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Dermatology Coding Alert

Answer 3 Questions to Optimize Your Nurse Code Reporting

Be on the safe side by sticking to 99211's coding requirements.

If used properly, 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician),otherwise known as the "nurse code," can be a revenue boosting tool.

Nurse your billing woes by answering three questions.

Question 1: Was the Provider of the Service On Site?

This refers to the "incident to" clause as defined by Medicare, which says: "Even though the 99211 code does not require the presence of the physician in the patient's room or a face-to-face encounter with the physician, the service would be done by face-to-face encounter with the physician's staff and 'incident to' (meaning the physician must be in the office suite and immediately available) a physician's service."

In short, your practice should document a face-to-face evaluation by a dermatologist's staff and the rendering of a medical service that has an impact on the patient's care. The "incident to" clause stems from Medicare's requirement which states that the physician must at least be in the office when the service is provided.

Why: Medicare considers these services to be an integral although "incidental" part of the physician's professional service. Nevertheless, you can bill 99211 as "incident to" other health professionals like physician assistants or nurses.

Question 2: Was an E/M Service Provided?

You must meet 99211's criteria. Generally speaking, the provider must review the patient's history, perform a limited assessment, or do some sort of decision making. "A change in the medical regimen is not an AMA CPT requirement to bill 99211. However, this may be required by various payers and as such included in their coverage policies/provider education materials," says **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO,** owner of MJH Consulting in Denver.

With any physician services, the E/M services reported by 99211 should always be medically necessary, and the ancillary staff should adequately document these services. "Something as simple as a blood-pressure check with a review of meds can be billed with a 99211 (CPT states 'presenting problem[s] is minimal'). If there is a change in plan of care, then the MD must be involved, thereby raising the E/M level," says **Linda H. Huckaby, CMA (AAMA),** medical assistant at Carolina Medical Rehabilitation LLC in Greenville, S.C., in support of the nonrequirement of a change in medical regimen.

Clue: If you cannot sustain the medical need for a service, do not report 99211. If another code more accurately describes the service being provided, drop 99211 and report that code instead. For instance, if your dermatologist instructs a patient to come to the office to have blood drawn for routine labs, the nurse or lab technician should report 36415 (Routine venipuncture) instead of 99211 since an E/M service was not required.

Question 3: Was Service Rendered Face-to-Face?

Red flag: Phone calls with patients do not fit the 99211 face-to-face requirement. The dermatologist or his staff should talk to the patient in person. One of the purposes of 99211 is to provide a mechanism to report services rendered by other individuals in the practice (e.g., a nurse or other clinical staff member).

The staff member may consult with the dermatologist, but direct involvement of the dermatologist is not required.

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Hidden trap: Medicare has it another way. While the physician's presence 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.

Question 4: Who Else Can Report 99211?

You can actually bill 99211 to report services that members of a dermatology medical staff, other than the nurse and the physician himself, provide, Hammer says. "Qualified, auxiliary personnel" includes medical assistants, licensed practical nurses, technicians, and other aides, and should be duly employed by the physician. On the other hand, the recipient of this E/M service should be any patient who has been billed by your dermatologist for a professional service in the past three years, notes **Beth Janeway, CPC, CCS-P, CCP,** president of Carolina Healthcare Consultants in Winston-Salem, N.C. In other words, if your dermatologist has not provided professional services to the patient within the last three years, you should use new patient E/M codes (99201-99205, New patient office visit).

Catch: If an auxiliary staff member renders an E/M service and plans to report 99211, the dermatologist must be present in the office, and the staff member must be qualified to perform the service. Logically, the staff member would be evaluating a problem that the dermatologist already evaluated, since you cannot declare an incident-to with a new problem.

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