



# InHealth Professional Services Coding and Compliance News Letter May 2021

WHEN TO USE THE NON PROVIDER CODE - 99211

MAJOR AND MINOR SURGERY

## When to use 99211

The requirements for most evaluation and management (E/M) codes have gotten more precise over the years. However, one notable exception to this is CPT's level-I established patient encounter code, 99211. CPT defines this code 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." It further states that the presenting problems are usually minimal. In 2021, the AMA eliminated the verbiage - typically five minutes are spent performing or supervising these services. Yet many physicians still struggle with when – or why – to report this code.

## Basic Rules for 99211

The following guidelines can help you decide whether a service qualifies for 99211:

- The patient must be established. According to CPT, an established patient is one who has received professional services from the physician or another physician of the same specialty in the same group practice within the past three years. Code 99211 cannot be reported for services provided to patients who are new to the physician.
- The provider-patient encounter must be face-to-face. For this reason, telephone calls with patients do not meet the requirements for reporting 99211.
- An E/M service must be provided. Generally, this means that the

patient's history is reviewed, a limited physical assessment is performed or some degree of decision making occurs. If a clinical need cannot be substantiated, 99211 should not be reported. For example, 99211 would not be appropriate when a patient comes into the office just to pick up a routine prescription.

Keep in mind that if another CPT code more accurately describes the service being provided, that code should be reported instead of 99211.

For example, if a physician instructs a patient to come to the office to have blood drawn for routine labs, the nurse or lab technician should report CPT code 36415 (routine venipuncture) instead of 99211 since an E/M service was not required.

- The service must be separate from other services performed on the same day. Services that are considered part of another E/M service provided on the same day should not be reported with code 99211. For example, if a nurse provides instructions following a physician's minor procedure or takes a patient's vital signs prior to an encounter with the physician, 99211 should not be reported for these activities because they are considered part of the E/M service already being provided by the physician.
- The presence of a physician is not always required. Although physicians can report 99211, CPT's intent with the code is to provide a mechanism to report services rendered by other individuals in the practice (such as a nurse or other clinical staff member). According to CPT, the staff member may communicate with the physician, but direct intervention by the physician is not required.

**Medicare's requirements on this point are different:** While the physician's presence in the room is not required at each 99211-service involving a Medicare patient, the physician must have initiated the service as part of a continuing plan of care in which he or she will be an ongoing participant. (To some carriers, this means that the physician must see the patient at least every third visit.) In addition, the physician must at least be in the office suite when each service is

provided. The reason for this difference is that Medicare considers these services to be an integral although "incidental" part of the physician's professional service. According to Medicare and most third-party payers, incidental services should generally be reported under the name and billing number of the physician or other professional in the office suite when the service is provided. Note, however, that the services can also be billed "incident-to" other health professionals, such as physician assistants or nurse practitioners.

- No key components are required. Unlike other office visit E/M codes – such as 99212, which requires at least a medically appropriate history, medically appropriate exam and straightforward medical decision making) – the documentation of a 99211 visit does not have any specific key-component requirements. Rather, the note just needs to include sufficient information to support the reason for the encounter and E/M service and any relevant history, physical assessment, and plan of care. The date of service and the identity of the person providing the care should be noted along with any interaction with the supervising physician. Some practices create templates for the nurse to use when documenting these encounters. The templates can be specific to the reason for the encounter, such as a template for a follow-up blood-pressure check, or they can be generic forms

that provide space for the suggested documentation components.

### Examples

Code 99211 is commonly used for services such as patient education, simple rechecks and medication reviews. Some procedures can also appropriately be reported with this code. To gain a better sense of the kinds of services that would qualify as a 99211, consult appendix C of the CPT manual and consider the following examples:

- An established patient comes to the office with complaints of urinary burning and frequency. The nurse takes a focused history, reviews the medical record, discusses the situation with the physician and orders a urinalysis. The nurse then presents the findings to the physician, who writes a prescription for an antibiotic. The nurse communicates the instructions to the patient, while the patient is still in the office, and documents the encounter in the medical record. In this example, 99211 and the appropriate laboratory code for the urinalysis should be reported because the E/M service is distinct from the lab service and appropriate for the evaluation of the patient's complaint.
- A patient comes to the office for a blood-pressure check. If the visit was scheduled at the request of the physician, 99211 should be reported. If the visit was prompted by

the patient, the use of 99211 depends on whether there are clinical indications for the visit. For example, 99211 should not be reported for the stable patient who decides to come in for a blood-pressure check while in the area, because the physician did not order the service and there were no clinical indications to validate the need for the visit. However, if the patient was experiencing problems (e.g., dizziness or headache) and the nurse took additional history, checked the patient's blood pressure and talked with the physician, 99211 would be appropriate since clinical indications prompted the intervention.

- A nurse performs a suture removal on a patient whose sutures were placed at a different practice. Code 99211 could be reported for this service, since it describes the service better than any other CPT code (there is no specific CPT code for suture removal). Note, however, that 99211 would not be appropriate for the suture removal if the sutures were placed and removed at the same practice, because the code reported for placing the sutures would also include the removal.
- A nurse performs a simple dressing change to assess and dress open wounds or other injuries. Code 99211 would be appropriate if the dressing change wasn't performed as part of burn

treatment (because there are other specific CPT codes that should be used for burns) or routine post-procedure care (because some procedures have a global period during which associated care is considered part of the payment for the procedure).

- An established patient presents for an INR test. The results are abnormal, and the nurse discusses the results with the physician. The physician instructs the nurse on the new dose schedule and the nurse then communicates those changes to the patient – while the patient is in the office. The nurse documents an EM note indicate the history, findings from the results of the INR test and the new dosage as well as the date for the next test.

### In Closing - Be Careful

Because some services are more appropriately reported with a CPT code other than 99211, because not every encounter has a clinical indication that supports a separate visit code, and because some patients may balk at the idea of being charged for some 99211 services (such as a blood-pressure check) be cautious about establishing a practice of billing an E/M service with every staff encounter.

Instead, use these guidelines and examples to determine the appropriate uses of 99211. Many Medicare carriers and other third-party payers periodically issue examples and guidelines regarding the proper use of certain codes,

including this one. Staying knowledgeable about these coding practices can improve your practice's reimbursement and reduce potential audit liability.

### Questions

If you want to talk about the issue in this newsletter, or any other coding dilemma – reach out to us anytime:

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### Coder Spotlight:

#### Sharee Sherrill, CPC

She is from Tennega, GA. She focuses on primary care coding and works with our convenient care locations as well as nursing home. She is well versed in Cerner Community Works And works with the EKGs.

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