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Internal Medicine Coding Alert

E/M Coding Clinic: History and Co-existing Conditions Can Make the Difference Between 99213 and 99214

Audits of physician documentation for level 3 and level 4 established patient visits (**CPT 99213** and 99214) often reveal a lack of appropriate documentation of a history of present illness (HPI), review of systems (ROS), or past, family, social history (PFSH), say coding consultants.

Physicians know that in an established patient exam you dont need all three componentshistory, exam, and medical decision making, says **Catherine Brink, CMM, CPC,** president of Healthcare Resource Management, a physician practice management consulting firm in Spring Lake, NJ. They know that you just have to have two out of three. So, most rely on having an appropriate exam and a high enough level of medical decision making (MDM), but fail to pay attention to documenting the history and chief complaint areas.

The CPT manual stipulates that, for each established patient E/M service (office/outpatient visit 99211-99215, established patient), only two of the three components must meet the required level of service in order to report a particular code.

For example, CPT states that code 99213 requires two of the following three components: an expanded problem-focused history, an expanded problem-focused exam, and medical decision making of low complexity. A physician could document only an expanded problem-focused examination and medical decision making of low complexity and still meet the requirements for 99213.

However, says Brink, physicians should be encouraged to get in the habit of always documenting the chief complaint and at the very least an interval history, to include any changes in the patients condition from the previous visit.

I think most physicians do this. They ask the patient how they have been doing and if there has been any change in the history since the last visit, says Brink. But, they forget to document it. In many charts that she has audited, the physician documented the chief complaint and then went right into documenting the physical exam performed, she says.

Visits That Dont Involve an Exam

For established patient visits that dont require a physical exam, getting at least a brief HPI and one problem-pertinent ROS is essential to meet the requirements for 99213. For example, you have a patient with severe headaches and you send them for an MRI, explains Brink. After the test is performed, you schedule a return visit with the patient for follow up, establishing a definitive diagnosis and plan of treatment.

The documentation should begin, The patient is here on follow-up for severe headache, she continues. Then, the internist goes into the test results and the plan for treatment. He doesnt have a history and he doesnt have an exam performed, all he has is the level of MDM. Accordingly, the internist hasnt met the requirements of any level of service.

Of course, the physician probably asked the patient whether his or her symptoms had gotten better or worse or were unchanged. But, without any documentation of any change in the patients history and the patients response, it cannot be considered a history element. The highest code available with this documentation would be a 99211, since that is the only code that does not require performance of history, physical or medical decision making.
If the physician had documented a brie
f HPI (one to three elements) and a review of the problem-pertinent system (the system related to the patients complaint), then that visit would be eligible for a 99213, says Brink.

The internist should get in the habit of documenting why the patient is there (the chief complaint), and then making a statement about the interval history. If it is unchanged, he should say it is unchanged since the last time the patient was there and then list the date that the patient was last seen, she explains. Then, he or she can go into discussing the test results and plan of treatment. He hasnt performed an exam, but you dont need an exam because you have the history and MDM.

On a related note, level 3 only requires a brief HPI, with only one of the available elements documented, adds Brink. (See related story on the requirements of reporting 99213 on page 76.) The elements of HPI are: location, quality, severity, duration, timing, context, modifying factors, associated signs or symptoms.

Level 4 requires a detailed history, she says. That is the main reason I see a lot of 99214s dropped down to 99213sit is a lack of documenting the detailed history.

Use History from Previous Visit

If the physician takes a patient history and it is unchanged, he should include a statement to the effect that patient states that medical history is unchanged since ___ and list the date the initial history was performed.

Lets say the initial visit was six months ago, says Brink. If the physician documented a comprehensive history, then whatever history he took six months ago can be brought into the follow-up examination, as long as they document that the history was unchanged since six months ago. Then, the auditor can go back and look up the previous visit to see what level of history was taken. If the patient was a new patient six months ago, the history was most likely comprehensive. For a new patient, you have an HPI, ROS, and PFSH.

That comprehensive history can be brought into the current visit and counted toward establishing a level of service, but only if the physician documents that the history is unchanged since that specific date.

Remember Co-Existing Conditions

Co-existing conditions, if they impact the decision making for the current problem, are considered in the MDM category number of diagnoses and management options considered.

Co-existing conditions should be listed as secondary diagnoses and forwarded on the claim form. For example, you have a patient who comes in with migraine headaches (346.9x), says Brink. Lab studies reveal that she has hypothyroidism (244.9), which is a secondary diagnosis. And, lets say, the patient told the physician at a prior visit that she knew that she had non-insulin dependent diabetes mellitus (NIDDM).

The patients diabetic condition will affect which medication she can be given, as well as present other treatment challenges.

That should be your third diagnosis, Brink explains. But, if the physician just documents migraine headaches, then that just leaves him with one diagnosis. If you consider the multiple diagnoses, he would at least be in the area of low-complexity MDM, if not even moderate.

Documentation of co-existing conditions often means the difference between a 99213 and 99214, due to the difference in MDM, she adds.