Codify by AAPC

Eli's Rehab Report

Multiple Diagnoses, High Risk May Increase Inpatient Code Level

According to CMS data, physiatrists report 99231 more than any other CPT code, which indicates either that most subsequent hospital visits are low-level services or that physiatrists routinely undercode. As long as your documentation warrants it, however, you should feel confident in coding higher-level E/M visits.

"When my patients are in the inpatient rehab unit, I am the attending physician, and I see them daily to manage their overall medical care and coordinate the rehab program," says **Christopher Belleau, MD,** a physiatrist who exclusively treats inpatients at Our Lady of the Lake Rehab Center in Baton Rouge, La.

Physiatrists usually pick up the patient's care after another physician such as an orthopedist or a neurosurgeon admits the patient to the hospital, which explains why physiatrists so frequently report subsequent hospital care (99231-99233) rather than initial hospital care (99221-99223). CMS likes to see a variation in your billing pattern, however, so auditors might think it odd if you report 99231 for every visit. And your practice loses money every time you erroneously downcode your claims. Therefore, it's essential that you identify CMS' requirements for billing higher-level codes.

Learn the Coding Levels,Then Review Charts

"Most practices believe that the first step in determining whether they can increase their inpatient coding levels is to check the documentation, but that's actually the second step," says **Jean Acevedo, CPC, LHRM,** senior consultant at Acevedo Consulting Inc., a national coding and compliance consulting firm in Delray Beach, Fla. "If you don't know what constitutes each level of service, reviewing the documentation won't help you, so your first step should be educating your practice on what CMS requires for each level of care." (See "Know CMS' Guidelines for Subsequent Hospital Care" on page 19 for a list of CMS'documen-tation guidelines for the three subsequent hospital care codes).

Of the three E/M components history, exam and medical decision-making you must fully document only two in a patient's chart to justify use of each code. Most physicians find that they can best fulfill these requirements by documenting the exam and medical decision-making components because they are dealing with subsequent hospital visits (and therefore the admitting physician already recorded the patient's history). But any level of service requires a chief complaint. (See "High-Risk Patients May Warrant 99233" on page 20 for inpatient PM&R coding examples).

Choosing a Level Is a Hard Process

"For purposes of coding and the reimbursement that will result from it, physicians are not really being evaluated on what they've done. They're being evaluated on how well they've documented it," Acevedo says. "The history and physical exam can hold back the coding level for a visit, but they can never boost it up to the next level. So, if you have performed medical decision-making of high complexity but the history and exam are only at the problem-focused level, you only have problem-focused documentation."

Moreover, the patient's condition contributes to the level of medical decision-making. For example, joint replacements require moderately complex medical decision-making, whereas head and spinal cord injuries often require high-level medical decision-making. But if the physiatrist does not record the relevant information, the coder cannot support a code for the level of care that the doctor may feel he deserves.

Include All Factors in Documentation

Unfortunately, many physiatrists are not aware that virtually everything they do involving a patient can contribute to the documentation. For example, merely looking at a patient's appearance and assessing his or her general appearance

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counts as one element in the examination portion.

When documenting a subsequent hospital visit, the physiatrist should not merely list the diagnosis. Remember to include additional observations, such as:

1. Is the patient's condition stable?
2. Is the condition either improving or worsening?
3. What is the severity of the condition?

For example, if a hospitalized patient's diagnosis includes hypertension (401.x-405.xx), the physiatrist should indicate whether the hypertension is controlled or uncontrolled. Documenting uncontrolled hypertension will generally support a higher-level code, owing to the greater complexity of medical decision-making required to manage it.

Practices should also consider such factors as lab values, x-ray readings, and EEGs. You can use this information to support your level of medical decision-making, Acevedo says. For instance, your rehab patient fell and fractured her leg. The referring orthopedist said that he reduced the fracture and that it is healing well. But when you read the x-ray, you see another, hairline fracture several inches from the main fracture. You discuss your findings with the referring physician and outline a plan of care. This work is part of your medical decision-making for the patient and most likely produces an additional diagnosis.

Most patients are sickest when first admitted, requiring a more complex diagnosis, examination and medical decision-making thus supporting a higher code. As the patient's condition improves, the level of subsequent visit coding will probably decrease because the physician must no longer perform a detailed exam or more complex medical decision-making. 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 physiatrist will likely perform more examinations and make medical decisions of varying complexity. Therefore, physiatrists unfortunately can't live by any hard and fast rules concerning selecting low levels of service for subsequent care.

Review Your Charts

"If your practice routinely reports the same code over and over, you should perform a chart review," Acevedo recommends. "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 see if they meet the requirements for a 99232 or 99233."

If the physicians fail to see the importance of such a review, you should place the number of visits they downcoded into a graphical format to show them how much money they left on the table. Because a 99231 pays about $20 less than a 99232, downcoding these claims just 10 times a month could cost your practice $2,400 per year.

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