Eli's Rehab Report

4 Surefire Steps Ensure Proper Subsequent Care Coding

Everything the physiatrist does can contribute to greater MDM

If you're falling back on 99231 for all your physiatrist's subsequent hospital care visits, then you could be raising a payer's red flag and marking your physical medicine and rehabilitation practice for a future audit -- and losing reimbursement. Just undercoding 10 times a month can cost your practice up to $2,400.

Physiatrists generally report 99231 (Subsequent hospital care, per day, for the evaluation and management of a patient ...) more often than any other subsequent hospital care code, according to CMS data. This means either most subsequent hospital visits are low-level services or doctors undercode their inpatient care. If the patient's medical condition warrants a higher-level subsequent hospital care code and as long as your documentation supports it, you should feel free to report it.

Bottom line: If your provider takes over a portion of the patient's care after another physician -- such as an orthopedist or neurosurgeon -- admits the patient to the hospital, you should report these services from the 99231-99233 code range.

Use the following four steps to ensure you're properly assigning these codes:

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 requires for each care level.

As a starting point for physiatrist education, coding experts suggest these basic guidelines for the three subsequent hospital care levels:

1. 99231 -- Patient is stable, recovering or improving.
2. 99232 -- Patient is responding inadequately to therapy or has developed a minor complication.
3. 99233 -- Patient is unstable or has developed a significant complication or a significant new problem.

Although the documentation (history, exam, medical decision-making, and possibly time) will ultimately drive the supported service level, these guidelines help illustrate the differences in terms more familiar to physiatrists, says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS**, senior instructor and director with the CRN Institute, an online certification training center. Make sure they understand the importance of their documentation.

If your practice routinely reports 99231 for all subsequent hospital care services, tell your physiatrists that this might raise red flags with your payers, coding experts say. Excessive reporting of 99231 would indicate that your practice is routinely downcoding, or perhaps your patients should have been discharged earlier.

Warning: A carrier may cite your practice for "poor quality of care" because you consistently report low-level codes. If you submit only **CPT 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 managed-care plans that your physiatrists are unlikely to perform a more extensive interval history or physical exam.

Step 2: Use MDM to Choose A Level

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

"For any code that says you need to document two of the three E/M components, I look at MDM for one of those components, see what level that gives me, and then see if either of the other two components supports that level as well," says **Mary Baierl, CCA, CMT**, a rehab coder at BayCare Health Systems, LLC, in Green Bay, Wis.

Exam and MDM key: Most physiatrists find that they can best fulfill the documentation requirements with the exam and MDM components during subsequent hospital visits (because the admitting physiatrist has already recorded the patient's history).

If the physiatrist performs high-complexity 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.

If the physiatrist does not record the relevant information, however, the coder cannot support assigning a code for the care level that the doctor may feel he deserves, coding experts say.

Step 3: Add Up Your Documentation

Unfortunately, many physiatrists are unaware that virtually everything they do involving a patient can contribute to the complexity of the visit. "To me, the most important part of subsequent care is what the provider is doing for the patient on an ongoing basis," Baierl says.

Heads up: 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:

4. Is the patient's condition stable?
5. Is the condition either improving or worsening?
6. Have any new problems developed?

For instance, if a hospitalized patient's diagnosis includes hypertension (401.X-405.XX), the physiatrist should document whether the hypertension is controlled or uncontrolled. Documenting uncontrolled hypertension may support a higher-level code because of the greater MDM complexity required to manage it.

Don't forget: You can use such factors as labs, x-ray readings and EEGs to support your level of MDM. For instance, your rehab patient fell and fractured her leg. The referring orthopedist said that he reduced the fracture and that it was healing well; but when your physiatrist reads the x-ray, he sees another hairline fracture several inches from the main one. The physiatrist discusses his findings with the referring orthopedist and outlines a plan of care. This work all counts as part of your MDM for the patient and most likely produces an additional diagnosis.

Most patients are sickest when first admitted, requiring a more complex history, examination and MDM -- thus supporting a higher-level code. As the patient approaches discharge, the level of subsequent visit coding will probably decrease because the patient's condition is improving and no longer requires the physiatrist to perform a detailed history and exam or more complex MDM.

Coding can fluctuate, however, among the three levels during the course of a hospital stay. For example, a patient's condition can worsen, such as a patient has increasing paralysis following a stroke. Or new problems or conditions arise during the course of the patient's hospital stay, such as a new complaint of chest pain and shortness of breath during an inpatient rehab hospitalization following a total joint replacement. In these circumstances, the treating physiatrist will

likely perform a more in-depth physical examination and make potentially complex medical decisions. Therefore, doctors unfortunately can't live by any hard and fast rules for selecting low subsequent care levels.

"If my provider is documenting the worsening condition and adequate MDM for that condition, then he should also have documented physical findings in the exam or enough history to support a higher level," Baierl stresses.

The challenge: Code 99231 involves "straight-forward or low-complexity decision-making," according to CPT. The problem is, many PM&R providers are not aware of what constitutes the differences between severities of the subsequent level codes. See the code breakdown in Step 1.

For example, if your physiatrist sees a patient post-open reduction and internal fixation of a fracture, you're likely to report 99231. If your physiatrist sees an auto accident patient who is slow to respond to ambulation training, however, you'll report 99232. Finally, if your physiatrist treats a quadriplegic with acute autonomic hyperreflexia who doesn't respond to initial care, you'll report 99233, according to CPT's clinical examples in Appendix C.

Step 4: Review the Charts to Identify Problems

If your practice routinely reports the same code over and over, you should perform a chart audit, Jandroep says. 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.

If the physiatrists fail to see the importance of such a review, try placing the number of visits they undercoded into a graphic format to show them how much money they left on the table.

Because 99231 pays approximately $20 less than 99232, incorrectly coding these claims just 10 times a month could cost your practice $2,400 per year.