Coding Training without Leaving the Office
Outreach Training Series

To Code or Not To Code?
Nurse Encounters and CPT 99211

Donna Monroe, CCS-P, CPC
Brown Consulting Associates, Inc.

Session Date: Tuesday, October 18, 2011
9:00 AM Pacific Time (be sure to note correct start time for your time zone)

Ten Minutes Prior to Training Time:
1. Join the meeting using the confirmation email you received after you reserved your seat.
   The subject line of the email says: “99211: The “Do’s” and the “Don’ts”
2. Join by clicking on the link in #1 that says “Click here to join the webinar”.
3. You will be given the telephone call-in number once you are in the webinar.

If you encounter problems, call Kerri Robbins at Brown Consulting Associates: 208-736-3755

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West Virginia and South Carolina Primary Care Associations
Indiana Primary Health Care Association
Missouri and Montana Primary Care Associations
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Central Valley Health Network (California)
Brown Consulting Associates, Inc.

Bonnie R. Hoag, RN, CCS-P, is a private practice reimbursement consultant who has served as a national physician office consultant and seminar speaker for a variety of firms, including St. Anthony Publishing and Consulting in Alexandria, Virginia and Medical Learning Inc. in Minneapolis, Minnesota. Bonnie currently presents approximately 30 seminars each year with the Idaho Medical Association, Montana Medical Association, Iowa Medical Society, National Association of Community Health Centers and other groups. She continues to present seminars and workshops for the Northwest Regional Primary Care Association, Center for Health Training and other groups. Brown Consulting Associates, Inc. has developed and presents live, web-based certification training for the Northwest Regional Primary Care Association. Bonnie is honored to serve as a board of directors’ member at the Community Health Center in her community. For eleven years, Bonnie taught a three-semester course for students aspiring to become certified coders at the College of Southern Idaho. During years 2005-2007 Bonnie also served on the AHIMA national Physician Practice Council Group. On occasion Bonnie is called upon to work with health care legal defense attorneys to assist physicians in resolving third-party-payer coding actions.

Sixteen years of clinical experience combined with twenty one years of coding consulting and training provides an exceptional skill base for application to the challenging and changing medical coding environment. Bonnie graduated from Los Angeles County-USC Medical Center School of Nursing in 1973. Her nursing experience includes office nursing and hospital nursing in the areas of surgery, ER, ICU and home health. She served as an Air Force Flight Nurse.

Bonnie has worked in physician office nursing and management, dealing directly with reimbursement issues in Las Vegas, Nevada; Salt Lake City, Utah; and Twin Falls, Idaho. She has been teaching and consulting since 1989 and has worked in 41 states. As a physician reimbursement consultant, Bonnie visits physician offices, clinics and ERs to assess the issues that directly and indirectly affect reimbursement and CMS compliance.

Shawn R. Hafer, CCS-P, CPC, Senior consultant and co-owner of Brown Consulting with more than 20 years of physician coding and reimbursement experience in a variety of specialties. She holds coding certifications from both the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC) and is a member of both organizations. Her background provides an excellent foundation for the demanding medical coding environment.

Shawn has been with Brown Consulting for 12 years, and is uniquely qualified due to her diverse management skills and experience, as well as her coding and billing expertise. Shawn also serves as a senior auditor conducting hundreds of medical record audits each year providing both clinician and coder training in all facets of coding and documentation. She has been involved in small rural health clinic projects served by visiting providers to large inner-city clinics with more than 100 providers. Shawn has worked with healthcare defense attorneys on behalf of physicians involved in third party payer audits. Shawn authors and presents coding seminars and webinars for our many workshop/seminar partners including the Idaho Medical Association, Montana Medical Association, Iowa Medical Society, West Virginia Primary Care Association, Northwest Regional Primary Care Association and many other regional and national groups.

For ten years, Shawn served as a coding instructor at the College of Southern Idaho and for Northwest Regional Primary Care Association, and was a long term member of the Advisory Committee for Coding Education at the College of Southern Idaho. Shawn attended the College of Southern Idaho in Twin Falls, ID and Pima College in Tucson, AZ.

Donna Monroe, CCS-P, CPC, BA, is a senior auditor for BCA, conducting hundreds of record audits each year and providing both clinician and coder training in all facets of coding and documentation. She is the Academic Director of our 23-week Comprehensive Coding Education Program designed for coders aspiring to certification. Donna authors and presents multiple BCA seminars and webinars, drawing from her diverse coding background which includes coding
administration and education for a 200-physician, 20-specialty Arizona trauma program, coding education for a multi-state neonatology group, management of a pulmonology physician practice and coding/patient accounts responsibility for a large Ob-Gyn practice. Donna served as Communications Director and Reimbursement Specialist for the Idaho Medical Association for five years, interfacing with physicians and medical office staffs to resolve reimbursement and compliance issues. She has expertise working directly with payers on behalf of physicians and with the American Medical Association and national specialty societies. She has developed educational programs on topics ranging from ICD-9-CM and CPT coding to reimbursement issues such as Medicare guidelines and payment methodology. Her current efforts include planning education for physician transition to use of ICD-10-CM for diagnosis coding.

Donna is a graduate of Tulane University (New Orleans) and certified by the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC). She participates in the Minnesota Health Information Management Association (MIHIMA)) and the Minneapolis Chapter of AAPC. As a recent breast cancer survivor, Donna ‘s “seize the day” enthusiasm encompasses her BCA work and her family, including husband Gary, daughter Kate, son-in-law Drew, and beloved black cat Toby. She resides in the Minneapolis suburb of Victoria, MN.

**Dana Fox, CCS-P, CPC**, began her Brown Consulting affiliation in June 2007, having completed the BCA coding curriculum at the College of Southern Idaho in Twin Falls. She entered the coding profession five years ago after working on the payer side of the healthcare system for 12 years. She began her career in the Seattle area working as an HMO hospital claims specialist with responsibilities including claims adjudication and research, utilization review, and benefits administration. She then transitioned to a position administering employer-sponsored medical, dental and vision benefits for a third party payer. In subsequent roles she has adjudicated claims for managed care plans, was a customer service representative for a major private insurer, and has provided claims re-pricing, hospital DRG, and claims system monitoring services.

Dana holds certifications and membership from both the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC). Her education in addition to the CSI credentials includes completion of technical courses encompassing computer and health insurance training and studies in medical terminology and anatomy.

**Our Commitment**
Brown Consulting Associates, Inc. has provided national physician training services since 1989. BCA recognizes the increasing and constantly changing demands placed on the physician office by federal and state government, CMS, Medicare, the Peer Review Organization, private insurance carriers and hospitals. In addition to serving physician offices, Brown Consulting Associates provides specialized training for various third party payers, Military Treatment Facilities, and Federally Qualified Health Care Centers. Brown Consulting Associates offers physician and staff education designed and customized to enhance operations and federal compliance.

Our association with the American Health Information Management Association, American Academy of Professional Coders, Medical Group Management Association well as other groups, helps to keep us current in the field of coding, documentation and reimbursement. Our programs and services are designed to assist physicians and their staff to meet the new demands and challenges of coding, documentation, compliance and reimbursement. Customized in-office services and live web-based programs designed to educate physicians and their staff regarding coding, documentation and billing issues will continue to be our focus.

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We Will Help You Work Smarter ✩✩✩ Not Harder
To Code or Not To Code: the Nurse Encounter and 99211

BCA Coding Workshop Series

Partners
- Central Valley Health Network (California)
- Idaho Medical Association
- Indiana Primary Health Care Association
- Iowa Medical Society
- Mid-Atlantic Community Health Centers
- Missouri Primary Care Association
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- Montana Primary Care Association
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Training sessions are provided by Brown Consulting Associates, Inc. and their educational partners. Your paid session includes:
- Live, interactive, web-based session
- Material and tools provided via download and/or US mail
- CEU certificate (3 CEUs)
- 2 additional CEUs for the post-course assessment, complete at http://www.coursesites.com. Must complete within two business days.
  - First complete and fax the evaluation to 208-736-1946 ASAP
  - Then complete the assessment and enter in Blackboard for two additional CEUs. AAPC requires passing grade of 70% or better.
  - Unlimited attempts to achieve passing grade during 2 day period.
- 30-day access to codingquestions@codinghelp.com for questions related to today’s webinar content.

Post Webinar Assessment

Brown Consulting Associates, Inc., uses Blackboard as it’s academic platform for the post-webinar assessments.
Blackboard upgraded to a newer version in early July which resulted in the need for everyone to have a new account.
- In the past BCA set-up your account for you, however, now you will be responsible for the one-time set-up of your own account.
- You are RESPONSIBLE TO REMEMBER YOUR USERNAME AND PASSWORD for future BCA webinars
- Attendees will need to fax the “Post Course Assessment and CEU Certificate Request” (last page of the training material) ASAP – within the hour following the webinar to receive instructions on how to set up your account.
  - If not faxed within the hour following the webinar, you will not receive instructions until the next day, delaying your access to Blackboard.
To Code or Not To Code: the Nurse Encounter and 99211

Goals and Objectives

- Identify appropriate clinical circumstances for assignment of E/M 99211 (nurse encounter).
- Recognize clinical interaction which does not support assignment of CPT 99211.
- Identify components of documentation.
- Discuss related third-party payer issues.

Agenda

- Such a little code – why the big deal?!
- 99211 Under the Microscope
- Scenarios – Thumbs Up? Down?
- 99211 Documentation
  - What payers tell us.
  - Teach with templates!
- A closer look at labs, injections, immunizations, BP checks, others
- Closing Considerations

99211

- Blood pressure monitoring
- Follow-up UTI, patient needs U/A today
- Patient needs a throat culture
- Prescription refill
- Depo-Provera injection
- Protime eval for patients on chronic warfarin anticoagulation
- Venipuncture for lab
- Wound check for chronic wound
- Dressing change
- Suture removal
- Patient education
- Group patient training
- Patient needs breathing treatment
- Phone call to patient
Big Deal? Clinic Perspective

- The 99211 Coding Dilemma
  - Can we code when ancillary staff provides services under the supervision of a clinician (physician, FNP or PA)?
  - Can we code when staff performs services for which there are no established codes?
    - Example: providing education to a patient following his/her doctor visit which is a value-added service to the visit.
  - What other services did we perform that can be coded?
  - Can we code “nurse visits” in an FQHC/RHC?
  - All your services must be documented but may/may not be eligible for coding.
  - 99211 has value – it generates revenue.

Big Deal? Payer Perspective

- 99211 has value!
  - 2011 Non-Facility RVU .58.
  - 2011 Part B par allowable $19.71
- Federal Audit Info: April 2009
  - CERT report: more than 15% of claims submitted to Part B for this code were missing critical documentation, causing Medicare to request more than $24 million back from providers.

Big Deal? Regulatory Perspective

- 2012 OIG Work Plan
  - Physicians: “Incident To” Services
    - We will review physician billing for “incident-to” services to determine whether payment for such services had a higher error rate than that for non-incident-to services. We will also assess OIG’s ability to monitor services billed as “incident-to.”
    - Medicare Part B pays for certain services billed by physicians that are performed by nonphysicians incident to a physician office visit.
    - A 2009 OIG review found that half of the services were not performed by a physician.
    - We also found that unspecified nonphysicians performed 21 percent of the services that physicians did not perform personally.
    - Incident-to services represent a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. They may also be vulnerable to overutilization and expose Medicare beneficiaries to care that does not meet professional standards of quality.
Big Deal? Regulatory Perspective

  - We will review Medicare claims for services furnished “incident to” the professional services of selected physicians. Medicare Part B generally pays for services “incident to” a physician’s professional service: such services are typically performed by a nonphysician staff member in the physician’s office. Federal regulations specify criteria for “incident to” services. We will examine the Medicare services that selected physicians bill “incident to” their professional services and the qualifications and appropriateness of the staff who perform them. This study will review medical necessity, documentation, and quality of care for “incident to” services.

“Incident to…”

- “Incident to” is a Medicare term defining services that are furnished incident to physician professional services in the physician’s office (whether the office is located in a separate building or is an office within an institution) or in a patient’s home.
- These services are billed as Part B services to your Medicare carrier/MAC as if the physician personally provided them and are paid under the physician fee schedule.

“Incident to…”

- “Incident to” services are can also be supervised by certain nonphysician practitioners such as physician’s assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists.
- These services are subject to the same requirements as physician-supervised services. The service is priced at the rate paid to the supervisor who is the person responsible for the appropriate rendering of the service.
“Incident to…”

- To qualify as “incident to,” services must be part of your patient’s normal course of treatment during which a physician personally performed an initial service and remains actively involved in the course of treatment. The physician does not have to be physically present in the exam room, but must provide **DIRECT SUPERVISION**; that is, he/she must be present in the office suite to render assistance if necessary.
- The patient record should document the essential requirements for incident to service.

Incident to...

- In an office, qualifying “incident to” services
  - Must be provided by a caregiver qualified to provide the service;
  - Are directly supervised by a physician or NPP; and
  - Represents a direct financial expense to the clinic/physician (such as a “W-2” or leased employee or an independent contractor).
- In a group practice, any physician/NPP member of the group may be present in the office to supervise.

Direct Supervision (CMS)

- **Direct supervision** in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
To Code or Not To Code: the Nurse Encounter and 99211

‘Nurse’ sees the patient on a day the clinician does not.

- When the patient is seen by the nurse rather than by the MD, DO, FNP, or PA, some of those “visits” may be coded and billed while others may not.
- CPT code 99211 is the only evaluation and management (E/M) code that may be assigned when the “nurse” sees the patient for the clinician.

99211 Under the Microscope: CPT Descriptor

- Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of the physician. Usually the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

- BCA NOTE: This patient must have previously been seen by one of your clinicians (MD, DO, FNP or PA).

Compare 99211 to Other E/M Codes

- 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 or supervising these services.

- 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:
  - A problem focused history;
  - A problem focused examination;
  - Straightforward medical decision making

  ... Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
Part B Medicare 99211 Definition

- Services billed to Medicare under CPT 99211 must be reasonable and necessary for the diagnosis and treatment of an illness or injury.
- Furthermore, a face-to-face encounter with a patient consisting of elements of both evaluation and management is required.
- The evaluation portion is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information between provider and patient.
- The management portion is substantiated when the record demonstrates an influence on patient care (e.g., medical decision making, patient education, etc.).

Who Typically Uses 99211?

Employed staff members as follows:
- RNs
- LPNs/LVN
- MAs
- CNAs
- CMAs
- Other assistants (technicians, etc.)

Who Else Can Assign 99211?

- MDs, DOs
- NPP
  - Nurse Practitioners
  - Physician Assistants
  - Certified Nurse Midwives
Ground rules for assigning 99211:

1. Patient must be seen face-to-face by the nurse/assistant who may be an RN, LPN/LVN, MA or other employed assistant.
2. The patient must be an established patient.
3. The problem must be an established problem with a treatment plan.
4. The service must be ordered by the clinician.
5. A supervising clinician must be in the office at the time of the nurse encounter. [Part B Medicare specific]

Direct supervision is defined as presence in the office suite where the services are being rendered, at all times while the services are being rendered. In addition, the physician must be immediately available to assist if needed.
- Midlevel providers (nurse practitioners, physician assistants) qualify as “physicians” under this definition.
- In a “physician-directed clinic,” any physician in the clinic may serve as the supervising physician.

More ground rules for 99211:

6. The service must be medically necessary.
7. The service must be provided within the performer’s “scope of practice” and in accordance with state laws.
8. Nursing documentation should reflect:
   - The order
   - The reason for the service (diagnosis)
   - Nursing assessment as indicated
   - Nursing action as indicated
   - Patient instructions
   - Follow-up
   - Nurse’s legible SIGNATURE and credentials
To Code or Not To Code: the Nurse Encounter and 99211

Billed as 99211: How’s the documentation?

Pt here in office, weight = 146#, 122/68, sent to lab for BMP today. Bilat LE edema has improved. – J. Jones, RN

 The order
 The reason for the service (diagnosis)
 Nursing assessment as indicated
 Nursing action as indicated
 Patient instructions
 Follow-up
 Nurse’s legible SIGNATURE and credentials

Billed as 99211: How’s the documentation?

Pt here for protime as ordered by Dr. Green. Notified of result, will return in 1 wk for rev per CG/N Black, LPN.

1. The order
2. The reason for the service (diagnosis)
3. Nursing assessment as indicated
4. Nursing action as indicated
5. Patient instructions
6. Follow-up
7. Nurse’s legible SIGNATURE and credentials

Will Your Documentation Support 99211?

Evaluate your process and documentation:
1. Does your note identify the ordering/ supervising physician?
   “Direct supervision” means the physician must be physically present in the office suite, not just in the building.
2. Does your note identify evaluation and management?
3. Does your note identify the nurse with credentials?
4. What is your protocol for medication changes?
   • Per physician’s order or per protocol?
   • Is this clear in your note?
To Code or Not To Code: the Nurse Encounter and 99211

Will Your Documentation Support 99211?

Evaluate your process and documentation:
5. Does your process identify the physician’s involvement?
   - Results and/or nursing information relayed to physician?
6. How often is the patient seen by the physician?
7. What instructions are given to the patient?
   - Medication changes only or other instructions, e.g. regarding bleeding (call the office)...

The FQHC/RHC Medicare rule:
99211 is not a ‘visit.’
- All-inclusive rate – payments from the Medicare program are made based on an all-inclusive rate per covered visit.
  - A “visit” is defined as a face-to-face encounter between a patient and a physician, NP, PA, CNM, CP, CSW, or visiting nurse (very limited cases in the home) during which an RHC or FQHC service is rendered.
  - A ‘Nurse Visit’ may and should be coded and counted in the FQHC but may not be billed as an “encounter.”

99211
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- Venipuncture for lab
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To Code or Not To Code: the Nurse Encounter and 99211

99211?
It depends on the documentation!

- 8/3
- BP recheck 130/76
  - S Hunter, CMA

8/3 -FU BP
NP Troy requested FU of this HTN patient who was started on new antihypertensive three weeks ago. Pt has been compliant with meds. BP today is 130/80, improved from 146/92. Lungs are clear and no ankle edema. We reviewed his med and diet plan. He will return as scheduled or call with any problems.
  - H. Gonzales, RN

BP Stamp for Nursing

99211?
It depends on the documentation!

- UA obtained.
  - S. Hunter, CMA

- August 3 -FU UTI
- At the request of Dr. Brown, pt is seen today for UTI on July 25th. Temp and other VS entered and are normal. Patient denies pain, burning, urgency or frequency. Shh has completed abx. She describes drinking at least 1.5 qts of water/day. UA is done and negative.
- Results shared, nursing education completed & instructions given. Results provided to doctor. Pt will return per
  - S. Hunter, CMA

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Services billed to Medicare under CPT 99211 must be reasonable and necessary for the diagnosis and treatment of an illness or injury. Furthermore, a face-to-face encounter with a patient consisting of elements of both evaluation and management is required. The evaluation portion is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information between provider and patient. The management portion is substantiated when the record demonstrates an influence on patient care (e.g., medical decision making, patient education, etc.). The medical record is expected to include the physician’s order for the medication management services. Documentation provided as “incident to” must demonstrate the services were provided under direct physician supervision (physician in office). Documentation should include the identity and credentials of the individual providing the face-to-face service.
To Code or Not To Code: the Nurse Encounter and 99211

Protime, 99211 and CMS

- Example: Office visit for an established patient with atrial fibrillation who is taking anticoagulants and having no complaints.
- Patient is queried by the nurse, vital signs are obtained [because VS relevant], patient is observed for bruises and other problems, and prothrombin time is obtained.
- Physician is advised of results and medication dose, and medication is continued at present dose with follow up prothrombin time in one month.
- History, vital signs, exam, PT/INR dosage and physician's decision and follow up instructions are recorded.

Anticoagulation Treatment Note – Train with templates!

Included in today's handout.

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To Code or Not To Code: the Nurse Encounter and 99211

Compare to template …

Pt here for protime as ordered by Dr. Green. Notified of result, will return in 1 wk for rev per CG/N Black, LPN.

1. The order
2. The reason for the service (diagnosis)
3. Nursing assessment as indicated
4. Nursing action as indicated
5. Patient instructions
6. Follow-up
7. Nurse's legible SIGNATURE and credentials

Protome and Diagnosis Coding

Diagnosis coding
1. First report code **V58.83** *Encounter for therapeutic drug monitoring.*
2. Followed by a code from subcategory **V58.6** (V58.61-V58.69) *Long-term (current) drug use:
   - V58.61 Long-term (current) use of anticoagulants
   - V58.63 Long-term (current) use of antiplatelets/antithrombotics
   - V58.66 Long-term (current) use of aspirin
3. You may then report the disease for which the medication is being given, but it's not required.
To Code or Not To Code: the Nurse Encounter and 99211

Protime and Diagnosis Coding

- CMS 2008 Standard Analytical File for hospital outpatient claims (141,245,646 claims):
  - 24.5% 99211 claims 427.31 Atrial fibrillation
  - 13.5% 99211 claims V58.61 Long term current use of anticoagulant
  - 5.18% 99211 claims 401.1 or 401.9 Benign, Unspecified hypertension

Injections and 99211: CPT, CMS

96360-96379: A matter of “Parts” and “Labor”

CPT Injections and 99211

- CPT: If a significant, separately identifiable E/M service is performed, the appropriate E/M service code should be reported using modifier 25 in addition to 96360-96549. [Infusions, Injections, Chemo]
- Review CPT guidelines under “Hydration, Therapeutic, Prophylactic and Diagnostic Injections and Infusions.”
  - Note direct supervision requirement.
  - Review also parenthetical note under 96372.
    - (Physicians do not report 96372 for injections given without direct physician supervision. To report, use 99211...)
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CPT-CMS: Big Differences

- Parenthetical note 96372 for Medicare (Part B contractor citation):
  - This coding guideline does not apply to Medicare patients. If the RN, LPN, or other auxiliary personnel furnishes the injection in the office and the physician is not present in the office to meet the supervision requirement, which is one of the requirements for coverage of an incident to service, then the injection is not covered.
  - The physician would also not report 99211 as this would not be covered as an incident to service.

Injection per CPT:
- 96372 + drug(s) with direct physician supervision
- 99211 + drug(s) without direct physician supervision
- Separate E/M (w/modifier 25) may be reported with 96372 when done and documented (could be 99211 if appropriate).

Injection per CMS:
- 96372 + drug(s) with direct physician supervision
- Drug(s) only (no 99211) without direct physician supervision
- Separate E/M (w/modifier 25) may be reported when done and documented, but not 99211.

Injections: A Matter of ‘Parts and Labor’

- Labor = Work of giving the injection:
  - 96372 Tx/Dx/Abx injection; subq or IM
  - 96374 Tx/Dx Injection; IV push, single or initial substance/drug
    - +96375 Tx/Dx Injection; IV push, each add'l sequential IV push

- Parts = Product (drug) administered
  - HCPCS Level II Codes
  - Select code based on dosage given.
    - J0696 x 4 units for Rocephin 1 gram
  - Assign appropriate administration code.
Injections on Your Encounter Form

Injection – What should be coded?

Enbrel injection given R thigh today.
Lot #POS9028 exp date 10/11
50mg/ml (.98ml) BP and pulse taken
130/80 P80       Sweet Heart, LPN

Pt here for MTX inj 0.8cc SubQ R
thigh. Pt tolerated well. VS 102/78,
HR 72, wt 100 lbs. Pt complained of
not sleeping well and will discuss w/
Dr. on appt on Thurs. Sam Care, RN

Train with templates!
General Principles

Report a minimum of 2 codes for an immunization service:
1. One code(s) defines the work of giving the immunization(s)
   - Administration code 90460-90477
   - “Labor”
2. Separate code = Vaccine Product
   - Vaccine/Toxoid codes 95476-90749
   - Many immunization services require multiple administration codes and multiple vaccine codes.
   - ICD-9-CM code demonstrates medical necessity.

General Principles

(Long-standing Immunization Administration Codes)

- 90471-90477 Immunization Administration
  - Select based on number of immunizations and route of administration.
    - Oral
    - Intranasal
    - Percutaneous, Intradermal
    - Subcutaneous
    - Intramuscular
  - Assign with the vaccine/toxoid injected.
    - CPT codes 90476-90749.
    - Do not assign a separate E/M unless there is separately identifiable Hx/Ex/MDM.
New Admin 90460, 90461:

- **90460** Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component.
- **90461** each additional vaccine/toxoid component (List separately in addition to code for primary procedure).

‘Parts and Labor’ Coding

- Immunization coding requires a minimum of two codes:
  1. Administration (Labor): 90471 and 90472
  2. Vaccines/Toxoids (Parts): 90476-90749

Services Included in Immunization Administration:

- Safe storage and inventory management
- Preadministration evaluation for contraindications or prior reactions
- Risk/benefit counseling with presentation of the Vaccine Information Statement(s), an activity usually performed by a physician or other qualified health care professional.
- Physical administration of the vaccine product
- Required documentation of each component administered and its lot number in both the medical record and statewide vaccine registry
- Postservice work of addressing any reactions or side effects.
General Principles Example

- **One Immunization = Two CPT Codes**
  - 60-year-old receives subcutaneous shingles vaccination.
    1. *90471* Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination)
    2. *90736* Zoster (shingles) vaccine, live, for subcutaneous injection
      - Dx code V05.8
        - Prophylactic vaccination; other specified disease

- **Multiple Immunizations = Multiple Administration Codes + Multiple Vaccine/Toxoid Codes:**
  - 5-year-old receives IM influenza, oral poliovirus, and IM diphtheria-tetanus-pertussis (DTaP)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Administration</th>
<th>Product</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>90471</td>
<td>90658</td>
<td>V04.81</td>
</tr>
<tr>
<td>Oral Polio</td>
<td>90474</td>
<td>90712</td>
<td>V04.0</td>
</tr>
<tr>
<td>DTaP</td>
<td>90472</td>
<td>90700</td>
<td>V06.1</td>
</tr>
</tbody>
</table>

General Principles

- **For 90471-90474**, note "one vaccine (single/combination)" codes versus "each additional" add-on codes:
  - Report only one ‘first’ administration during a single patient encounter.
    - If you administer one injectable vaccine and one intranasal vaccine, report 90471 for the injection and 90474 [add-on] for the intranasal.
    - Do not report 90471 and 90473 for the same visit.
    - The resources expended, and therefore the relative value units assigned, are higher for the ‘first’ administration code.
To Code or Not To Code: the Nurse Encounter and 99211

90460, 90461: A different protocol

- **90460** Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component
- **+90461** each add'l vaccine/toxoid component
  - Note 90460-90461 structure accounts for each vaccine component.
  - Route of administration is not a coding consideration.
  - Codes 90465-90468 deleted 1-1-2011.

6-month old receives DTaP, Pneumococcal, and Comvax (Hepatitis B + Hib). Physician provides counseling per AAP recommendations.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Administration</th>
<th>Product</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP</td>
<td>90460, 90461 x 2 (includes 3 components)</td>
<td>900700</td>
<td>V06.1</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>90460</td>
<td>90670</td>
<td>V03.82</td>
</tr>
<tr>
<td>Comvax</td>
<td>90460, 90461 (includes 2 components)</td>
<td>90748</td>
<td>V06.8</td>
</tr>
</tbody>
</table>

E/M and Immunization

What does CPT Say?

- If a significant separately identifiable Evaluation and Management service (eg, office or other outpatient service, preventive medicine service) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes.
  - This E/M service will have a different diagnosis code and be fully documented in the record.
  - If the doctor sees the patient for HTN and orders a vaccine, of course the E/M for HTN can be coded.
  - If the RN provides wound care and incidentally gives an immunization, both are coded.
To Code or Not To Code: the Nurse Encounter and 99211

E/M and Immunization

What does Medicare Part B Say?

- Take Care! 99211 is “bundled” into HCPCS and CPT immunization administration services. See CCI edits:
  - 99211 is a column 2 edit of covered immunization administration codes G0008, G0009, G0010.
  - Ex: Code 99211 is a component of Column 1 code G0008 and cannot be billed using any modifier.
  - 99211 is a column 2 edit of CPT immunization codes 90460-90474:
    - Ex: Code 99211 is a component of Column 1 code 90471 and cannot be billed using any modifier.
    - Code 99211 is a component of Column 1 code 90460 and cannot be billed using any modifier.
    - PCP E/Ms are not bundled and may be coded for different diagnoses.

Advance Beneficiary Notice (ABN)

Patient must sign before the service.

Advance Beneficiary Notice (ABN)

Often the responsibility of the nurse.

- Definition:
  - An ABN is a written notice a physician or supplier gives to a Medicare beneficiary before items or services are furnished when the physician or supplier believes that Medicare probably or certainly will not pay for some or all of the items or services.
  - Medicare requires use of a standard ABN in conjunction with Medicare coverage policy and claims.
    - Regulation is § 1862 (a) (1) of the Social Security Act.
    - Part of the CMS Beneficiary Notices Initiative (BNI):
      - Goal = making ABNs more beneficiary-friendly, reliable, and understandable with patient options clearly defined.
Advance Beneficiary Notice (ABN)

- Advance Beneficiary Notices
  - Spanish ABNs available.
  - Download from [https://www.cms.gov/BNI/02_ABN.asp](https://www.cms.gov/BNI/02_ABN.asp)
  - Complete ABN instructions published on the CMS Web site at the same web address as above.

Closing 99211 Considerations
To Code or Not To Code: the Nurse Encounter and 99211

Circumstances where assignment of 99211 is not appropriate.
1. Services of an individual not directly employed by the clinic/physician (leased employees allowed).
2. For a patient not seen face-to-face.
3. For services on the same day as a clinician visit.
4. In cases where services are provided over the telephone.
5. For triage services for a new problem.
6. For administrative paper work.
7. For services which are face-to-face with a family member or caregiver in the absence of the patient.
8. Group training/education.

More circumstances where assignment of 99211 is not appropriate
9. For services which are included in a global package (your physician performed procedure):
   - Routine post-operative dressing changes or incision checks.
   - Suture removal in cases where services are provided during the prescribed follow-up time frame.
10. For routine OB checks which are included in the global package during a normal pregnancy.
11. For “value-added” services such as blood pressure checks on demand.

More circumstances where assignment of 99211 is not appropriate
12. In cases where another CPT/HCPCS code is a more appropriate choice for the service
   - Allergy Immunotherapy (95115)
   - Inhalation self-treatment instruction (94664)
   - For blood draw (36415/36416)
   - X-ray/Ultrasound (7X00X)
   - EKG (93000/93005)
13. When a supervising physician/clinician is NOT in the office during the 99211 service. [Part B Medicare]
To Code or Not To Code: the Nurse Encounter and 99211

Not appropriate 99211s … why?

- Office visit for an established patient with pernicious anemia who has no complaints and is given a monthly Vitamin B-12 injection.
- Office visit for a normotensive established patient who presents solely to have a routine blood pressure check which is recorded in the chart.
- Office visit for an established patient with a previous stroke who comes to a coagulation clinic staffed by a lab technician or pharmacist. There is no physician in the facility at the time that the blood is drawn. Flow sheet records the date, prothrombin time, INR and Coumadin dosage. After results are available, they are sent to the patient’s doctor, who contacts the patient by phone.

Also not appropriate 99211s …

- Office visit for an established patient with long standing allergic rhinitis who receives the monthly maintenance allergy injection. Patient is having no symptoms and the flow sheet lists the date, dilution strength, dosage and instructions regarding the next injection date.
- Office visit for an established patient seen one week previously for pernicious Anemia and asked to return solely for a demonstration of and instructions in how to self-administer Vitamin B12. (Vitamin B12 is considered to be a self-administered drug and instruction in how to self administer is not a separately covered service.)

Other Visits for 99211 Consideration

- Established patient who is performing glucose monitoring and wants to check accuracy of machine with blood glucose lab; your tech checks accuracy and function of patient machine.
- Established patient for supervised drug screen.
- Established patient for instruction re: peak flow meter.
- Established patient needs a heparin flush.
- Wound evaluation/dressing changes.
Sometimes 99211 is not the best code for the service.

- Cast and splint applications
- Nebulizer education
- Allergy services
- Wound care by endostomal nurses
- Nutritional therapy by RDs [not RNs]

HCPCS Codes

- T1961 Nursing assessment / evaluation
- T1983 OIND services, up to 15 minutes
- T1985 CPT4 services, up to 15 minutes
- T1984 Decision of a qualified nursing aide, up to 15 minutes

Check with your payers for guidance before assigning these HCPCS Level II codes.

Our References

Your Resources

- 2012 ICD-9-CM Official Coding Guidelines
- CPT Assistant (publication of the AMA)
- American Academy of Family Physicians
- Centers for Medicare and Medicaid Services
- National Government Services
- CMS Medlearn Matters SE0441
  - Publish Date August 2004 (Incident to)
To Code or Not To Code: the Nurse Encounter and 99211

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99211: A little code, but a lot to think about!

Thank you! Questions?
“Like” Brown Consulting Associates, Inc. on Facebook!
Diagnoses today: Encounter for therapeutic drug monitoring V58.83: and Long term use of anticoagulants V58.61:

Has patient had:
- unusual bruising? no yes
- dark tarry stools? no yes
- orange or red colored urine? no yes
- bright red blood in urine/stool? no yes
- bleeding gums or nose bleeds? no yes

Since last visit has patient:
- made a diet change? no yes
- missed coumadin doses? no yes
- changed alcohol consumption? no yes
- had a sick visit here, elsewhere or been seen in the ER? no yes

Assessment and Plan

Patient Concerns/Questions

Clinician comments/initials

Copy below and give to patient

Patient Instructions Today

1. Take your Coumadin/warfarin according to the schedule below.

   **Today's Coumadin Instructions**

<table>
<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   [ ] No change
   [ ] New order
   [ ] Per protocol

2. Observe for any signs of bleeding problems.
3. Call the office with any concerns.
4. Keep your scheduled appointment with the clinician.
Other:

Clinician Initials

INR Today | Protime Today

Patient taken pain or fever medications?
List

Patient taking new prescriptions?
List

Patient taking any new over-the-counter medications, herbals or vitamins?
List

Other:

Patient Signature

Nurse Signature and credential
<table>
<thead>
<tr>
<th>Date</th>
<th>Weight</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>LMP</td>
<td></td>
</tr>
<tr>
<td>Pregnancy test:</td>
<td>[ ] None [ ] POS [ ] NEG</td>
<td></td>
</tr>
<tr>
<td>Last Inj date</td>
<td>[ ] Depo Provera 150mg</td>
<td></td>
</tr>
<tr>
<td>Excessive bleeding?</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Severe mood swings?</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Abd pain/discomfort?</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Headaches?</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Vision changes?</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Chest pain?</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Shortness of breath?</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Leg pain?</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depo Provera 150 mg per protocol today</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Lot#</td>
<td>Location</td>
<td>[ ] Patient understands.</td>
</tr>
</tbody>
</table>

Instructions:

Signature

Brown Consulting Associates, Inc.  208-736-3755
New CPT Modifier for Preventive Services

The implementation of health care reform regulations has begun with a significant change involving preventive services. The Patient Protection and Affordable Care Act (PPACA) requires all health care insurance plans to begin covering preventive services and immunizations without any cost sharing, ie, they must provide first-dollar-coverage for certain specified preventive services. The timing of this being implemented is dependent on when health insurance plans renew or change. The regulations specify that plans cannot impose cost-sharing requirements, such as co-pays, coinsurance, or deductibles with respect to specified preventive services in which preventive services are billed separately. When these services are part of an office visit, the office visit may not have cost-sharing if the primary reason for the visit is to receive preventive services. However, cost-sharing is permitted for an office visit when the office visit and covered preventive services are billed separately, and the primary purpose of the office visit is not delivery of the covered preventive services.

In addition, insurance plans are permitted to impose cost-sharing (or choose not to provide coverage) for recommended preventive services if they are provided out-of-network. Not all services that some or many clinicians consider as preventive are included in the law. For preventive services not covered in the statute and regulations, plans are permitted to require cost-sharing. The new mandate may also affect payer coverage or payment policies for services listed in the Counseling Risk Factor Reduction and Behavior Change Intervention section of CPT (99401-99429).

In response to this PPACA requirement, CPT modifier 33 has been created to allow providers to identify to insurance payers and providers that the service was preventive under applicable laws, and that patient cost-sharing does not apply. This modifier assists in the identification of preventive services in payer-processing-systems to indicate where it is appropriate to waive the deductible associated with copay or coinsurance and may be used when a service was initiated as a preventive service, which then resulted in a conversion to a therapeutic service. The most notable example of this is screening colonoscopy (code 45378), which results in a polypectomy (code 45383).

Note that Medicare has created HCPCS II codes for some of these preventive medicine services. CPT modifier 33 is effective after January 1, 2011, and should be appended to codes representing the preventive services, unless the service is inherently preventive, eg, a screening mammography or immunization recognized by the Advisory Committee on Immunization Practices (ACIP). If multiple preventive medicine services are provided on the same day, the modifier is appended to the codes for each preventive service rendered on that day.

The CPT modifier’s descriptor has additional non-Affordable Care Act (ACA)-specific language for states or other mandates that have similar insurance benefit requirements for other services than those covered in the federal law. For example, if a state mandates first-dollar-coverage for PSA screening, the modifier would be appropriate to use for insureds with plans affected by the mandate. It is hoped that the modifier will create less reliance on combining complex procedures and diagnosis codes without diminishing the importance of correct diagnostic coding.

Modifier 33, Preventive Service: When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending modifier 33, Preventive Service, to the service. For separately reported services specifically identified as preventive, the modifier should not be used.

CPT modifier 33 is applicable for the identification of preventive services without cost-sharing in these four categories:

1. Services rated “A” or “B” by the US Preventive Services Task Force (USPSTF) (see Table 1) as posted annually on the Agency for Healthcare Research and Quality’s Web site: www.uspreventiveservicestaskforce.org USPSTF /USPSabrecs.htm;

2. Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics) as supported by the Health Resources and Services Administration; and

4. Preventive care and screenings provided for women (not included in the Task Force recommendations) in the comprehensive guidelines supported by the Health Resources and Services Administration.

Services with ‘A’ or ‘B’ ratings by the USPSTF are services that are recommended to be offered or provided. Services that are graded with an ‘A’ rating have been judged to have a high certainty that the net benefit is substantial. Services that are graded with a ‘B’ rating have been judged to have a high certainty of moderate to substantial net benefit.

continued on page 19
Table 1. USPSTF A and B Recommendations for Preventive Services

The following is a list of preventive services that have a rating of A or B from the US Preventive Services Task Force (USPSTF) that are relevant for implementing the Affordable Care Act (ACA).

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Grade</th>
<th>Date in Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal aortic aneurysm screening: men</td>
<td>The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.</td>
<td>B</td>
<td>February 2005</td>
</tr>
<tr>
<td>Alcohol misuse counseling</td>
<td>The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.</td>
<td>B</td>
<td>April 2004</td>
</tr>
<tr>
<td>Anemia screening: pregnant women</td>
<td>The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.</td>
<td>B</td>
<td>May 2006</td>
</tr>
<tr>
<td>Aspirin to prevent CVD: men</td>
<td>The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.</td>
<td>A</td>
<td>March 2009</td>
</tr>
<tr>
<td>Aspirin to prevent CVD: women</td>
<td>The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.</td>
<td>A</td>
<td>March 2009</td>
</tr>
<tr>
<td>Bacteriuria screening: pregnant women</td>
<td>The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.</td>
<td>A</td>
<td>July 2008</td>
</tr>
<tr>
<td>Blood pressure screening</td>
<td>The USPSTF recommends screening for high blood pressure in adults aged 18 and older.</td>
<td>A</td>
<td>December 2007</td>
</tr>
<tr>
<td>BRCA screening, counseling about</td>
<td>The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.</td>
<td>B</td>
<td>September 2005</td>
</tr>
<tr>
<td>Breast cancer preventive medication</td>
<td>The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.</td>
<td>B</td>
<td>July 2002</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older.</td>
<td>B</td>
<td>September 2002*†</td>
</tr>
<tr>
<td>Breastfeeding counseling</td>
<td>The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.</td>
<td>B</td>
<td>October 2008</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.</td>
<td>A</td>
<td>January 2003</td>
</tr>
<tr>
<td>Chlamydial infection screening: non-pregnant women</td>
<td>The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.</td>
<td>A</td>
<td>June 2007</td>
</tr>
<tr>
<td>Chlamydial infection screening: pregnant women</td>
<td>The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.</td>
<td>B</td>
<td>June 2007</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: men 35 and older</td>
<td>The USPSTF strongly recommends screening men aged 35 and older for lipid disorders.</td>
<td>A</td>
<td>June 2008</td>
</tr>
</tbody>
</table>
### Table 1. (cont.)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
<th>Grade</th>
<th>Date in Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol abnormalities screening: men younger than 35</td>
<td>The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>B</td>
<td>June 2008</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: women 45 and older</td>
<td>The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>A</td>
<td>June 2008</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: women younger than 45</td>
<td>The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>B</td>
<td>June 2008</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.</td>
<td>A</td>
<td>October 2008</td>
</tr>
<tr>
<td>Dental caries chemoprevention: preschool children</td>
<td>The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.</td>
<td>B</td>
<td>April 2004</td>
</tr>
<tr>
<td>Depression screening: adolescents</td>
<td>The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.</td>
<td>B</td>
<td>March 2009</td>
</tr>
<tr>
<td>Depression screening: adults</td>
<td>The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.</td>
<td>B</td>
<td>December 2009</td>
</tr>
<tr>
<td>Diabetes screening</td>
<td>The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.</td>
<td>B</td>
<td>June 2008</td>
</tr>
<tr>
<td>Folic acid supplementation</td>
<td>The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.</td>
<td>A</td>
<td>May 2009</td>
</tr>
<tr>
<td>Gonorrhea prophylactic medication: newborns</td>
<td>The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.</td>
<td>A</td>
<td>May 2005</td>
</tr>
<tr>
<td>Gonorrhea screening: women</td>
<td>The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).</td>
<td>B</td>
<td>May 2005</td>
</tr>
<tr>
<td>Healthy diet counseling</td>
<td>The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.</td>
<td>B</td>
<td>January 2003</td>
</tr>
<tr>
<td>Hearing loss screening: newborns</td>
<td>The USPSTF recommends screening for hearing loss in all newborn infants.</td>
<td>B</td>
<td>July 2008</td>
</tr>
<tr>
<td>Hemoglobinopathies screening: newborns</td>
<td>The USPSTF recommends screening for sickle cell disease in newborns.</td>
<td>A</td>
<td>September 2007</td>
</tr>
<tr>
<td>Hepatitis B screening: pregnant women</td>
<td>The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.</td>
<td>A</td>
<td>June 2009</td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
<td>Grade</td>
<td>Date in Effect</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
<td>----------------</td>
</tr>
<tr>
<td>HIV screening</td>
<td>The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.</td>
<td>A</td>
<td>July 2005</td>
</tr>
<tr>
<td>Hypothyroidism screening: newborns</td>
<td>The USPSTF recommends screening for congenital hypothyroidism in newborns.</td>
<td>A</td>
<td>March 2008</td>
</tr>
<tr>
<td>Iron supplementation in children</td>
<td>The USPSTF recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.</td>
<td>B</td>
<td>May 2006</td>
</tr>
<tr>
<td>Obesity screening and counseling: adults</td>
<td>The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.</td>
<td>B</td>
<td>December 2003</td>
</tr>
<tr>
<td>Obesity screening and counseling: children</td>
<td>The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.</td>
<td>B</td>
<td>January 2010</td>
</tr>
<tr>
<td>Osteoporosis screening: women</td>
<td>The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.</td>
<td>B</td>
<td>September 2002</td>
</tr>
<tr>
<td>PKU screening: newborns</td>
<td>The USPSTF recommends screening for phenylketonuria (PKU) in newborns.</td>
<td>A</td>
<td>March 2008</td>
</tr>
<tr>
<td>Rh incompatibility screening: first pregnancy visit</td>
<td>The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</td>
<td>A</td>
<td>February 2004</td>
</tr>
<tr>
<td>Rh incompatibility screening: 24-28 weeks gestation</td>
<td>The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks’ gestation, unless the biological father is known to be Rh (D)-negative.</td>
<td>B</td>
<td>February 2004</td>
</tr>
<tr>
<td>STIs counseling</td>
<td>The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.</td>
<td>B</td>
<td>October 2008</td>
</tr>
<tr>
<td>Tobacco use counseling and interventions: non-pregnant adults</td>
<td>The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.</td>
<td>A</td>
<td>April 2009</td>
</tr>
<tr>
<td>Tobacco use counseling: pregnant women</td>
<td>The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.</td>
<td>A</td>
<td>April 2009</td>
</tr>
<tr>
<td>Syphilis screening: non-pregnant persons</td>
<td>The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.</td>
<td>A</td>
<td>July 2004</td>
</tr>
<tr>
<td>Syphilis screening: pregnant women</td>
<td>The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.</td>
<td>A</td>
<td>May 2009</td>
</tr>
<tr>
<td>Visual acuity screening in children</td>
<td>The USPSTF recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.</td>
<td>B</td>
<td>May 2004</td>
</tr>
</tbody>
</table>

*The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendation on breast cancer screening of the US Preventive Services Task Force.

†Denotes coinsurance/deductible is not waived for this service in calendar year 2011.
<table>
<thead>
<tr>
<th>Immunizations</th>
<th>Code Administration(s) &amp; Vaccine(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunizations Coding Worksheet</strong></td>
<td></td>
</tr>
<tr>
<td>Administration without PCP/QHCP counseling. Route of administration may influence code selection. Do not code &quot;components.&quot;</td>
<td></td>
</tr>
<tr>
<td>90471</td>
<td>Administration of any 1 CPT below</td>
</tr>
<tr>
<td>90472</td>
<td>+each additional CPT below</td>
</tr>
<tr>
<td>Administration codes 90460 &amp; 90461 are reserved for use when the PCP/QHCP provides necessary counseling to the patient who is less than 19 years. You will need to code &quot;components.&quot;</td>
<td></td>
</tr>
<tr>
<td>90460</td>
<td>1st vaccine component, any route, with qualifying counseling of patient under 19 years.</td>
</tr>
<tr>
<td>90461</td>
<td>+each add'l vaccine component</td>
</tr>
<tr>
<td><strong>Components only reported when PCP/QHCP counsels regarding vaccinations. Use 90460-61.</strong></td>
<td></td>
</tr>
<tr>
<td>90700</td>
<td>DTaP (&lt; 7 yrs)</td>
</tr>
<tr>
<td>90715</td>
<td>Tdap &gt;7 yrs (Boostrix)</td>
</tr>
<tr>
<td>90723</td>
<td>DtaP-HepB-IPV(Pediarix)</td>
</tr>
<tr>
<td>90633</td>
<td>Hep A peds/adol. (2 dose)</td>
</tr>
<tr>
<td>90744</td>
<td>Hep B peds/adol. (3 dose)</td>
</tr>
<tr>
<td>90743</td>
<td>Hep B adol.(2 dose)</td>
</tr>
<tr>
<td>90746</td>
<td>Hep B (MCare admin. G0010)</td>
</tr>
<tr>
<td>90648</td>
<td>Hib PRP-T (4 dose)</td>
</tr>
<tr>
<td>90657</td>
<td>Flu split 6-35 mos</td>
</tr>
<tr>
<td>90658</td>
<td>Flu split 3yr-adult (MCare admin G0008)</td>
</tr>
<tr>
<td>90663</td>
<td>H1N1 flu</td>
</tr>
<tr>
<td>90713</td>
<td>IPV</td>
</tr>
<tr>
<td>90707</td>
<td>MMR</td>
</tr>
<tr>
<td>90698</td>
<td>Pentacel (DTaP-IPV-Hib)</td>
</tr>
<tr>
<td>90669</td>
<td>Pneumo 7-valent IM (MCare adm G0009)</td>
</tr>
<tr>
<td>90732</td>
<td>Pneumo (MCare admin G0009)</td>
</tr>
<tr>
<td>90718</td>
<td>Td (&gt; 7 yrs)</td>
</tr>
<tr>
<td>90703</td>
<td>Tetanus toxoid</td>
</tr>
<tr>
<td>90716</td>
<td>Varicella vaccine</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

34
Post Course Assessment Instructions: MAY ONLY BE TAKEN ONLINE, DO NOT FAX TO BROWN CONSULTING.

Please complete this assessment on paper first, then enter your answers on-line for additional CEUs. AAPC requires a passing grade of at least 70% to earn the additional CEUs. Your on-line assessment must be completed within two business days following the webinar. To complete the on-line assessment, go to http://www.coursesites.com and look for the announcement for this webinar. You will be responsible for setting up your own account in Blackboard. You will only need to do this once, however, you will need to REMEMBER YOUR USERNAME AND PASSWORD to access your account for future webinars. Please see the email that you will receive entitled “Blackboard Account Instructions” in order to set up your account.

Read each question carefully. When you have finished entering your answers, click Submit at the bottom of the page. You will then receive immediate feedback and you can print your completed assessment to save for your records. If you have any questions or problems, call Brown Consulting at 208-736-3755. Be sure to look for any additional instructions for each individual assessment.

Question 1 The CPT code descriptor reads: "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, 5 minutes are spent performing or supervising these services." From the list below, identify types of providers who might assign this CPT code. Select all that may apply.

☐ Nurses or medical assistants
☐ Physicians
☐ Nurse Practitioners or Physician Assistants
☐ Massage therapists whose services are considered non-covered

Question 2 Federally Qualified Health Care Centers (FQHCs) are typically reimbursed for Medicare and Medicaid clinic services under a single all-inclusive payment. Which of the following types of providers are commonly reimbursed?

☐ RNs and LPNs
☐ Medical Assistants
☐ Physicians, Nurse Practitioners and Physician Assistants

Question 3 Which CPT code would be appropriate for assignment if the nurse spent 30 minutes with an established patient. She was performing wound care and extensive patient education.

☐ 99214
☐ 99203
☐ 99212
☐ 99211

Question 4 For which type of patient may a 99211 be assigned?

☐ New patient
☐ Established patient
☐ Consult code
☐ Preventive code
Question 5 Your physician told you she was hiring a nurse with a PhD degree in nursing. The nurse, Dr. Miranda Lopez, is known to have excellent skills in the area of patient education. The physician instructed you to schedule the nurse's appointments for a minimum of 45 minutes. The physician said it was probably OK to assign high levels of E/M codes because the new nurse is a PhD. What would be your response as the clinic's coding specialist?

- That sounds reasonable to me.
- We can probably assign the lower three levels of EMs but not the higher two levels.
- Because she is not a physician (MD or DO), NP or PA, we can only assign 99211. Shall I find that documentation for you?
- We should assign the psychiatric counseling codes instead.

Question 6 "Incident to..." physician services are Medicare services that are not performed by the physician but are provided in the clinic if the following basic guidelines are met. Select all guidelines below that apply.

- The patient is established.
- The problem is being managed by a physician and is not a new problem today.
- A physician or NPP (Non-physician Provider, such as an NP or PA) is in the clinic providing direct supervision.
- The nurse or medical assistant is qualified to perform the service.

Question 7 Which of the following would represent what CMS calls "direct supervision"?

- The physician is in the office while the service is performed by the nurse.
- The physician is across the street in the hospital.
- The physician is in the exam room while the service is performed.

Question 8 What level of physician supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required (in the office suite) during the performance of the procedure? The physician continues to be "responsible" during the service performed.

- Direct supervision
- General supervision
- CMS supervision
- Good supervision

Question 9 Select all of the following items which are important in nursing documentation:

- The nurse should document the physician/clinician order for the service and note the reason for the visit.
- Nursing assessment and nursing action should be documented.
- Patient instructions and follow-up plan should be noted.
- The nurse should date and sign the notes with her/his credentials.

Question 10 Some services can be provided by a nurse, medical assistant or technician when the physician/clinician is not in the office. In these cases, the services are coded to their appropriate CPT codes. 99211 is not coded. Select below all cases where you suspect this is true.

- EKGs
- X-rays
- Blood draws and labs
- Dressing changes
Question 11  The patient was seen by the PA for cellulitis on Monday and was instructed to return to the office on Tuesday for an injection of Rocephin 1000 mg. The PA was in the office on Tuesday, and the nurse documents the following: "1000 mg of Rocephin given IM, left hip." Select all codes that are appropriate for this documentation.

☐ 96372
☐ 99211
☐ J0696 x 4 units
☐ 90471

Question 12  Select all services from the list below which could be coded to 99211 if well documented by the nurse and performed while the physician/clinician was in the office.

☐ Evaluation of blood pressure and ankle edema for a patient recently started on Lasix.
☐ The patient is having a pro-time lab drawn.
☐ The patient picked up a new prescription at the front desk.
☐ Dressing change for a diabetic ulcer.

Question 13  "3cm laceration of forehead closed by ER 10 days ago. Our doctor evaluated Monday, and at our doctor’s request I inspected the wound today; reveals well healed closure without sign of infection or complications. Sutures removed, instructions given. The doctor is in the clinic today but did not see the patient. S. Hernandez, LPN” What five digit CPT code would you assign? (enter 5-digit code only in space below)


Question 14  The physician/clinician is in the clinic. An established patient who is seen and treated in your clinic for low back pain came in and asked to have his blood pressure checked. You have not treated him for blood pressure problems in the past. The blood pressure is normal. What code would you assign today?

☐ 99211
☐ 99201
☐ No code

Question 15  A 2 year old is seen today for immunization. The nurse completes the Vaccination Information Sheet and assesses the child, finding no contraindication to giving the vaccines. The nurse gives the vaccines per order and documents appropriately. She provides excellent documentation. A supervising clinician is in the office. What should the nurse code today?

☐ 99211, the administration codes, and the vaccine products.
☐ 99211
☐ The administration codes and the vaccine products.
☐ No codes appropriate today, but she should document the service.
Question 16 Identify from the choices below the specific levels of History, Examination, and Medical Decision Making the nurse must document in order to support coding of 99211.

- The nurse must document at a minimum two of the following three E/M Key Components: straightforward History and Exam and/or straightforward Medical Decision Making.
- 99211 does not require documentation of any specific levels of History, Exam, and Medical Decision Making. The nurse should keep in mind that 99211 is an E/M code, some history (reason for visit and reference to order) and if appropriate, nursing assessment, as well as her/his nursing interventions should be documented.
- All E/M Key Components should be documented at a minimum of Expanded Problem Focused level.
- 99211 is supported if the nurse documents any one Key Component at the Detailed/Moderate Complexity level.

Question 17 Which of the following are examples of 99211 found in Appendix C in your CPT book for which you would be willing to assign a 99211 code. (You might not be willing to report 99211 for all of the CPT examples, depending on documentation and circumstance.)

- Office visit for an established patient who had undergone orthodontics and now complains of a wire irritation. Nurse/assistant checks the skin area... [and reports/documents].
- Office visit for removal of uncomplicated facial sutures 7 days post op; your doctor did the repair. [Your doctor did the repair 7 days ago. The procedure code includes 10 days of follow-up care in the Medicare Physician Fee Schedule Data Base.]
- Office visit for a patient who lost her prescription and came in for a new one. [No nursing assessment of management; patient picked up prescription at the front desk.]

Question 18 Identify from the choices below the correct first-listed ICD-9-CM diagnosis code for the patient presenting for a PT/INR lab. The patient takes Coumadin to control his afibrillation problem.

- 427.11
- V58.61
- V58.83

Question 19 Which type of code is best used to identify injectable medications such as Lasix, Rocephin or steroids?

- HCPCS Level II codes
- CPT 99070
- Internal codes developed by your clinic
- Assign only the administration code.

Question 20 If an ABN (Advanced Beneficiary Notice) is needed, when is the appropriate time to obtain signature from the patient?

- Prior to administration of the service.
- Immediately after the service.
- Signature is only required if patient wishes for you to bill Medicare.
Question 21 Nurses and assistants are not trained in coding. Who is responsible to train these individuals regarding coding and documentation?

- The government
- The doctor
- Other nurses who think they know
- Clinic manager/certified coder

Question 22 When the patient is new in the clinic and is seen by the nurse for a pregnancy test, what CPT E/M code should be assigned?

- 99211
- 99201
- 99202
- No appropriate E/M code has been designed for this service, although Title X (and other special programs) may allow payment. This is a case where you must know your payer policy.

Question 23 Nurses and assistants often provide a variety of services to patients. Which statement below is true?

- All nursing services are billable.
- No nursing services are billable.
- It is illegal for nurses to perform services without the clinician present.
- While it is appropriate for nurses and assistants to perform a wide variety of services, this does not mean all those excellent services can be billed.

Question 24 Select all that are true related to nursing services.

- Nurses must document all services.
- It is not necessary for the clinician to sign the nurse's note, but the clinic should have a policy requiring review of the documentation.
- It is not necessary for the nurse/assistant to document if the physician mentioned the requested service in his/her last dictation.

Question 25 If the nurse/assistant provides extensive patient care information and instruction over the phone, what may be billed?

- 99211
- 99499
- 90401
- Nothing

Question 26 What nursing visit may be coded when the patient is in for a lab draw or EKG only.

- No visit at all may be coded.
- 99211
- 99499
- 99211-52
Question 27  All services provided to a Medicare or Medicaid patient anywhere in the US must be medically necessary and include a diagnosis that identifies the specific medical necessity. If services are provided which might be considered "unnecessary," what document must be signed by a Medicare patient if they choose to have the service?

- "Refusal to Pay" Document
- An ABN (Advanced Beneficiary Notice)
- An "Agreement to Pay" document
- Any form made up by the clinic which indicates understanding of medical necessity and allows the patient to agree to pay.

Question 28  "Incident to..." physician service regulations require that a supervising clinician must be in the office during a qualifying nursing service. These regulations are written by CMS and apply specifically to which group of patients?

- Contraceptive management patients
- Medicaid children
- Medicare
- HIV patients

Question 29  The patient on coumadin comes to the office, and the nurse draws a pro-time which is run in the office. What is coded?

- Blood draw only
- Blood draw and laboratory study code
- Laboratory study code only
- 99211 and blood draw

Question 30  Who can assign code 99211? Select all that apply.

- The physician.
- The NPP: physician assistant, nurse practitioner, certified nurse midwife.
- The nurse or medical assistant.
- Other technicians employed by the physician/clinic.

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Post-course Assessment and CEU Certificate Request

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305 Webinar Audience: Coders, auditors, compliance staff, nurses, physicians, non-physician clinicians and clinic management

Program: 305 99211: The “Do’s” and the "Don'ts"
Date: Tuesday, October 18, 2011
Instructor: Donna Monroe, CCS-P, CPC

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1. You signed into the live Webinar session by first and last name.
2. This completed and signed CEU request is received by the end of the next business day. Thank you.

Program Evaluation

<table>
<thead>
<tr>
<th>Rate your experience.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My coding will improve as a result of this Webinar.</td>
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<tr>
<td>The course met my expectations.</td>
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<tr>
<td>The speaker was knowledgeable.</td>
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<tr>
<td>The course material was helpful.</td>
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<tr>
<td>Would you recommend this course to other coding professionals?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments?

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Please print clearly using black or blue ink.

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  - CCS
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