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BY AAPC

Internal Medicine Coding Alert

Outpatient E/M: Coding 99211: Learn Regulations or Risk Losing $20 Per Encounter

Turn thorough documentation into successful claims.

If you are automatically reaching out to 99211 whenever an established patient is evaluated by your nurses, physician assistants, non-physician practitioners, and other non-physician healthcare professionals, you are running the risk of denials. Get to know the rules for reporting 99211 to ensure proper reimbursement.

Check the Code Criteria

The first key criterion for reporting 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem[s] are minimal. Typically, 5 minutes are spent performing or supervising these services) is that the patient must be established. One of your physicians, or more than one physician, in the same specialty and under the same group ID as the provider performing the service, must have seen the patient for a face-to-face service within the past 36 months.

The visits you can report using 99211 are usually for minor problems where vitals may be checked, injections are given, or current medications are reviewed. The provider usually completes the service in a short time period of five minutes or less.

Red flag: If a nurse sees a patient prior to the patient seeing her physician that is considered part of the E/M service being provided by the physician, not a separately billable service.

Unlike other established patient outpatient E/M codes, you don't actually need to reach a particular level of history, exam, or medical decision making to report 99211, because the code descriptor does not reference the level of those key components.

Don't overlook: If you want to make sure that your practice is reimbursed for the visit, the patient must be established, the service must be medically necessary, and a well-documented E/M provided. To ensure the documentation supports billing 99211, your provider should include at least these five criteria:

- The date of the visit.
- The name of the service provider.
- Reason for the visit.
- Some indication of an evaluation of the patient (e.g. brief exam, including vital signs such as weight and temperature).
- Brief assessment of the situation reflecting some management of the patient.

Profit: If you provide enough information, you could get paid about $20 per 99211 encounter (0.56 total non-facility RVUs times the 2014 national, geographically unadjusted Medicare conversion factor of $35.8228). That may not sound like much, but if your practice performs five of these visits a week, then after a year, over $5,000 has been made or lost.

Avoid Using 99211 in Some Circumstances

According to experts, there are at least three "don'ts" when it comes to reporting 99211 to Medicare:

1. Don't use 99211 for a nurse visit for services that are a part of another E/M.

Example: A nurse measures the patient's height, weight, and blood pressure before the physician sees the patient. The nurse's work would be a part of the physician's E/M.

2. Don't report 99211 for telephone calls to patients because there has to be a face-to-face contact.

Example: A nurse returns a patient's phone call and gives instructions over the phone.

3. Don't underestimate the impact the documentation can have on your reimbursement. When it comes to documenting nurse visits, the report is critical. The care provider must provide the reason and the details for the encounter. This could include educational services or an evaluation of the patient's condition with management of the condition handled by the physician.

Example: Problems can occur when billing 99211 with a 'routine BP check,' says an expert. "The medical record needs to state why the patient came in for a BP check."

To clearly state that there is medical necessity for performing 99211, the physician may document "patient BP not under control. BP meds increased to 300 mg. Patient is to return in three weeks for a BP check. If BP is still not under control, we will change his BP meds." rather than the physician documentation just stating "return in 6 weeks for BP check." That only justifies a BP check and not an E/M, Brink explains.

4. Don't use 99211 to report another service that has its own CPT® code.

Example: If a patient is seen solely to receive an influenza vaccination, which the nurse provides, the practice should report the code for vaccine administration (plus the code for the flu vaccine itself) rather than 99211.

5. Don't report 99211 to Medicare for a "nurse visit" under the physician's Medicare provider number unless the encounter fulfills Medicare's "incident to" requirements.