This piece is written by a professional coder and coding trainer, Holly Cassano, CPC, and was formerly available at http://www.medicalbillingandcoding.org/blog/how-to-handle-provider-queries/ (the blog has been deleted since the Psychiatric Code Coach page was developed)

CPT: *Medical Coding Roundtable: Why 99214 Is Your New BFF*

Code 99214 ranks as the second highest level of care for established patients, yet stands as one of the most underutilized codes out of the CPT book.

It is commonly thought that physicians may down-code to a 99213, if the physician is not sure their documentation supports a level 4 established patient visit. They leave a lot of money on the table that they are legitimately entitled to, if they just understood some simple basics that support a 99214.

There are several possibilities that could lead a provider to under-code a 99214. They are as follows:

- Fear of fraud and abuse laws /penalties

- Medicare Audits

- Misunderstanding the Evaluation and Management (E&M) documentation guidelines

Dollars and Sense (99214's BFF Qualifications)

Some studies have indicated that aggregately, 37.3% of internists use 99214 for established patients. That is not a high number of providers utilizing this code, especially when the 2012 national Medicare (CMS) reimbursement for this visit is approximately $104. In other words, that's a lot of money being left on the table due to fear or misunderstanding of how to properly code 99214.

Mind Your Minutes

Providers must remember that time is also a factor when it comes to coding to a higher level. Once the decision has been made to code a 99214, be mindful of the time spent with the patient. If the provider spends at least 25 minutes with the patient with more than half the time involved with counseling or coordination of care, 99214 is appropriate to code.

NOPP – Nature of the Presenting Problem

As with all high level codes, the provider must bear in mind that the presenting problem must be of moderate to high severity for a 99214. As long as the documentation of the presenting problem is consistent with medical necessity (which is the overarching criteria for code selection), the next step is ensure that the documentation is bulletproof, in the event of an audit. It is essential that the provider thoroughly and accurately documents each step of the visit to support the code being billed.

TIP

Documenting all diagnosis codes/problems discussed during the visit is a good way to ensure and support medical necessity for coding a 99214 (or any high level code).

Making 99214 Your BFF

CPT 4 defines 99214 as an "office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components":

- A detailed history

- A detailed examination

- Medical Decision Making (MDM) of moderate or high complexity

With that being said, documenting a 99214 is relatively simple. Since CPT 4 says that only two out of three key components must satisfy the documentation requirements for any particular level of care. It is up to the provider decide which elements to document, as the amount of required documentation is quite simplistic.

Step right up and get TWO of THREE (History, PE, MDM) to code for 99214. Some providers may find it easier to get to a 99214 by working in reverse through the elements to establish moderate MDM by documenting a combination of the following:

- Prescription drug management: Does not just require NEW meds it can also indicate:
  - Refilling meds
  - Ordering labs to monitor for side effects
  - Documenting side effects or medical compliance
- This is all considered MANAGEMENT of prescription drugs
  - OR 2 or more STABLE chronic illnesses. Yes, STABLE
  - OR 1 chronic illness with progression or side effect of treatment
- AND Presenting Problems:
  - 3 stable chronic illnesses
  - OR 1+ stable chronic illness and 1+ unstable
  - OR uncontrolled illness
  - OR 1+ new problem with or without additional workup

Key Points to Remember for 99214

Apply 99214 for any of the following:

- New complaint with potential for morbidity if untreated or misdiagnosed
- Three or more old problems
- New problem that requires a prescription for a controlled substance
- Three stable problems which require medication refills
- One stable problem and one poorly controlled problem that requires medication refills or adjustments

The take-away from this lesson is that 99214 can be every provider's BFF by keeping the following in mind: remember to take the time to quantify the MDM in the required documentation so that your record is bulletproof and supports your 99214.

TrailBlazer: Documentation for 99214

E&M University: Coding for 99214

99214 Resources

Happy Coding!

Holly