UNIVERSITY HEALTHCARE ALLIANCE

CODING CORNER

When to Report Evaluation and Management Code 99211

CPT 99211 is an office or other outpatient facility visit for the evaluation and management (E/M) of an established patient that may not require the presence of a physician. Usually the presenting problem is minimal. Typically, 5 minutes arespent performing or supervising these visits. (Reminder: Since this is an E/M visit, patient co-payment mayapply)

The medical record must adequately document the reason for the patient's visit and any treatment rendered. There must also be recorded elements of history of obtained, examination performed and /or medical decision making, as well as documented evidence of physician supervision. *Incident to billing applies when providing a 99211 visit by an ancillary staff.*

Examples of when CPT 99211 CANNOT be billed:

- Blood Draw Only
- Injection/Immunization Only (covered under administration charges)
- DME/Supplies Application or Fitting
- Infusion Visit without complications
- Prescription Refill

Examples of when CPT 99211 CAN be billed:

- Blood Pressure Monitoring
- Injection teaching – self-administered medications
- TB Reading
- Genetic Testing

Guidelines for Incident to with Ancillary Staff

- Documentation must support a 99211
- Patient must be initially seen by a physician/Allied Health Professional (AHP)
- The physician/AHP must establish a plan of care
- The physician/AHP must periodically see the patient during treatment to reflect his/her active involvement in the patient's care
- A supervising physician/AHP (billing physician/AHP) must be present in the suite and immediately available if needed during the service
- All encounters must be signed by the supervising physician/AHP

Documentation examples:

Nurse visit for an established patient with hypertension:

CC: HTN Height: 1.753 m (5' 9") Weight: 71.668 kg (158 lb.) BP: 148/83 *(exam)*
Patient here for BP check at Dr. Smith's request, currently taking 25mg HCTZ daily *(history).* Today BP 148/83, patient with no other complaints *(exam).* Dr. Alan advised *(physician supervision),* request patient come back next week for addition BP check *(clinical decision).*

CC: elevated BP Height: 5' 5"Weight: 140 lb. BP: 130/78 *(exam)*
Patient her to recheck BP, elevated at yesterday's visit *(history).* BP today is 130/78, will route chart to Dr.Wall *(physician supervision).*

Nurse visit for an established patient with atrial fibrillation:

CC: atrial fibrillation BP 118/80 | Pulse 66 | INR 2.4 *(exam)*
Patient is here for anticoagulation monitoring; missed one dose last week, no bruising, see flow sheet *(history).* Today's INR 2.4, per Dr. Green *(physician supervision)* continue same dose of coumadin, 6 mg on M,W,F and 5 mg on all other days, recheck in 1 month *(clinical decision).*

In each of the above examples, the deciding factor in whether an independent E/M service may be billed is whether the patients were provided medically necessary services, and documentation included clinical history, clinical exam and/or making a clinical decision, and physician supervision.