99211: The little code with big headaches

CMS has reported E/M prepayment audits revealed a slew of errors and abuse of **99211**. At the bare minimum, you need the date, the service provided and the signature of the nurse or other provider. It's good also for you to note the patient's vital signs and the reason they presented to you, even though this code is not based on time or levels of history, medical decision-making and exam.

Caution: You can't check vital signs such as blood pressure or temperature across the board on patients who come in for a blood draw or other minor service, just so you can bill 99211. CMS warns you must document the medical necessity for the check. Example: You may use 99211 for a blood pressure check, but there must be a doctor's order that this must be done. You must have a need for doing it. A diagnosis is needed. The nurse should say 'as per doctor's order' the blood pressure was checked.
Injections and vaccinations also cause trouble. Do not bill a 99211 if a patient visits the office solely to receive a flu or other shot. If you follow the guideline that says you report the (CPT code) service that most closely represents what you've done, then injections should be coded with the vaccine and administration codes – not 99211.

Another point of contention: Which providers *should* use 99211? Not your physicians, or else you're taking money out of your own pocket. It's not that physicians can't use 99211, but since the code descriptor says services provided may not require physician presence, the lowest level a physician typically should bill is a **99212**.

Caution #2: Some carriers won't pay for 99211 unless a physician performs the services. Even if your carrier does allow a nurse to perform the services, make sure you follow the "incident to" rules. In basic terms, that means although a physician does not need to be in the exam room, he must be somewhere in the office suite before a nurse billing under the physician's number may perform services coded 99211.

Although the code says "may not require the presence of a physician," it does not say it *doesn't* require the presence of a patient. A nurse or physician is supposed to have face-to-face contact with the patient, but there have been problems with practices billing 99211 for phone orders. So, here's a quick list of times when you should not code 99211:

- Doctor gives patient orders over the phone.
- Doctor calls in prescription refill to the pharmacy.
- Staff calls patient to reschedule a procedure.
- Staff faxes medical records to a hospital.
- Staff records lab results in a patient's chart and/or calls to inform patient of lab results.

Medicare Part B

"Incident To" Clarification for Evaluation and Management Code CPT 99211

This article from "Medicare B News," Issue 201 dated January 27, 2003 is being updated and reprinted to ensure that the Noridian Administrative Services provider and supplier community has access to recent publications that contain the most current, accurate and effective information available.

NAS continues to experience requests for the clarification of billing "incident to" office services for CPT 99211. Confusion is most often apparent related to recurring and regular injections, prescription refills, blood pressure monitoring, immunotherapy and anticoagulation monitoring visits.

CPT 99211 is an office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problem is minimal. Typically 5 minutes are spent performing or supervising these services.

Documentation is Very Important

The medical record must be adequately documented to reflect the reason for the patient's visit and any treatment rendered. There must be recorded elements of history obtained, examination performed and/or clinical decision making, as well as physician supervision. "Incident to" services only apply when there is supervision by a physician.

If the patient is not seen by the physician, all "incident to" provisions must be met in order for CPT 99211 to be billed. (See the Internet Only Manual (IOM) Medicare Benefit Policy Manual, Publication 100-02; Chapter 15, Sections 60-60.4 for a full description of the "incident to" provisions.)

If the sole purpose of a visit to the physician's office is to draw blood or receive an injection, then 99211 should not be billed and only the appropriate injection or blood drawing code should be billed.

Was There a Change in or Review of Treatment or Prescription?

Conversely, if the patient presents for a prescription refill, blood pressure monitoring, injection, immunotherapy or anticoagulation monitoring where there is a documented, medically necessary decision by the physician to change or maintain medication dosage, 99211 may be appropriate. In this case, the medical record must document that the history and/or exam required a decision and that the physician made the decision, even though the physician did not personally see the patient.

CPT 99211 should not be used for routine in-person prescription renewals unless the patient's condition requires reevaluation prior to the renewal determination.

The following are examples of when CPT 99211 might be used:

1. Office visit for an established patient for blood pressure check and medication monitoring and advice. History, blood pressure recording, medications, and advice are documented and the record establishes the necessity for the patient's visit.

2. Office visit for an established patient for return to work certificate and advice (if allowed by other than the physician). Exam and advice are noted and the Return to Work Certificate is completed, copied and placed in the record.

3. Office visit for an established patient on regular immunotherapy who developed wheezing, rash, and swollen arm after the last injection. Possible dose adjustments are discussed with the physician and injection is given. History, exam, dosage and follow up instructions are recorded.

4. Office visit for an established patient's periodic methotrexate injection. Lab tests are monitored, signs and symptoms are queried, vital signs are obtained, and injection is given with repeat testing and injection advised. All of this information is recorded and reviewed by the physician. (Note that in this circumstance, if 99211 is billed, the injection code is not separately billable).

5. Office visit for an established patient with a new or concerning bruise which is checked by the nurse (whether or not the patient is taking anticoagulants), and patient is advised on how to care for the bruise and what to be concerned about, and, if on anticoagulants, continuing or changing current dosage is advised. History, exam, dosage and instructions are recorded and reviewed by the physician.

6. Office visit for an established patient with atrial fibrillation who is taking anticoagulants and having no complaints. Patient is queried by the nurse, vital signs are obtained, patient is observed for bruises and other problems, prothrombin time is obtained, physician is advised of prothrombin time and medication dose, and medication is continued at present dose with follow up prothrombin time in one month recommended. History, vital signs, exam, prothrombin time, INR, dosage and physician's decision and follow up instructions are recorded.

In each of the above examples, the deciding factor in whether or not an independent E/M service may be billed is whether there were provided and documented medically necessary services, including clinical history, clinical exam and/or making a clinical decision, and physician supervision.

The following are examples of when CPT 99211 should not be used:

1. Office visit for an established patient with Pernicious Anemia who has no complaints and is given a monthly Vitamin B-12 injection.

2. Office visit for a normotensive established patient who presents solely to have a routine blood pressure check, which is recorded in the chart.

3. Office visit for an established patient with a previous stroke who comes to a coagulation clinic staffed by a lab technician or pharmacist. There is no physician in the facility at the time that the blood is drawn. Flow sheet records the date, prothrombin time, INR and Coumadin dosage. After results are available, they are sent to the patient's doctor, who contacts the patient by phone.

4. Office visit for an established patient with long standing allergic rhinitis who receives the monthly maintenance allergy injection. Patient is having no symptoms and the flow sheet lists the date, dilution strength, dosage and instructions regarding the next injection date.

5. Office visit for an established patient seen one week previously for pernicious Anemia and asked to return solely for a demonstration of and instructions in how to self-administer Vitamin B12. (Vitamin B12 is considered to be a self-administered drug and instruction in how to self administer is not a separately covered service.)

In each of the above examples, some or all of the following items are not present and criteria for 99211 are not met. There is no medical necessity for the visit, no documentation of clinical history, no clinical exam, no clinical decision, and/or no physician supervision.

Applies to the states of: AK, AZ, MT, ND, OR, SD, UT, WA & WY.

Source: Internet Only Manual (IOM) Medicare Benefit Policy Manual, Publication 100-02; Chapter 15, Sections 60-60.4