Subsequent Hospital Care Visits (99231-99233)

CPT Code	History (Interval)	Exam	Medical Decision Making	Time
99231	Problem Focused	Problem Focused	Straightforward/Low	15 min
99232	Expanded Problem Focused	Expanded Problem Focused	Moderate	25 min
99233	Detailed	Detailed	High	35 min

Choosing the correct level for subsequent hospital encounters requires 2 out of the 3 key components: Interval History, Exam, and Medical Decision Making.

An Interval History is what happened to the patient between each time the provider visited the patient during the course of his/her hospital stay. For example, it could look something like this: The patients states that left shoulder pain has improved since yesterday. Sitting up with no new complaints. Note: the typical requirement for past, family, and/or social history is waived for hospital progress notes per the 1997 E/M guidelines.

To assist in determining the appropriate code, documentation for each progress note should include:

- Results of diagnostic testing and changes to the patient's status since the last assessment by the provider. These changes would include the patient's interval history, their physical condition, and their response to treatment.
- The nature of the presenting problem. This typically determines the level of history and physical exam that is required. If documentation supports that the patient is stable, recovering, improving and/or preparing for discharge, CPT code 99231 could be supported. If the documentation supports that the patient is not responding to treatment, requires careful monitoring due to a minor complication and/or the conditions are requiring continuous and active management, CPT code 99232 could be supported. Lastly, if the documentation supports that the patient is unstable or has a significant new problem or complication, CPT code 99231 could be supported.

If is reasonable to expect higher levels of history and physical exam be performed and documented in the days immediately following a hospital admission. However, the higher levels most likely would not be medically necessary when the patient is stable and improving , particularly when advancing toward discharge.

Like when choosing levels for other E/M services, time can also be used. To use time as the controlling factor, the physician must spend the entire allotted time face-to-face with the patient AND at least 50% of that time must be used for "counseling and coordination of care". Documentation must include the total duration of the encounter, as well as state that over half of that time was spent on counseling and coordination of care.

In addition to documenting the duration of the encounter, the nature of the counseling and coordination of care must also be documented. For example: "A total of 15 minutes was spent face-to-face with the patient during this encounter, and great than 50% of that time was spent on counseling and coordination of care. We discussed the importance of being compliant with medications to prevent recurring episodes of lightheadedness. I also educated the patient regarding lifestyle modifications to improve cholesterol."

This Week's Tip Provided by:

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