests, immunization, etc. is done ***AND***
    d) Some degree of decision making occurs (such as triage for express vs non-express visits)
4. Service must be separate from other services performed that same day.
    a) QP doesn't also see patient and bill another E&M code
5. Presence of a QP is not always required.
    a) The NPI of the QP is used to report 99211 on the claim, but it is intended for services rendered by non-qualified providers such as RN or other staff member
    b) For Medicare, there must be a QP in the office suite when each service is provided
    c) These visits generally are reported under the name and NPI number of the QP in the office suite when the service is provided
6. Documentation should include sufficient information to support the reason for the encounter and E&M visit, as well as any relevant history, physical assessment, and plan of care.

Note that state Medicaid fee-for-service programs may not pay an STI clinic for a 99211 visit, as some consider RN services provided as part of the enhanced rate paid to health departments. Some state health departments have negotiated with their state Medicaid programs to reimburse for 99211 nurse visits in STI clinics. Be sure to check with your state Medicaid office.

In addition to the E&M visit, the following tasks performed by RNs on site are billable, and CPT codes are added to the claim:

- Procedures (e.g., injection, venipuncture, finger stick)
- Medications and immunizations given
- Lab tests: All lab tests which are performed in-house in the STI clinic are billable and are added to the claim along with the E&M code for the visit. Clinical Laboratory Improvement Amendments (CLIA)-waived tests may be performed by RNs. On the claim, use Modifier U6 to indicate the test was performed in the clinic and Modifier 92 if a rapid kit was used. Tests which are 'sent-out' to a laboratory, whether public health or private, must be billed by the laboratory.

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Preventive Services

Preventive services (PS) in STI clinics include gonorrhea, chlamydia and syphilis testing, HIV and viral hepatitis screening, immunizations, risk assessment, sexual risk reduction counseling, and most recently HIV pre-exposure prophylaxis (PrEP). If performed by QPs, these PS can be billed in addition to the clinic visit using Modifiers 25 and 33 on the claim. The Affordable Care Act (ACA) passed in 2010 requires insurance plans to reimburse for preventive services with no co-pay or deductible applied.

Preventive services which are covered under non-patient specific orders can be performed by RNs and billed under the NPI number of the MD or APP who signed the orders.

The preventive services covered are those selected by the Center for Medicare and Medicaid Services based on United States Preventive Services Task Force (USPSTF) recommendations with Grade A or B ratings. For current USPSTF Recommendations for Preventive Services: Infectious Diseases, visit the USPSTF website.

Did You Know?

State health departments can play a role in advocating for RNs in STI clinics to be considered QPs and bill for the PS they provide. An ACA regulation (CMS –2334-F) provides a mechanism to expand the definition of QPs for billable PS to include non-clinicians such as RNs, health educators, case managers, etc. However, each state Medicaid Program has to determine which non-clinicians can be included. Be sure to refer to your state Medicaid Office for state-specific guidelines. Learn more by reading the federal policy guidance on Medicaid.gov.

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Appendix A

Billable Service Chart

RNs perform many of the services described in this document. This chart indicates which are billable.

RN Service	Billing Codes & Procedure
Express visit/Established patient	CPT 99211
STI follow-up visit	CPT 99211
PrEP follow-up visit	CPT 99211
Services provided under Non-Patient Specific Orders	Billed under NPI of MD or APP who signed the orders
Procedures	Billed on the same claim as the E&M visit
Medications, vaccines administered	Billed on the same claim as the E&M visit
Lab tests	CLIA-waived lab tests performed in the clinic billed on the same claim as the E&M visit

Case Example

STI Express Visit or a PrEP Follow-up Visit for an Established Patient

The patient completes an intake form and is routed to an express visit. The RN orders the routine series of STI/HIV testing and provides a risk assessment and risk reduction counseling, as well as a second Hepatitis A/Hepatitis B vaccination. The CPT and ICD-10 codes that are billable for the RN services provided include the following:

CPT (procedural codes indicating services provided)

99211 – E&M Visit (established patient) – Nurse visit with Modifier 25

96160 – Risk assessment

36415 – Venipuncture

86701 – HIV-1 test with Modifier 92 for use of rapid kit

86803 – Hepatitis C antibody test with Modifier 90 for use of rapid kit

90472 – Vaccine administration

90746 – Hepatitis B vaccine

99401 – STI risk reduction counseling or G0445

ICD-10 (diagnostic or life-style codes which justify the services provided)

Z11.4 – HIV screening

Z11.3 – Screening for STIs

Z11.8 – Screening for Chlamydia

Z72.51 – High risk heterosexual behavior ***OR***

Z72.52 – High risk homosexual behavior ***OR***

Z72.53 – High risk bisexual behavior

Z41.8 – Encounter for prophylactic treatment (if it is a PrEP follow-up visit)

Z23 – Encounter for immunization

86780 – Syphilis ELISA

87491 – Chlamydia NAAT

87591 – Gonorrhea NAAT

Billing Resources

- **CMS Website** – cms.gov
- **The Medicare Learning Network®** – cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index
- **NCSD STD TAC Billing Toolkit** – ncsddc.org/std-tac-billing-toolkit
- **STD TAC Billing & Coding FAQ** – stdtac.org/wp-content/uploads/2016/05/RN-Billing-FAQ_STDTAC-1.pdf
- **NACCHO Billing Toolkit** – toolbox.naccho.org/pages/index.html?v=4&id=243&topicname=Billing

Appendix B

The following charts show the CPT billing codes and documentation requirements for E&M visits for new and established patients. CPT codes for 99205 and 99215 visits are not shown as they are typically not provided in an STI clinic.

New Patient E&M Visit

Patient *has not* had face-to-face service by provider of same specialty within a group practice in the past three years.

Three of the three key components must meet or exceed the stated requirements to qualify for a particular level of services.				
CPT Code	**99201 Problem Focused**	**99202 Expanded Problem Focused**	**99203 Detailed**	**99204 Comprehensive**
Chief Complaint	Required	Required	Required	Required
1. History	1-3 HPI	1-3 HPI 1 problem pertinent (PP) ROS	4 HPI 1 PP ROS & 2-9 ROS 1 PP PFSH	4 HPI 1 PP ROS & 10+ ROS 2-3 PFSH
2. Exam - Single Organ System	1-5 bulleted elements	6 bulleted elements	12 bulleted elements	All bulleted elements
3. Medical Decision Making	Straightforward	Straightforward	Low	Moderate
Time (minutes)	10	20	30	45

HPI = History of Present Illness PP = Problem Pertinent ROS = Review of Symptons PFSH = Past, Family, and/or Social History

For examples of bulleted items for E&M visits, please see the 1997 Documentation Guidelines for E&M Services at CMS.gov.

Established Patient Office Visit

Patient *has* received services from a provider of the same specialty within the same practice in the past three years.

Two of the three key components must meet or exceed the stated requirements to qualify for a particular level of services.				
CPT Code	**99211***	**99212 Problem Focused**	**99203 Expanded Problem Focused**	**99204 Detailed**
Chief Complaint	Required	Required	Required	Required
1. History	Minor problem or follow-up visit. Patient may not see a Qualified Provider. *Nurse visit	1-3 HPI	1 problem pertinent (PP) ROS	4 HPI 1 PP ROS & 2-9 ROS 1 PP PFSH
2. Exam - Single Organ System		1-5 bulleted elements	6 bulleted elements	12 bulleted elements
3. Medical Decision Making		Straightforward	Low	Moderate
Time (minutes)	5	10	15	25

Billing by Time as the Controlling Factor

When counseling and coordinating care comprise more than 50% of the face to face time spent with the patient and/or family, time can be used as the key controlling factor in determining the level of E&M service billed. This is an option for STI clinics as many visits require additional time for counseling and care coordination (i.e. HIV post-test counseling and linkage to care for a newly diagnosed patient). Both the extent of counseling and coordination of care and the total length of the visit must be documented in the medical record including the following statement: *"I spent ___ minutes with this patient; greater than 50% of this ____ minute visit was spent in counseling and coordinating care of _____."* In this case, the provider uses the E&M CPT code that corresponds to the time spent, and does not meet the required history, exam, and medical decision making elements.