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Part B Insider (Multispecialty) Coding Alert

Medicare Error Rates: Reporting 'Low-Level' 99211? You Still Need Complete Documentation, One MAC Reminds

Just because 99211 is known as a 'nurse visit' doesn't mean you can report it without the appropriate notes.

When your practitioner performs a level-one established patient E/M service, you probably report 99211 without much thought, because the so-called "nurse's code" only pays about $19.00. However, you should put just as much effort into ensuring that you're reporting 99211 as accurately as your other codes. Not only is it compliant and correct coding to do so, but MACs are watching.

WPS Medicare, a Part B payer in Illinois, Michigan, Minnesota, and Wisconsin, recently updated the results of its CERT review, noting that it found several errors among the claims for 99211--most of which related to a lack of thorough documentation.

For instance, the CERT reviewer commented that a chart only included documentation of a prothrombin anticoagulation check, with no notes about an E/M visit, but the practice billed both 85610 (Prothrombin time) and 99211. Another chart specifically stated, "Patient had labs done only. Did not see the doctor," but still billed 99211.

Even visits where the physician is confirmed to have seen the patient were under-documented, WPS Medicare found. For instance, one record said that the patient presented "for his first Synvisc injection" and the provider billed the arthrocentesis and Synvisc injection codes along with 99211 and modifier 25. "However, submitted documentation does not support modifier code," the reviewer noted. "Documentation states, 'Detailed note is in the chart from his last visit.'"

You Must Document Face-to-Face Visit

As with the other E/M codes in the 99201-99215 category range, your 99211 claims "must be reasonable and necessary for the diagnosis and treatment of an illness or injury," WPS Medicare reminds practices. "Furthermore, a face-to-face encounter with a patient consisting of elements of both evaluation and management is required."

You should not report 99211 if the provider simply calls a patient on the phone, draws blood, or administers medications "when an injection or infusion code is submitted separately," WPS notes.

For more on WPS Medicare's audit of 99211 claims and the MAC's tips on reporting it, visit www.wpsmedicare.com/part_b/departments/certfocus99211.shtml.

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