Part B Insider (Multispecialty) Coding Alert

E/M Coding: 3 Tips Are Key to Deciphering 99213 From 99214

Avoid these upcoding mistakes.

Do you recognize when your physician documents a 99214 but only circles a **CPT 99213** on the superbill? If you don't, then your practice could be losing money.

Every year when CMS releases its benchmarking data, code 99213 (Office or other outpatient visit...) ranks number one as the top-billed code by medical practices. But just because you're billing it frequently doesn't mean you're billing code 99213 correctly.

Check out these three quick tips to determine whether your **CPT 99213** coding could use a tune-up.

Tip 1: Get an Auditing Tool

Some practices say that they report 99213 often because in some situations they "think" the doctor has documented enough to warrant 99214, but they aren't sure so they bill 99213 to be safe.

Solution: "If the coders are assigning the levels of service, they should be using an auditing tool," says **Suzan Berman-Hvizdash, CPC, CPC-EM, CPC-ED,** manager of coding and compliance with the UPMC-Department of Surgery in Pittsburgh. "There are many auditing tools available, including the ones that the payers use and make available on the web."

For example, she says, http://www.highmarkmedicareservices.com publishes its auditing tool on its Web site.

"Coders should never 'think' the doctor documented one way or another; they should know," Berman-Hvizdash says. "And then if the documentation and the medical appropriateness of the code is there, it should be billed that way," Berman-Hvizdash says.

Tip 2: Check All Elements

When you're assigning E/M levels, you can't afford to miss any of the elements of history, medical-decision making, or exam.

"The history is usually the portion of the visit, especially on an established patient, that is not always thorough," Hvizdash says. "However, depending on the payers' interpretation, the exam might not be documented well. There is a difference between an 'expanded problem focused' exam and a 'detailed' exam," she says.

"The payers may have different rules on this," Berman-Hvizdash advises. "One payer says that 2-7 body areas or organ systems with at least one system being more detailed should count as a 'detailed' visit, while another payer says that at least 4 organ systems should have 4 descriptors under each one."

Solution: The coding staff members should have in writing the E/M definitions of their top payers so they can identify when a 99213 was accurately documented.

Tip 3: Avoid 99213 on Every Visit

Some insurers raise red flags when a practice reports only 99213 for established patient E/M services.

Example: "Imagine you are the insurance company, you look more at charts and graphs than medical books," says

Denae M. Merrill, CPC-E/M, owner of Merrill Medical Management.

"Reviewing claims from Dr. A. shows a straight line of all 99213s, while reviewing claims from Dr. B. shows a bell curve utilizing codes 99211-99215. You have national and local averages to compare these doctors with to make sure there isn't anything that should be investigated further. When you compare the averages with Dr. A and Dr. B, Dr. A stands out like a sore thumb. You wonder why Dr. A. does not follow the average and want to look at the documentation to support the 99213s."

Solution: Choose your E/M code based on the documentation every time, and your coding will naturally reflect the doctor's range of services.

Coding based on the E/M documentation saves you time and money in the long run -- not just because you'll collect the money you're due, but also because your staff members will avoid performing extra work in the future auditing all of your records to confirm why you billed all 99213s, Merrill says.