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Internal Medicine Coding Alert

Remember to Use the 25 Modifier When Billing Critical Care and Separate Procedures

Billing for critical care (99291-99292) is one of the most difficult areas of internal medicine . Proper coding is dependent on specific documentation of the time spent with a patient who had a life-threatening medical problem, and of the problems that necessitated treatment. (See related story on four key strategies for optimal coding of critical care, pages 27-28.)

In addition, some procedures that often accompany critical care (interpretation of chest x-rays and ECGs, for example) are included in the code definition and cannot be billed separately. However, other procedures that are often performed are not included and should be billed separately.

The challenge is that some payers try to bundle almost all procedures in with the critical care service if they are performed on the same day. So, how do you know which ones to code separately?

Dr. Serbo did a CVP line (central venous catheter placement, 36489) on a patient in the hospital on January 1, 1999, reads a letter from the office of **James Serbo, MD,** of Internal Medicine Associates, Inc. in Dubois, PA. He also performed critical care 99291 and 99292 for a total of two hours on the same date of service. Medicare is denying the critical care, saying that it is included in the code for the CVP line. Can you give me some insight on this? Should Medicare pay for the CVP line and the critical care or not?

The answer to this question is yes, says **Laura Driscoll** principal with IMPACT Medical Consulting in Atlanta, GA. The placement of deep lines, such as a CVP line, is not included in the CPT definition of critical care and should be reported in addition to the critical care codes.

The claim rejection may be because the critical care codes should also have a -25 modifier (significant, separately identifiable procedure or other service on the same day) attached (99291-25 and 99292-25) to indicate the performance of a separately identifiable service performed on the same day, she advises. In this example, the EOB the office received stated that the payment for critical care was denied because it is included in the CVP line code.

Obviously, two hours of critical care services are not required to place a CVP line, and these codes represent a separate service provided by the physician.

Medicare carriers often deny critical care claims when they are accompanied by a minor surgical procedure such as 36489, agrees **Kathryn Cianciolo, MA,** chair of the Society for Clinical Coding and an independent coding consultant in Waukesha, WI.

Often, they will pay for the procedure and not the critical care, she notes. However, if you appeal and resubmit with the supporting documentation of the critical care indicating that it is a separate service, then usually they will pay.

Cianciolo also recommends the use of a modifier with the critical care code.

Use of -25 Modifier for Critical Care

It is important to recognize that the -25 modifier should be applied to critical care codes because critical care is an other service as reflected in the descriptor for this modifier, Driscoll notes. Critical care codes and prolonged service codes (99354-99359) are E/M codes that can also be reported in addition to other E/M codes and procedures performed on the

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same day. However, if an E/M code is reported on the same day as a separate procedure most carriers will bundle the E/M unless the modifier is applied.

If the physician performed an evaluation of the patient on that dayto determine that the patient was in respiratory failure, for examplethen an E/M code should be reported to indicate this service as well as the critical care code.
In the above case, it would most likely be hospital inpatient services (99221-99223, initial hospital care, or 99231-99233, subsequent hospital care).

This is separate from the critical care delivered, so both services should be reported; the basic E/M code is also reported with a -25 modifier to ensure payment for both services.

If an E/M visit code and a critical care code and a procedure that is not included in critical care are reported for the same day, both the visit level and the critical care code require a -25 modifier in order to get the procedure recognized separately, adds Driscoll.

Determining Whether a Procedure is Bundled

In many cases, unlike the one cited above, the critical care codes are recognized by third-party payers, but the procedure codes are not reimbursed when the practice receives payment.

In general, coders should answer the following questions to determine whether a procedure is bundled with the critical care code or whether a denial of payment for the procedure should be appealed:

1. Does CPT consider the procedure a part of the critical care service? According to CPT, interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71020), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data [99090]); gastric intubation (91105); temporary transcutaneous pacing (92953); ventilator management (94656, 94657, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36600) are included in the reporting of the critical care codes. CPT also notes that: Any services performed which are not listed above should be reported separately.

2. Is the code bundled under Medicares
Correct Coding Initiative (CCI)? For Dr. Serbos question, Driscoll also checked the latest version of CCI. This list contains edits for carriers claims systems that include codes that Medicare considers to be part of another comprehensive service, or codes that are mutually exclusive and cannot be coded together. Although the code for the CVP line was not included in CCI, some other codes may be included there that are not included in critical care according to CPT.

3. Is the code a black box edit? Another potential problem are the new black box edits that Medicare included in CCI, but which are not included in published versions of the edits made available to the public and to providers, says **Catherine Brink, CMM, CPC,** president of Healthcare Management Resources, a medical practice consulting firm in Spring Lake, NJ.

Because the new edits originally came from another companys commercially available coding software package, these bundling edits have been deemed the proprietary information of that company.

Although there is no way for coders to look up whether a code is in the new package of edits, they may be able to ascertain from repeated Medicare denials that this code is considered bundled.

However, in instituting the proprietary edits, HCFA administrator **Nancy Ann Min-DeParle** indicated that providers would be given an explanation of the medical rationale for the edit.

Editors Note: For more information, see the article on CCIs black box edits in the October 1998 issue of Internal Medicine Coding Alert, page 21.)

4. Does the ICD-9 code indicate a diagnosis requiring critical care? For any type of denial involving critical care services,

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Brink recommends checking the ICD-9 code.

Critical care should only be billed when the physician is providing continuous care to a person with a serious medical problem, and some carriers will deny critical care if it is linked to a diagnosis code that does not appear to indicate serious injury or illness, she says.

This is not always fair because some seemingly innocuous diagnoses cause severe medical complications, Brink adds. However, this situation is a reality with many payers.

It may be that Medicare has an edit for which the diagnosis of respiratory failure was not specific enough, she states. I would resubmit the claim with the -25 modifier, and look at the ICD-9 code to see whether or not something more specific should be used.

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