Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: 5 Steps Break You of Bad Subsequent Care Coding Habits

Virtually everything your physician does can contribute to the documentation.

If you report 99231 for all your subsequent hospital care services, you may be costing your practice more than money -- you could be raising a red flag to payers. Analysts say that many specialists report 99231 more often than any other subsequent hospital care code.

What that means: This indicates that either most subsequent hospital visits are low-level services or physicians routinely undercode for inpatient care. Since not all hospital visits are low-level, you should be reporting higher-level subsequent hospital care too -- provided your documentation warrants it.

Problem: Because carriers usually bundle hospital care into postsurgical visits, many doctors aren't familiar with the documentation guidelines associated with subsequent hospital care for nonsurgical situations. If you pick up the patient's care after another physician -- such as a patient's primary care physician -- admits the patient to the hospital, you should report 99231-99233.

To ensure you're properly assigning these codes, use the following five steps:

Step 1: Learn the Coding Levels

You may believe that reviewing documentation is the first step to determining whether you can increase your inpatient coding levels,but that's actually the second step. If you don't know what constitutes each service level, reviewing the documentation won't help. So educate

your practice regarding what CMS and CPT requires for each care level. As a starting point for physicianeducation, **Geri Montoya, CPC,** coding auditor at Exempla Healthcare in Denver, Colo., suggests these basic guidelines for the three subsequent hospital care levels:

• 99231: Patient is stable, recovering, or improving

• 99232: Patient is responding inadequately to therapy or has developed a minor complication

• 99233: Patient is unstable or has developed a significant complication or a significant new problem.

Keep in mind: Coding can fluctuate, however, among the three levels during the course of a hospital stay. If, for example, a patient's condition worsens or if new problems or conditions arise during the hospital stay, the treating physician will likely perform more examinations and make potentially complex medical decisions. Therefore, your physicians unfortunately can't live by any hard and fast rules for selecting low subsequent care levels.

For instance, you may have a mixture of diagnoses that would never warrant the 99231 level. More commonly, you might use 99232 for the daily charge or 99233 if she is having acute complications.

Step 2:Warn Doctors of 'Playing It Safe' Dangers

If your practice routinely reports 99231 for all subsequent hospital care services, tell your physicians that this might raise red flags with your payer, says **Cindy Foley,** billing manager for three gyn, ob-gyn, and gyn oncology practices in Syracuse, N.Y. "Coding 99231 across the board will not exempt you from a government audit," says **Deborah M.**

Cooper, CFPC, quality auditor at Duke University Health System in Durham, N.C. For example, a carrier may identify your practice for "poor quality of care" because you consistently report low-level codes. If you submit only 99231, the payer may interpret that as saying all hospital patients, regardless of their conditions, receive only a problem-focused history and exam. This can indicate to managedcare plans that your physicians never take a detailed history or exam.

Step 3: Rely on MDM to Choose Level

Of the three E/M components -- history, exam, and medical deci- sion making (MDM) -- you have to document only two to use one of the subsequent care codes, according to CPT.

Most physicians find that they can best fulfill the documentation requirements with the exam and MDM components when dealing with subsequent hospital visits (because the admitting physician has already recorded the patient's history).

If the physician performs highcomplexity MDM but only a problem- focused history and exam, you have problem-focused documentation.

You would code this type of visit using 99231, regardless of the patient's case complexity. But remember that the patient's condition contributes to the MDM level.

Step 4: Add Your Documentation

Unfortunately, many physicians are unaware that virtually everything they do involving a patient can contribute to the documentation. For example, merely assessing a patient's general appearance counts as one element of the service's examination portion. When documenting subsequent hospital care, remember to include additional observations, coding experts say, such as:

• Is the patient's condition stable?

• Is the condition either improving or worsening?

• Have any new problems developed?

For example, if a hospitalized gestational diabetic patient's diagnosis includes high blood pressure, the physician should document whether it worsens or improves.

Documenting blood pressure and its resistance to change may support a higher-level code because of the greater MDM complexity required to manage it. You should also consider such factors as lab values and ultrasound readings because you can use this information to support your MDM level.

Most patients are sickest when first admitted, requiring a more complex diagnosis, examination, and MDM -- thus supporting a higher-level code. As the patient's condition improves, the level of subsequent visit coding probably will decrease because the physician no longer must perform a detailed exam or more complex MDM. Remember, mentioning that the patient will be discharged either the day of the visit or the next morning means you'll have a hard time convincing a payer that anything other than 99231 is appropriate, Montoya notes.

Step 5: Review Charts to Identify Problems

If your practice routinely reports the same code over and over, you should perform a chart review. Take a random chart sampling in which you reported 99231. On each file you should determine the history, exam, and MDM levels and determine whether it meets the 99232 or 99233 requirements.

You may be surprised what you find. "I've seen documentation that didn't even support a 99231, such as 'Patient feeling OK today' as the only documentation for a subsequent daily visit," Cooper says.

Tactic: If the physicians fail to see the importance of such a review, you should place the number of visits they

undercoded into a graphic format to show them how much money they left on the table.

Because a 99231 pays approximately $20 less than a 99232, downcoding these claims just 10 times a month could cost your practice $2,400 per year. Add to that the number of providers in the practice plus the number of hospital visits, and this could be a very substantial amount on a yearly basis.

Bottom line: "All you can do is code according to the physician's documentation," Cooper says. "I encourage physicians to make sure they include a diagnosis every day they see the patient because that may change from day-to-day. For instance, a patient hospitalized for seven days might develop pneumonia. This is very common, but if the physician doesn't code it, then he or she risks losing revenue based on the complexity of the situation. Too many times I have seen the physician use the same diagnosis from day one to discharge, even when they document the patient has developed another complication."