CPT® Code 99211 Details

Code Symbols

MIPS : Merit Based Incentive Payment System

Code Descriptor

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

CPT® Advice

No data Available

Illustration

No data Available.

Fee Schedule

Medicare Physician Fee Schedules (MPFS)	
Sources:	2019 National Physician Fee Schedule Relative Value File, GPCI19, NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE CALENDAR YEAR 2019, MCR-MUE-PractitionerServices
Publisher:	CMS
Effective:	July 01, 2019
Medicare Carrier/Locality:	ALASKA** 01-02102
Conversion Factor:	36.0391

Note: A value in "Medicare Fees" does not necessarily indicate payment. Scroll down to see Medicare's status on the code for coverage specifics. Medicare has assigned relative value units (RVUs) to codes the agency does not cover to allow payers that follow the resource based relative value system to have an agreed upon valuation rate.

Code Status A
A = Active Code. These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

Medicare Fees					
	National	**Adjusted**	**26**	**TC**	**53**

Facility	$9.37	$12.80	$0.00	$0.00	$0.00
Non Facility	$23.07	$28.10	$0.00	$0.00	$0.00

RVU - Nonfacility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	0.18	0.27	0.00	0.00	0.00
PE RVU:	0.45	0.50	0.00	0.00	0.00
Malpractice RVU:	0.01	0.01	0.00	0.00	0.00
Total RVU:	0.64	0.78	0.00	0.00	0.00

RVU - Facility					
	National	**Adjusted**	**26**	**TC**	**53**
Work RVU:	0.18	0.27	0.00	0.00	0.00
PE RVU:	0.07	0.08	0.00	0.00	0.00
Malpractice RVU:	0.01	0.01	0.00	0.00	0.00
Total RVU:	0.26	0.36	0.00	0.00	0.00

Global & Other Info		
	Global Split	
Preoperative %:	0	
Intraoperative %:	0	
Postoperative %:	0	
Total RVU:	0	
Global Period (days):	XXX	

XXX = The global concept does not apply to the code.

Radiology Diagnostic Tests : 99

99 = Concept does not apply

PC/TC Indicator : 0

0 = Physician Service Codes--Identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUS include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

Endoscopic Base Code : None

Modifier Guidelines		
	Modifier	**Rules(Click on rules for Details)**

MULT PROC	51	No multiple procedure payment adjustment

51 = Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes

0 = No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.

BILAT SURG	50	No 150% bilateral payment boost

50 = Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, should be identified by adding modifier 50 to the appropriate five digit code.

0 = 150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100% of the fee schedule amount for a single code.

ASST SURG	80	Assistant payment allowed when supported

80 = Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

CO-SURG	62	Co-surgeons not permitted

62 = Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

0 = Co-surgeons not permitted for this procedure.

TEAM SURG	66	Team surgeons not permitted

66 = Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.

0 = Team surgeons not permitted for this procedure.

MINIMUM ASST SURG	81	Assistant payment allowed when supported.

81 = Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
ASST SURG (QUALIFIED RESI. NA)	82	Assistant payment allowed when supported.
82 = Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s)		
0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.		
PHYSICIAN SUPERVISION	*PS	Concept does not apply.
PS = This field is for use in post payment review.		
9 = Concept does not apply		

Medically Unlikely Edits

Source: 2019 Medically Unlikely Edits (MUE)

Publisher: CMS

Date: July 01, 2019

Services	MUE	MAI	MUE Rationale
Practitioner Services	1	3	Clinical: Data
DME Supplier Services	NA	NA	NA
Facility Outpatient Services	2	3	Clinical: Data

MAI 1: Line Edit
MUE MAI "1" indicates a claim line edit. When it's appropriate to report units that exceed the MUE, use one or more additional claim lines with an appropriate modifier appended to the code. Payers who apply the MUE will process each claim line separately for payment.

MAI 2: Date of Service Edit: Policy
MUE MAI "2" indicates an absolute date of service (DOS) edit based on policy. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. CMS has not identified any instances in which exceeding an MAI 2 MUE is correct.

MAI 3: Date of Service Edit: Clinical
MUE MAI "3" indicates a date of service (DOS) edit based on clinical benchmarks. Payers who apply the MUE sum the code's same-DOS units (not counting lines with modifier 55). If the sum exceeds the MUE value, the payer will deny same-DOS lines with that code on the current claim. MACs may pay excess units upon appeal or may bypass the MUE based on documentation of medical necessity.

LCD Details

LCD Details for 99211

The chosen state has no LCD for this code/title. Please search All States to see if another state has an LCD for this code/title.

Article Details for 99211

State(s)	Contractor Type	Contractor Name (Contractor No.)	Article ID	Article Title	Future Policy
Alaska	MAC - Part A	Wisconsin Physicians Service Insurance Corporation (05901)	A56795	Billing and Coding: Erythropoiesis Stimulating Agents (ESAs)	
Alaska	A and B MAC	Noridian Healthcare Solutions, LLC (02102)	A53046	Wound Care and Debridement - Provided by a Therapist, Physician, NPP, or as Incident-to Services	
Alaska	A and B MAC	Noridian Healthcare Solutions, LLC (02101)	A53046	Wound Care and Debridement - Provided by a Therapist, Physician, NPP, or as Incident-to Services	

A56795 (05901 Billing and Coding: Erythropoiesis Stimulating Agents (ESAs))

ICD-9-CM

No ICD-9-CM data found.

ICD-10-CM

A. End Stage Renal Disease (ESRD) ON dialysis J0882, J0887, Q4081, and Q5105.
Requires <u>both</u> diagnoses below:

D63.8	Anemia in other chronic diseases classified elsewhere
Z01.818	Encounter for other preprocedural examination

B. Chronic Kidney Disease NOT on dialysis
DUAL DIAGNOSIS NECESSARY FOR J0881, J0885, J0888, and Q5106.
Requires:

D63.8 Anemia in other chronic diseases classified elsewhere
Z01.818 Encounter for other preprocedural examination

AND one of the following:

D63.8 Anemia in other chronic diseases classified elsewhere
Z01.818 Encounter for other preprocedural examination

C. Indications other than Renal Disease
Anemia related to therapy with Zidovudine (AZT)
DUAL DIAGNOSIS NECESSARY FOR J0881, J0885, and Q5106.
Requires one of the following:

D63.8 Anemia in other chronic diseases classified elsewhere
Z01.818 Encounter for other preprocedural examination

AND one of the following:

D63.8 Anemia in other chronic diseases classified elsewhere
Z01.818 Encounter for other preprocedural examination

Anemia associated with chemotherapeutic medications when medically necessary for a non-cancer diagnosis or following stem cell transplantation and associated immunosuppression.

This policy does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) and does not contain specific diagnosis codes related to CMS Publication 100-03 *Medicare National Coverage Determinations (NCD) Manual* Chapter 1- Coverage Determinations, Part 2 Section 110.21 - Erythropoiesis Stimulating Agents (ESA's) in Cancer and Related Neoplastic Conditions.

Drug induced anemia indicates the anemia is secondary to chemotherapy properly administered to treat a **non-cancer diagnosis** such as Hepatitis C treatment with ribravirin and interferon alfa or ribravirin and peginterferon alfa.

THREE DIAGNOSES ARE NECESSARY FOR J0881, J0885, or Q5106

Requires: *D64.81, *Z79.899, **AND an additional diagnosis code INDICATING THE CONDITION BEING TREATED**

D63.8 Anemia in other chronic diseases classified elsewhere
Z01.818 Encounter for other preprocedural examination

Myelodysplastic Syndromes (MDS) for J0881, J0885, or Q5106
Requires:

D63.8	Anemia in other chronic diseases classified elsewhere
Z01.818	Encounter for other preprocedural examination

Anemia of chronic disease
DUAL DIAGNOSIS NECESSARY FOR J0881 or J0885
Requires:

D63.8	Anemia in other chronic diseases classified elsewhere
Z01.818	Encounter for other preprocedural examination

AND one of the following:

D63.8	Anemia in other chronic diseases classified elsewhere
Z01.818	Encounter for other preprocedural examination

Prophylactic pre-operative use for reduction of allogeneic blood transfusions prior to elective hip and knee replacement surgery.
BOTH DIAGNOSES ARE NECESSARY FOR J0881, J0885, and Q5106.
Requires:

D63.8	Anemia in other chronic diseases classified elsewhere
Z01.818	Encounter for other preprocedural examination

CPT/HCPCS

J0881, J0885, and Q5106 Must have a valid modifier - EA, EB, or EC