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When Is it Appropriate to Report 99211 During Immunization Administration?

American Academy of Pediatrics Committee on Coding and Nomenclature

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**Abstract:** Code **99211** should not be reported for every nurse-only vaccine administration patient encounter. Rather, careful consideration needs to be given regarding the significance and medical necessity for such a visit.  
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When vaccines are given in the pediatric office, questions often arise concerning the reporting of evaluation and management (E/M) services performed during the same visit where vaccines are administered. The answer always depends on whether the provider performs a *medically necessary and significant, separately identifiable E/M visit, in addition to the immunization administration*. If such a service is performed, an E/M code is reported, most likely from the **99201-99215** code family (office or other outpatient service), in addition to the appropriate code for immunization administration (**90460-90461** or **90471-90474**) plus the code for the vaccine product(s). In such cases, payers may require that modifier **25** (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) be appended to the E/M code to distinguish it from the actual administration of the vaccine.

The identification of a significant, separately identifiable service for E/M codes usually involves the performance and documentation of the “key components” (ie, history, physical examination, and medical decision making) or time. However, the reporting of code **99211** is unique among E/M codes in having no key component requirements. The *Current Procedural Terminology (CPT®)* descriptor for code **99211** states, “*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.*” Therefore, how this concept is defined when the E/M code in question is **99211** needs further clarification.

To address this issue, it becomes important to determine the following:

- What services are included in the immunization administration codes?
- What additional services are required to appropriately report a **99211**?
- What are the documentation requirements for a **99211**?

What Services Are Included in the Immunization Administration Codes?

The following services are included in the immunization administration CPT codes:

- Administrative staff services, such as making the appointment, preparing the patient chart, billing for the service, and filing the chart
- Clinical staff services, such as greeting the patient, taking routine vital signs, obtaining a vaccine history on past reactions and contraindications, presenting a Vaccine Information Sheet (VIS) and answering routine vaccine questions, preparing and administering the vaccine with chart documentation, and observing for any immediate reaction

The relative value units (RVUs) for the immunization administration codes were significantly increased in 2005 and 2006. These increases can be attributed to the fact that CMS views many of the services that are included under code **99211** as part of the immunization administration codes. Accordingly, the RVUs for code **99211** have essentially been “built” into the RVUs for the immunization administration codes.

The immunization administration codes are valued on the Medicare physician fee schedule (Resource-Based Relative Value Scale [RBRVS]) as follows:

CPT Code	Work RVUs	Non-Facility Practice Expense RVUs	Malpractice RVUs	Total Non-Facility RVUs	2011 Medicare Non-Facility Payment
90460‡	0.17	0.50	0.01	0.68	\$17.35*
90461‡	0.15	0.18	0.01	0.34	\$8.68
90471	0.17	0.50	0.01	0.68	\$17.35
90472	0.15	0.18	0.01	0.34	\$8.68
90473	0.17	0.50	0.01	0.68	\$17.35
90474	0.15	0.18	0.01	0.34	\$8.68

RVUs = Relative Value Units

‡Codes 90460 and 90461 require vaccine counseling to be performed by the physician or other qualified health care professional

*Sample conversion for 90460

Medicare 2011 conversion factor = \$25.5217

0.68 RVUs x \$25.5217 = \$17.35

What Additional Services Are Required to Appropriately Report a 99211?

The E/M service must exceed those services included in the immunization administration codes. In addition, there are 2 principles to keep in mind. They are as follows:

1. The service must be medically necessary.
2. The service must be separate and significant from the immunization administration.

When the provider (usually the nurse) evaluates, manages, and documents the significant and separate complaint(s) or problem(s), the additional reporting of **99211** is justified. In such circumstances, the nurse typically conducts a brief history and record review along with a physical assessment (eg, indicated vital signs and observations) and provides patient education in helping the family or patient manage the problem encountered. These nursing activities are all directly related to the significant, separate complaint, and unrelated to the actual vaccine administration.

What Are the Documentation Requirements for a 99211?

All reported E/M codes must meet documentation requirements as outlined in *CPT* guidelines or in the Centers for Medicare & Medicaid Services (CMS) Documentation Guidelines. For most of the E/M services that physicians perform, this means that some designated combination of the key components of history, physical examination, and medical decision making must be met and clearly documented. Alternatively, if more than 50% of the time spent during the E/M service is spent in counseling or coordinating care, time becomes the “key” or controlling factor in selecting a code.

Code 99211 is the one E/M service typically provided by the nurse and not the physician. As such, its documentation requirements differ. There are no required key components typical of the physician services noted above. Further, the typical time published in CPT for 99211 is 5 minutes. The American Academy of Pediatrics encourages documenting the date of service and reason for the visit, a brief history of any significant problems evaluated or managed, any examination elements (eg, vital signs or appearance of a rash), a brief assessment and/or plan along with any counseling or patient education done, and signatures of the nurse and supervising physician.

While not required, it may help payers to better understand the medical necessity of the nurse E/M service if it is linked to a different *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* code than the one used for the vaccine given when appropriate. Further, encounter documentation should be a separate entry from the charting of the vaccine itself (product, lot number, site and method, VIS date, etc, which usually are all recorded on the immunization history sheet). Each practice should consider developing protocols and progress note templates for vaccine services.

Finally, if the nurse provides the **99211** visit, it is reported under the physician’s name/tax ID number, making it inherently an “incident to” service. In such situations, it is a service restricted to established patients and requires the supervising physician’s “direct supervision,” which is defined by the CMS as the physician being physically present in the office suite (not in the patient’s room) and immediately available to provide assistance. Most “nurse” E/M services are carried out under a protocol of orders developed by the physician for the particular service and should be fully documented in the record. As always, the physician supervising the care should sign the chart entry.

Coding Information From Current Procedural Terminology and CMS

The American Medical Association provides some instruction on the correct reporting of **99211** at the time of immunization administration via *Current Procedural Terminology* guidelines. Within the

Immunization Administration for Vaccines/Toxoids section of the CPT nomenclature, it states, “ If a significant separately identifiable Evaluation and Management service (eg, office of other outpatient services, preventive medicine services) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes.”

CMS also provides direction for reporting **99211** during visits where only the nurse sees the patient and gives an injection. Under CMS Medicare payment policy, it is not correct to report an E/M service if the nurse services are only related directly to the injection itself. In that vein, CMS significantly increased its Medicare fee for immunization administration in 2005, providing reimbursement for the typical activities of the nurse as listed above under the immunization administration codes.

Coding Examples

Vignette #1

A 7-month-old girl visits your office to be immunized against influenza and is seen only by your nurse. The nurse takes a brief history and learns the infant has a cough without change in appetite, sleep, or activity level. He takes vital signs and assesses that the infant has no contraindications to getting the vaccine, and discusses the office practice protocol for the management of the respiratory problem with the mother. Additionally, the nurse documents that the patient meets the current guidelines for vaccination and has no contraindications to the immunization per the Centers for Disease Control and Prevention (CDC) guidelines. Next, he reviews the VIS with the mother and obtains consent for the immunization. The nurse then administers the influenza vaccine.

The encounter would be reported as follows:

CPT

99211-25 (E/M service)

90657 (influenza vaccine)

90471 (immunization administration)

ICD-9-CM

786.2 (cough)

V04.81 (need for prophylactic vaccination and inoculation against certain viral diseases; influenza)

V04.81 (need for prophylactic vaccination and inoculation against certain viral diseases; influenza)

An example of written documentation for this **99211** encounter follows (the actual vaccine data with lot number and site/route and VIS date are recorded on a separate immunization record):

The patient is here for the influenza vaccine. Mother reports a cough for several days without any fever. She is eating well and there has been no wheezing or rapid breathing. Her temperature is 98.7°F and respiratory rate is 38/minute – she appears well. The symptomatic treatment of the cough per protocol was discussed and the mother was instructed to call or return if the problem worsened.

She has no allergies to foods or history of reactions to past vaccines. The risks and potential side effects of the hepatitis B vaccine were discussed after the VIS was given, and the mother was informed of the

correct dosage of an antipyretic should fever or fussiness occur afterwards. An influenza vaccine was given.

K. Brooks, LPN/R. Dunn, MD (signatures/date)

Vignette #2

A five-year-old is brought in by the mother for a catch-up measles-mumps-rubella (MMR) vaccine. She says the child is fine and has already been counseled on the vaccine and has no concerns. The nurse proceeds to review the vaccine history, presents the VIS, and receives an order for the vaccine from the physician. She then administers and documents the vaccine. In this situation, the service is only vaccine related and no significant or separate E/M service is provided. Therefore, the only services reported are the immunization administration and the vaccine product code.

The encounter would be reported as follows:

CPT

90707 (MMR vaccine)

90471 (immunization administration)

ICD-9-CM

V06.4 (*need for prophylactic vaccination and inoculation against combinations of diseases; measles-mumps-rubella [MMR]*)

V06.4 (*need for prophylactic vaccination and inoculation against combinations of diseases; measles-mumps-rubella [MMR]*)

Vignette #3

A 4-month-old patient had an illness with high fever at her preventive medicine visit 2 weeks ago, and now returns to see your nurse for her second hepatitis B vaccine. The nurse performs an interval history, finding the symptoms from the earlier illness had resolved. She then confirms that the infant is afebrile by taking the infant's temperature, and makes the observation that the infant is playful. After assessing that the patient is currently in good health, she confirms that there are no contraindications to the immunization per the CDC guidelines. Next, the nurse reviews the VIS with the father, antipyretic dosage for weight, and gets the father's consent for the immunization. The nurse then administers the hepatitis B vaccine, observes for immediate reactions, and schedules the third hepatitis B immunization visit for 2 months later.

This encounter would be reported as follows:

CPT

99211-25 (E/M service)

90744 (hepatitis B vaccine)

90471 (immunization administration)

ICD-9-CM

V67.59 (*follow-up examination; following other treatment; other*)

V05.3 (*need for other prophylactic vaccination and inoculation against single diseases; viral hepatitis*)

V05.3 (*need for other prophylactic vaccination and inoculation against single diseases; viral hepatitis*)

An example of written documentation for this **99211** encounter follows (the actual vaccine data with lot number and site/route and VIS date are recorded on a separate immunization record):

The patient is here for a missed hepatitis vaccine and has had no fever for 7 days, is eating again, and seems to be well per father. Past vaccines have been well tolerated. Her temperature now is 98.7°F and she appears well. The risk and potential side effects of the hepatitis vaccine were discussed after the VIS was given and the parent was informed of the correct dosage of an antipyretic should fever or fussiness occur afterwards. The night call system was explained and the access number given.

K. Brooks, LPN/R. Dunn, MD (signatures/date)

NOTE: Some payers may inappropriately deny claims that link code **99211** to a "V" ICD-9-CM code. Neither CPT nor ICD-9-CM guidelines* prohibit such reporting when the ICD-9-CM code reported is the most specific one available to describe the patient encounter. Furthermore, CPT guidelines clearly outline the requirements for reporting a given level E/M code. If the key components of history, physical examination, and medical decision making or time requirements (when greater than 50% of the visit is spent counseling/coordinating care) are met for a given code, the physician is correct in the reporting of that code. *Current Procedural Terminology* guidelines do not make the reporting of a certain level E/M code contingent upon the patient exhibiting certain symptoms or falling under a particular diagnosis. *Current Procedural Terminology* guidelines correctly recognize that there can be considerable variation in the treatment of a patient with a particular diagnosis and that it is inappropriate to validate the legitimacy of a reported E/M code by the presence of a certain diagnosis(es). Claims adjudication processes that prohibit the reporting of "V" ICD-9-CM codes with anything other than Preventive Medicine Services CPT codes are inconsistent with CPT and ICD-9-CM guidelines and are counterintuitive to the continuum of care that can be provided for a patient with a given diagnosis. Further, it should be noted that the Office or Other Outpatient Services CPT codes (**99201-99215**) are *not* limited to "sick" visits only. Therefore, it is appropriate to report "V" codes or any other ICD-9-CM codes that most appropriately reflect the reason for the encounter with the Office or Other Outpatient Services codes.

*International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) *Official Guidelines For Coding and Reporting*

C. Chapter-Specific Coding Guidelines

C18. Classification of Factors Influencing Health Status and Contact with Health Service

A. ICD-9-CM provides codes to deal with encounters for circumstances other than a disease or injury. The *Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01.0 - V83.89)* is provided to deal with occasions when circumstances other than a disease or injury (codes **001-999**) are recorded as a diagnosis or problem. There are four primary circumstances for the use of V codes, including:

1. When a person who is not currently sick encounters the health services for some specific reason, such as to act as an organ donor, to receive prophylactic care, such as inoculations or health screenings, or to receive counseling on health related issue.

D. Categories of V Codes

2. Inoculations and vaccinations: Categories **V03-V06** are for encounters for inoculations and vaccinations. They indicate that a patient is being seen to receive a prophylactic inoculation against a disease. The injection itself must be represented by the appropriate procedure code. A code from **V03-V06** may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.

For questions, please contact the AAP Coding Hotline at aapcodinghotline@aap.org.