Part B Insider (Multispecialty) Coding Alert

READER QUESTION: Your Physician Can Report 99211

But watch your documentation carefully

Question: Our physician billed 99211 a few times last year, and we just got a letter from our carrier saying they want to see the notes from that visit. I am surprised because this is such a low-level code for the insurer to audit, but our office manager says the reason for the audit is because physicians aren't allowed to bill 99211. Is this accurate?

Answer: No. The 99211 descriptor specifies that the visit -may not require the presence of a physician,- but that doesn't mean it's restricted to nonphysician practitioners. If the physician meets the requirements for 99211, he or she can report it.

Example: You can bill 99211 for blood pressure monitoring for hypertensive patients under a physician's plan of care, as long as there is documentation establishing medical necessity for the blood pressure check. In some small practices where the physician is the only person available, he or she may personally perform the blood pressure check and therefore may not qualify for a higher code than 99211.

For instance: The physician examines a 65-year-old female patient during a preoperative exam and finds that her blood pressure is high. He decides to put her on medication to correct the problem. He 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.- The physician's notes indicate medical necessity for reporting 99211 when the patient returns. In this case you could report 99211 for the low-level visit to check the patient's blood pressure.

Keep in mind: To report 99211, you should make sure that the practitioner actually performs an evaluation (and doesn't simply weigh the patient or write a prescription refill). In addition, make sure the patient is not a new patient and that the patient presents for a medically necessary reason.
The practitioners should document the reason for the visit, a brief history of the patient's illness, any exam processes such as weight or temperature, and a brief assessment.

You could be the subject of a random audit, or the carrier may be auditing you because it believes the physician coded incorrectly. Although some practices believe that Medicare only audits practices that are suspected of upcoding, that is incorrect.

Medicare may view undercoding as inducement, which may then be considered fraud or abuse. Medicare considers inducement as -offering any free service to a patient to encourage providing a service that would be covered by Medicare.-

Therefore, always code according to the documentation. If your physician's documentation supports 99211, your auditor should recognize that.

Send your reader questions to us at Torrey@partbinsider.com.