LEVEL-II VS. LEVEL-III VISITS: Cracking the Codes

Once you learn the rules, choosing the right code is easier than you think.

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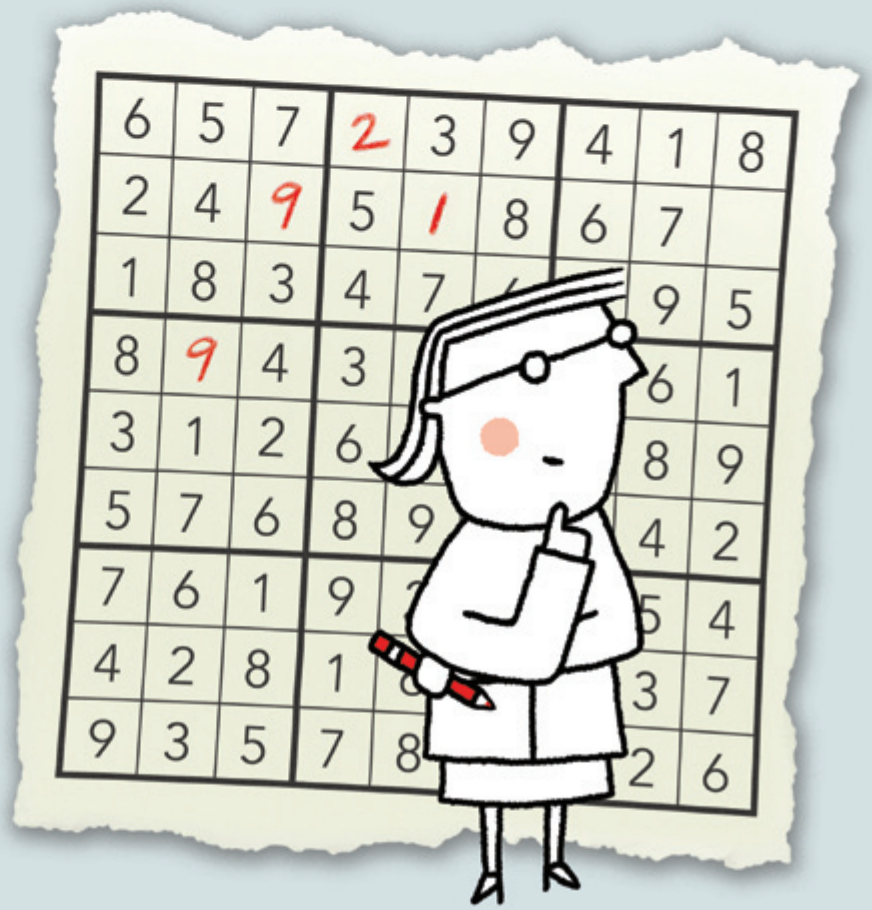
Careful and correct documentation and coding are vital skills for every family physician. They enable us to record the high-quality care we provide for our patients and help ensure that we don't undercode or overcode the services we provide.

My previous article, "Coding Level-IV Visits Without Fear" (*FPM*, February 2006), focused on ensuring that you're coding all the level-IV visits you're entitled to. This article will focus on the slight differences in the requirements for established patient level-II (99212) and level-III (99213) visits – differences that can have a surprisingly significant effect on your bottom line if you don't understand them well. For example, the 2007 Medicare allowance (not adjusted for geographic differentials) for a 99212 is $37.14, while the allowance for a 99213 is $59.50. Consequently, each time you code a 99212 when you should have coded a 99213, you leave $22.36 on the table. If you undercode 10 of these visits a week, you've failed to capture $223.60 per week, or more than $10,700 over 48 weeks. ➤



CHRISTINE SCHNEIDER

Each time you code a 99212 when you should have coded a 99213, you are leaving $22.36 on the table.

Coding your patient visits accurately reflects the care you provide and ensures that you are reimbursed appropriately.

Distinguishing between level-II and level-III visits is not difficult once you learn the requirements.

Established patient visits require that you meet or exceed criteria for two of the three key components to qualify for a certain level of E/M service.

Of course, learning when a 99213 is really a 99212 is also important. Thorough documentation of the work you perform, along with careful attention to medical necessity, will help you audit-proof your practice.

History and exam

Medicare's *Documentation Guidelines for Evaluation and Management Services*, which most private payers also rely on to a great degree, divides documentation into three key components: history, exam and medical decision making. For established patient visits (99211-99215), two of the three key components must meet or exceed criteria to qualify for a specific level of evaluation and management (E/M) services. (This does not apply to new patient visits, 99201-99205, which require not only all three key components but also more detail for certain key components.)

The documentation guidelines are available in 1995 and 1997 versions, and we are allowed to use either one. Of note, the only significant difference between the two versions is the exam section. I prefer to use the 1995 guidelines, and I have used them in this article, because I believe the exam requirements are easier to follow. Here are the criteria to keep in mind when conducting a patient history and exam:

History. The history requirements for level-II and level-III visits are comparable. They both require that you note a chief complaint (CC) and one to three elements (location, quality, severity, duration, timing, context, modifying factors, or associated signs and symptoms) that describe the history of present illness (HPI). A past medical, family and social history (PFSH) is not required for either level-II or level-III visits.

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The only difference between the history requirements for a level-II and a level-III visit is the review of systems (ROS). A level-II visit does not require an ROS, while a level-III visit requires a problem-pertinent ROS, which is a description of one system that is directly associated with the problem. This additional component raises the level of history from problem-focused to expanded problem-focused.

Exam. The exam requirements are slightly different for level-II and level-III visits. Under the 1995 guidelines, a level-II exam must be problem-focused, which requires the description of one component of the affected body area or organ system. A level-III exam is expanded problem-focused, which requires the description of one component of the affected body area or organ system and at least one other affected body area or organ system. The body areas include the following: head/face, neck, chest/breasts/axillae, abdomen/genitals/groin/buttocks, back/spine and each extremity. The organ systems include the following: constitutional (general appearance or vital signs); eyes/ears/nose/mouth/throat, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, skin, neurologic, psychiatric and hematologic/lymphatic/immunologic.

The 1997 guidelines require documentation of one to five specific exam "bullets" for level II and six to 11 bullets for level III. You can find a complete list of exam bullets, as well as the 1995 and 1997 guidelines in their entirety, on the Centers for Medicare & Medicaid Services' Web site at http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp.

Medical decision making

The medical decision making component represents the most significant difference between a level-II and a level-III visit. "Straightforward" decision making is sufficient for level II, while "low complexity" decision making is required for level III. Three parameters (diagnosis, data and risk) combine to determine the level of decision making. When two of the three parameters meet or exceed the specified requirements,

BREAKING DOWN THE REQUIREMENTS

Coding 99212 vs. 99213[1]		
	99212	**99213**
HISTORY	Problem-focused	Expanded problem-focused
	CC: yes HPI: brief (1-3 elements) PFSH: none ROS: none	CC: yes HPI: brief (1-3 elements) PFSH: none ROS: 1 system
EXAM[2]	Problem-focused	Expanded problem-focused
	1 component of affected body area/organ system.	1 component of affected body area/organ system, plus an additional 1-7 symptomatic-related body areas/organ systems.
MEDICAL DECISION MAKING[3]	Straightforward	Low complexity
Diagnosis	Diagnosis/management options: Minimal Need 1 point Examples: • One self-limited/minor problem (1 point). • One stable established problem (1 point).	Diagnosis/management options: Limited Need 2 points Examples: • One self-limited/minor problem AND one stable established problem (2 points). • One established problem, worsening (2 points).
Data	Amount/complexity of data: Minimal Need 1 point Examples: • Review and/or order lab, radiology or medical test (1 point). • Discuss results with testing physician (1 point). • Obtain old records (1 point).	Amount/complexity of data: Limited Need 2 points Examples: • Review and/or order lab test (1 point). • Review and/or order radiology test (1 point). • Review and/or order medical test (1 point). • Independently interpret specimen/imaging/tracing (2 points). • Summarize review of old records/additional history (2 points).
Risk[4] Presenting problem	Level of risk: Minimal Examples: • One self-limited or minor problem, e.g., cold, insect bite, tinea corporis.	Level of risk: Low Examples: • Two or more self-limited or minor problems. • One stable chronic illness, e.g., controlled hypertension, diabetes mellitus, benign prostatic hyperplasia. • One acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain.
Diagnostic procedures	• Lab with venous puncture. • Chest X-ray. • ECG. • Urinalysis. • Ultrasound. • Wet prep.	• Physiologic tests not under stress, e.g., pulmonary function tests. • Non-CV imaging studies with contrast, e.g., barium enema. • Superficial needle biopsies. • Lab tests with arterial puncture. • Skin biopsies.
Management options	• Rest. • Gargles. • Elastic bandages. • Superficial dressings.	• OTC drugs. • Minor surgery with no identified risk factors. • Physical or occupational therapy. • IV fluids without additives.

1. Two of the three key components (history, exam and medical decision making) must meet or exceed requirements for the code.
2. Examples follow the 1995 Medicare documentation guidelines.
3. Two of the three sections must meet or exceed requirements for the overall level of medical decision making.
4. The highest risk level of the three sections determines the overall risk level.

then the overall level of decision making is determined.

You can use a simple point system to evaluate the number of possible diagnoses or management options and the amount of data to be evaluated. While the point system is not part of the documentation guidelines, it is widely used by Medicare carriers, coders and physicians to assess documentation and aid in code selection.

Diagnosis. The number of diagnoses or management options needed for a level-II visit is considered minimal; only one point is required. You can earn one point if the patient has a self-limited or minor problem (e.g., cold, insect bite, tinea corporis) or an established problem that is stable or improved.

The number of diagnoses or management options for a level-III visit is considered limited, with two points required. Two self-limited problems, two stable established problems or one established problem with mild exacerbation would each yield two points.

Data. In the data section, points are earned according to the amount and complexity of

The history requirements for level-II and level-III visits are similar, but a level-III visit requires a problem-pertinent review of systems.

A level-III visit requires a problem-focused exam, which involves a limited exam of the affected body area plus one to seven symptomatic-related areas.

Level-II visits involve straightforward decision making, while level-III visits involve low-complexity decision making.

LEVEL-II AND LEVEL-III ESTABLISHED PATIENT EXAMPLES

The examples below illustrate the slight differences between a level-II visit and a level-III visit. Each row includes two visits that involve a similar chief complaint, but the visit described in the left column warrants a 99212, while the visit in the right column warrants a 99213. Note that the 99213 visits include an expanded problem-focused exam and a review of systems (ROS).

99212	99213
CC: Cold **HPI:** 6-year-old with sore throat and headache. No fever. **Exam:** ENT normal. **Assessment/Plan:** Upper respiratory infection. Symptomatic therapy only.	**CC:** Cold **HPI:** 6-year-old with sore throat and headache. **ROS:** Positive fever and nausea. **Exam:** Tonsils enlarged with exudative material, shoddy cervical nodes. **Assessment/Plan:** Swab to rule out strep. Antibiotic treatment if positive.
CC: Rash **HPI:** 65-year-old with rash on both arms. Worked in yard yesterday. **Exam:** Linear rash, few vesicles. **A/P:** Contact dermatitis, likely from poison oak. Avoid plant.	**CC:** Rash **HPI:** 65-year-old with rash on arms and trunk. Worked in yard yesterday. **ROS:** Denies shortness of breath. **Exam:** Diffuse vesicles, blisters, erythema. **A/P:** Contact dermatitis. Cold wet compresses, oral steroid.
CC: Blood pressure medication monitoring **HPI:** 50-year-old started new blood pressure medication. No adverse reactions. **Exam:** 120/80, heart regular rate and rhythm. **A/P:** Blood pressure controlled.	**CC:** Six-month follow-up **HPI:** 50-year-old with insulin-dependent diabetes mellitus and stable coronary artery disease; A1C 6.4. **ROS:** No chest pain or shortness of breath. **Exam:** Lungs clear; heart regular rate and rhythm. **A/P:** Diabetes mellitus, stable, continue medications. Coronary artery disease stable.
CC: Acne **HPI:** 11-year-old for follow up of acne. **Exam:** Acne on cheeks improved. **A/P:** Comedonal acne, improved. Continue topical therapy.	**CC:** Acne **HPI:** 11-year-old for follow up of acne. **ROS:** Skin irritated and burning. **Exam:** Acne worse; papules present. **A/P:** Comedopapular acne, not responding to topical therapy. Discussed use of systemic medication.

The only difference between the history requirements for a 99212 and a 99213 is the review of systems.

data to be ordered or reviewed. You should document your review of lab, radiology or other diagnostic tests. If you order, plan, schedule or perform a diagnostic service at the time of the encounter, you should document this as well.

For a level-II visit, you need one point to meet the data requirement, which is considered minimal. You can earn one point by ordering or reviewing lab, radiology or procedure reports, or simply by obtaining old records about the patient or obtaining history from someone other than the patient (e.g., a family member or caregiver).

The data for a level-III visit is considered limited and requires a total of two points. You can earn two points by reviewing or ordering two different types of tests (e.g., a complete blood count and a chest X-ray). You can also earn two points by summarizing old records or discussing the case with another health care provider.

Risk. The risk associated with an E/M visit is based on the chance that significant complications, morbidity or mortality occur during the current encounter/procedure or between the present encounter and the next one. The guidelines characterize these in the context of the presenting problems, diagnostic procedures and management options. The highest level of risk in any one of the three categories determines the overall risk.

The risk associated with a level-II visit is considered minimal. Examples include a presenting problem that is self-limited or minor; diagnostic procedures such as labs with venous puncture, chest X-rays, ECGs, EEGs, urinalysis, ultrasound and KOH preparation; or management options such as prescribing rest, gargles, elastic bandages and superficial dressings.

Level-III visits are considered to have a low level of risk. Patient encounters that involve two or more self-limited problems, one stable chronic illness or an acute uncomplicated illness would qualify. Diagnostic procedures with low risk include physiologic tests not under stress, non-cardiovascular imaging studies with contrast, superficial needle biopsies, labs requiring arterial puncture and skin biopsies. Low-risk management options include prescribing over-the-counter drugs, minor surgery with no identified risk factors, physical therapy, occupational therapy and IV fluids without additives.

Time-based billing

Another option for coding level-II and level-III encounters is to use time as your guide. According to CPT, a typical level-II visit lasts 10 minutes, while a typical level-III visit lasts 15 minutes. If counseling or coordination of care account for more than 50 percent of the visit, then you can select your E/M code based on the length of the visit. In general, the time spent face-to-face with the patient (and the time spent in counseling) should meet or exceed the listed typical visit times. Remember, the coders who audit your charts do so by counting required components as well as noting recorded visit times. If you decide to use time-based billing, make sure to include in your note that at least half of the face-to-face time was spent counseling or coordinating care (e.g., "total visit time was 15 minutes, half of which was counseling"). Your documentation should also describe the nature of the counseling or care coordination.

Coding with confidence

Although E/M coding is not always instinctive, understanding the differences between level-II and level-III visits will help you choose the appropriate code for your patient encounters and receive the proper reimbursement for your work. Every day you provide your patients with the best possible care. Document it accurately and code with confidence. FPM

Send comments to **fpmedit@aafp.org.**

- Medical decision making is determined using three parameters: diagnosis, data and risk.
- The level of risk depends on three factors: the presenting problem, the diagnosis options and the management options.
- You can also code based on time if more than half of your face-to-face time with the patient is spent counseling or coordinating care.

CODING GUIDANCE IN YOUR POCKET

The *FPM* Pocket Guide to the E/M Documentation Guidelines can help you code new- and established-patient office visits. To order, call 800-944-0000, and ask for item 556, which is based on the 1995 guidelines, or item 557, which is based on the 1997 guidelines.