CODING LEVEL-IV VISITS WITHOUT FEAR

Use this worksheet to quickly assess whether you can code a 99214.

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Colleagues frequently tell me that they want to code more level-IV established patient (99214) visits. They have a notion that they are seeing many patients whose visits and documentation would qualify for that level of charge. However, they end up undercoding to 99213 (level III) to be safe because they are unsure of the exact requirements and fear being audited. This is unfortunate because proper coding could potentially reap an extra $20,000 per year, assuming a physician's daily schedule includes at least 20 visits and at least two of those visits could be coded at level IV instead of level III, resulting in an additional $100 per day or $500 per week.

Often, physicians are seeing patients whose visits would qualify. By documenting correctly, they would simply be getting paid more for the work they are already doing.

Documenting a level-IV established patient visit is not terribly difficult. It only requires a few extra items as compared to a level-III visit. The worksheet on page 35 was designed to assist with level-IV coding. It will help you quickly assess whether your current patient encounter has what it takes and will clarify what needs to be included in your documentation. You may want to refer to it as you read further about how to use the worksheet, which is based on Medicare's 1995 *Documentation Guidelines for Evaluation and Management Services*.

About the Author

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Three key components

Any evaluation and management (E/M) service has three key components: history, exam and medical decision making. For an established patient visit, two of the three components must meet specific criteria when you're performing documentation-based billing. The criteria for an established patient level-IV visit are summarized on the worksheet and explained below.

History. The history component is fairly straightforward. Start the note with a chief complaint. Then add an extended history of present illness (HPI) that includes four or more descriptive elements (location, quality, severity, duration, timing, context, modifying factors or associated symptoms) about the chief complaint. Do not forget that only four are required. If you want or need to add more, please do so. (You can also meet the HPI requirements by documenting the status of at least three chronic conditions.[1])

Next, a pertinent past, family and social history needs to be noted. This involves documenting at least one specific item from any of the three history areas. A classic example is "non-smoker." That's one powerful notation that fulfills your history requirement.

Finally, document an extended review of systems by noting two to nine systems that are associated in some way with the chief complaint.

ESTABLISHED PATIENT LEVEL-IV (99214) VISIT WORKSHEET

Think level IV if you do any of the following at a patient visit:

- Order an X-ray and review it;
- Order an ECG and review it;
- See a new problem with uncertain prognosis (e.g., lump in breast);
- See a complicated injury (e.g., fall with loss of consciousness);
- See three chronic, stable illnesses;
- Spend more than 25 minutes with a patient.

To confirm that it's a level-IV visit, check the requirements below.

DOCUMENTATION-BASED BILLING

Your documentation must have two of the following three elements.

1. HISTORY: Include all of the following:
   - ☐ CHIEF COMPLAINT: Any
   - ☐ HISTORY OF PRESENT ILLNESS: Four elements (location, quality, severity, duration, timing, context, modifying factors or associated symptoms) or the status of at least three chronic conditions
   - ☐ PAST HISTORY: One item (medical, family or social – e.g., non-smoker)
   - ☐ REVIEW OF SYSTEMS: Two systems

2. EXAM: Include five organ systems.
   - ☐ Examination of affected body area and at least four other symptomatic-related organ systems

3. MEDICAL DECISION MAKING: Meet the requirements for at least two of the following:

   - ☐ DIAGNOSIS: 3 points required
     - New problem, additional work-up planned = 4 points
     - New problem, no work-up planned = 3 points
     - Established problem, worsening = 2 points
     - Established problem, stable = 1 point

   - ☐ DATA: 3 points required
     - Independent review of X-ray, ECG or blood work = 2 points
     - Order or review blood work = 1 point
     - Order or review X-ray = 1 point
     - Order or review procedural test (e.g., ECG, spirometry or EGD) = 1 point
     - Review and summarize old records or discuss case with another provider = 2 points

   - ☐ RISK: One of the following required
     - One chronic illness with mild exacerbation
     - Two stable chronic illnesses
     - Previously undiagnosed new problem of uncertain prognosis (e.g., breast lump or chest pain)
     - Acute complicated injury (e.g., head injury with loss of consciousness)

TIME-BASED BILLING

The visit must meet the following requirements:

- ☐ Total visit time: 25 minutes or more
- ☐ Counseling time: More than half of the total visit time

continued ➤

LEVEL-IV ESTABLISHED PATIENT EXAMPLES

The six documented cases below qualify as level-IV visits. The two key qualifying components are noted in parentheses at the top of each case. As you'll see, it's not the length of the documentation but the content that is important.

(HPI and new problem/X-ray)

CC: Ankle pain

HPI: 35-year-old male with sharp pain in left ankle. It began two weeks ago and has gotten worse in the past three days.

PH: Left ankle injury due to football in 1999.

ROS: No neurological symptoms. No rashes.

EXAM: Pain with palpation over medial malleolus. No bruising. Range of motion good but produces pain. Neuro intact. No rash.

DATA: Ankle X-ray ordered. I reviewed results personally and found no signs of fracture or dislocation.

A/P: Left ankle pain, likely strain or tendonitis. Referred to sports medicine department to evaluate and treat.

(HPI and new problem/uncertain prognosis)

CC: Chest pain

HPI: 58-year-old female with intermittent, sharp chest pain over two weeks. Episodes last 10 minutes at a time. Pain occurs at rest.

PH: Non-smoker, no family history of cardiovascular problems.

ROS: No shortness of breath. No reflux.

EXAM: Vitals: BP 120/80, P 65

Lungs: clear to auscultation

CV: normal

A/P: Chest pain. ECG and stress test ordered. Follow up scheduled.

(HPI and exam)

CC: Cough

HPI: 75-year-old male with productive cough for five days, worse at night. Patient also has fever and chest pain. Patient using cough syrup without improvement.

PH: Non-smoker.

ROS: Denies shortness of breath or heart palpitations.

EXAM: Vitals: temp 101.5, BP 140/80

ENT: negative

Neck: negative

Chest: rhonchi bibasilar, pain on deep inspiration

CV: negative

Abd: negative

A/P: Acute bronchitis. Rx: Azithromycin, expectorant. Follow up as needed.

(HPI and chronic illness mild exacerbation/testing)

CC: Shortness of breath

HPI: 60-year-old female with emphysema and increased shortness of breath over past five days. She uses albuterol and ipratropium three to four times per day, which helps. Denies cough.

PH: Former smoker.

ROS: Denies chest pain or fever.

EXAM: Vitals WNL

Chest: poor air movement

CV: normal

A/P: Emphysema with mild exacerbation. Requested chest X-ray, electrocardiogram and complete blood count. Will switch her to inhaled tiotropium.

(Time-based)

CC: Depression

HPI: 53-year-old male with depression and some anxiety issues. Denies suicidal ideations. Has taken alprazolam in past.

EXAM: Vitals: BP 120/80, P 63

Affect appropriate

A/P: Depression. Had long discussion with patient and counseled him on exacerbating factors and treatment options. Rx: Fluoxetine 20mg.

Total visit time 25 minutes, counseling time 15 minutes.

(Three chronic, stable illnesses)

CC: Follow-up on medical problems

HPI: 63-year-old male with hypertension. Blood pressure has been controlled. Denies headache. His emphysema is stable, but he does get mildly short of breath with activity. His hypothyroidism is now stable. Recent thyroid stimulating hormone testing was normal.

PH: Not smoking.

ROS: Noted above.

EXAM: Vitals: BP 138/78

Chest: Clear to auscultation

CV: Regular rhythm and rate

A/P: Hypertension, stable, continue meds.

Emphysema, stable, continue meds.

Hypothyroidism, stable, continue meds.

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These days, undercoding is not financially viable.

In most cases, the criteria for this section will be the easiest to fulfill. This is considered a detailed history, and once it is attained, you only need one of the next two components to meet the necessary criteria for an established patient level-IV visit.

Exam. The note's exam portion is a little more challenging because you might not have the time or the need to perform a detailed exam in a short visit or with a straightforward complaint. To meet the criteria here, five to seven body areas or other symptomatic-related organ systems must be examined and documented.[1] The body areas include the head, neck, chest, abdomen, genitalia, back and each extremity. The organ systems include constitutional (e.g., vital signs), eyes, ENT (ears, nose, throat), cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, skin, neurologic, psychiatric and hematologic. Remember, a notation indicating "negative" or "normal" is sufficient to document normal findings.

Medical decision making. This component is often the deciding factor as to whether your visit reaches level-IV status. It is divided into three sections – diagnosis, data and risk – that are used to determine the complexity of the patient encounter. To qualify for a level-IV charge, only two of the three sections must meet specific criteria. The diagnosis and data sections can be simplified with a point-scoring system.

The *diagnosis section* deals with the number of possible diagnoses or the management options that must be considered. A point system can be applied to this section with 3 points needed to meet the 99214 criteria. Basically, if your patient has a new, previously undiagnosed problem, you have met the criteria for this component. If you plan to obtain additional work-up (e.g., blood work or an X-ray), you earn 4 points. If no additional work-up is planned, you earn 3 points.

If you are dealing with an established, previously diagnosed problem, decision making will be less complex, and the patient will have to have more than one problem to meet the level-IV criteria. An established problem that has worsened earns 2 points. An established problem that is stable earns only 1 point. In this case, you could add up three stable problems or have one stable and one worsening problem and score 3 points for the diagnosis section.

The *data section* deals with the amount and complexity of data to be ordered or reviewed. Like the diagnosis section, the data section requires 3 points to qualify for a level-IV code. The easiest way to achieve 3 points here is to order an X-ray, ECG or blood work, and to independently review the results yourself at the time of the E/M encounter. Ordering the test earns 1 point, and personally reviewing the results earns 2 points.

Another way to earn 3 points is ordering or reviewing multiple tests. Ordering clinical lab tests (e.g., blood work), radiologic tests (e.g., X-ray) and procedural tests (e.g., stress tests or pulmonary-function testing) all earn 1 point each.

Finally, you can earn 2 points for both review and summarization of old records and discussion of the case with another health care provider. Combine that with ordering any testing, and 3 points are achieved.

The *risk section* is based on the overall risk associated with the presenting problems, diagnostic procedures and management options. The highest level of risk in any one of these three categories determines the overall risk. Therefore, the worksheet focuses only on the presenting problem, as it is often the easiest to quickly identify if the patient encounter is of moderate risk, which is required for a level-IV code.

For the presenting problem to be of moderate risk, your patient needs to have one chronic illness with mild exacerbation, two or more stable chronic illnesses, an undiagnosed new problem with uncertain prognosis (e.g., lump in breast or chest pain), an acute illness with systemic symptoms (e.g., pyelonephritis) or an acute complicated injury (e.g., head injury with loss of consciousness).

- Many 99214 visits end up being undercoded because physicians want to play it safe.
- The worksheet in this article can help you quickly assess whether a patient encounter is a level-IV visit.
- The medical decision making component is often the deciding factor as to whether a visit qualifies as level IV.

The other two categories of risk usually follow suit with the presenting problem. Moderate risk diagnostic procedures (e.g., cardiac stress testing, endoscopy, deep needle biopsy, cardiac catheterization, lumbar puncture or thoracentesis) and management decisions (e.g., minor surgery, prescription drug management, IV fluids or closed fracture treatment) would usually be ordered or performed on patients with one of the qualifying presenting problems listed above.

In certain circumstances, physicians can code level-IV visits on the basis of time.

Time-based billing

Another way to qualify for a level-IV code is time-based billing. Often those quick acute illness visits turn into much longer visits than anticipated due to patient needs. If you spend at least 25 minutes with the patient and more than half of that time was spent in counseling, then you have qualified for a level-IV charge. Document as appropriate, but you do not have to concern yourself with as much detail. Just be sure that at the end of your visit documentation you describe the content of your counseling or care coordination and report the total visit time and counseling time (e.g., "total visit time was 25 minutes, more than half of which was spent counseling the patient and coordinating care").

The worksheet with this article includes six examples of level-IV patient visits.

Level-IV examples

On the back of the worksheet, you will find six documented cases of level-IV established patient visits. At the top of each one, the two key qualifying components are noted in parentheses. As you can see, it is not the length of the documentation that is important. (Be aware that most of the notes fulfill minimum requirements only.)

Get coding

These days, undercoding is not financially viable. You may have incorrectly coded in the past due to lack of knowledge, or even out of fear. In the future, strive to be properly compensated for the complex work that you perform every day, and use this worksheet to help you code established patient level-IV visits with confidence. FPM

Send comments to **fpmedit@aafp.org.**

1. Many coding instructors teach that under the 1995 documentation guidelines an expanded problem focused exam involves two to four organ systems and a detailed exam involves five to seven organ systems. Many also teach that under the 1995 and 1997 versions of the guidelines physicians can fulfill the extended history of the present illness (HPI) requirements by including either four or more elements of the HPI or the status of three or more chronic conditions. Staff from the Centers for Medicare & Medicaid Services (CMS, formerly the Health Care Financing Administration) announced these changes in a public forum in 1996 and indicated that the 1995 guidelines would be modified to incorporate them. Unfortunately, CMS never published the changes.

Consequently, the 1995 version of the documentation guidelines makes no distinction between expanded problem focused and detailed exams in terms of organ systems/body areas; each may involve two to seven. The only distinction in the guidelines is that an expanded problem-focused exam is "limited" and a detailed exam is "extended." The 1995 guidelines also do not incorporate the "3+ chronic disease" rule in the definition of HPI, although the 1997 guidelines do.