99213 or 99214?
Three Tips for Navigating the Coding Conundrum

Here’s how to quickly identify whether you’re on the path to a 99214 versus a 99213.

Perhaps one of the most confounding aspects of evaluation and management (E/M) coding is the distinction between a 99213 and a 99214 visit. Some may view this as a distinction without a difference, but medical practices that confuse the two codes either forfeit revenue earned or risk penalties for upcoding.

Family physicians provide a staggering number of established patient office visits each year — 38,249,187 in 2016, according to the Centers for Medicare & Medicaid Services (CMS). Of those, 42 percent were reported as 99213 visits and 50 percent were reported as 99214 visits. With these two codes accounting for such a large proportion of office visits, and with a difference of about $35 per

ABOUT THE AUTHOR
Richelle Marting is an attorney practicing with Forbes Law Group in Overland Park, Kan., where she focuses on regulatory compliance and health care reimbursement. Author disclosure: no relevant financial affiliations disclosed.
visit (using the national average Medicare allowed amounts), the distinction between the two can quickly become significant. For example, 250 Medicare visits coded 99213 rather than 99214 amounts to nearly $9,000 less revenue.

THE REQUIREMENTS AT A GLANCE
The E/M documentation guidelines require that established patient office visits meet two of three key components of the E/M code being reported. Alternatively, if more than half the visit involves counseling or coordination of care, the visit may be reported based on time. (See "Key components and average times for codes 99213 and 99214," page 7.)

CPT provides definitions for each level of history, exam, and medical decision making, but the definitions prove to be subjective and difficult to distinguish in practice. For example, an "expanded problem focused" exam is defined as a "limited examination of the affected body area or organ system and other symptomatic or related organ system(s)" and a "detailed" exam is defined as an "extended examination of the affected body area(s) and other symptomatic or related organ system(s)” (emphasis added). These definitions leave physicians wanting further definitions of “limited” and “extended” to help distinguish between these two levels of exam.

KEY POINTS
• With 42 percent of office visits to family physicians reported as 99213s and 50 percent reported as 99214s, and with a difference of about $35 per visit, the distinction between these two levels can quickly become significant.

• Remember 4, 2, 1 for the detailed history of a 99214 — four elements of the history of present illness, two organ systems reviewed, and one element of the past medical, family, and social history.

• One way to remember the requirements for a detailed exam consistent with a 99214 is the 4x4 method — four items of exam in four different body areas/organ systems.

• Think 99214 if the presenting problem involves a chronic condition with exacerbation, multiple stable chronic conditions, an acute complaint with systemic symptoms, an acute complicated injury, or an undiagnosed new problem with uncertain prognosis.

changes coming to the e/m guidelines
In June 2017, in the proposed rule for the 2018 Medicare physician fee schedule, the Centers for Medicare & Medicaid Services (CMS) sought feedback about the E/M guidelines, noting that they have heard from stakeholders that the guidelines are overly burdensome and outdated.


Some commenters noted that the guidelines are inconsistent with the current emphasis on team-based care and should therefore be revised to allow any member of the care team to enter medical information related to a visit. Others suggested eliminating or reducing the history and exam components and allowing medical decision making and/or time to serve as the key determinant of an E/M visit level. Still others called for eliminating the guidelines altogether for codes 99211-99215 and 99201-99205. You can read the American Academy of Family Physician’s written comments to CMS here: https://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/LT-CMS-EMSuggestions-042318.pdf.

At press time, CMS had not yet released its proposed changes to the E/M guidelines, but they are expected to be part of the 2019 proposed Medicare physician fee schedule. Following a brief comment period, the final rule will be released at the end of October.

FPM will update the online version of this article when the information becomes available.
When E/M codes underwent significant changes in the early 1990s, a large Wisconsin-based physician group worked with its local Medicare carrier to develop and test a tool that would translate CPT's narrative descriptions of E/M codes into an objective score sheet. CMS did not formally adopt the score sheet as part of the 1995 or 1997 Documentation Guidelines for E/M Services, but the group's system for scoring medical decision making is commonly used. Some Medicare administrative contractors have adopted similar score sheets.

Although some interpretation is still necessary, these tools have helped quantify the difference between levels of service based on certain aspects of documentation.

In response to growing criticism that the E/M guidelines are outdated and overly burdensome, CMS has recently indicated some willingness to revise them, but details and timelines are not yet final. (See “Changes coming to the E/M guidelines,” page 6.)

In the meantime, the following tips can help ease the coding and documentation burden and help you recognize when a visit meets the requirements of a 99214 versus 99213.

1. REMEMBER 4, 2, 1 FOR A DETAILED HISTORY

To achieve a detailed history consistent with a 99214, you need to document four elements of the history of present illness (HPI), two organ systems in the review of systems (ROS), and one element of the past, family, and social history (PFSH). These elements are in addition to the chief complaint, unless the visit is preventive and has none.

Four elements of HPI. A few descriptive words, such as “severe pain” or “located in the epigastric region,” can make the difference between the level of history. An expanded problem-focused history, consistent with a 99213, requires one to three HPI elements while a detailed history consistent with a 99214 requires four or more HPI elements. The eight possible elements are location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms. Many patient visits involve the assessment of chronic conditions for which details such as “location” may not apply. In these instances, instead of documenting HPI elements, you may document the status of three or more chronic conditions and still meet the criteria for a detailed history; this is allowed under both the 1995 and 1997 guidelines.

Two organ systems for ROS. A review of systems consistent with a 99213 would typically involve a single organ system pertinent to the chief complaint, but a review of systems consistent with a 99214 would typically involve two to nine organ systems — the system directly related to the chief complaint and at least one other affected system:

- Allergic/immunologic,
- Cardiovascular,
- Constitutional,
- Ears, nose, mouth, throat,
- Endocrine,
- Eyes,
- Gastrointestinal,
- Genitourinary,
- Hematologic/lymphatic,
- Integumentary (skin and/or breast),
- Musculoskeletal,
- Neurologic,
- Psychiatric,
- Respiratory.

One PFSH. In a typical 99213 visit, you may not need to review or update the
patient’s PFSH at all, but a 99214 requires at least one of those areas be reviewed and documented. One common pitfall in the use of electronic health records is that they often count at least one history item by default when pulling medication lists, allergies, problem lists, or PFSH data into the progress note. Such auto-population of data fields can result in overdocumentation and cause a higher level of service to be billed than was performed or warranted for the patient’s condition. Only count PFSH elements that you actually review or update and only if they are relevant to a condition you address at the visit.

2. PICK A METHOD — 12, 5-7, OR 4X4 — FOR DOCUMENTING A DETAILED EXAM
The difference between an expanded problem-focused exam consistent with a 99213 and a detailed exam consistent with a 99214 is one of the most debated distinctions in E/M coding. There is little consistency even among Medicare administrative contractors on this difference. The 1995 guidelines (https://go.cms.gov/1LjiQwx) provide a narrative description, consistent with the definitions provided in CPT. However, as previously noted, determining what constitutes a “limited” versus “extended” exam of the affected body areas poses a significant challenge.

A variety of methods are used for more objectively assessing the level of exam. **The 12 bullet point method.** The 1997 guidelines attempted to quantify common aspects of exams and define expanded problem-focused and detailed exams based on the number of bullet points performed and documented. (See the full list of bullet points on page 13 of the guidelines at https://go.cms.gov/2sy2Q4f.) Documenting even a negative finding can satisfy a bullet point under this set of guidelines. Documentation of six to 11 bullet points — whether normal or abnormal — constitutes

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**USING TIME AS THE CONTROLLING FACTOR**

When selecting a level of service based on time, the distinction between a 99213 and 99214 visit is relatively straightforward. You can take this route when counseling and coordination of care comprise more than half of your face-to-face time with the patient (staff time with the patient does not count).

Counseling includes discussion with the patient or family concerning one or more of the following:

- Diagnostic results, impressions, or recommended diagnostic studies,
- Prognosis,
- Risks and benefits of management (treatment) options,
- Risk factor reduction,
- Patient and family education.

You do not need to complete a history or physical exam to select the level of service based on time unless it is medically necessary. For example, if a patient is returning to discuss the findings of a test you ordered at a previous visit, there may be no need to repeat a full history and exam at the current visit. Simply document the total time of the visit and the amount of time spent in counseling or coordination of care activities. A detailed description of the counseling provided isn’t required; a summary is all that is necessary for most payers.

The times listed in the CPT code descriptors are averages, not thresholds, so select the code closest to the time spent. For example, if the total duration of face-to-face physician-patient time is 21 minutes, select code 99214 because the duration of visit is closer to 25 minutes, the average time for a 99214, than it is to 15 minutes, the average time for a 99213.
an expanded problem-focused exam consistent with a 99213. Documentation of at least 12 bullet points constitutes a detailed exam.

The 5-7 method. Some Medicare administrative contractors use what is referred to as the “2-4, 5-7” method. Under this method, documentation of findings in two to four organ systems or body areas meets the criteria for an expanded problem-focused exam consistent with a 99213. Documentation of findings in five to seven organ systems or body areas meets the criteria for a detailed exam consistent with a 99214. At least one system should be in detail, but the rest can be in brief.

The 4x4 method. Another Medicare administrative contractor, Novitas Solutions, uses the “4x4” method (https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00147593) to distinguish between an expanded problem-focused and detailed exam. Using this method, physicians should document four items of exam in four different body areas/organ systems for the exam to qualify as detailed consistent with a 99214. Documenting fewer items than this would generally constitute an expanded problem-focused exam consistent with a 99213.

3. THINK IN THREES FOR MODERATE DECISION MAKING

Although the documentation guidelines state that only two of the three key components must be met to satisfy a level of service, some payers require that medical decision making be one of the two key components. Their argument is that medical decision making drives medical necessity, and they often cite CMS Pub 100-04, Chapter 12, Section 30.6.1.A, which states “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.” If your payers take this approach, documenting a detailed history and exam may not support billing a higher level of service for a relatively straightforward complaint. Your medical decision making will be key to code selection.

One of the scoring systems described earlier that is not part of the formal guidelines describes the moderate complexity decision making consistent with a 99214 as involving two of the following three components.

Three points for diagnoses or management options. Points are assigned as follows:
- 1 point each (maximum of two problems) — Self-limited or minor problem,
- 1 point each — Established problem, stable/improved,
- 2 points each — Established problem, uncontrolled/worsening,
- 3 points each (maximum of one problem) — New problem, no additional work-up planned,
- 4 points each — New problem, additional work-up planned.

Three points for data reviewed. Points are assigned as follows:
- 1 point — Review/order labs,
- 1 point — Review/order radiology services,
- 1 point — Review/order medical diagnostic studies,
- 1 point — Discuss tests/studies with performing physician,
- 1 point — Decide to obtain old records,
- 2 points — Review and summarize old records, or obtain history from someone other than patient,
- 2 points — Directly visualize and independently interpret an image, tracing, or specimen.

Three options for moderate risk.
The risk component doesn’t have points assigned to it, so it is more subjective and difficult to identify, but here’s what to look for in moderate risk consistent with a 99214 (remember, you need just one of the following for moderate risk, which is one of three factors overall for medical decision making):
- A presenting problem such as a chronic condition with mild exacerbation, side
have considerable impact on your practice. Familiarizing yourself with the number of items required for each section for a 99214 can help make the distinction easier in a majority of the cases, bringing some objectivity to an otherwise subjective conundrum.


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