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Internal Medicine Coding Alert

Answer Three Questions to Solve 99211 Puzzle

Coders are probably more confused about how to use 99211 than any other code in the E/M section of the CPT book. The key issues that come up time and again are who can use the code and whether it can be used instead of or in conjunction with other codes.

Experts say you can determine if 99211 is the right code by carefully answering three questions:

1. **Is the person who will provide the service considered "auxiliary personnel," which includes nurses, medical assistants and other office employees who are not providers?**

   "99211 is often called a nurse visit," says **Catherine Brink, CMM, CPC,** president of Health Care Resource Management Inc., in Spring Lake, N.J. It is the lowest-level E/M visit for an established patient and is typically used when the nurse sees a patient for a minor problem.

   Although physicians and nonphysician practitioners (e.g., nurse practitioners and physician assistants) are not barred from using 99211, they will use a higher-level E/M code in most cases because of the greater complexity of care they usually provide.

   Many coders don't realize that 99211 can be used by office employees other than the nurse, says **Kathy Pride, CPC, CCS-P,** HIM applications specialist with the San Rafael, Calif.-based QuadraMed. Any qualified "auxiliary personnel" who are employees of the physician (such as medical assistants, licensed practical nurses, technicians and other aides) and are working under the physician's direct supervision can provide services to patients under the "incident-to" umbrella using 99211, as long as the visit meets the "medical-necessity" requirement for billing an E/M code, she says. The physician must be present in the office when the service is performed, and the auxiliary personnel must be qualified to perform the service. (For more detail, read Section 2050.1 of the Medicare Carriers Manual.)

2. Is there a CPT code that describes the service that was performed?

   Coders frequently question whether they can use 99211 when a patient comes to the office for common procedures such as lab work, a blood-pressure check or a prescription refill.

   The first question the coder should ask is: Does the service that was provided have its own CPT code?

   "If the service has an identifiable code, then you bill that code," Pride says.

   For example, a patient comes to the office for a urinalysis as part of routine lab work scheduled a week before a regular checkup. Use CPT code 81002 (Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy).

   You cannot code 99211 for the time that the nurse or assistant spends with the patient unless another medically necessary service is provided in addition to the lab work. For example, the routine urinalysis is positive, indicating a urinary tract infection. The nurse must then discuss the findings with the doctor, who decides he doesn't need to see the patient before the annual exam the following week, but will write a prescription for an antibiotic to be started in the interim. The criteria for medical necessity have been met, and 99211 can be coded in addition to 81002, with diagnosis

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code 599.0 (Urinary tract infection, site not specified).

3. Can you document medical necessity for an E/M visit?

If the service provided to the patient by auxiliary personnel does not have an identifiable CPT code of its own, you may be able to use 99211. Because 99211 does not have required elements of history, examination and decision-making, many physician offices are unsure when and how to use the code. The key is to establish the same medical necessity that is required for all E/M codes. "Make sure you document what service was performed and the medical necessity for it," Pride says.

"Here are three of the most common scenarios where coders question if 99211 is the proper code and some expert advice on when to use it."

Scenario 1: Routine BP Checks Aren't Covered

If a patient comes in to have her blood pressure checked because the doctor said she should have it done every two weeks, the visit can't be billed, Brink says. Providing a blood-pressure check in the absence of other problems should be considered "a good-will gesture" to patients, she says.

However, if there is medical necessity for the blood-pressure check, it will meet the criteria for 99211, Brink says. For example, the doctor examines a 65-year-old female patient whose blood pressure is high and decides to try a new medication. The physician notes in the chart that "the patient should return in two weeks to see the nurse for a blood-pressure check, an evaluation of how the new BP medicine is working, and follow-up." His notes create medical necessity for 99211 to be coded when the patient returns.

Many offices believe they can create medical necessity by having the nurse ask how the patient is feeling at a routine blood-pressure check but that's not the case, Brink says. If, however, the nurse asks and the patient responds, "I've been dizzy, and I think it's because of this new medicine," then medical necessity exists for coding 99211 or perhaps even a higher-level visit with the doctor, depending on what the nurse's initial assessment shows, Brink says.

Scenario 2: 99211 Can Be a Prescription for Denial

Another frequent question is whether offices can code 99211 for a prescription refill.

"Did the doctor write out the prescription and leave it at the front desk for the patient to pick up?" Pride asks. If the answer is yes and the patient simply picked up the prescription and left, the refill cannot be billed.

However, if there is a medical reason for the nurse or other office personnel to evaluate the patient when he comes in to pick up the prescription, use 99211. For example, the doctor recently changed blood-pressure medications and wants the nurse to evaluate the effect on the patient before giving him a three-month prescription of the medicine.

Scenario 3: Injections Present Sticky Coding Issue

Coders often disagree about whether to use 99211 or the 90782-90799 series (Therapeutic, prophylactic or diagnostic injections) for shots given in the office. Although CPT lists a routine B-12 shot for pernicious anemia among its examples of correct 99211 coding, Medicare specifically says in 15502 (D) of the Medicare Carriers Manual not to use 99211 for injections, warning that the code "cannot be used to report a visit solely for the purpose of receiving an injection which meets the definition of CPT codes 90782, 90783, 90784 or 90788." If an E/M service is provided along with an injection, Medicare says, the E/M service is covered but the administration of the injection (90782-90799) is bundled into the E/M. In both cases, use a J code to indicate the drug administered.

To code 99211 for an injection, you have to do more than administer the shot, Pride says. For example, a 75-year-old female patient receives her B-12 shot for pernicious anemia then says she feels dizzy. The nurse evaluates her and monitors her for 20 minutes before the woman feels better and leaves.

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Code this visit with 99211 and J3420 (Injection, vitamin B-12 cyanocobalamin, up to 1,000 mcg), along with diagnosis codes of 281.0 (Pernicious anemia) and 780.4 (Dizziness and giddiness).

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