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Internal Medicine Coding Alert

Reporting 99231-99233: Don't Risk Losing $2,400 a Year

Expert answers can strengthen your documentation

Are you worried that your internist is downcoding subsequent-care claims, but you don't know what do? Use our experts'answers as a guide for documenting subsequent-care E/M components, body systems and service levels.

The bottom line: Underdocumenting can result in undercoding, which in a year could cost the physician thousands of dollars.

For example, suppose your internist believes his documentation won't support a higher-level subsequent-care code, so he always uses 99231. Because 99231 pays about $20 less than 99232, downcoding these claims just 10 times a month could cost your practice $2,400 per year, coding experts say.

Question 1: Did your internist specify two of the three E/M components?

To avoid underreporting and underpayment for subsequent-care claims, make sure your internist's documentation assigns two of the key components to the following daily subsequent-care codes for a patient's evaluation and management:

1. 99231 -- ... problem-focused interval history, problem-focused exam, straightforward or low-complexity medical decision-making
2. 99232 -- ... expanded problem-focused interval history, expanded problem-focused exam, moderate-complexity medical decision-making
3. 99233 -- ... detailed interval history, detailed exam, high-complexity medical decision-making.

Remember: The key components are the history, the exam and the medical decision-making (MDM), says **Brett Baker,** third-party payment specialist for the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in Washington, D.C.

"The extent to which a physician performs history, exam, and medical decision-making determines the level of service that is selected for a subsequent hospital care visit," Baker says.

For instance, if the physician performs a subsequent-care visit on a diabetes (250.xx) patient and accurately documents an expanded problem-focused history and moderate-complexity medical decision-making, you may be able to report 99232. **Helpful:** You should consider medical decision-making the most important E/M component to satisfy because it best supports medical necessity, says **Carol Pohlig, BSN, RN, CPC**, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia.

Question 2: Did the internist report two to seven body systems?

If the internist sees a patient for congestive heart failure (428.0), the physician must examine and document at least two to seven body systems: constitutional; eyes; ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary (skin and/or breast); neurological; psychiatric; endocrine; hematologic/lymphatic; and allergic/immunologic.

Question 3: How can I check whether we're accurately reporting 99231?

If your internal medicine practice repeatedly reports the same subsequent hospital care code, you should perform a chart review to ensure you're accurately coding the visits, coding experts say.

"Take a random sampling of charts where you reported 99231, and on each file you should determine the history, exam and medical decision-making levels and determine whether they meet the requirements for a 99232 or 99233," says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS,** director and senior instructor for the CRN Institute, an online coding certification training center.