

Part B Insider (Multispecialty) Coding Alert

Coding Quiz: Can You Spot Which 99211 Rules Are Accurate?

Hint: You can't automatically tack 99211 on to every service just because the nurse was present.

Most practices agree that 99211 is a ubiquitous code, reported nearly every day for visits ranging from blood pressure checks to medication updates. But the so-called "nurse visit" code may not always be appropriate. Many MACs are scrutinizing these claims and attempting to clarify when 99211 is appropriate and when it isn't, as Part B MAC Cahaba GBA did this past June. Check out these common clinical scenarios and determine whether 99211 is appropriate for the circumstances.

Know Whether 99211 Applies to X-Rays

Question 1: A patient comes to see the physician for a leg problem. The staff performs x-rays and then the patient waits in the exam room for the doctor, but gets a call and has to leave before she actually sees the physician. Does 99211 apply to this visit?

Answer 1: What is unanswered is whether the x-ray was ordered by the doctor. If the physician ordered and read it, bill the x-ray unmodified. If the physician did not order the x-ray, then nothing can be billed.

In short, you cannot report 99211 unless an actual evaluation and management service was provided.

Will 99211 Cover Vaccines?

Question 2: A patient presents for vaccines only. The nurse administers two vaccines and the patient leaves. Should you report 99211 with the vaccine administration codes?

Answer 2: Not as a rule, no. If the nurse simply administers a vaccine and the patient leaves, the nurse most likely has not met the criteria for billing 99211. If, however, the nurse spends a lot of time counseling the patient or the patient has other diagnoses that the nurse goes over, then 99211 might be appropriate.

In some cases, depending on the CCI edits for the specific vaccine codes you're using, you may need to append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to 99211.

In black and white: "Services billed to Medicare under CPT® code 99211 must be reasonable and necessary for the diagnosis and treatment of an illness or injury," says a policy on 99211 written by Part B MAC WPS Medicare. "Furthermore, a face-to-face encounter with a patient consisting of elements of both evaluation and management is required. The evaluation portion is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information between provider and patient. The management portion is substantiated when the record demonstrates an influence on patient care (eg., medical decision making, patient education, etc.)."

Therefore, documentation of a vaccine alone would not allow you to meet the requirements of 99211. Similarly, other injections follow the same rule. Medicare Advantage contractor The Health Plan reported in May that if a patient presents for a B-12 shot, you'd report the administration code and the J-code to identify the medication injected (typically 96372 and J3420), but "code 99211 would not be reported because other codes are available to report the vitamin B-12 injection."

Can You Downcode to 99211 for Incomplete Physician Notes?

Question 3: A patient presents for a visit but the physician fails to complete the office note, leaving his portion

completely blank, although the nurse completes her portion. When asked about the visit after the fact, the physician does not remember the details of the visit. Can you report just the nurse's portion of the visit with 99211, or should you not bill the claim at all?

Answer 3: You can report 99211 based on the nurse's documentation. It is important to document the fact that the visit was actually done on the date of service it occurred and ideally if the staff is proficient in this case, will also document the fact that the patient was seen by the doctor but no documentation was made specifically by the physician so it was not billed as a "face to face" (physician) visit per guidelines set forth in CPT®.

Is Face-to-Face Required?

Question 4: A patient comes in to drop off a urine sample to make sure her recurrent urine tract infection (UTI) has resolved. Does the dropoff warrant reporting 99211?

Answer 4: You should not use 99211 when clinical staff does not provide direct face-to-face contact with the patient. The face-to-face provider must be an employee, contractor or leased employee operating under direct supervision (meaning a supervising physician or nonphysician provider is in the office suite) with an order for the service and the ordering physician/practitioner identified. Documentation should include some E/M of the patient's condition, not just receipt of a specimen.

Suture Removal May Warrant 99211

Question 5: An established patient hit his forehead on his surfboard while on vacation in Hawaii; he had a 2.7cm laceration just above his left eyebrow sutured shut in a Hawaiian ED. He reported to your practice for suture removal. One of your nurses spends four minutes taking the sutures out. Does 99211 apply in this scenario?

Answer: Since the patient had the sutures done at a different practice, you can report 99211 for this visit, along with the diagnosis code V58.32 (Attention to surgical dressings and sutures; encounter for removal of sutures). A nurse's performance of suture removal when the patient had the sutures placed elsewhere is listed as an acceptable use of 99211 in The Health Plan's policy.