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Part B Insider (Multispecialty) Coding Alert

Part B Insider Coding Coach: Don't Sacrifice $22 Per Nurse Visit - Know When To Report 99211

Proper documentation is the key to nurse-visit coding

A "nurse-only" visit may seem simple, but many practices shy away from reporting these visits because they don't know the three basic requirements for a 99211: A valid E/M service, medical necessity and an established patient. Familiarize yourself with these requirements and you won't have to forfeit the $22 this code brings.

The key to 99211 success is applying the code **only** when the practitioner provides a medically necessary service to an established patient and the practitioner has the training or necessary credentials to perform the service according to state and payer requirements.

And remember, although we often refer to this code as the "nurse's code," a physician and other personnel can report it if an E/M visit doesn't meet the documentation requirements of the higher-level established patient E/M codes (99212-99215) but satisfies the 99211 criteria.

Some Medicare carriers, such as **HGS Administrators**, the Part B carrier for Pennsylvania, have issued a clarification regarding 99211 use, says **Mary Mulholland, BSN, RN, CPC**, a reimbursement analyst for the office of clinical documentation at the University of Pennsylvania's department of medicine in Philadelphia. HGS has restated the requirement that the physician be present in the office whenever using 99211; otherwise, the physician isn't meeting the direct supervision requirement.

Coding experts recommend that you report 99211 (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 problem[s] are minimal. Typically, 5 minutes are spent performing or supervising these services) if the service meets three criteria:

1. Staff Performs an Actual E/M Visit

To report 99211, a practitioner must perform an E/M service, so don't use 99211 to get any simple service paid.

What doesn't work: A nurse speaks to a patient on the phone and agrees to obtain a prescription refill for her. The patient comes to the practice an hour later and the nurse hands her the prescription through the reception window. Because the nurse did not evaluate the patient and no medical necessity required that she meet with her, you should not report an office visit.

A better way: You may report 99211 if the nurse checks a patient's blood pressure. But the patient should have a blood pressure problem, such as hypertension (401.x) or elevated blood pressure without hypertension (796.2), which supports medical necessity, says **Beverly Roy, CPC, CCP**, a professional coder for internists at **Summit Medical Associates** in Hermitage, TN.

In other words, patients with stable blood pressure coming to the office for monthly monitoring would not meet the medically necessary requirement (see point #2, below), rendering the visit unbillable. In this visit's documentation, you should look for notes like "Medication is controlling the situation" or "Prior check showed blood pressure was too high," Roy says.

Also, make sure the nurse or medical assistant documents the reason for the visit, a brief patient history, any exams such as weight or temperature and a brief assessment, coding experts say.

2. The Service Is Medically Necessary

Coders often complain that CPT doesn't provide enough guidance as to what warrants a 99211-level visit. A good way to determine whether the visit qualifies is to know what your payer expects the medical record to show.

If the payer reviewed the medical record, it would expect to see "that the service provided required more than simply collecting a specimen or administering an injection," says **Judy Richardson, MSA, RN, CCS-P**, senior consultant with **Hill & Associates** in Wilmington, NC. "A bit more expertise should go into the record."

Example: A patient on Coumadin (a blood thinner) becomes unstable or has bruising, so the physician orders a change in medication. The nurse sees the patient, draws blood and examines the bruising and other side effects from the Coumadin. In this case, you could report 99211, as long as the documentation supports the charge.

The nurse reports 99211 along with the appropriate ICD-9 codes, such as 427.31 (**Atrial fibrillation**) for the primary and V58.61 (**Long-term [current] use of anticoagulants**) for the secondary diagnosis, Roy says.

Snag: Not all nurse visits warrant reporting 99211. Suppose the patient phones your office and says her chemotherapy pump has broken. She returns to your office, where the nurse provides a new pump. Because the nurse simply gives her the new pump, you should not report 99211.

3. The Patient Is an Established Patient

The new patient E/M codes do not offer an equivalent to 99211. Registered nurses cannot report 99201, the lowest-level new patient office visit code, because physicians must see new patients or established patients who have new problems before you can report 99211.

"Remember, however, that Medicare [and most other payers] does not pay for some services, such as 90782 (Therapeutic, prophylactic or diagnostic injection [specify material injected]; subcutaneous or intramuscular) and 90788 (Intramuscular injection of antibiotic [specify]), with any E/M codes," Richardson says. "This policy includes CPT 99211."

Lesson learned: That means you can report 90782 or 90788 when a nurse performs the service on a new patient, as long as you don't also bill an E/M code for the visit.