

Internal Medicine Coding Alert

Stung by Allergic Reaction Coding?

Try 4 strategies for improving pay

You could be losing out when an internist treats bee-venom-triggered anaphylaxis in the office, but coding experts say you'll boost reimbursement if you zero in on the time and complexity of the anaphylactic-shock services the physician provides.

1. Use 99291-99292 for Life-Saving Measures

Although some allergy coders think that 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and +99292 (... each additional 30 minutes [list separately in addition to code for primary service]) are for hospital use only, you may use these high-paying codes in the office if you follow CPT's guidelines for reporting critical care services, says **Diane M. Minard, CPC**, a coding specialist for Dartmouth Hitchcock Medical Center in Lebanon, N.H. The Medicare Physician Fee Schedule, which many private payers use as a guide, pays a geographically unadjusted nonfacility rate of \$210.07 for 99291 and \$107.79 for 99292.

Indeed, in some instances of anaphylaxis due to bee or wasp venom, the patient's condition may require critical care services.

For instance, a patient who has an anaphylactic reaction to a bee sting may have respiratory distress, vascular collapse, shock, urticaria (hives), angioedema and pruritus. If the episode meets the criteria for billing critical care services, using a higher-level office visit code, such as 99214 (Office or other outpatient visit for the E/M of an established patient ... physicians typically spend 25 minutes face-to-face with the patient and/or family) instead of 99291-99292, will cost your practice \$130.24.

But before you start reporting critical care codes, make sure you know the rules. CPT defines a critical illness or injury as one that impairs one or more vital organ systems, creating a high probability of imminent or life-threatening deterioration in the patient's condition. Therefore, if the severe systemic reaction to the insect sting becomes life-threatening and affects one or more of the patient's vital organ systems, and the physician provides direct medical care, critical care services may apply, Minard says.

Remember that CPT states that critical care involves high-complexity decision-making used to assess, manipulate and support vital system function(s). In critical care, the physician treats single or multiple vital organ system failure(s) and/or prevents further life-threatening deterioration of the patient's condition.

For instance, the patient may have difficulty breathing and go into shock. The physician must continue these life-sustaining services for 30 minutes to qualify for 99291.

Although the physician does not usually provide these services in the office for an extended time, he or she may perform them until the patient can be transported to a hospital or critical care unit.

2. Fall Back on E/M Codes

Even so, in many instances of anaphylaxis, the patient may respond to treatment before qualifying for the 30 minutes necessary to bill 99291.

The question to ask is, did the physician spend 30 minutes providing critical care to the patient? In most cases, epinephrine will resolve the condition before that, says **Susan Callaway, CPC, CCS-P**, an independent coding and

reimbursement specialist and educator in North Augusta, S.C.

She says that when critical care services do not total 30 minutes, CPT instructs physicians to use the appropriate-level E/M code - in this case an established patient office visit, 99212-99215.

For instance, a 25-year-old female patient comes in after a yellow-jacket sting. The sting site shows generalized signs of swelling and redness. During the examination, the patient begins to wheeze, and her blood pressure drops. She shows signs of abdominal cramping and altered consciousness. The physician intramuscularly administers (90782, Therapeutic, prophylactic or diagnostic injection [specify material injected]; sub-cutaneous or intramuscular) 2.5 mg of dexamethasone acetate (J1094, Injection, dexamethasone acetate, 1 mg) and 0.18 ml of epinephrine (J0170, Injection, adrenalin, epinephrine, up to 1 ml ampule).

After about five minutes, the patient's signs begin to subside, and the physician gives a shot of 25 mg of diphenhydramine hydrochloride (J1200, Injection, diphenhydramine HCl, up to 50 mg) and a nebulized albuterol treatment (94640, Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes [e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device]). The patient's condition is stable within 15 minutes. The physician and a nurse monitor the patient off and on during the next three hours.

Although the patient's symptoms were initially life-threatening, she shows signs of organ stability prior to reaching the 30 minutes of instability necessary to bill critical care services.

Consequently, you should report a high-level E/M code, such as 99214 or 99215 (... physicians typically spend 40 minutes face-to-face with the patient and/or family), in addition to the procedures and drugs, says **Jeffrey Linzer Sr., MD, MICP, FAAP**, assistant professor of pediatrics for the division of emergency medicine at Emory University School of Medicine in Atlanta, and emergency medical services coordinator for the emergency pediatric group at Children's Healthcare of Atlanta at Egleston.

Append modifier -25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) to the E/M code, if the payer requires it, to show that the office visit is a significant, separately identifiable service from your physician's procedures.

Some insurers may also require you to add modifier -51 (Multiple procedures) to the subsequent injections (90782, 90782-51) or include them in the E/M.

3. Take Credit for Face-to-Face Beyond E/M Time

Another area that you may inadvertently sacrifice is reporting prolonged services. "To capture extra time over that included in the office visit, you may bill 99354-99355," Minard says. Because these codes encompass direct face-to-face contact, the physician must provide direct care to the patient and document the start and stop times.

"Although the patient may be physically in the office for three hours, you should report the prolonged service code only for the time the physician has direct contact with the patient," Linzer says. The time does not need to be continuous.

For instance, if the physician in the above scenario codes 99215 after spending a total of 120 minutes face-to-face with the patient (120 minutes of total face-to-face time - 40 minutes of 99215 = 80 minutes of prolonged service), he or she should also report +99354 (Prolonged physician service ... requiring direct [face-to-face] patient contact beyond the usual service [e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting]; first hour [list separately in addition to code for office or other outpatient E/M service]) for the first additional 30-74 minutes of direct patient care time and +99355 (... each additional 30 minutes ...) for the additional time after the first hour.

"Because these are add-on codes, they do not require modifier -25," Linzer adds.

4. Report 99058 for In-Office Emergencies

When you perform emergency services - such as anaphylactic-reaction treatment - in your office, report 99058 (Office services provided on an emergency basis).

Because the patient's clinical condition demands immediate physician care and requires the doctor to interrupt her or his normal schedule to see the patient, you should report 99058, which is modifier -51 exempt, Linzer says.

And unlike prolonged services, which exclude billing critical care codes, you may report the emergency code with either 99211-99215 or 99354-99355.

Payment for the emergency service may prove difficult. Because the Blue Cross Blue Shield of Massachusetts fee schedule does not contain the code, many insurers deny 99058.

But you should always try billing the service, Minard says. CPT requires reporting to the highest specificity possible and coding for the entire event.