Psychiatry Coding & Reimbursement Alert

E/M Coding Update: 5 Steps Ensure Success With Subsequent Hospital Care Codes

Incorporating each of these steps into your coding might better your practice's reimbursement.

When reporting subsequent hospital care, it is probably incorrect if you are reaching out to the lowest level code 99231 each time. In such a case, you are more likely undercoding and costing your practice money

Read on and learn how to recognize when you are overusing 99231 (Subsequent hospital care, per day, for the evaluation and management of a patient ...), and how to look to the physician's report to correct the coding.

Identify the Problem

A red flag to payers, which coding analysts recognize, is that many specialists report 99231 more often than any other subsequent hospital care code, but if you report 99231 for all your subsequent hospital care services, you may be costing your practice more than money.

What that means: Reporting only 99231 indicates that either most subsequent hospital visits are low-level services or physicians routinely undercode for inpatient care. Since not all subsequent hospital visits are low-level, you should be reporting higher-level subsequent hospital care, too provided your documentation warrants it.

Problem: Many doctors aren't familiar with the documentation guidelines associated with subsequent hospital care. 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 clinicians regarding what CMS and CPT® requires for each care level. You may want to look at these basic guidelines for the three subsequent hospital care levels:

- 99231: Patient is typically 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 more 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. Contrary to popular belief, coding 99231 across the board will not exempt you from a

government audit.

For example, a payer 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 interval history and exam. This can indicate to managed care plans that your physicians never take a detailed history or exam.

It may also suggest to a payer that the physician does not understand E/M coding in general. That, in turn, could lead to an audit of the physician's claims for other kinds of E/M services.

Step 3: Focus on Medical Decision Making (MDM)

Of the three key E/M components history, exam, and medical decision making you have to document only two to use one of the subsequent hospital 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).

Unfortunately, if the physician documents high-complexity MDM but only a problem-focused history and exam, you have a problem-focused visit that you would code using 99231, regardless of the patient's case complexity. Remember that the patient's condition contributes not only to the MDM level but also to the extent of history and exam required.If the patient's condition supports high complexity medical decision making, then it also likely supports something more than a problem-focused interval history and exam. Encourage your physicians to use medical decision making as a gauge against which to measure their documentation of the history and exam to ensure that all three are in alignment with the patient's condition.

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 patient with Bipolar disorder is also being monitored for high blood pressure and diabetes because they affect pharmacotherapy, the physician should document whether these conditions are worsening or improving.

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 extensive history and examination and more complex MDM thus supporting a higher-level code. As the patient's condition hopefully 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 the next morning means you'll have a hard time convincing a payer that anything other than 99231 is appropriate.

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. "Patient feeling OK today" does not even support 99231 □ but some coders have reported seeing documentation as sparse as this in physician's notes during subsequent visits.

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 99231 pays approximately $30 less than 99232, downcoding these claims just 10 times a month could cost your practice $3,600 per year. Multiply that by 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. Encourage your 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 risks losing revenue based on the complexity of the situation.