Documentation Requirements for CPT Code 99211

CPT code 99211© is used to report a low-level Evaluation and Management (E/M) service. The *CPT* book defines code 99211 as:

> "Office or other outpatient visits 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."

Code 99211 requires a face-to-face patient encounter; however, when billed as an "incident to" service, the physician's service may be performed by ancillary staff and billed as if the physician personally performed the service. For such instances, all billing and payment requirements for "incident to" services must be met.

As with all services billed to Medicare, code 99211 services must be reasonable and necessary for the diagnosis or treatment of an illness or injury. Unlike the other E/M CPT codes, the *CPT* book does not specify completion of particular levels of work for code 99211 in terms of key components or contributory factors. Also, unlike the other E/M codes, CMS did not provide documentation requirements for code 99211 in the "E/M Documentation Guidelines."

CPT code 99211 describes a service that is a face-to-face encounter with a patient consisting of elements of both evaluation **and** management. The evaluation portion of code 99211 is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information (historical information and/or physical data) between the provider and the patient. The management portion of code 99211 is substantiated when the record demonstrates influence by the service of patient care (medical decision-making, provision of patient education, etc.). Documentation of all code 99211 services must be legible and include the identity and credentials of the individual who provided the service.

For code 99211, services performed by ancillary staff and billed by the physician as an "incident to" service, the documentation should also demonstrate the "link" between the non-physician service and the precedent physician service to which the non-physician service is incidental. Therefore, documentation of code 99211 services provided "incident to" should include the identity and credentials of both the individual who provided the service and the

supervising physician. Documentation of a code 99211 service provided "incident to" should also indicate the supervising physician's involvement with the patient care as demonstrated by one of the following:

- Notation of the nature of involvement by the physician (the degree of which must be consistent with clinical circumstances of the care).
- Documentation from other dates of service that establishes the link between the services of the two providers.
- Medicare has reviewed numerous claims on which 99211 was reported inappropriately. All 99211 services for which supporting documentation does not demonstrate that an E/M service was performed and was necessary as outlined in this document will be denied upon review.

Among other things, code 99211 **should not** be used to bill Medicare:

- For phone calls to patients.
- Solely for the writing of prescriptions (new or refill) when no other E/M is necessary or performed.
- For blood pressure checks when the information obtained does not lead to management of a condition or illness.
- When drawing blood for laboratory analysis or when performing other diagnostic tests, whether or not a claim for the venipuncture or other diagnostic study test is submitted separately.
- Routinely when administering medications, whether or not an injection (or infusion) code is submitted on the claim separately.
- For performing diagnostic or therapeutic procedures (especially when the procedure is otherwise usually not covered/not reimbursed or payment is bundled with payment for another service), whether or not the procedure code is submitted on the claim separately.

The table below contains elements that would constitute adequate documentation of a code 99211 service in selected clinical circumstances:

Clinical Circumstance	Adequate Documentation for Code 99211
Blood pressure check	1. Blood pressure and other vital signs recorded. 2. Clinical reason for checking blood pressure recorded (i.e., follow up to previous abnormal finding, symptoms suggestive of abnormal blood pressure, etc). 3. Current medications listed (with notation of level of compliance). 4. Indication of doctor's evaluation of the clinical information obtained and his management recommendation. 5. Identity and credentials of provider(s) as listed in text above.

Clinical Circumstance	Adequate Documentation for Code 99211
Prescription refill or injection/infusion	1. Reason for the visit. A physician visit is not necessary to routinely provide stable patients with an ongoing medication supply. Therefore, the documentation for code 99211 or any other E/M code in this circumstance must demonstrate a need for clinical evaluation and management (for instance, symptoms or signs reported that are significant enough to necessitate evaluation). 2. Current medications listed (with notation of level of compliance). 3. Indication of doctor's evaluation of the clinical information obtained and his management recommendation. 4. Identity and credentials of provider(s) as listed in text above.
Prothrombin time evaluation for patients on chronic warfarin anticoagulation	1. Reason for the visit. A physician visit is not routinely necessary to draw blood for prothrombin time or other laboratory tests. Therefore, the documentation for code 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 was performed include an evaluation of significant new symptoms (such as excessive bruising or hemorrhage). Alternatively, for patients who have no new clinical concerns, documentation that contemporaneous laboratory values were obtained, reviewed, and used to guide current and/or future therapy documents that a separately payable E/M service has been performed. 2. Current medications listed (with notation of level of compliance). 3. Indication of doctor's evaluation of the information about signs/symptoms and laboratory test result and his management recommendation. 4. Identity and credentials of provider(s) as listed in text above.