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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Avoid Losing $35 Per Visit By Correctly Choosing Between 99213 and 99214

Knowing what to look for in documentation is the key to deciding outpatient visit leveling.

Are you a chronic E/M downcoder?

Physicians tend to report 99213 for a larger percent of their office visits than they do 99214, when in fact reporting 99214 may be more accurate if you have supporting documentation. But because 99213 pays about $73 compared to $108 for 99214, you could be forfeiting $35 every time you downcode your claims.

Read on for tips that will help you confidently select between these two common office visit codes.

Rely on the Descriptor and Examine the Note

Once you're familiar with the key components history, examination, and medical decision making (MDM) that you'll use to determine a level of service for outpatient encounters, you will know what to look for in your doctor's note. The difference between reporting 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity ...) and reporting 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity ...) will lie in the documentation details.

Established patient encounters that have two of the three key elements, reach a certain level. For 99213 you need expanded-problem focused (EPF) history, EPF exam, and/or low complexity MDM. One level up, 99214 requires a detailed history and exam with an MDM of moderate complexity. You need to support two of the three key components with the note on the code you report.

"The documentation speaks loudly," says **Suzan (Berman) Hauptman, MPM, CPC, CEMC, CEDC**, director of coding operations at Allegheny Health Network in Pittsburgh, Pa. "Understanding the E/M elements will help and then reading the components that the physician emphasizes will certainly lead you to the right code."

Recognize What Tips the History Scale

If you have an extended review of systems (ROS) and pertinent past medical, family, social history (PMFSH), the deciding factor in getting to detailed, rather than expanded problem-focused (EPF) history, is the history of present illness (HPI).

In order to get from brief to extended HPI, you need to have either three chronic conditions or at least four HPI elements. You'll look for mention of the location, severity, quality, duration, timing, context, modifying factors, and/or associated signs and symptoms if you are counting elements.

If you have either three chronic conditions or at least four HPI elements, you have extended HPI. If you have one or two chronic conditions or less than four HPI elements, you have brief HPI. Combined with an extended or complete ROS and pertinent or complete PMFSH, extended HPI will support 99214, rather than 99213.

"In order for the history to be detailed, it's important to be able to pull out at least four elements of the history of present illness, along with some system review, and at least one item in past, family or social history (if not more when relevant)," explains Hauptman.

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Warning: Watch out for falsely elevated history and exam levels in electronic health records (EHRS). "We need to remember, particularly with EHR's capability to easily 'create' a detailed level of history and physical exam, that the underlying medical necessity of the patient's condition needs to support performance and documentation of that level of service," says **Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CPCO**, owner of MJH Consulting based in Denver, Co.

Count Systems and Determine the Detail of the Exam

The difference between an EPF and detailed exam component is the number of body areas or organ systems and the detail of the exam. A detailed or comprehensive exam will support 99214, while 99213 only requires an EPF exam. Your payer will dictate how they define an EPF exam versus a detailed exam.

Whether an examination is detailed depends on which guidelines your payer uses. If your payer scores/counts body areas or organ systems, they follow the 1995 guidelines. According to Hauptman, most payers use one of three philosophies:

1. Five to seven body areas/organ systems need to be illustrated in the note

2. Two to seven body areas/organ systems illustrated in the note with at least one having more detail

3. Four by four rule having at least four body areas/organ systems illustrated with at least four descriptors under each of them.

Novitas, for example, uses a 4 by 4 method in determining the difference. This means the provider exams at least four elements in at least four organ systems or body areas with. Other payers look for two to seven systems with at least one being more detailed.

If your payer uses the 1997 guidelines, they count the general multi-system or a single-organ system. No matter which guidelines your payers use, it will guide you to whether the exam is expanded or detailed.

Use Three Factors to Get MDM

To determine the MDM, you need to look at three components: the number diagnoses or treatment options, level of risk, and the amount and complexity of the data. To support reporting 99214 using MDM, you'll want to go from low complexity to moderate complexity decision making.

Remember: MDM is not the same as medical necessity. Medical necessity should always be the overarching factor used to select the E/M service level, which CMS has reiterated several times, including in Transmittal 178 (www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf). Be sure your provider's documentation supports medical necessity before you choose 99214 over 99213.

Don't Look to Coding Based on Time

If your provider's documentation does not meet the code requirements based on the key elements of history, exam, and MDM, you may still be able to report 99214 rather than 99213. If the physician spent more than half the encounter on counseling or coordination of care, you can bill based on time. Note that, to bill on time alone, the documentation must include the total time spent on the encounter, the portion of time spent on counseling and/or coordination of care, and the topic of the counseling or coordinator or care.

Caveat: "Time is generally not meant to be used in selecting the level of E/M service; it is merely one of the contributing factors," says **Linda Smith, CPC, CPC-I, CEMC, CMSCS, CMBS**, at MedOffice Resources in Greene, N.Y. "Providers should be discouraged from routinely selecting the level of service based on the amount of time spent with the patient unless more than 50 percent of the total time spent with the patient, was spent counseling and coordinating care."

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