

Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Eliminate Ventilator-Associated Pneumonia Uncertainty With Clear Diagnosis Parameters

Tip: Other conditions 'mimic' ventilator-associated pneumonia and can lead to misdiagnosis.

Ventilator-associated pneumonia (VAP) is a difficult diagnosis to make, but once the doctor diagnoses it in a patient, your E/M options may increase. Maintain diagnostic accuracy and pinpoint E/M levels with these from-the-field VAP coding tips.

Be Precise When Reporting VAP

When you come across a case of suspected VAP (997.31), consider how long the patient has been on a ventilator before showing signs of pneumonia. In general, VAP refers to pneumonia that occurs more than 48 hours after endotracheal intubation, according to the Cleveland Clinic

(www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/infectious-disease/health-care-associated-pneumonia).

While diagnosis may seem straightforward, "the diagnosis of VAP is challenging," remarks **Steven M. Gordon, MD**, chairman of the department of infectious disease in the Medicine Institute at the Cleveland Clinic in Ohio. Often, physicians do not perform bronchoscopies to obtain specimens or order chest computed tomographies (CTs) when making a diagnosis, Gordon says. In many cases, a physician treating pneumonia for a patient on a ventilator would simply code the diagnosis as VAP.

You may want to consider alternate diagnoses before documenting VAP. Conditions such as heart failure (428.9), hemorrhage (786.3), acute respiratory distress syndrome (ARDS, 518.82), and influenza (487.x) can all look like VAP, Gordon points out.

Try this: To rule out VAP, "I would look at bronchoalveolar lavage (BAL), a chest CT, cultures of endotracheal secretions, or mini BAL for indicators," shares Gordon.

Step two: According to ICD-9 guidelines, you should also use an additional code to identify the organism causing the infection. Most of these infections are due to gram negative organisms, such as *Pseudomonas*, or staph (methicillin-susceptible staph aureus [MSSA] or methicillin-resistant staph aureus [MRSA]), explains **Alan L. Plummer, MD**, professor of medicine in the division of pulmonary, allergy, and critical care at Emory University School of Medicine in Atlanta.

Thus, when reporting ventilator-associated pneumonia, you might code:

- 997.31 and 482.1 (Pneumonia due to *Pseudomonas*)
- 997.31 and 482.41 (Methicillin susceptible pneumonia due to *Staphylococcus aureus*), or
- 997.31 and 482.42 (Methicillin resistant pneumonia due to *Staphylococcus aureus*).

Make the Right Call on E/M Level

The E/M service level for VAP would depend on the documentation the doctor provides, observes **Becky Zellmer, CPC, MBS, CBCS**, medical billing and coding supervisor for SVA Healthcare in Milwaukee.

Option 1: For instance, if the doctor is monitoring the ventilator and the patient does not require critical care, then using the ventilator management codes (94002-94004) may be an option, Zellmer says.

Option 2: Alternatively, you may report one of the subsequent hospital visit codes (99231-99233) according to the hospital note detailing the complexity of recent events, the exam, and the medical decision making.

Option 3: If the VAP is severe or causes an acute exacerbation of the underlying illness, then documenting and using one of the critical care codes (99291 [Critical care, evaluation and management of the critically ill or critically injured patient, first 30-74 minutes] and possibly +99292 [...each additional 30 minutes]) may be most appropriate -- and would also result in the highest amount of reimbursement. "VAP increases the complexity of the patient's illness(es) in the intensive care unit (ICU) ... and usually leads to the necessity to code critical care," says Plummer.

Remember that if you select a critical care code, the patient's condition, the highly complex interventions, and the time the physician spends with the patient must be documented correctly in the chart, says Zellmer. Represent the first 30-74 minutes of care with 99291 and subsequent 30- minute episodes of care with +99292.

Watch out: Don't confuse the need to manage a ventilated patient with the need for critical care services. According to CMS, "Daily management of a patient on chronic ventilator therapy does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long term management of the ventilator dependence." Note: For more on meeting critical care criteria, reference CMS Transmittal 1530 and MLN Matters article MM5993.

Treatment: Most patients with suspected VAP will receive broad spectrum antibiotics (extended spectrum penicillins, cephalosporins, or quinolones), says Gordon. Since a ventilator-assisted patient would be a hospital inpatient or long-term care resident, the facility, rather than the doctor, would report the antibiotic administration. "The course of treatment would not be reported per se, but would be incorporated into the physician work used to document a 99291 (critical care) or 99233 (subsequent hospital care) visit," says Plummer.

Resource: Find Guidelines for the Management of Adults with Hospital-acquired, Ventilator-associated, and Healthcare-associated Pneumonia on the American Thoracic Society Web site at www.thoracic.org/sections/publications/statements/pages/mtpi/guide1-29.html.

Don't Overuse VAP Diagnosis

While not yet a 'non-event,' CMS has its eye on VAP.

Ventilator-associated pneumonia (VAP) is in the undesirable category of hospital-acquired conditions -- but if CMS has its way, the need for making the diagnosis would occur much less frequently.

CMS has tried to place VAP (997.31) into the "nonreimbursable event" category of hospital acquired diseases and conditions that carriers will not pay for. This category includes events such as operating on the wrong limb, leaving equipment in the patient, etc., Plummer says. "So far this attempt has been blocked from happening by the pulmonary and critical care community ... but most feel that CMS will attempt to place VAP back on the list in the future."

Given VAP's potentially negative ramifications, hospitals are wise to use VAP-preventive measures and to monitor any suspected VAP cases to be certain before making the diagnosis, comments **Jill M. Young, CPC, CEDC, CIMC**, of Young Medical Consulting in East Lansing, Mich.

Much of the grey area derives from VAP being a "diagnosis of exclusion." For instance, the cause of pneumonia may be difficult to determine if the patient decompensated quickly and the physician did not order a chest X-ray. Even if the provider orders a chest X-ray or a culture, getting an accurate diagnosis is still not guaranteed.

Bottom line: Don't be too quick to report 997.31 on patients who are ventilated and showing signs of pneumonia. First, consider the patient's history and possible alternate diagnoses. Attempt to confirm VAP with a trachea culture combined with a new or enlarging infiltrate chest X-ray, or a bronchoscopy plus bronchoalveolar lavage with a new or enlarging infiltrate chest X-ray, relates Young. Search for another diagnosis if cultures are negative.