

Internal Medicine Coding Alert

99211: Coding Tips and Cautions

Editors Note: This is the first of a series of articles on coding evaluation and management (E/M) services. In subsequent issues, we will cover codes 99212-99215 and 99202-99205 individually, detailing the documentation requirements for each code specific to internal medicine and highlighting common problems experienced by internal medicine practices.

Code 99211 is often referred to as a nurse visit code in internal medicine offices, because the physician rarely sees the patient face-to-face during these encounters.

In most cases, 99211 is reported when the patient comes in for a very minor check-up and is seen by the office nurse or, sometimes, by a mid-level provider.

These are very basic visits, maybe glucose checks for diabetic patients, blood pressure checks, etc., says **Jim Stephenson**, billing manager for Premium Medical Management Inc., a 20-physician multispecialty practice (with nine internal medicine physicians) in Elyria, OH. The physician is in the office or area, but doesn't actually see the patients. This code is almost always billed incident to.

According to CPT, code 99211 is for 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 problems are minimal. Typically, five minutes are spent performing or supervising these activities.

The code does not require a certain level of history, exam or medical decision-making, according to CPT.

Although code 99211 does not specify that these visits do not involve face-to-face interaction with the physician, in most cases, if the physician is involved in the patient's care, the visit documentation will support a higher level code, adds **Susan Callaway-Stradley, CPC, CCS-P**, a practice management consultant with the accounting firm of Elliott, Davis, and Co. in Augusta, GA.

A typical 99211 visit would be an established patient with controlled hypertension who is on new medication, she illustrates. After prescribing the medication and instructing the patient how it is to be taken, the internist asks her to come back to the office in four days in order to check her blood pressure, says Callaway-Stradley. The patient comes back in and the nurse checks her blood pressure, the level is OK, and she tells the doctor, Mrs. Smith was in for her blood pressure check and it is fine. The physician then writes a prescription for the new medication for the next four months and instructs the nurse to tell the patient to continue taking the medication as directed. This would be a 99211 visit because the nurse spent just enough time with the patient to check her pressure and report to the physician, who made a decision to continue with treatment.

However, say her blood pressure was up, says Callaway-Stradley. The nurse would inform the physician, who would probably say, Have her wait for a few minutes; I want to see her.

The internist would most likely ask the patient detailed questions to see whether she had been following the instructions with the medication and taken it properly, she explains. He also would probably perform a workup to determine the cause of the increase in blood pressure and a new course of treatment. Right there, you are going to code at a higher level.

If you have a problem-focused history, and a problem-focused examination, and straightforward medical decision-making (the lowest level), you have already met the requirements for 99212, notes Callaway-Stradley. Medicare requirements do stipulate that you take at least three vital signs, but that indicates, basically, that they want proof that the patient was

physically in the office.

Be Cautious of Fraud

Overreporting of 99211 has been a focus of Medicare's fraud investigations, Callaway-Stradley reports, but only because some practices report the code in an inappropriate way. There are some practices billing 99211 to Medicare when the patient didn't even come into the office or, for example, just came into the office to sign consent forms for surgery and get their prep instructions, she says. The code is for a medical visit. It is not appropriate to report this code for administrative functions or filling out paperwork. That is a practice expense and is covered in the other codes reported for that patient's care.

Note: Practice expense relative value units (RVU) are incorporated into the total RVUs for each code paid by Medicare and are considered to represent the value of the practice's expense for treating the patient. Therefore, practice expenses for a patient are covered in the codes representing the patient's clinical care and are not reported separately.

Code 99211 is also inappropriate for phone calls to refill prescriptions or phone calls to discuss the patient's care. Calls to refill prescriptions are also a practice expense, and there are other CPT codes that should be used to report telephone calls to patients and phone consultations with other providers (99371-99373, Case Management Services, telephone calls). Payment is variable with the other codes, so some providers have decided to bill a low-level E/M code to Medicare and other payers. However, this is inappropriate and could result in fines and refunds due to the carrier, if these charges are discovered.

Code 99201 is Rare

Code 99201 (office or other outpatient visit for the evaluation and management of a new patient), the corresponding new patient level to the established patient 99211, is rarely seen in internal medicine, says Stephenson.

For 99201, the physician has to actually see the patient because he or she is new, he explains. For any new patient, the internist normally has to talk to them and do some sort of examination and, usually, if the physician is involved, it won't end up being a level one.

Even if there is nothing very wrong with the patient, if it is the first time someone has been in that practice, then you still need to get a pretty extensive history for that patient, Stephenson believes. Then you are talking about a 10- or 15-minute patient visit.

According to CPT, the requirements of a 99201 are different from 99211 in more than just whether the patient is new or established. Requirements for reporting 99201 are:

- a problem-focused history
- a problem-focused examination; and
- straightforward medical decision-making.

The physician typically spends 10 minutes with the patient and/or the patient's family.

CPT defines a problem-focused history as the documentation of a chief complaint, and a brief history of present illness or problem. A problem-focused examination is defined as a limited examination of the affected body area or organ system. Straightforward medical decision-making is defined as requiring consideration of a minimal number (1-4) of diagnoses or management options; no review of data or minimal amount and/or complexity of reviewed data; and minimal risk of complications and morbidity or mortality presented by the presenting problem or treatment options.

Requirements for the next higher code, 99202, are:

- an expanded problem-focused history
- an expanded problem-focused examination; and

straightforward medical decision-making.

In most cases, Stephenson feels, an internist will perform at least an expanded problem-focused history or higher on a new patient, as well as an expanded problem-focused exam, and this would merit application of at least 99202, he adds.

It is a matter of the physician's discretion, Stephenson says. The physician should ask himself or herself, Did I really do just a brief history and exam? Or did I see the patient and discuss their hypertension and diabetes and whatever else? If the patient is new, many physicians feel they need to check almost everything.