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Internal Medicine Coding Alert

3 Nurse-Visit Coding Tips You Can't Do Without

Solid documentation could bring you $22 a pop for 99211

Although you may think reporting a "nurse-only" visit is simple, many internal medicine coders forfeit the $22 this code brings because they don't know the three criteria every 99211-level visit should meet.

The key is applying the code **only** when the practitioner provides a medically necessary service to an established patient **and** the practitioner has the training or necessary credentials to perform the service according to state and payer requirements.

And remember, although we often refer to this code as the "nurse's code," your internist and other personnel could report it if an E/M visit doesn't meet the documentation requirements of the higher-level established patient E/M codes (99212-99215) but satisfies the 99211 criteria.

Some Medicare carriers, such as HGS Administrators, the Part B carrier for Pennsylvania, have issued a clarification regarding 99211 use, says **Mary Mulholland, BSN, RN, CPC**, a reimbursement analyst for the office of clinical documentation at the University of Pennsylvania's department of medicine in Philadelphia. "Our carrier is restating the requirement of the physical presence of the physician in the office when the service is provided (to provide direct physician supervision) whenever this code is reported."

Coding experts recommend that you report 99211 (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[s] are minimal. Typically, 5 minutes are spent performing or supervising these services) if the service meets three criteria:

1. Staff Performs an Actual E/M Visit

To report 99211, a practitioner must perform an E/M services , so don't use 99211 to get any simple service paid.

What doesn't work: A nurse speaks to a patient on the phone and agrees to obtain a prescription refill for her. The patient comes to the practice an hour later, and the nurse hands her the prescription through the reception window. Because the nurse did not evaluate the patient and no medical necessity required that she meet with her, you should not report an office visit.

A better way: You may report 99211 if the nurse checks a patient's blood pressure. But the patient should have a blood pressure problem, such as hypertension (401.x) or elevated blood pressure without hypertension (796.2), which supports medical necessity, says **Beverly Roy, CPC, CCP,** a professional coder for internists at Summit Medical Associates in Hermitage, Tenn.

In other words, patients with stable blood pressure coming to the office monthly to monitor blood pressure would not be medically necessary and therefore not a billable service.

In this visit's documentation, you should look for notes like "Medication is controlling the situation" or "Prior check showed blood pressure was too high," Roy says.

Also, make sure the nurse or medical assistant documents the visit's reason, a brief patient history, any exams such as weight or temperature, and a brief assessment, coding experts say.

2. The Service Is Medically Necessary

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Internal medicine coders often complain that CPT doesn't provide enough guidance as to what warrants a 99211-level visit. But a good way to determine whether the visit qualifies is to know what your payer expects the medical record to show.

"What the payer expects to see if they were to review the medical records is that the service provided required more than simply collecting a specimen or the administration of an injection," says **Judy Richardson, MSA, RN, CCS-P,** senior consultant with Hill & Associates in Wilmington, N.C. "A bit more expertise should go into the record."

For example, a Coumadin patient becomes unstable or has bruising, so the physician orders a change in medication. The nurse sees the patient, draws blood, and examines the bruising and other side effects from the Coumadin. In this case, you could report 99211, as long as the documentation supports the charge.

The nurse reports 99211 along with the appropriate ICD-9 codes, such as 427.31 (Atrial fibrillation) for the primary, and V58.61 (Long-term [current] use of anticoagulants) for the secondary diagnosis, Roy says.

Snag: Not all nurse visits warrant reporting 99211. Suppose the patient phones your office and reports that her chemotherapy pump has broken. She returns to your office, where the nurse provides a new pump. Because the nurse simply gives her the new pump, you should not report 99211.

3. The Patient Is an Established Patient

The new patient E/M codes do not offer an equivalent to 99211. Registered nurses cannot report 99201, the lowest-level new patient office visit code, because physicians must see new patients or established patients who have new problems before you can report 99211.

"Remember, however, that Medicare [and most other payers] does not pay for some services, such as 90782 (Therapeutic, prophylactic or diagnostic injection [specify material injected]; subcutaneous or intramuscular) and 90788 (Intramuscular injection of antibiotic [specify]), with any E/M codes," Richardson says. "This policy includes CPT 99211."

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