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Internal Medicine Coding Alert

Requirements of Reporting 99213

According to **Catherine Brink, CMM, CPC,** president of Healthcare Management Resources Inc. in Spring Lake, NJ, **99213 CPT Procedure Code** is commonly used in internal medicine practices for return visits by patients with a chronic medical problem that requires follow-up but is not an acute problem and, usually, the patient has some type of co-existing condition.

Usually, you are going to have some kind of worsening condition, Brink advises. If you have a patient with only one condition and no change in the diagnosis, you are going to still be in minimal decision making, which often means that you wont get above a 99212.

But, if the patient has one or more co-existing conditions, or there is a change in the patients medical problem from the last visit, or the physician is required to review a significant amount of lab studies or other test results, then the visit will be the higher code.

If the physician reviews a number of old records, MRIs, lab results, the more complicated the review, the code is most likely going to move up to a 99214, she says.

Here are the specific requirements for reporting 99213:

According to CPT, code 99213 consists of an expanded problem-focused history, an expanded problem-focused examination, and medical decision making of low complexity.

Physicians must document at least two of the three following areas at a level sufficient to support the code definition.

1. Expanded Problem-Focused History: According to the 1997 E/M documentation guidelines, an expanded problem-focused history requires a brief HPI of one to three elements and a review of the system that is related to the problem. For this level, no past, family, social history (PFSH) is required.

Note: According to the documentation guidelines, the elements of the HPI are location, quality, severity, duration, timing, context, modifying factors, and associated signs or symptoms. A patient who presents with an HPI of a severe migraine headache for the past seven hours has indicated two elements (duration [seven hours], and severity [severity of headache]).

The systems that can count for the ROS are constitutional (weight loss, etc.); eyes; ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary (skin, breast); neurological, psychiatric; endocrine; hematologic/lymphatic; allergic/immunologic; or all others negative.

2. Expanded Problem-Focused Exam: According to the documentation guidelines for 1995, an expanded problem-focused exam consists of the examination of the affected body area or organ system and any other symptomatic or related organ systems, up to a total of seven body areas/organ systems.

According to the 1997 guidelines, an expanded problem-focused visit should include performance and documentation of at least six elements identified by a bullet () in one or more organ system(s) or body area(s).

The 1997 guidelines include templates for a general multi-system examination and single organ system examinations that feature bulleted elements detailing the different components of each examination.

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3. Medical Decision Making of Low Complexity: Coders and/or physicians must calculate the level of medical decision making used in a particular visit by considering three different components: the number of diagnoses or management options considered, the amount and/or complexity of data reviewed, and the risk of complications and/or morbidity or mortality to the patient.

According to the documentation guidelines, the overall level of medical decision making is taken from the highest level attained by two of the three components of medical decision making.

Because these elements are so difficult to quantify, many internal medicine practices use the method employed by Medicare auditors to quantify the medical decision making. Medicare assigns a point system for each component, then arrives at a score for each of the three elements and uses each score to determine the overall level of decision making.

Note: This process is detailed in a form called the E/M Documentation Auditors Worksheet that has been compiled by the Medical Group Management Association (MGMA) in Englewood, CO. Copies of this worksheet may be ordered through the MGMA by writing to: MGMA Order Department, 104 Inverness Terrace East, Englewood, CO, 80112-5306. Practices may contact ACP-ASIM for this work sheet or contact their regional carrier to obtain their auditors instructions.

CPT defines a low level of medical decision making as limited number of diagnoses or treatment options, a low level of risk to the patient, and a limited amount and/or complexity of data reviewed.

In determining the score for number of diagnoses or treatment options, Medicare considers five categories:

1. Problems that are self-limited or minor (stable, improved, or worsened)worth 1 point per problem to a maximum of two points, according to the carriers audit sheet;

2. Established problems that are stable or improvedworth 1 point per problem;

3. Established problem that is worseningworth 2 points per problem;

4. New problem with no additional work-up plannedworth 3
points with a maximum of one problem; and

5. New problem, additional work-up plannedworth 4 points per problem.

A limited number of diagnoses or treatment options are
considered a score of at least 2.

When considering the amount and/or complexity of data reviewed, Medicare assigns points in the following categories:

Review and/or order of clinical lab tests in the Pathology and Laboratory section of CPT, 80049-89399worth 1 point;

Review and/or order of tests in the Radiology section of CPT, 70010-79999worth 1 point;

Review and/or order of test in the Medicine section of CPT, 90281-99199worth 1 point;

Discussion of test results with performing physician, worth 1 point;

Decision to obtain old records and/or obtain history from someone other than patientworth 1 point;

Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion with other healthcare providerworth 2 points; and

Independent visualization of image, tracing, or specimen (not simply review of report)worth 2 points.

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Limited review of data or review of data with limited complexity is considered a score of 2.

Calculating Risk

For Medicare carriers, the risk of complications or morbidity and/or mortality is determined by considering the degree of risk in three different areas: the presenting problem(s), the diagnostic procedures ordered, and the management options selected.

Low risk in all three areas would be two or more self-limited or minor problems, one stable chronic illness, or an acute uncomplicated illness or injury. Diagnostic tests would include physiologic tests not under stress, non-cardiovascular imaging studies, superficial needle biopsies, clinical laboratory tests requiring arterial puncture, and skin biopsies. Management options selected would include over-the-counter drugs, minor surgery with no identified risk factors, physical therapy, occupational therapy, and IV fluids without additives.

However, remember that the highest level of risk in two of these three areas determines the overall level of risk considered.

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