CODING Q&A

How to Use the Level 1 Established Patient E/M Code (99211)

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Q. What is the code 99211?

A. The official description is as follows: "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, five minutes are spent performing or supervising these services."

This is a low-level Evaluation and Management (E/M) service. The code requires a face-to-face patient encounter with a staff member in the physician office, but a face-to-face encounter with the physician is not required. Even though the services may be performed by ancillary staff, it may be billed as if the physician personally performed the service if all billing and payment requirements for "incident-to" services are met.

To comply with incident-to requirements, documentation must show either:

- a link back to a previous visit with the physician (e.g., "Patient is seen on follow-up as directed by Dr. Smith".
- involvement of the physician directly in the visit (e.g., "History reviewed with Dr. Smith, who concurs").

Q. What specific documentation is required for 99211?

A. Unlike with other E/M services, the Centers for Medicare and Medicaid Services (CMS) has not quantified *specific* levels of history, physical exam, and complexity of medical decision making needed to meet requirements for 99211. Nevertheless, this should *not* be misunderstood to mean that there are no documentation requirements for 99211.

Although CMS has intentionally left the requirements somewhat vague, there are several documentation requirements in addition to the already-mentioned incident-to requirements. The record must document *clinically relevant and necessary exchange of information* (historical information and/or physical exam data) between provider (and/or ancillary staff) and patient. Documentation should also demonstrate an *influence on patient care* (medical decision-making, provision of patient education, etc.). Documentation of services coded to substantiate the code 99211 must be *legible* and must include the *identity and credentials* of the individual who provided the service.

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Q. When is it appropriate to use 99211?

A. Generally, visits to ancillary staff that involve an element of both evaluation and management may qualify for 99211. Examples of visits that qualify for 99211 include:

Blood pressure check that includes documentation of:

- a clinical reason for checking blood pressure
- blood pressure and other vital signs
- current medications listed (with level of compliance noted)
- the identity and credentials of the provider(s)

Recheck for cellulitis for a patient who has shown continuous improvement over several days but requires repeated antibiotic injection treatments.

Documentation may include:

- a clinical reason for recheck
- vital signs
- history of pain, fever, or other symptoms
- erythema, warmth, swelling, etc.
- the injection of antibiotic including drug name, lot number, and location of injection
- the identity and credentials of the provider(s)

Recheck for medication refill, with documentation including:

- a clinical reason for recheck
- current medications and compliance
- history of symptoms or their absence since previous visit
- the identity and credentials of the provider(s). ■