Part B Insider (Multispecialty) Coding Alert

CCI EDITS: Are You Missing Out On Critical Care Reimbursement?

2 CCI changes that should change the way you code

If you-re not keeping up with the latest changes to the Correct Coding Initiative, you could be missing out on reimbursement. Here are two recent changes that could make a huge difference to your bottom line:

1) You can bill for critical care and discharge separately. The most recent CCI update, version 12.2 (effective July 1, 2006), deletes an edit that made critical care codes 99291-99292 components of hospital discharge day management code 99239 (Hospital discharge day management; more than 30 minutes). So if a patient presents in an emergency situation that requires 30 minutes or more of critical care and is discharged from the hospital that same day, you can bill for both services.

Before July 1, the **Centers for Medicare & Medicaid Services** (CMS) considered critical care and hospital discharge to be mutually exclusive services that the physician would not reasonably perform at the same session, says **Barbara Cobuzzi**, president of **CRN Healthcare Solutions**, in Tinton Falls, NJ. So insurers would only pay for 99239, not the critical care code.

1) Don't forget 59 modifier when you bill for injections with moderate sedation. CCI version 12.1 classified 107 codes as components of moderate sedation (99143-99150).

So you-ll lose out on reimbursement if you don't include the appropriate modifier when billing for moderate sedation along with intracatheter introduction (36000), venipuncture (36400-36410, 36420-36425), hydration (90760) and many injection procedures.

If the procedures meet the criteria for modifier 59, you can report them together, says **Carol Pohlig** with **Hospital of the University of Pennsylvania** in Broomall, PA. In addition, NCCI 12.1 made numerous procedures components of 90760, she says.

For instance, you shouldn't typically report venipuncture requiring a physician's skill in addition to hydration, according to NCCI version 12.1, Pohlig says. But if the blood draw is for a different reason than hydration assessment (such as a complete blood count to detect infection) and occurs at a separate site from the hydration insertion, you can code both.

In this case, you should report the venipuncture and the hydration (90760, Intravenous infusion, hydration; initial, up to 1 hour), Pohlig says. You would append modifier 59 to the component code: 36410 (Venipuncture, age 3 years or older, necessitating physician's skill [separate procedure], for diagnostic or therapeutic purposes [not to be used for routine venipuncture]).

Note: Some non-Medicare payors may not apply these bundles, note experts.