National Government Services Job Aid
Evaluation and Management Billing for 99211
Provider Outreach and Education
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Procedure Code 99211 Job Aid

Definition for 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 these services.

As with all services billed to Medicare, procedure code 99211services must be reasonable and necessary for the diagnosis or treatment of an illness or injury.

Procedure code 99211 requires a face-to-face encounter. However, when billed as an "incident to" service, the physician's service *may be* performed by ancillary staff (such as a nurse, or other qualified clinical staff such as a nurse practitioner) and billed as if the physician personally performed the service. The authorization or order for the ancillary staff's service must be indicated in the physician/non-physician provider's plan of care.

In such cases, *all* billing and payment requirements for "incident to" services must be met. Please refer to the "incident to" billing checklist, and resources below.

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 patient must be seen for a problem that has already been diagnosed with a treatment plan established by the physician/ non-physician provider.

A face-to-face encounter between the physician and the patient 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 qualified clinical staff). According to CPT, the nurse may communicate with the physician, but direct intervention by the physician is not required.

Do not be confused by the statement: "The presence of a physician is not always required." It means the physician does not have to "personally" see the patient. For Medicare purposes, the physician must provide "direct supervision" (be physically present in the office suite when ancillary staff evaluates and/or treats the patient, and be immediately available to communicate with and direct the staff). The service may be billed as an "incident to" service

using the supervising physician's National Provider Identifier (NPI) *if* the documentation supports the service *and* all the "incident to" requirements are met. For "incident to" purposes any physician within a physician "group" may serve as the supervising physician.

An evaluation and management (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. 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 provider-patient encounter must be face-to-face: For this reason, telephone calls with patients *do not* meet the requirements for reporting 99211. A refill of a prescription when no other evaluation and management service was performed *would not* meet the requirements either.

No key components are required: Unlike other office visit E/M codes - such as 99212, which requires at least two of three key components (problem-focused history, problem-focused examination and straightforward medical decision making) the documentation of a 99211 visit does not have any specific key-component level requirements. Instead, the medical record must include sufficient information to support the reason for the E/M service with relevant history, physical exam, and plan of care. The date of service and the identity and credentials of the person providing the care should be noted along with any interaction with the supervising physician.

Billing Reminders: Do not bill 99211 in the following situations:

Injections

- The *only* service was an injection

Blood Draw (venipuncture)

- The *only* service was a blood draw (venipuncture)

Prescriptions

- Prescription refill (e.g., the physician called in a refill at the pharmacy or the pharmacy called to obtain a renewal on the prescription).
- A new prescription was written and no other E/M service was performed.
- The patient changes insurance companies, and needs all new prescriptions for the new mail-order pharmacy. The physician has the patient present to the office the nurse who prepares the new RX (either paper or electronic) for the physician's review/signature. In this instance, billing 99211 is not appropriate.

Blood Pressure Checks

- Blood pressure checks that have not been ordered by the physician for a specific reason. Simply taking the patient's blood pressure on the day the patient presents for a test does not allow the practice to bill 99211 for the nurse's time.
- The use of 99211 depends on whether there are clinical indications for the visit. Procedure code 99211 should not be reported for the stable patient who decides to come in for a blood-pressure check while in the area.

For Telephone Calls

- Telephone calls are considered part of the post-work or pre-work of other E&M services. Telephone calls are not separately reimbursable.

Prothrombin Time and Evaluation of Patient Anti-coagulation Status

If the patient does not have any new symptoms or require a change in the dosage of his/her medication, the physician *cannot r*eport 99211.

When a face-to-face medication management is provided by qualified office staff on the same date of the laboratory test, the physician may bill CPT code 99211 if the services are medically necessary and constitute a distinct, separately identifiable evaluation and management (E&M) service that is consistent with the criteria for a low-level office visit.

The following describes adequate documentation for CPT code 99211 when billed for an evaluation of a chronically anti-coagulated patient for whom a prothrombin time has been drawn and determined.

- Reason for the visit. A physician visit is not routinely necessary in order to draw blood for prothrombin time or other laboratory tests. Therefore, the documentation for 99211 or any other E&M code in this circumstance must demonstrate a need for clinical evaluation and management. In this case, services that would serve to demonstrate that evaluation and management were performed include evaluation of significant new symptoms (such as excessive bruising or hemorrhage). Alternatively, for patients who have no new clinical concerns, demonstrating how the relevant laboratory information obtained was used to modify therapy will document that a separately payable E&M service has been performed.
- Current medications listed (with notation of level of compliance).
- Indication of physician's evaluation of the information about signs/symptoms and laboratory test result and his or her management recommendation.
- Identity and credentials of provider(s) as listed in text above.

Other

- For services provided solely to meet the requirements of office policy when no medical necessity exists.

Billing Reminders: When you may be able to bill a 99211

Example One: Established patient is seen in physician clinic for hypertension. The physician changes the patient's medication and documents "see nurse in one week for Blood Pressure (BP) check to evaluate response to new medication." During the return visit, the nurse would ask the patient about any side-effects, concerns, etc and document the patient responses, check the patient's BP, and report results to physician who would then document his review.

Example Two: A physician reviewed established patient's lipid profile and writes on the results "see nurse to get diet instructions." The nurse would see the patient on a day when the patient did not see the physician. The nurse gives the patient a diet plan to follow, educational materials and documents the discussion with patient regarding the cause of hyperlipidemia, the importance of lowering the lab values, and goes over the diet plan with the patient to make sure he/she understands.

Medicare 99211 Checklist

CPT® defines 99211 as 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.

The answer to questions 1 – 10 must be YES	Yes	No
1. Has medical necessity been established and documented?		
2. Is there a face to face encounter with patient?		
3. Does documentation include both elements – evaluation and management?		
4. Evaluation - Does the patient record include documentation that is relevant and necessary to the clinical exchange of information between the provider and patient?		
5. Management – Does the patient record include documentation that shows the influence of the service on patient care, such as medical decision making, patient education, etc.		
6. Does the documentation include the identity and credentials of the person who performed the service?		
7. Are all signatures, credentials and documentation legible?		
8. Are all signatures hand written or secure electronic?		
9. Is the date of service listed in the documentation?		
10. For evaluation of patient anticoagulation status does the patient have new symptoms? Or a change in medication dosage?		
The answer to questions 11 – 13 must be NO		
11. Am I using 99211 to bill for a phone call to patient?		
12. Is the only service provided a new or refill prescription?		
13. Is the only service provided a blood pressure check without a clinical reason for evaluation and management?		
Billing 99211 as "Incident To"		
The answer to questions 14 – 16 must be YES		
14. If the services are provided as "incident to" the services of a physician or non-physician practitioner are all "incident to" requirements met?		
15. If billed as "incident to" does documentation show the link between the incident to service and the plan of care established by the physician at the initial visit?		
16. Does the record documentation show that the supervising physician was involved in the care of the patient and was present and available during the visit providing "direct supervision"?		
17. Are the signature and credentials of the auxiliary personnel performing the service in the documentation?		

Disclaimer: The checklist should not be used solely for the purpose of billing a 99211 service. Please review the Job Aid, and all CPT guidelines to ensure correct coding.

Resources/Evaluation and Management Services

www.cms.hhs.gov/Manuals/IOM/list.asp

"Incident To" Billing

- Publication 100–02, *Medicare Benefit Policy Manual*
  - Chapter 15–50.3, 60–60.4.1, 180, 190, 200, 210
- Publication 100–03, *Medicare National Coverage Determination Manual*
  - Chapter 1, Part 1, Section 70.3
- Publication 100–04, *Claims Processing Manual*
  - Chapter 12– 30.5F, 30.6.1, 30.6.13E, 30.6.4, 120, 120.1, 130.1, 130.2
  - Chapter 26–10.4

Medicare University

"Incident To" Computer Based Training (CBT) Module

- http://www.ngsmedicare.com/content.aspx?CatID=2&DOCID=3518

Guides

http://www.cms.gov/MLNProducts/

- Guided Pathways Basic Curriculum
- Guided Pathways Intermediate Curriculum
- CMS Evaluation and Management Services Guide

http://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp

- 1995 Documentation Guidelines for Evaluation and Management Services
- 1997 Documentation Guidelines for Evaluation and Management Services

Signature Guidelines for Medical Review Purposes and Medical Record Retention

http://www.cms.gov/MLNMattersArticles/

- MM6698 and SE1022