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# Internal Medicine Coding Alert

## Code Same-Date E/M, Critical Care With Caution or Risk Audit

Medicare warns of possible 'discretionary reviews' on 99291 claims

You'll need to be sure that your critical care-E/M combo claims satisfy the criteria set forth in transmittal 1545; CR 5792 explains more clearly when you can -- and when you cannot -- code an E/M service and critical care on the same date.

Medicare just released more guidance on coding critical care on the same date as other E/M services. MLN Matters change request 5792 is a clarification of transmittal 1545, which came out earlier this summer.

Separate E/M, Critical Care Minutes

The article states that you can bill critical care and an E/M on the same date of service, which is news to a lot of coders. "I have never known Medicare to pay for subsequent visits on the same date" as critical care, states one anonymous coder.

This, however, is actually a clarification of previous Medicare literature, says **Mary Falbo, MBA, CPC,** president of Millennium Healthcare Consulting Inc. in Lansdale, Pa.

The article also states that "critical care management of a patient whose services do not meet the level of critical care should be reported using an inpatient hospital care service with CPT codes for subsequent hospital care (99231-99233)."

This means that if the internist provides hospital care and critical care to the same patient on the same date, you'll have to carve out the critical care time.

Check out this example:

At 9 a.m., the internist comes to the hospital to visit a patient suffering from cardiac arrhythmia. He speaks with the patient about how he's feeling, checks labs and adjusts medications. Notes indicate a level-two hospital service.

At 11:30 a.m. the same day, the patient suffers cardiac arrest, and the internist returns after the patient has been resuscitated to provide 63 minutes of critical care for management of paroxysmal ventricular tachycardia and acute pulmonary edema secondary to idiopathic cardiomyopathy.

You should be able to report the hospital visit and the critical care for this patient, provided the internist meets all the guidelines for both services, says **Leslie Bowers,** coder at Bay Ocean Medical in Tillamook, Ore. On the claim, you would report:

• 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) for the critical care

• 427.1 (Paroxysmal ventricular tachycardia) appended to 99291 to represent the tachycardia

• 425.4 (Other primary cardiomyopathies) appended to 99291 to represent the cardiomyopathy

• 428.1 (Left heart failure) appended to 99291 to represent the heart failure.

• modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) appended to 99291 to show that it was separate from the hospital care

• 99232 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision-making of moderate complexity) for the hospital service

• 427.9 (Cardiac dysrhythmia, unspecified) appended to 99232 for the arrhythmia.

Medicare Mentions 'Discretionary Review'

Medicare also puts providers on notice in the transmittal, stating that "physicians and qualified NPPs are advised to retain documentation for discretionary Medicare review in case the claims are questioned."

And, as always, your critical care documentation "must support critical care services and, most importantly, the time spent on critical care," explains Bowers.

OV-Critical Care Combo Also Possible

The clarification also explains that you can code for both services if the internist conducts an office visit for a patient, and then provides critical care to the same patient later in the same day, confirms **Catherine Brink, CMM, CPC, CMSCS,** president of Healthcare Resource Management in Spring Lake, N.J.

In these instances, be sure to separately document what the patient came to the office for and the reason for the critical care, Brink says.

Example: The internist sees an established patient with lung emphysema in the office for a follow-up visit. Notes indicate a level-three E/M. Later that day, the patient goes into respiratory failure and is admitted to the intensive care unit, where the internist provides 43 minutes of critical care.

In this instance, you should report an office E/M and 99291, but be sure that the diagnoses line up with the services. On the claim, report the following:

• 99291 for the critical care

• modifier 25 appended to 92991 to show that it was separate from the hospital care

• 518.81 (Acute respiratory failure) appended to 99291 to represent the patient's respiratory failure

• 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity) for the E/M

• 492.8 (Other emphysema) appended to 99213 to represent the patient's emphysema.

ED E/Ms Excluded From Allowable List

Medicare allows you to code for critical care and an E/M service -- unless the E/M occurs in the ED (99281-99285, Emergency department visit for the evaluation and management of a patient, which requires these three key components ...). For more information on this Medicare exception, see "File Cleaner 99291 Claims by Keeping Up With Transmittals."