CME

Christian Hermansen, MD, and Joan Jackson, CPC, CPC-H, LPN

# When Is It Right to Code 99215?

Knowing the rules will give you the confidence to submit this seldom-used code.

The CPT evaluation and management (E/M) code 99215, "Office or other outpatient visit for an established patient," is rarely used, accounting for about 5 percent of E/M visits.[1] However, depending on the fee schedule, payment for 99215 could be about 25 percent more than for 99214, so when the clinical circumstances and your documentation support 99215, you should claim the payment that you've earned. Of course, inappropriate or excessive use of 99215 can result in audits. Understanding the requirements as well as the differences between 99215 and 99214 (see page 13) – and between 99215 and the newer transitional care management code 99496 (see page 14) – will help to ensure that you can code with confidence.

## History

The history component of a 99215 visit requires a comprehensive level of documentation. Documenting a *comprehensive history* means addressing four elements of the history of the present illness or the status of three chronic diseases in your documentation. Ten of the 14 body systems should be reviewed and commented on – significantly more than the two required for documenting a level-four history. At least two aspects of past, family, and social history should also be included.

## Exam

This article focuses on the 1997 version of the E/M guidelines, which lists 14 organ systems and body areas comprising the general multisystem exam. Each has multiple elements. For instance, four exam elements define the "Respiratory" portion of the general multisystem exam: assessment of respiratory effort, percussion of the chest, palpation of the chest, and auscultation of the lungs. Coding 99215 requires a *comprehensive exam* in which two elements in each of nine or more organ systems and body areas are documented. A common way of remembering the exam documentation requirements for each level of exam is to build from a problem-focused visit to a comprehensive visit using the "rule of

**About the Authors**

Dr. Hermansen is senior physician leader at Lancaster General Health Physicians in Lancaster, Pa., associate director at Lancaster General Family Medicine Residency, and medical director of Downtown Family Medicine. Joan Jackson is a coding specialist at Lancaster General Hospital. Author disclosures: no relevant financial affiliations disclosed.

When conditions warrant a comprehensive history or physical exam and high complexity medical decision-making, 99215 can be the most correct and lucrative option.

sixes." (See "Rule of sixes for general multisystem exam documentation," page 14.)

The 1997 guidelines are quite specific and rely on documentation of individual bullets, which makes it easier to support the level of service submitted. (For more information, read "Exam Documentation: Charting Within the Guidelines," *FPM*, May/June 2010, http://www.aafp.org/fpm/2010/0500/p24.html.) The 1995 guidelines are vague by comparison and may create trouble if your definition of the exam does not coincide with the definitions used by the auditor, so we recommend using the more specific 1997 guidelines.

## Medical decision-making

Medical decision-making should be the primary driver for code selection. For example, a physician may treat a patient for a hangnail and perform a comprehensive history and physical examination in the process, detailing every inch of the patient's history and performing an exam of his or her entire body. However, if the patient does not require medications, testing, or even a bandage for the hangnail, it is doubtful that the high level of care provided was medically necessary. We urge you to routinely make medical decision-making one of the two key components used for deciding if the patient's care is worthy of the 99215 code.

Medical decision-making is also the most complex of the three key components of the documentation guidelines, having three subsections: problem points, data points, and risk. These help determine the level of medical complexity from minimal complexity to high complexity. *High complexity medical decision-making* is associated with a 99215 visit. Two of the three subsections (problem, data, or risk) are needed for determining the level of medical decision-making. Typically, risk is used as one of the defining criteria; however, any two of the subsections could be used as the basis for code selection. (See "The elements of medical decision-making," page 16.)

**Problem.** Although a point system for quantifying the diagnoses and management options associated with patients' health problems is not an official part of the E/M documentation guidelines, many Medicare contractors use a point system for educational and auditing purposes. A total of four points is associated with high

### COMPARISON OF CODES 99214 AND 99215

| Key components (2 of 3 required, plus medical necessity) | 99214 | 99215 | Difference |
|---|---|---|---|
| History | Detailed:<br>• 4+ HPI elements or status of 3 or more chronic diseases<br>• Review of 2 to 9 systems<br>• 1 PFSH element | Comprehensive:<br>• 4+ HPI elements or status of 3 or more chronic diseases<br>• Review of 10 or more systems<br>• 2 PFSH elements | • Review of additional 8 systems<br>• 1 additional PFSH element |
| Exam | Detailed:<br>• 12+ exam elements from 2 or more systems | Comprehensive:<br>• 18+ exam elements; 2 exam elements from *each* of 9 systems | • 6 additional exam elements from *each* of 9 systems |
| Medical decision-making | Moderate complexity:<br>• Prescription medications<br>• Multiple diagnoses or management options | High complexity:<br>• Parenteral controlled substances<br>• Multiple diagnoses or management options | • 1 parenteral controlled substance |

HPI = History of present illness; PFSH = Past, family, and social history.

## 99215 AND TRANSITIONAL CARE MANAGEMENT

Both 99215 and the transitional care management code 99496 require high complexity medical decision-making. The 99496 code requires that the office contact the patient within two days of discharge and provide an office visit within seven days of discharge with high complexity medical decision-making. Practices that fall short of meeting these and the other detailed requirements associated with code 99496 could bill 99215 instead, assuming documentation and medical necessity support the level of service. Code 99215 pays approximately $80 less per visit. The 2014 work RVUs (relative value units) are 2.11 for 99215 and 3.05 for 99496. For more information, see "Transitional Care Management Services: New Codes, New Requirements," *FPM*, May/June 2013, http://www.aafp.org/fpm/2013/0500/p12.html.

Coding 99215 requires a comprehensive exam in which two elements in each of nine or more systems are documented.

Medical decision-making should routinely be the driver for code selection.

A point system for quantifying diagnoses and management options can be used to determine medical complexity.

complexity medical decision-making. Points are assigned as follows:

- Each minor problem earns one point with a maximum of two,
- Each stable established problem earns one point with no maximum,
- Each established but worsening or uncontrolled problem earns two points,
- One new problem that does not need workup after the visit is worth three points and, if additional workup is needed, four points.

**Data.** A point system is also used for quantifying information gathered or requested during the visit. Again in this section of the guidelines, a total of four points meets the high complexity decision-making metric. Each of the following tasks earns one point regardless of the number of tests ordered:

- Reviewing or ordering lab tests,
- Reviewing or ordering radiology tests,
- Reviewing or ordering medical studies such as pulmonary function tests or electrocardiograms.

The following tasks also earn points:

- Documenting a discussion of contradictory or unexpected test results with the testing physician (one point),
- Independently reviewing an image, specimen, or tracing (two points),
- Reviewing old records and summarizing them in the record (two points),
- Requesting old records or obtaining history from a source other than the patient, such as a family member or an emergency medical technician (one point).

**Risk.** This element takes into account the risk of complications, morbidity, and mortality based on the patient's condition. High risk is associated with high complexity medical decision-making. High risk could be associated with visits involving patients who have severe exacerbations of their problems or acute injuries that pose a threat to bodily functions. Diagnostic procedures or management options associated with highly complex care include cardiac electrophysiology studies, diagnostic endoscopy, discography, major surgery, parenteral controlled substances, or drug therapy with the need for intensive monitoring. For example, a high-risk visit might involve a patient who requires a parenteral medication in the office such as an injection for a migraine, supplementary fast-acting insulin for hyperosmolar hyperglycemia cases, or warfarin adjustment due to a supratherapeutic international normalized ratio. Documentation of the decision to de-escalate care in situations of poor prognosis is also a mark of a high-risk visit.

The assessment of risk of the presenting problem or problems is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk for selecting diagnostic procedures and man-

## RULE OF SIXES FOR GENERAL MULTISYSTEM PHYSICAL EXAM DOCUMENTATION

| | |
|---|---|
| Problem-focused visit | Less than 6 bullets in 1+ systems |
| Expanded problem-focused visit | 6+ bullets in 1+ systems |
| Detailed visit | 12+ bullets in 2+ systems |
| Comprehensive visit | 18+ bullets;<br>2 in each of 9+ systems |

## TEST YOUR CODING SKILLS

### CASE 1

The patient is a 46-year-old male with diabetes who is back to see you after visiting the emergency department the day before for acute nausea and vomiting. The patient had chest pain and was tested for a possible blood clot with a CT scan that was negative for pulmonary embolism. The patient is no longer with chest pain but complains of fatigue and slight abdominal pain. He cannot tolerate crackers, lives with his wife, and drinks two beers every night at bedtime. No family history of heart disease and no allergies. Medications include simvastatin, lisinopril, metformin, and glyburide.

Vitals: BP 100/60 (last BP 146/86), P 56, WT 240, RR 20, Temp 99.2.

General: Appears older than stated age, dry heaving in office, obese, moderate distress.

HEENT: PERRL, slight conjunctival injection, mild pharyngeal edema, deviated septum on right.

Neck: No JVD, no thyromegaly.

Lymph: No cervical, axillary, or inguinal adenopathy.

Cor: Brady S1/S2, 1/6 systolic murmur.

Lungs: Decreased BS bilaterally without wheeze or crackles, normal effort, no dullness to percussion.

Abdomen: Diffuse mild abdominal pain without rebound or guarding, no organomegaly.

Extremities: No clubbing or cyanosis, 1+ edema bilaterally.

Skin: No rashes, tattoo on left scapula.

Neurological: CN 2-12 intact; normal DTRs bilaterally, symmetrically; muscle strength seems normal throughout.

A1C in office 10.2, last A1C 3 months ago 13.4.

Assessment/Plan:

1. Acute nausea/vomiting, recent chest pain, mild anemia.
2. Suspect lactic acidosis given CT scan and metformin.
3. Can be life threatening so will send to emergency department for potential hemofiltration and IV fluids.

Answer on page 16

### CASE 2

The patient is a 36-year-old female who has returned to the office with acute sharp stabbing RLQ pain with nausea/vomiting since 2 p.m. The patient has no desire to eat and reports having a low-grade fever at home but no chills. Not better with ibuprofen. No chest pain/shortness of breath/rash/dysuria/myalgia/sore throat/numbness/vision changes. Smokes one pack per day. Previous history of GERD and PCOS. Current medication is metformin.

Vitals: BP 96/88, P 114, RR 20, Temp 101.6.

General: Sick appearing, in pain, obese.

Neck: No JVD, supple.

Cor: Brady S1/S2.

Lungs: CTA bilaterally.

Extremities: No edema.

UA in office: Positive for ketones but no blood or leukocyte esterase.

Urine pregnancy negative.

WBC in office 16.5.

Assessment/Plan:

1. Acute abdominal pain with rebound tenderness, leukocytosis.
2. Likely needs imaging to rule out appendectomy, other abdominal pathology.
3. Needs IVF, to consider evaluation for sepsis given hypotension.
4. Start hydromorphone 0.2 mg IV once while awaiting transport for ED/imaging.
5. Will contact hospitalist as FYI.

Answer on page 16

### CASE 3

The patient is a 16-year-old male who returned for follow-up for depression and hypothyroidism. You have not examined him for about four months. The patient states he is not doing well. He continues to have significant problems with his mother since her divorce. He is getting terrible grades in school mostly because of the distraction of constant teasing. During continued nightmares, he recognizes a face he believes resembles his father. He has not felt comfortable talking about this until now, but states his father sexually abused him as a child. He thinks his dreams represent a flashback to those events. He has not seen his father since he moved away but gets sweaty just thinking about him. Medications include Paxil and Synthroid, but they have been missed due to a change in insurance plans.

General: NAD, some psychomotor agitation, and crying occasionally. We spent 45 minutes together with greater than 50 percent of the time spent counseling and coordinating care.

Assessment/Plan:

1. Depression; probable PTSD; hypothyroidism.
2. Prozac now covered by insurance; see medication flow sheet.
3. Discussed the need for counseling to continue to discuss these issues so he can get better.
4. Coordinated appointment with new support group at hospital for victims of abuse.
5. Will see again next week and on a regular schedule to continue to provide support.
6. Generic Synthroid (levothyroxine) given; repeat TFTs ordered.

Answer on page 16

## THE ELEMENTS OF MEDICAL DECISION-MAKING

| Type of decision-making | Problem(s) | Data | Risk |
|---|---|---|---|
| Straightforward | Minimal | Minimal or none | Minimal |
| Low complexity | Limited | Limited | Low |
| Moderate complexity | Multiple | Moderate | Moderate |
| High complexity | Extensive | Extensive | High |
| | At least two of the three criteria – problem(s), data, risk – must be met or exceeded. | | |

agement options is based on the risk during and immediately following any procedures or treatment.

### Time-based coding

Alternatively, if more than 50 percent of the face-to-face portion of the office visit was spent counseling and coordinating care, you can code it on the basis of time. Your documentation should reflect your discussion or coordination of any of the following:

- Diagnostic results, impressions, or recommended diagnostic studies,
- Prognosis,
- Risks and benefits of management (treatment) options,
- Instructions for management (treatment) or follow-up,
- Importance of compliance with chosen management (treatment) options,
- Risk factor reduction,
- Patient and family education.

If you and your patient spend more than 20 minutes of a 40-minute face-to-face visit together in this manner, a 99215 code is justifiable as long as you have detailed documentation of the context of the counseling and care coordination.

Note that new codes for complex care coordination (99487-99489) will take effect in January 2015. These may affect the frequency with which physicians use time-based coding, particularly for higher levels of service.

The assessment of risk should be based on the risk during and immediately following treatment.

If more than 50 percent of the office visit was spent coordinating care or counseling, you can code on the basis of time.

A comprehensive history and exam and high complexity decision-making warrant code 99215.

### Don't overlook 99215

Family physicians may hesitate to code 99215. However, when conditions warrant a comprehensive history or physical exam and high complexity medical decision-making, 99215 can be the most correct and lucrative option.

To get a sense of whether your current use of 99215 is in line with benchmarks, analyze your E/M coding profile using the "Coding frequency comparison spreadsheet" which is available from the *FPM* Toolbox at http://bit.ly/1yI3aeG. We've also included "Test your coding skills," on page 15, so that you can apply what you have learned to several clinical vignettes. FPM

1. U.S. Department of Health and Human Services, Office of Inspector General. Coding trends for evaluation and management codes in all visit types from 2001 to 2010. http://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf. Published May 2012. Accessed Sept. 29, 2014.

### TEST YOUR CODING SKILLS: ANSWERS

Case 1: Level 99215 was met with the comprehensive exam (two bullets from each of nine systems) and high complexity medical decision-making (possible life-threatening condition). Consider adding to the note the total time spent with the patient.

Case 2: Level 99215 was met with the comprehensive history and high complexity medical decision-making (new problem with additional workup and IV use of a controlled substance). Consider adding to the note the total time spent with the patient.

Case 3: Level 99215 was met because more than 50 percent of the total face-to-face time of > 40 minutes was spent counseling and coordinating care.

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