

Tips to avoid trouble with subsequent hospital visit codes

If you overuse level 3 codes to describe hospitalized patients, you may attract the attention of federal auditors

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As a hospitalist, using the ever-popular subsequent hospital visit codes (CPT 99231-99233) can be a daunting task. While choosing the correct code is confusing for physicians, subsequent visit codes can attract the attention of the Office of Inspector General (OIG). Unless you know how to use these correctly—particularly the level 3 codes—you could be setting yourself up for problems in the future.

In this article, I'll provide a primer on how to use subsequent hospital visit codes, along with tips to steer clear of increasing scrutiny from federal regulators.

Level 3 codes

If there is one point you should take away from this article, it is this: Hospitalized patients who are stable or improving do

not meet the requirements for the highest level subsequent hospital care code, CPT 99233. This code was not meant to describe a "courtesy visit".

Unless your hospitalized patient's condition is deteriorating or critical (which should be indicated by appropriate diagnosis codes), you should use either a level 1 (99231) or level 2 (99232) code. This means that patients who are recuperating in the hospital—a large number of your patients—likely qualify for low to moderate visits.

Exactly when can you use CPT 99233? CPT lists the elements you need to qualify for each of these codes. (See "CPT criteria for subsequent hospital visit codes," this page, for a full list of criteria for all three levels of service.)

For the highest level subsequent hospital visit code, for example, you need to meet or exceed two of the three following elements: a detailed history (four-plus elements in the HPI and two to nine elements in the ROS), a detailed exam (five to seven elements), and a high complexity of medical decision-making.

In order to establish the process of medical decision-making, you must consider the following elements: number of diagnoses or management options, amount or complexity of data to be reviewed, and risks of complications and/or morbidity or mortality.

After using an admission code, you would typically use the higher levels of subsequent visit codes (99222 and 99233) in the patient's hospitalization, tapering down to an improved, stabilized patient ready for discharge. Your goal is to improve patients' health until they are discharged, and your coding should reflect that progress. (See "A scenario of inpatient codes," next page, for a detailed look at how to use these codes.)

However, if the patient's health takes a turn for the worse—hypertension worsens and requires increased management—you can consider using higher level subsequent hospital visit codes. Once the patient has stabilized, consider using moderate to low levels of service.

If your hospitalized patient becomes critically ill, consider using critical care codes. (When using these codes, remember to document total duration of time.) Critical care codes not only

Coding and patient care

CPT criteria for subsequent hospital visit codes

Two out of three areas must meet or exceed to qualify for any given level.

99231	Problem-focused history	Problem-focused exam	Low-complexity exam
99232	Expanded problem-focused history	Expanded problem-focused exam	Moderate complexity medical decision-making
99233	Detailed history	Detailed exam	High-complexity medical decision-making

Documentation requirements for CPT 99231-99233

CPT 99231	CPT 99232	CPT 99233
Chief complaint	Chief complaint	Chief complaint
1-3 elements in HPI	1-3 elements in HPI	>4 elements in HPI
0 elements in ROS	1 element in ROS	2-9 elements in ROS
0 elements in PFSH	0 elements in PFSH	0 elements in PFSH
1 element in exam	2-4 elements in exam	5-7 elements in exam
Est. time: 15 minutes	Est. time: 25 minutes	Est. time: 35 minutes

Critical care codes not only provide higher reimbursement, but they better reflect the services you're providing.

A scenario of inpatient codes

Day 1	Initial visit: admit to hospital	99223: patient presents with hypertension, CHF, pneumonia
Day 2	Subsequent visit	99232: stable and improving, low-grade fever
Day 3	Subsequent visit	99233: hypertension becomes uncontrolled
Day 4	Subsequent visit	99232: hypertension controlled, fever gone, pneumonia improving
Day 5	Subsequent visit	99231: patient improving, no new complaint
Day 6	Discharge services	99239: MD spent 45 minutes preparing discharge orders and working with family

provide higher reimbursement, but they better reflect the services you're providing. If the patient doesn't qualify for greater than 30 minutes of critical care time but is still facing serious health issues, consider using 99233.

Other considerations

Here are some other issues to consider when using subsequent hospital visit codes:

■ **Time.** A single provider—or more than one physician from the same group—can't bill more than one subsequent hospital visit code in a calendar day. You should instead combine the services provided during multiple visits and then bill for the highest level of service you can support through documentation.

■ **Clustering.** When using subsequent hospital visit codes, coding "clusters" will attract the attention of auditors. Clustering occurs when physicians tend to use the similar codes in patterns.

An example of this is using an admission code then 99232 every day until the patient is discharged, regardless of the patient's health. When auditors detect this type of pattern, they are more likely to conduct an audit.

■ **Concurrent care.** Some payers limit the number of physicians that can bill for a subsequent care visit in one day. If a hospitalist, a cardiologist and a pulmonologist all see a patient on a certain day and bill a subsequent hospital visit, the payer may reject one of those codes, depending on how many it allows.

It is important to know your payers' guidelines, as this will avoid any unnecessary denials hindering the reimbursement process. **TH**

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