CPT 99213 vs 99214: Real Coding Examples & Case Studies
Step-by-Step Coding Decisions with Documentation Samples

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CASE STUDY #1: ROUTINE DIABETES FOLLOW-UP
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PATIENT PROFILE:
- 58-year-old female, established patient
- Type 2 diabetes mellitus, well-controlled
- Quarterly follow-up visit

VISIT DOCUMENTATION:

Chief Complaint: "Routine diabetes check"

History of Present Illness:
Patient reports good glucose control with home monitoring. Average morning glucose 110-130 mg/dL. No episodes of hypoglycemia. Compliant with metformin 1000mg BID. No new symptoms.

Review of Systems:
Negative for polyuria, polydipsia, weight loss, visual changes, or foot problems.

Physical Examination:
- Vital Signs: BP 128/78, HR 72, Weight 165 lbs (stable)
- HEENT: Fundoscopic exam normal
- Cardiovascular: Regular rate and rhythm
- Extremities: Feet examined, no ulcers, pulses intact, monofilament sensation intact

Assessment & Plan:

Type 2 DM, well-controlled. A1C today 6.8% (improved from 7.2%). Continue metformin 1000mg BID. Return in 3 months. Reinforced dietary counseling.

Time Documentation:
Total time: 18 minutes
- Chart review: 3 minutes
- Patient interaction: 12 minutes
- Documentation: 3 minutes

CODING DECISION: CPT 99213

RATIONALE:
✅ Time: 18 minutes (under 20-minute threshold for 99213)
✅ History: Expanded problem-focused (HPI + ROS)
✅ Exam: Expanded problem-focused (3 organ systems)
✅ MDM: Low complexity (1 stable chronic condition)
✅ Medical Necessity: Routine diabetes monitoring

REIMBURSEMENT: ~$109 (Medicare)

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CASE STUDY #2: HYPERTENSION WITH NEW CHEST PAIN
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PATIENT PROFILE:
- 62-year-old male, established patient
- Hypertension, controlled
- New complaint of chest pain

VISIT DOCUMENTATION:

Chief Complaint: "Chest pain for past 2 weeks"

History of Present Illness:
Patient reports substernal chest discomfort, 4/10 intensity, occurring with mild exertion like climbing stairs. Episodes last 2-3 minutes, resolve with rest. No radiation to arms. No nausea, diaphoresis, or shortness of breath. Family history significant for father with MI at age 58.

Past Medical History: HTN x 5 years, controlled on lisinopril 10mg daily

Review of Systems:
Cardiovascular: Chest pain as above, no palpitations

Respiratory: No dyspnea at rest
GI: No nausea or reflux symptoms

Physical Examination:
- Vital Signs: BP 142/88, HR 78, RR 16, O2 sat 98%
- HEENT: Normal
- Cardiovascular: Regular rate, no murmurs, gallops, or rubs
- Respiratory: Clear to auscultation bilaterally
- Extremities: No edema, pulses intact
- 12-lead EKG performed: Normal sinus rhythm, no acute changes

Laboratory Data Reviewed:
Lipid panel from last month: Total cholesterol 245, LDL 158, HDL 38

Assessment & Plan:
1. Chest pain, possible stable angina - Order exercise stress test, start low-dose aspirin 81mg daily, cardiology consultation
2. Hypertension, poorly controlled - Increase lisinopril to 20mg daily
3. Dyslipidemia - Start atorvastatin 20mg daily

Time Documentation:
Total time: 32 minutes
- Chart review including prior notes: 5 minutes
- Patient encounter including EKG: 22 minutes
- Care coordination/cardiology call: 3 minutes
- Documentation: 2 minutes

CODING DECISION: CPT 99214

RATIONALE:
✅ Time: 32 minutes (exceeds 30-minute threshold)
✅ History: Detailed (comprehensive HPI, ROS, PMH)
✅ Exam: Detailed (5 organ systems + EKG)
✅ MDM: Moderate complexity
   - New problem with uncertain prognosis (chest pain)
   - Multiple management options considered
   - Moderate risk (potential cardiac disease)
   - Data: Review lab results AND order stress test
   - Coordination with specialist

REIMBURSEMENT: ~$148 (Medicare)

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CASE STUDY #3: MULTIPLE CHRONIC CONDITIONS
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PATIENT PROFILE:
- 69-year-old female, established patient
- Type 2 DM, HTN, Osteoarthritis
- All conditions requiring management

VISIT DOCUMENTATION:

Chief Complaint: "Follow-up diabetes, blood pressure, and knee pain"

History of Present Illness:
1. Diabetes: Home glucose readings averaging 140-160 mg/dL, higher than usual. Compliant with medications.
2. Hypertension: No symptoms, taking medications as prescribed
3. Osteoarthritis: Right knee pain worsening, 6/10, limiting mobility. OTC ibuprofen provides minimal relief.

Current Medications:
- Metformin 1000mg BID
- Lisinopril 10mg daily
- Ibuprofen 400mg TID PRN

Review of Systems:
MSK: Right knee pain and stiffness
Otherwise negative

Physical Examination:
- Vital Signs: BP 156/92, HR 84, Weight 178 lbs (+3 lbs)
- Cardiovascular: Regular rate and rhythm
- Extremities: Right knee with effusion, limited ROM, crepitus
- Diabetic foot exam: No ulcers, sensation intact

Laboratory Results Reviewed:
A1C: 8.2% (increased from 7.4%)
Basic metabolic panel: Glucose 168, Cr 1.1 (stable)

Assessment & Plan:
1. Type 2 DM, poorly controlled - Add glipizide 5mg daily, diabetes education referral, return in 6 weeks
2. Hypertension, uncontrolled - Increase lisinopril to 20mg daily
3. Osteoarthritis, right knee - Discontinue ibuprofen (renal protection), start meloxicam 15mg daily, physical therapy referral, consider knee injection

Time Documentation:
Total time: 28 minutes
- Chart review: 4 minutes

- Patient encounter: 20 minutes
- Care coordination (PT referral): 2 minutes
- Documentation: 2 minutes

CODING DECISION: CPT 99214

RATIONALE:
✅ MDM: Moderate complexity (3 chronic conditions, all requiring changes)
✅ History: Detailed (multiple problems addressed)
✅ Exam: Detailed (multiple systems)
✅ Problems: Multiple stable chronic illnesses (qualifies for moderate MDM)
✅ Risk: Prescription drug management requiring monitoring
✅ Even though time <30 minutes, MDM complexity supports 99214

REIMBURSEMENT: ~$148 (Medicare)

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CASE STUDY #4: TIME-BASED CODING EXAMPLE
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PATIENT PROFILE:
- 45-year-old male, established patient
- Depression and anxiety, stable
- Extensive counseling session

VISIT DOCUMENTATION:

Chief Complaint: "Medication refill and counseling"

History of Present Illness:
Patient reports stable mood on current medications (sertraline 100mg daily). However, experiencing work-related stress and relationship difficulties. Requests counseling regarding coping strategies.

Assessment & Plan:
Depression/anxiety, stable on medications. Continue sertraline. Extensive counseling provided regarding stress management, cognitive behavioral techniques, and relationship communication strategies.

Counseling/Coordination Topics Discussed (detailed):
- Stress management techniques (15 minutes)
- Cognitive behavioral therapy principles (10 minutes)
- Relationship communication strategies (8 minutes)
- Work-life balance recommendations (5 minutes)

- Follow-up plan and resources (2 minutes)

Time Documentation:
Total time: 45 minutes
- Brief chart review: 3 minutes
- History and exam: 8 minutes
- Counseling and patient education: 40 minutes
- Documentation: 4 minutes

CODING DECISION: CPT 99214

RATIONALE:
✅ Time: 45 minutes (well above 30-minute threshold)
✅ Counseling >50% of visit time (40/45 minutes = 89%)
✅ Documented specific counseling topics
✅ Medical necessity supported (mental health management)

Note: When counseling/coordination dominates the visit (>50% of time), code selection can be based on total time regardless of other E/M components.

REIMBURSEMENT: ~$148 (Medicare)

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CASE STUDY #5: ACUTE ILLNESS FOLLOW-UP
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PATIENT PROFILE:
- 34-year-old female, established patient
- Upper respiratory infection, follow-up visit
- Initially seen 5 days ago

VISIT DOCUMENTATION:

Chief Complaint: "Still have cough and congestion"

History of Present Illness:
Patient seen 5 days ago for URI. Prescribed supportive care. Cough improved initially but worsened over past 2 days. Now productive with yellow sputum. No fever. Minimal appetite.

Physical Examination:
- Vital Signs: Temp 99.2°F, BP 118/72, HR 88, RR 18
- HEENT: Nasal congestion, postnasal drip
- Respiratory: Rhonchi bilateral lower lobes, no wheezes
- Otherwise normal

Assessment & Plan:
Acute bronchitis, secondary bacterial infection likely. Start azithromycin Z-pack. Supportive care. Return if not improved in 3 days or if fever develops.

Time Documentation:
Total time: 15 minutes
- Chart review of prior visit: 2 minutes
- Patient encounter: 10 minutes
- Documentation: 3 minutes

CODING DECISION: CPT 99213

RATIONALE:
✅ Time: 15 minutes (under 20-minute threshold)
✅ History: Expanded problem-focused
✅ Exam: Expanded problem-focused
✅ MDM: Low complexity (acute uncomplicated illness with progression)
✅ Straightforward management decision

REIMBURSEMENT: ~$109 (Medicare)

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CASE STUDY #6: COMPLEX MEDICATION MANAGEMENT
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PATIENT PROFILE:
- 72-year-old male, established patient
- Multiple conditions: CHF, AFib, COPD, DM
- Medication reconciliation and adjustments

VISIT DOCUMENTATION:

Chief Complaint: "Medication review and shortness of breath"

History of Present Illness:
Patient reports increased dyspnea over past week. Compliance with medications variable due to confusion about dosing schedule. Recent hospitalization discharge 2 weeks ago with medication changes.

Current Medications (Post-Discharge):
- Lisinopril 5mg daily (changed from 10mg)
- Metoprolol 25mg BID (new)
- Furosemide 40mg daily (increased from 20mg)
- Warfarin 5mg daily (dose adjusted)

- Metformin 500mg BID (reduced from 1000mg BID)
- Albuterol inhaler PRN

Review of Systems:
Cardiovascular: Dyspnea on exertion, no chest pain
Respiratory: Cough, mild wheeze
GI: No nausea

Physical Examination:
- Vital Signs: BP 138/84, HR 78 irregular, RR 22, O2 sat 94%, Weight 185 lbs (+5 lbs from discharge)
- Cardiovascular: Irregular rhythm, Grade 2/6 systolic murmur
- Respiratory: Bibasilar crackles, mild expiratory wheeze
- Extremities: 1+ pedal edema bilaterally

Data Reviewed:
- Discharge summary from hospitalization
- Recent echo: EF 35%
- INR from yesterday: 3.2 (elevated)
- BNP: 450 (elevated)

Assessment & Plan:
1. CHF exacerbation - Increase furosemide to 60mg daily, daily weights, low sodium diet
2. Atrial fibrillation - Continue metoprolol, reduce warfarin to 2.5mg daily, recheck INR in 3 days
3. COPD - Continue albuterol, add tiotropium inhaler
4. Type 2 DM - Continue reduced metformin dose, monitor glucose

Care Coordination:
- Called cardiologist to discuss medication changes
- Scheduled INR recheck
- Arranged home health for medication management
- VNA referral for CHF monitoring

Time Documentation:
Total time: 38 minutes
- Chart review including discharge summary: 8 minutes
- Patient encounter: 22 minutes
- Care coordination calls: 5 minutes
- Documentation: 3 minutes

CODING DECISION: CPT 99214

RATIONALE:
✅ Time: 38 minutes (exceeds 30-minute threshold)

✅ MDM: Moderate complexity
   - Multiple chronic conditions with changes
   - Prescription drug management requiring intensive monitoring
   - Review of external records (discharge summary)
   - Coordination with external physician
✅ Risk: Moderate (drug interactions, anticoagulation management)

REIMBURSEMENT: ~$148 (Medicare)

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DOCUMENTATION TEMPLATES
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TEMPLATE FOR CPT 99213:

ESTABLISHED PATIENT VISIT - CPT 99213

Date: [DATE]
Total Time: [15-29 minutes]

CHIEF COMPLAINT: [Brief statement]

HISTORY OF PRESENT ILLNESS:
[Expanded problem-focused history - HPI with 4+ elements or status of 3+ chronic conditions]

REVIEW OF SYSTEMS:
[1+ systems reviewed]

PHYSICAL EXAMINATION:
[Expanded problem-focused - 1-4 organ systems]
- Vital Signs:
- [System 1]:
- [System 2]:
- [System 3]:

ASSESSMENT AND PLAN:
[Medical decision making - low to moderate complexity]
1. [Diagnosis 1] - [Plan]
2. [Diagnosis 2] - [Plan]

TIME DOCUMENTATION:
Total time on date of service: [XX] minutes
- Chart review: [X] minutes
- Patient encounter: [XX] minutes
- Documentation: [X] minutes

Code: 99213 - Based on [time/medical decision making]

[Provider signature and credentials]

TEMPLATE FOR CPT 99214:

ESTABLISHED PATIENT VISIT - CPT 99214

Date: [DATE]
Total Time: [30+ minutes]

CHIEF COMPLAINT: [Brief statement]

HISTORY OF PRESENT ILLNESS:
[Detailed history - Extended HPI with 4+ elements AND context]

REVIEW OF SYSTEMS:
[2-9 systems reviewed]

PAST MEDICAL/SURGICAL/SOCIAL HISTORY:
[At least 1 area reviewed]

PHYSICAL EXAMINATION:
[Detailed examination - 5-7 organ systems]
- Vital Signs:
- General Appearance:
- HEENT:
- Cardiovascular:
- Respiratory:
- Abdomen:
- Extremities:
- [Additional systems as indicated]

DATA REVIEWED:
[Specify external records, test results, consultations]

ASSESSMENT AND PLAN:
[Medical decision making - moderate complexity]
1. [Diagnosis 1] - [Detailed plan with rationale]
2. [Diagnosis 2] - [Detailed plan with rationale]
3. [Additional diagnoses as applicable]

CARE COORDINATION:

[Document any coordination with other providers]

TIME DOCUMENTATION:
Total time on date of service: [XX] minutes
- Pre-visit preparation: [X] minutes
- Face-to-face patient time: [XX] minutes
- Care coordination: [X] minutes
- Post-visit documentation: [X] minutes

Code: 99214 - Based on [time/medical decision making complexity]

[Provider signature and credentials]

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COMMON CODING PITFALLS & SOLUTIONS
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PITFALL #1: Time Documentation Errors
❌ Wrong: "Spent 30 minutes with patient"
✅ Right: "Total time 30 minutes: 5 min chart review, 20 min patient encounter, 3 min care coordination, 2 min documentation"

PITFALL #2: Vague Medical Decision Making
❌ Wrong: "Complex patient with multiple problems"
✅ Right: "Moderate complexity MDM: 3 stable chronic conditions requiring medication adjustments, reviewed external cardiology notes, coordinated care with specialist"

PITFALL #3: Inadequate Exam Documentation
❌ Wrong: "Physical exam normal"
✅ Right: "Physical exam: VS stable, HEENT normal, CV RRR no murmur, Lungs CTAB, Abd soft, Ext no edema" (document specific systems examined)

PITFALL #4: Inconsistent Code Selection
❌ Wrong: Using 99214 for all established patients
✅ Right: Match code to actual complexity and time spent

PITFALL #5: Missing Medical Necessity
❌ Wrong: No connection between exam findings and plan
✅ Right: Clear link between patient complaints, exam findings, and treatment decisions

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AUDIT PROTECTION CHECKLIST
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Before Submitting Claims:

For CPT 99213:
☐ Time documented if used for selection (15-29 minutes)
☐ History supports expanded problem-focused level
☐ Exam supports expanded problem-focused level
☐ MDM clearly low to moderate complexity
☐ Medical necessity documented

For CPT 99214:
☐ Time documented if used for selection (30+ minutes)
☐ History supports detailed level OR time threshold met
☐ Exam supports detailed level OR time threshold met
☐ MDM clearly moderate complexity OR time threshold met
☐ Medical necessity for higher level service documented
☐ Care coordination documented when applicable

General Requirements:
☐ Provider signature and credentials present
☐ Date of service clearly documented
☐ Patient identification verified
☐ Chief complaint documented
☐ Assessment and plan match documentation level

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These examples represent typical clinical scenarios and appropriate coding decisions. Always ensure documentation supports the selected code level and follows current CPT guidelines and payer policies.

Last Updated: July 2025