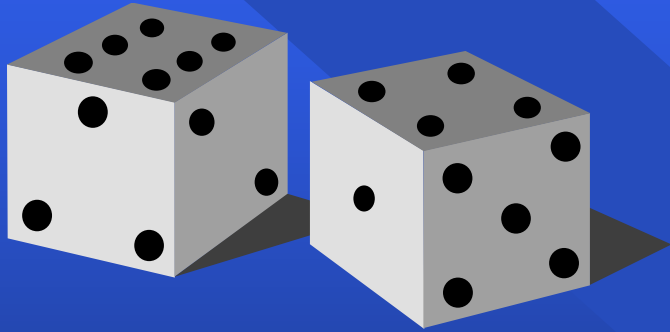


Coding and Documentation for Trauma and Surgical Critical Care



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OBJECTIVES

- Describe the current system for coding and billing physician professional services
- Review regulatory and operational concepts for documentation and coding
- Review examples of documentation and coding for trauma physicians

OUTLINE

- INTRODUCTION TO E&M CODING
- REGULATORY CONSIDERATIONS
- CRITICAL CARE DOCUMENTATION AND CODING
- CASE STUDY FOR PHYSICIAN CODING

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INTRODUCTION TO E&M CODING

E&M CODING

- Evaluation and Management codes are used to describe physician's non-procedural activities (the so-called "cognitive" services)
- Coding refers to the process of selecting:
 - (1) a numeric descriptor of the professional service provided and
 - (2) the medical diagnosis prompting the physician to provide that service
- Diagnostic codes are then "matched-up" with E&M codes or procedure codes

UNDERLYING RULES

- Billing for professional services cannot be accomplished without coding
- Coding must be accurate and supported by documentation
- Documentation must be complete and legible
- Some 3rd-party payors will seek to deny payment and assume you are overbilling (under-documenting?)
- Disclaimer: *CMS (HCFA) documentation guidelines in flux; guidelines now in force are from 1995. New variations appear constantly. CMS now considering further changes.*
- It is imperative that you maintain excellent, regular communication with your coding/billing and compliance groups

DIAGNOSTIC CODING

- ICD-9 provided over 12,000 diagnostic codes
- ICD-10 provides over 60,000, 58% are injury related !!!
- Global fee concept excludes all services related to the operation within 90 days
 - ❖ *Only the operation and the operative diagnoses are affected*
- Non-operative diagnoses require services not covered by the global fee
- Key is to employ separate diagnoses and modifiers that indicate unrelated services (-24, -25, etc)

HOW WE' D LIKE IT TO WORK (or Medicine in the good old days)

- We go to school and learn surgery
- We get a job
- We work really hard
- We get paid really well
- There is no silly paperwork
- All the patients say thank you



HOW IT REALLY WORKS

We work really hard, then we work really hard to get paid

- Billing for professional services cannot be accomplished without coding → To get paid, you have to send a bill describing what you did
- Coding must be accurate and supported by documentation in the clinical record → What you write in the chart is what you did
- Documentation must be complete and legible → If I can't read it, you didn't do it
- Some 3rd-party payors will seek to deny payment and assume you are overbilling (under-documenting?) → You are committing fraud

The background of the slide features a dark blue field with several lighter blue diagonal stripes running from the top-left towards the bottom-right. The stripes are parallel and have a consistent width and spacing.

REGULATORY CONSIDERATIONS

THE "BALANCE"

~~unethical~~

~~intimidated~~

**FAIR AND
APPROPRIATE
COMPENSATION**

**ONEROUS,
UNREASONABLE AND
UNPREDICTABLE REGS**

~~Buried in
paperwork~~

LEGISLATIVE UPDATE

- In November 2003, Congress approved the Medicare Prescription Drug, Modernization and Improvement Act of 2003 by a vote of 220 to 215 in the House and 54 to 44 in the Senate
- President Bush signed the bill into law 12/8/03
- Among its (many) provisions, the bill prohibits the implementation of new E&M guidelines until HHS conducts pilot projects and consultation with a range of practicing physicians

Health care fraud still a key target of federal False Claims Act

Physicians are seldom named in false claims cases but are often in a position to blow the whistle on fraud they observe.

AMY LYNN SORREL
AMNEWS STAFF

Health care continues to top the government's list of federal fraud investigation priorities, yielding the lion's share of recoveries in false claims cases in 2008.

The latest figures from the Dept. of Justice show enforcement officials recouped \$1.34 billion in settlements and judgments under the False Claims Act in the fiscal year ending Sept. 30. Of that total, \$1.12 billion, or 84%, came from health care entities. The act gives federal officials authority to prosecute fraudulent billing of any government program.

That number represents a drop

from the \$1.54 billion in recoveries reported in 2007 and a record \$2.2 billion in 2006. But that doesn't mean federal prosecutors have let up efforts to combat health care fraud, said Russell Hayman, a partner and health care fraud expert with McDermott Will & Emery LLP in Los Angeles.

"Health care services account for roughly 10% of the nation's gross domestic product. Put that together with the fact it is so heavily regulated by the federal government and states, and you have a recipe for False Claims Act activities on the scale we've seen in recent years," he said.

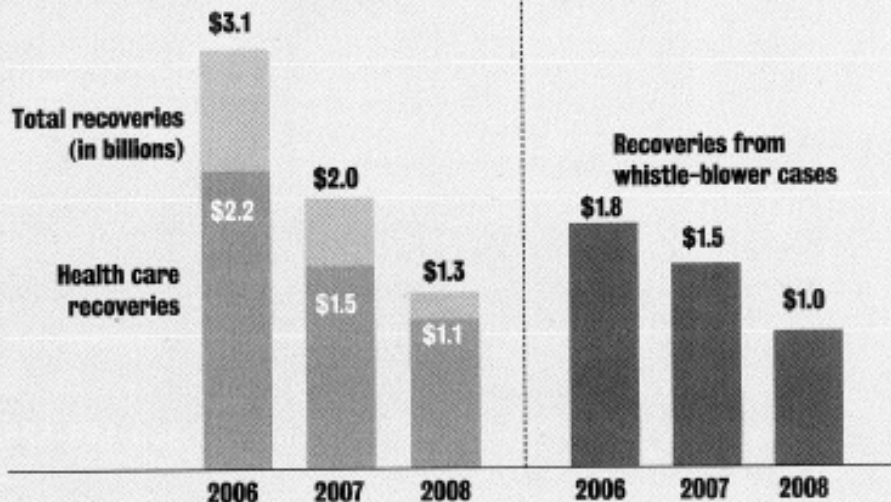
Hayman attributed the relative decline in recoveries to a spate of settlements with drug and device companies in 2007. In 2006, the government pulled in a \$920 million settlement with Tenet Healthcare Corp., one of the nation's largest hospital chains.

The government tallied its biggest
Continued on next page

FIGHTING FRAUD

Health care fraud continues to be a major focus of the government's enforcement of the False Claims Act ...

... while whistle-blowers are a driving force in reporting all types of fraud.



SOURCE: U.S. DEPT. OF JUSTICE



Billing & Coding Consultant

FALSE CLAIMS ACT

- Signed in to law by President Lincoln, the original law was intended to prosecute those defrauding the Union government – selling sawdust instead of gunpowder
- Since 1986, when the Federal False Claims Act was revamped, the US government has recovered \$15 billion under the Act and health care cases dominated
- Treble damages as well as civil penalties of \$5000 to \$11,000 for each false claim
- In fiscal 2005 (ending Sept. 30), the US recovered \$1.4 billion - \$1.1 billion was health care related

FALSE CLAIMS ACT

- Whistleblowers were awarded \$166 million in 2005
- The standard for a whistleblower to receive an award is that they must provide “unique knowledge” of activities or conduct in which they were not involved
- A whistleblower or “relator” receives between 15 and 30% of amount recovered
- Some state and local governments have a version of the act

QUI TAM

*“Qui tam pro domino rege
quam pro se ipso in hac parte
sequitur”*

Latin for:

“He who brings an action for the king as
well as for himself”

Joint Health Care Fraud Prevention and Enforcement Action Team - "HEAT"

- Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC) under the joint direction of the Attorney General (DOJ) and the Secretary of the Department of Health and Human Services (HHS)
- In FY 2013, set new records for recoveries (\$4.3 Billion), Health Care Fraud and Abuse (HCFAC) Program Report ("Fraud Report")
- HCFAC recovered \$25.9 billion since program inception in 1997

<http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf>

Joint Health Care Fraud Prevention and Enforcement Action Team - "HEAT"

- Strike force set records in number of cases filed (137), individuals charged (345), guilty pleas secured (234) and jury trial convictions (46) – an average of 52 months in prison for those sentenced in 2013
- Justice Department opened 1,013 new criminal health care fraud investigations: 1,910 potential defendants, 718 defendants convicted of health care fraud-related crimes during the year, 1,083 new civil health care fraud investigations opened

CMS Recovery Audit Program

Mission: ...to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers

Background - product of a successful demonstration program that utilized Recovery Auditors to identify Medicare overpayments and underpayments to health care providers and suppliers in randomly selected states.....between 2005 and 2008 and resulted in over \$900 million in overpayments being returned to the Medicare Trust Fund and nearly \$38 million in underpayments returned to health care providers. Congress required the Secretary of the Department of HHS to institutea permanent and national Recovery Audit program to recoup overpayments associated with services for which payment is made under part A or B

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/>

Recovery Audit Contractors (RACs)

- Recovery Audit Contractors (RACs):
 - 4 regional agencies
 - detect and correct improper payments
 - Paid contingency fees based on amount corrected - for both overpayments and underpayments (9% - 12.5%)
 - Maximum look-back period is 3 years
- Comprehensive Error Rate Testing (CERT) program:
 - Overall rate in 2012: 8.5% or approx. \$ 29.6 billion
 - Medicare Part A: 5.7%
 - Medicare Part B: 9.9%

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GLOBAL SURGICAL PACKAGE

Global Period

- RVU table published annually by CMS also identifies “Global Days” associated with procedures
- Global package derived from surgical tradition of providing post-operative care
- Adoption by Medicare carriers in 1980s
 - Variable definitions
 - » Services included in global surgery
 - » Duration of surgical period

Global Period

- National global surgery policy (HCFA) became effective for surgeries performed on and after January 1, 1992
- Defined services included in global surgical period
 - Concept of “Routine” postoperative care
- Different global periods for different procedures
 - 90 days
 - 10 days
 - 0 days
 - “YYY” – variability in global period can be determined by carrier
- ***Critical Care is specifically not included as a component of the Global Surgical Package***

Specialty Codes

- 65 Specialties Defined by Medicare
 - includes Midwives, CRNAs, PAs & NPs
- Each physician can be defined as only one primary specialty code for Medicare reimbursement
 - General Surgery: 02
 - Neurosurgery: 14
 - Orthopedic Surgery: 20
 - Vascular Surgery: 77
 - Critical Care: 81
 - Surgical Oncology: 91
- No Trauma Specialty Code!!

Specialty Codes

- Physicians may choose one primary and one secondary code
- Physicians are considered the same individual when providing care for a single patient if:
 - They comprise the same provider group and
 - They have the same Specialty Code
- Billing during the global package period for a patient requires a modifier for services provided by physicians sharing the same Specialty Code

Billing During the Postoperative Period: Modifiers!!

- Modifiers are used to indicate that the underlying assumptions about a charge are altered
- In the case of global surgical package conditions, these often indicate charges for services that should *not* be considered part of the global package
- HCFA/CMS Carriers' Manual states that global fee does not include:
 - Treatment for conditions unrelated to surgical diagnosis
 - Treatment for underlying conditions
 - Added course of treatment that is not part of normal recovery from surgery

Appendix A

Modifiers

This list includes all of the modifiers applicable to *CPT* 2002 codes.

- 21 **Prolonged Evaluation and Management Services:** When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier '-21' to the evaluation and management code number or by use of the separate five digit modifier code 09921. A report may also be appropriate.
- 22 **Unusual Procedural Services:** When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-22' to the usual procedure number or by use of the separate five digit modifier code 09922. A report may also be appropriate.
- 23 **Unusual Anesthesia:** Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier '-23' to the procedure code of the basic service or by use of the separate five digit modifier code 09923.
- 26 **Professional Component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '-26' to the usual procedure number or the service may be reported by use of the five digit modifier code 09926.
- 32 **Mandated Services:** Services related to *mandated* consultation and/or related services (eg, PRO, third party payer, governmental, legislative or regulatory requirement) may be identified by adding the modifier '-32' to the basic procedure or the service may be reported by use of the five digit modifier 09932.
- 47 **Anesthesia by Surgeon:** Regional or general anesthesia provided by the surgeon may be reported by adding the modifier '-47' to the basic service or by use of the separate five digit modifier code 09947. (This does not include local anesthesia.) **Note:** Modifier '-47' or 09947 would not be used as a modifier for the anesthesia procedures 00100-01999.
- 50 **Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier '-50' to the appropriate five digit code or by use of the separate five digit modifier code 09950.
- 51 **Multiple Procedures:** When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier '-51' to the

Billing During the Postoperative Period: Modifiers!!

- Postoperative period modifiers:
 - “-57” if you’re billing for a decision for surgery on same day as the surgery (ie in global period)
 - “-24” if you’re billing for an unrelated E&M service (not on day of surgery)
 - “-25” if you’re billing for an unrelated E&M service (on day of surgery)

Billing for Decision for Surgery: *Illustration*

- Scenario #1: A patient is seen in your office for a colon lesion on Monday – you bill outpatient consultation
 - Comes to hospital Thursday, you do H&P, undergoes left hemicolectomy and is admitted to hospital postop – you cannot bill for the H&P (global period)
- Scenario #2: A patient presents to ED, perforated colon
 - You are consulted so you see the patient, do H&P and take to surgery that same day
- Can you bill for the H&P in Scenario #2?

Yes, you can (and should) bill for the admission H&P but need to use modifier “57” – decision for surgery

Billing During the Postoperative Period: *Illustration*

- Patient seen in your office in consultation for a colon lesion on Monday
 - Undergoes left hemicolectomy on Thursday
- On Friday, develops aspiration pneumonitis and is intubated and admitted to ICU
- You provide the ICU care (99291) and provide good chart documentation
- Can you bill for the ICU care even though its in the global period?

Yes, you can (and should) bill for the 99291 but need to use modifier “24” – unrelated E&M in the postoperative period

Critical Care Services During the Global Period

K. Global Surgery

Critical care services shall not be paid on the same calendar date the physician also reports a procedure code with a global surgical period unless the critical care is billed with CPT modifier -25 to indicate that the critical care is a significant, separately identifiable evaluation and management service that is above and beyond the usual pre and post operative care associated with the procedure that is performed.

Services such as endotracheal intubation (CPT code 31500) and the insertion and placement of a flow directed catheter e.g., Swan-Ganz (CPT code 93503) are not bundled into the critical care codes. Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing the pre, intra, and post procedure work of these unbundled services, e.g., endotracheal intubation, shall be excluded from the determination of the time spent providing critical care.

This policy applies to any procedure with a 0, 10 or 90 day global period including cardiopulmonary resuscitation (CPT code 92950). CPR has a global period of 0 days and

L. Critical Care Services Provided During Preoperative Portion and Postoperative Portion of Global Period of Procedure with 90 Day Global Period in Trauma and Burn Cases

Postoperative

Postoperatively, in order for critical care services to be paid, two reporting requirements must be met. Codes 99291 - 99292 and modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or

general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period, for reasons unrelated to the surgery, these are separately payable as well.

Examples of patients whose medical condition may warrant critical care services:

1. An 81 year old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and pressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
2. A 67 year old female patient is 3 days status post mitral valve repair. She develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.
3. A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive 2 days after admission.
4. A 68 year old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

IMPOR



PROGRAM MEMORANDUM

Department of Health and Human Services
Health Care Financing Administration



Transmittal No. B-99-43 Date DECEMBER 19, 2007

SUBJECT: Issues Related to Critical Care

This Program Memorandum is to clarify a 1992 American Medical Association's (AMA) CPT Code 99292. The clarifications pertain mainly to the changes in this PM are already in effect and are mer

1. Use of the critical care CPT codes 99291 - 99292

(A) Definition of Critical Illness or Injury

The AMA's CPT has redefined a critical illness or injury as "A critical illness or injury acutely impairs or jeopardizes the patient's life or limb."

Please note that the term "unstable" is no longer used in the CPT definition to describe critically ill or injured patients.

Physician Quality Reporting Initiative (PQRI) - The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the 2007 PQRI Feedback Reports will be made available in mid-July on a secure website. More information on how to access 2007 PQRI Participant Feedback Reports will be posted on <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> on the CMS website. CMS will begin testing eleven new quality measures for possible adoption in the PQRI program in future years. To learn more about how you can help CMS test these measures, visit <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> on the CMS website and select the "Measures/Codes" link on the left side of the page. And as a reminder, all educational resources about the 2008 PQRI are available on the dedicated PQRI webpage on the CMS website. To access this web page, visit <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> on the CMS website.

MLN Matters Number: MM5993

Related Change Request (CR) #: 5993

Related CR Release Date: July 9, 2008

Effective Date: July 1, 2008

Related CR Transmittal #: R1548CP

Implementation Date: July 7, 2008

Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)

Note: This article was updated on July 12, 2013, to reflect current Web addresses. This article was previously revised on July 23, 2008, to reflect additional changes made to CR5993 on July 9. CR5993 was revised to correctly state the payment policy regarding emergency department visits on the same day as



CRITICAL CARE

CODING FOR CRITICAL CARE SERVICES

- Care rendered to critically ill or injured patients under specific conditions may qualify for a critical care E&M code
- Time based code: 99291 for first hour (30-74 min)
99292 for each subs. 30 min
- RVU = 4.5
- Historically: confusion and disagreement over proper use of critical care codes

CRITICAL CARE CODING UPDATE: “Rudolph Memo”

- In December 1999, HCFA issued a “Program Memorandum” to its carriers
- Intent was “to clarify a number of issues related to the interpretation, reporting and payment” of critical care codes 99291 and 99292
- Effective January 1, 2000
- Similar to the “Cusick” memo of 1995 clarifying almost identical issues
- **DIFFERENCE:** AMA CPT 2000/2001 definitions for critical care codes (99291-99292) have changed

Y2K CPT GUIDELINES FOR CRITICAL CARE CODES

- Enhanced/expanded definition of Critical Care:
 - no longer includes “unstable”
 - no longer has “constant attendance/attention” *but still requires MD to devote "his/her full attention to the patient and therefore cannot provide services to any other patient during this period of time"*
- 30 minutes is now sufficient for 99291 (in past 31 minutes or more required)
- Continues to require documentation of amount of time spent caring for and/or coordinating care of critically ill or injured (includes time with family on floor or unit but not time on the phone elsewhere)

Y2K GUIDELINES 99291

■ HCFA memo to carriers specified criteria for acceptable coding:

1) **Clinical condition criterion:** *“There is a high probability of sudden, clinically significant, or life threatening deterioration in the patient’s condition which requires the highest level of physician preparedness to intervene urgently”*

2) **Treatment criterion:** *“Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient’s condition”*

3) **Full attention criterion:** *“Cannot provide services to any other patient during the same period of time”*

4) **Documentation of time:** *“Critical care time: 45 minutes excluding procedures”*

Total Duration of Critical Care	Codes
Less than 30 minutes	99232 or 99233 or other appropriate E/M code
30 - 74 minutes	99291 x 1
75 - 104 minutes	99291 x 1 and 99292 x 1
105 - 134 minutes	99291 x1 and 99292 x 2
135 - 164 minutes	99291 x 1 and 99292 x 3
165 - 194 minutes	99291 x 1 and 99292 x 4
194 minutes or longer	99291 - 99292 as appropriate (per the above illustrations)

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

What about Advanced Practitioners?

D. Critical Care Services and Qualified Non-Physician Practitioners (NPP)

Critical care services may be provided by qualified NPPs and reported for payment under the NPP's National Provider Identifier (NPI) when the services meet the definition and requirements of critical care services in Sections A and B. The provision of critical care services must be within the scope of practice and licensure requirements for the State in which the qualified NPP practices and provides the service(s). Collaboration, physician supervision and billing requirements must also be met. A physician assistant shall meet the general physician supervision requirements.

2. Split/Shared Service

A split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) cannot be reported as a critical care service. Critical care services are reflective of the care and management of a critically ill or critically injured patient by an individual physician or qualified non-physician practitioner for the specified reportable period of time.

Unlike other E/M services where a split/shared service is allowed the critical care service reported shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified non-physician practitioner and shall not be representative of a combined service between a physician and a qualified NPP.

CASE STUDY FOR PHYSICIAN CODING

CASE STUDY

- 65 yo male brought to ED with BP 80 and multiple injuries: CHI, ruptured spleen, bilateral femoral shaft fxs, left hemopneumothorax (“Hurt Bad”)
- You are present and direct initial resuscitation including femoral line and chest tube placement by your residents

QUESTION #1

Outpatient consult only if:

- patient discharged from ED
- you do not take over care
- you communicate with requesting doctor

Acceptable charges in ED/Trauma bay include:

– 9924x (outpatient consultation)

✓ – 9928x (Emergency Room visit)

or ✓ – 9922x (inpatient admission)

or ✓ – 99291 (critical care code)

and ✓ – 36489 (central line, percutaneous)

and ✓ – 32020 (tube thoracostomy)

Good choice but likely
used by ER doc

Some intermediaries consider 36489 as part of 99291. However, the CPT manual specifies which codes are part of 99291, and 36489 is not one of them

Diagnosis & Procedure Match-Up

- 99291 (Critical Care CPT code)

 - 958.4: Traumatic shock

 - 850.0: Concussion w/o LOC

 - 865.04: Ruptured spleen

 - 821.01: Femoral shaft fracture

 - 860.4 : Hemopneumothorax

- 32020 (chest tube CPT code): 860.4

- 36489 (central line CPT code): 958.4

CASE STUDY

- Patient goes to OR, and you assist your resident in performing a splenectomy
- You also find a ruptured small bowel loop and repair it primarily
- Orthopedics rods the femurs
- Neurosurgery places an ICP monitor

QUESTION #2

Modifiers

- 22 Difficult cases, Obesity, Shock
- 51 Multiple procedures

■ Acceptable charges for Operative Procedure include:

- 49000-51 (exploratory laparotomy)
- 38100-51 (splenectomy)
- 44602 (small bowel repair)
- ✓ – 38100 and 44602
- ✓ – 38100-22, 44602-51
- 38100-51, 44602
- none, unless you personally perform entire procedure

NB: CMS no longer requires the 51 modifier

Diagnosis & Procedure Match-Up

- 38100-22 (Splenectomy with modifier for Unusual Procedural Services)
Diagnosis 865.04 (ruptured spleen)
- 44602-51 (Intestinal repair with modifier indicating secondary procedure of multiple procedures)
Diagnosis 863.29 (intestinal injury)

REQUIRED FOR 22 MODIFIER

Most payors require supporting documentation to be submitted with the claim. We suggest sending a cover letter justifying the increased charge in addition to a copy of the operative note!

- Increased risk
- Difficult procedure
- Hemorrhage
- > 600 ml EBL
- Extended services
- Contamination control
- Unusual findings
- Complications
- Prolonged operation
- Obesity
- Severe respiratory distress

American Academy of Procedural Coders Independent Study Prog. Module 2 3-3 to 3-4, 1996.

From the Desk of the Medical Director: -22 Modifier. Medicare Part B Newsletter No. 00-001, October 11, 1999

CASE STUDY

- Shortly after midnight, patient is brought to ICU with BP 80 and hypoxemia
- You are personally at bedside for 31 minutes managing resuscitation and ventilator
- You go home to rest/see family and sign out to your partner who is covering the ICU
- She places a PA catheter and is at bedside for 2 hours

QUESTION #3

Since single group, total critical care charges = 2.5 hours

■ Acceptable charges for 1st ICU Day include:

– 99291 (critical care) & 94656 (ventilator management) for you and 99291, 99292 x 2 and 93503 (PA catheter insertion) for her

– You: 99291-25 & 94656;
Her: 99291-25, 99292-25 x 2, 93503-59

✓ – You: 99291-24 -25;
Her: 99292 -24 -25 x 3, 93503

– none for you;
Her: 99291-25, 99292-25 x 2, 93503-59

– none for either of you (global fee concept)

-25 significant, separately identified E&M by same MD on same day of procedure or service (*so you can be paid for a procedure - PA cath- and an E&M - 99291- on same day*)

-24 unrelated E&M during post-op

Diagnosis and Procedure Match-Up

We recommend that you document the critical care services as clearly separate from routine post-operative care. It is possible you will be asked to provide documentation to support the additional charge

- 99291-24 -25 (1st hour critical care) for you
 - 518.81 (Respiratory failure)
 - 958.4 (Traumatic shock)
 - 850.0 (Concussion)
- Be sure to use:
 - the -24 modifier (unrelated E&M in the postoperative period)
 - the -25 modifier (significant, separately identifiable E&M on same day as procedure or service)
- Note the absence of operative diagnoses!!!

Diagnosis and Procedure Match-Up

- 99292-24-25 x 3 (each additional 30 min with modifier -24 for unrelated E&M in the postoperative period and modifier -25 for separate E&M on day of procedure or service) for her:
 - 518.81 (respiratory failure)
 - 958.4 (traumatic shock)
 - 850.0 (concussion)
- 93503 (PA catheter insertion) for her:
 - 958.4 (traumatic shock)
- Note the absence of operative diagnoses!!!

CASE STUDY

- Patient has relatively good day next day with stable VS and slow wean of ventilator (still ventilator dependent)
 - His post-operative hemoglobin is 10.5 gm/dl
- You visit patient briefly; your partner is managing patient with the residents
- You do nice hernia repair with intern

QUESTION #4

- 24 unrelated E&M during post-operative period

■ Acceptable charges on this patient for the 2nd ICU Day include:

- 99291 for you; 99291 for partner

- none for you; 99291-24 for partner

~~- none for you; 99233-24 (subsequent hospital care, complex) & 94657-79 (ventilator maintenance) for your partner~~

- none for either of you because pt. is post-op & stable

- none for you; 99233-24 for your partner

Can't charge Medicare a vent code and an E&M

And for you?

- None for you

but don't forget to bill your 49505 for the hernia repair on the other patient...

Diagnosis & Procedure Match-Up

- 99291-24 for your partner (subsequent hospital care, complex) with:
 - 24 for Unrelated E&M Service by the Same Physician During a Postoperative Period
 - 518.81 (Respiratory failure)
 - 850.0 (Concussion)
 - 285.1 (Acute posthemorrhagic anemia)
- ****Must be supported by documentation******

CASE STUDY

- On third day you take patient back to OR for acute onset peritonitis
- You repair a missed small bowel injury and place feeding jejunostomy
- You feel very badly and advise family immediately

QUESTION #5

-78: Return to the Operating Room for a Related Procedure During the Postoperative Period

■ Acceptable charges for 2nd Operative Procedure include:

- 49002-78-51 (reopening recent *ex lap*),
44602-78 (repair small bowel *lac*)
44015-78-51 (feeding jejunostomy)
- 49002, 44602, 44015



- 44602-78 and 44015-51-78 only
- no charge since it's a missed injury

Diagnosis & Procedure Match-Up

- 44602-78 (Repair small bowel laceration with modifier for Return to the Operating Room for a Related Procedure During the Postoperative Period)
 - Diagnosis 863.29 (intestinal injury)
- 44015-51-78 (Feeding jejunostomy with modifiers for multiple procedures and for return to OR during postop period)
 - Diagnosis 560.1 (paralytic ileus)

CONCLUSIONS

- Proper billing for E&M and procedures in the ICU requires documentation and coding of separate and distinct diagnoses requiring critical care services
- Most critically ill patients have several diagnoses (and codes) that can be used
- Use of modifiers helps to ensure that your billable services are not denied payment on their first submission

CONCLUSIONS

- Critically ill and injured patients require more care in the peri-operative period than patients undergoing similar operative procedures who do not require critical care (i.e., elective splenectomy vs. splenectomy for trauma)
- Payment for such services is appropriate with supporting documentation

CONCLUSIONS

- Optimal financial outcomes require:
 - ✓ an understanding of the coding system
 - ✓ personal involvement in billing - “billing at the point of care”
 - ✓ timely preparation and submission of charges
 - ✓ staying current regarding regulations
 - ✓ strong documentation
 - ✓ delivering high quality care

RESOURCES (continued)

- CMS' s web site: www.cms.gov
- American College of Surgeons: www.facs.org
- ACS Coding Hotline **1-800-ACS-7911 (227-7911)**
- *ACS ICD-9-CM and CPT Coding Workshops*
- AMA CPT manual
- Brett A. New Guidelines for Coding Physician' s Services - A Step Backward. NEJM 1998; 339:1705-08. (Editorial: E&M Guidelines- Fatally Flawed., NEJM 1998; 339:1697).
- Fakhry SM. Billing, Coding & Documentation in the Critical Care Environment. Surg Clin N Am 80:1067-83, June, 2000.
- Yealy DM, Fakhry SM. Documentation, Coding, Compliance, and EMTALA. In The Trauma Manual: Trauma and Acute Care Surgery (3rd Ed), Peitzman AB et al (Eds.), 2008, Wolters Kluwer - LWW, 2008, pp 121-130.

RESOURCES (continued)

- Fakhry SM, Reed RL. Coding for Trauma/Burn Care and Surgical Critical Care. In Coding and Billing for Critical Care: A Practice Tool (3rd Ed). Sample GA and Dorman T (Eds), SCCM, 2009, pp 35-50.

- Reed RL, Fakhry SM. Coding for Special Circumstances: Trauma, Burns and Surgical Critical Care: The Global Surgical Package and Related Surgical Considerations. In Coding and Billing for Critical Care: A Practice Tool, 6th Ed. Dorman T, Britton F, Brown DR, Munro N (Eds), SCCM, Mount Prospect, Illinois, 2013, pp 85-104.

- Medicare Learning Network (MLN) Matters, Number: MM5993, Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292).

- “Rudolph Memo”: PROGRAM MEMORANDUM CARRIERS, Department of Health and Human Services, Health Care Financing Administration, Transmittal No. B-99-43, Date DECEMBER 1999, Change Request 1029, SUBJECT: Issues Related to Critical Care Policy.



Thank you!

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