

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Learn The Do's & Don'ts Of Deciphering 99213 and 99214

Make sure your upcoding practices are on the up and up with these 3 tips

Payors audit 99214 more than any other E/M code, so its imperative that you know how to properly report [CPT 99213](#) and 99214 on your claims.

Follow our tips to determine when you can bump your visit up to 99214 and when you should stay in the 99213 zone.

Do Nail Down Vital 99213-99214 Elements

Pay attention to the differences in the descriptors for codes 99213 and 99214:

- 99213--Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem-focused history, an expanded problem-focused examination, medical decision-making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

- 99214--- a detailed history, a detailed examination, medical decision-making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Tip: You can successfully code and document level-four established patient office visits (99214) for many of your patients by remembering the code's minimum criteria. Compare 99213's E/M documentation guidelines to 99214-s.

Don't Fall For These Common Upcoding Mistakes

If your physician's documentation supports a level-four visit, you should report 99214.

Caution: But watch out for these hidden traps:

1. Make sure your physicians understand that medical necessity is the overreaching criterion that dictates the service level they provide and report. Automated systems set up to document every possible piece of history and examination for every patient will certainly attract the attention of auditors.

Payors and auditors may view obtaining a higher-level component than medically necessary just to charge a higherlevel E/M service as -gaming the system,- says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME**, president of **CRN Healthcare Solutions** in Tinton Falls, N.J.

2. You should keep in mind that E/M codes are not completely diagnosis-driven. Don't assume you can report higher-level E/M codes--rather you should base your E/M choice on the documentation.

Example: An established patient who usually visits your physician for her Crohn's disease reports with vomiting and fever. Your physician orders a round of blood/stool tests and a CT scan of the abdomen, recommends some dietary

changes, and prescribes Prednisone for the condition. The encounter lasts a total of 13 minutes.

You determine that you have:

- several diagnoses or management options;
- moderate amount and/or complexity of data to be reviewed;
- high risk of complications and/or morbidity or mortality.

Solution: Despite the encounter time of only 13 minutes, this service merits 99214, not 99213. The reason is that the physician is considering several diagnosis possibilities of a complex nature or high risk of complications including Crohn's fistula, abdominal abscess, intestinal obstruction, and medication side effects.

Remember: You should add 780.6 (Fever) and 787.03 (Vomiting alone) in addition to 555.9 (Crohn's disease) to 99214 to show medical necessity for your code choice. On the other hand, an office visit for follow-up of Crohn's disease with adjustment of medicine for variable diarrhea and cramps would more likely merit only 99213.

Even if you had extensive documentation of every possible piece of history and examination, you only have medical necessity for medical decision-making of low complexity.

Don't Send Up Red Flags By Using 99213 Every Time

Some insurers raise red flags when a practice reports only 99213 for established patient E/M services, says **Heather Corcoran**, coding manager at **CGH Billing Services** in Louisville, Ky. Payors wonder what type of patient care a practice is providing when it never codes anything higher or lower than that, she adds.

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

Hint: See the easy-to-use chart below for clues on what you should look for with each code.

