

Understanding When to Use

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Using CPT code 99211 can boost your practice's revenue and improve documentation.

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The requirements for most evaluation and management (E/M) codes have gotten more precise over the years. However, one notable exception to this is CPT's level-I established patient encounter code, 99211. CPT defines this code as an "office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician." It further states that the presenting problems are usually minimal, and typically five minutes are spent performing or supervising these services. Yet many physicians still struggle with when – or why – to report this code. This article describes how appropriately reporting 99211 can improve revenue and documentation, and provides specific guidelines and examples that can help physicians identify appropriate uses for the code.

The benefits of 99211

Reporting 99211 can bring additional revenue into your practice. Specific payment amounts will vary by payer, but the average unadjusted 2004 payment from Medicare for a 99211 service is \$21. This means that only five 99211 encounters with Medicare patients

in a week will result in over \$5,000 per year for a practice. Although this may not sound like a lot of money, it is easy revenue. Most practices already provide a number of 99211 services but fail to capture those charges. Remember, all services have a cost associated with them, and practices need to recoup as much of these costs as is legitimately possible.

Appropriately reporting 99211 services can also improve documentation in a practice. Staff members who are cognizant of billing guidelines tend to pay increased attention to documentation, which, in turn, can result in a more useful medical record for all providers involved in the care of the patient.

Basic guidelines

The following guidelines can help you decide whether a service qualifies for 99211:

- **The patient must be established.**

According to CPT, an established patient is one who has received professional services from the physician or another physician of the same specialty in the same group practice within the past three years. Code 99211 cannot be reported for services provided to patients who are new to the physician.

- **The provider-patient encounter must be face-to-face.** For this reason, telephone calls with patients do not meet the requirements for reporting 99211.

- **An E/M service must be provided.** Generally, this means that the patient's history is reviewed, a limited physical assessment is performed or some degree of decision making occurs. If a clinical need cannot be substantiated, 99211 should not be reported. For example, 99211 would not be appropriate when a patient comes into the office just to pick up a routine prescription.

KEY POINTS

- Only five 99211 encounters with Medicare patients in a week will result in over \$5,000 per year.
- Physicians can report 99211, but it is intended to report services rendered by other individuals in the practice, such as a nurse or other staff member.
- Unlike other office visit E/M codes, a 99211 office visit does not have any specific key-component documentation requirements.

Keep in mind that if another CPT code more accurately describes the service being provided, that code should be reported instead of 99211. For example, if a physician instructs a patient to come to the office to have blood drawn for routine labs, the nurse or lab technician should report CPT code 36415 (routine venipuncture) instead of 99211 since an E/M service was not required.

• **The service must be separate from other services performed on the same day.** Services that are considered part of another E/M service provided on the same day should not be reported with code 99211. For example, if a nurse provides instructions following a physician's minor procedure or takes a patient's vital signs prior to an encounter with the physician, 99211 should not be reported for these activities because they are considered part of the E/M service already being provided by the physician.

• **The presence of a physician is not always required.** Although physicians can report 99211, CPT's intent with the code is

to provide a mechanism to report services rendered by other individuals in the practice (such as a nurse or other clinical staff member). According to CPT, the staff member may communicate with the physician, but direct intervention by the physician is not required.

Medicare's requirements on this point

are slightly different: While the physician's presence is not required at each 99211 service involving a Medicare patient, the physician must have initiated the service as part of a

continuing plan of care in which he or she will be an ongoing participant. (To some carriers, this means that the physician must see the patient at least every third visit.) In addition, the physician must at least be in the office suite when each service is provided. The reason for this difference is that Medicare considers these services to be an integral although "incidental" part of the physician's professional service.

According to Medicare and most third-party payers, incidental services should generally be reported under the name and billing number of the physician or other professional in the office suite when the service is provided. Note, however,

that the services can also be billed "incident-to" other health professionals, such as physician assistants or nurse practitioners. [For more on incident-to billing, see "The Ins and Outs of 'Incident-To' Reimbursement," *FPM*, November/December 2001, page 23.]

• **No key components are required.**

Unlike other office visit E/M codes – such as 99212, which requires at least two of three key components (prob-

lem-focused history, problem-focused examination and straightforward medical decision making) – the documentation of a 99211 visit does not have any specific key-component requirements. Rather, the note just needs to include sufficient informa-

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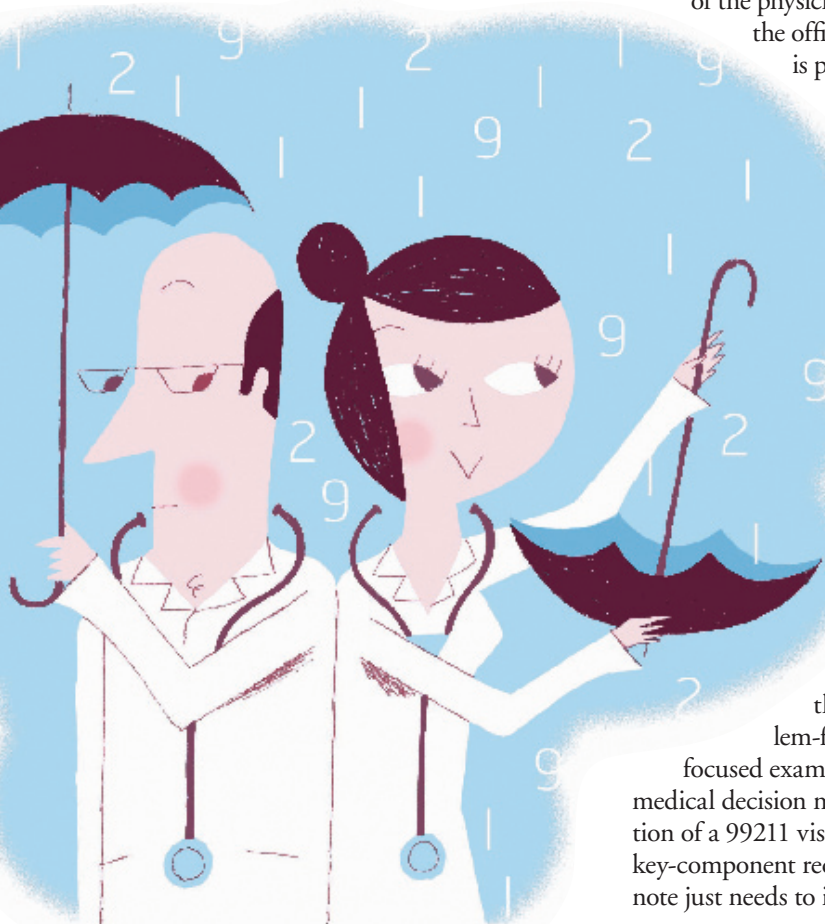
It can also improve documentation in your practice, which, in turn, can result in a more useful medical record for all providers involved in the care of the patient.



To qualify for a 99211 service, the patient must be established, and an E/M service must be provided.



Also, the service must be separate from other services performed on the same date, and neither the presence of a physician nor any documentation of key components are required.





Code 99211 can be used for services such as patient education, simple rechecks, medication reviews and some procedures.



Depending on the specific circumstances, 99211 may be appropriate for a blood-pressure check, a suture removal or a simple dressing change.



Some services are more appropriately reported with a code other than 99211 and not every encounter has a clinical indication that supports a separate visit code.



Staying knowledgeable about the coding requirements for this and other codes can improve your reimbursement and reduce potential audit liability.

tion to support the reason for the encounter and E/M service and any relevant history, physical assessment and plan of care. The date of service and the identity of the person providing the care should be noted along with any interaction with the supervising physician. Some practices create templates for the nurse to use when documenting these encounters. The templates can be specific to the reason for the encounter, such as a template for a follow-up blood-pressure check, or they can be generic forms that provide space for the suggested documentation components. [For some examples of flow sheets that can be used for 99211 services, see “Coding Level-One Office Visits: A Refresher Course,” *FPM*, July/August 2000, page 39.]

Be cautious about establishing a practice of billing an E/M service with every staff encounter.

Examples of 99211 services

Code 99211 is commonly used for services such as patient education, simple rechecks and medication reviews. Some procedures can also appropriately be reported with this code. To gain a better sense of the kinds of services that would qualify as a 99211, consult appendix C of the CPT manual and consider the following examples:

- An established patient comes to the office with complaints of urinary burning and frequency. The nurse takes a focused history, reviews the medical record, discusses the situation with the physician and orders a urinalysis. The nurse then presents the findings to the physician, who writes a prescription for an antibiotic. The nurse communicates the instructions to the patient and documents the encounter in the medical record. In this example, 99211 and the appropriate laboratory code for the urinalysis should be reported because the E/M service is distinct from the lab service and appropriate for the evaluation of the patient's complaint.


- A patient comes to the office for a blood-pressure check. If the visit was scheduled at the request of the physician, 99211 should be reported. If the visit was prompted by the patient, the use of 99211 depends on whether there are clinical indications for the visit. For example, 99211 should not be reported for the stable patient who decides to come in for a blood-pressure check while in the area, because the physician did not order the

service and there were no clinical indications to validate the need for the visit. However, if the patient was experiencing problems (e.g., dizziness or headache) and the nurse took additional history, checked the patient's blood pressure and talked with the physician, 99211 would be appropriate since clinical indications prompted the intervention.

- A nurse performs a suture removal on a patient whose sutures were placed at a different practice. Code 99211 could be reported for this service, since it describes the service better than any other CPT code (there is no specific CPT code for suture removal). Note, however, that 99211 would not be appropriate for the suture removal if the sutures were placed and removed at the same practice, because the code reported for placing the sutures would also include the removal.

- A nurse performs a simple dressing change to assess and dress open wounds or other injuries. Code 99211 would be appropriate as long as the dressing change wasn't performed as part of burn treatment (because there are other specific CPT codes that should be used for burns) or routine post-procedure care (because some procedures have a global period during which associated care is considered part of the payment for the procedure).

Use good judgment

Because some services are more appropriately reported with a CPT code other than 99211, because not every encounter has a clinical indication that supports a separate visit code and because some patients may balk at the idea of being charged for some 99211 services (such as a blood-pressure check) be cautious about establishing a practice of billing an E/M service with every staff encounter. Instead, use these guidelines and examples to determine the appropriate uses of 99211. Many Medicare carriers and other third-party payers periodically issue examples and guidelines regarding the proper use of certain codes, including this one. Staying knowledgeable about these coding practices can improve your practice's reimbursement and reduce potential audit liability. 

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