Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Take The Guesswork Out Of Ventilation Management Coding

3 helpful hints show you how to get the reimbursement you deserve

Selecting the proper ventilation management code depends on several important factors, specifically the date of care--but that's not all. Here are three clues to help you cut out denials and know the right codes to use for the right circumstances.

1. Choose a Management Code Based on Method

When your physician uses ventilation management to treat respiratory failure, you should choose from the following codes:

• 94656--Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day

• 94657--.... subsequent days

• 94660--Continuous positive airway pressure (CPAP) ventilation, initiation and management

• 94662--Continuous negative pressure (CNP) ventilation, initiation and management

Tip: To pick the right procedure code, you need to know your physician's method for administering ventilation management, coding experts say.

Look for: The first and foremost documentation that the physician should include is the ventilator settings/adjustments, says **Carol Pohlig, BSN, RN, CPC**, senior coding and education specialist at the **University of Pennsylvania Department of Medicine** in Philadelphia. This includes the initial or current vent settings, any changes to those parameters (for example, titration of peak-end expiratory pressure [PEEP] to keep FiO2 low), and recommendations and/or orders relating to the vent setting changes.

Once you know how your physician administered the ventilation, look at when he administered the treatment. Choose the correct code based on whether you're reporting the first day of ventilation or subsequent days.

None of these codes are time-based, and there are no documentation guidelines for any of these codes, says **Alan L. Plummer, MD,** professor of medicine, **Division of Pulmonary, Allergy and Critical Care at Emory University School of Medicine** in Atlanta. If your physician just sets the patient up on the ventilator without giving input on any other aspects of the patient's treatment, you should use 94656 for mechanical ventilation.

Example: A patient has respiratory failure superimposed on congestive heart failure. Another physician calls your physician into the coronary intensive care unit to set up the patient, who has just been intubated, on a ventilator.

The physician examines the patient, reviews the pertinent data including chest x-rays, and orders the ventilator settings. He then writes a note describing what he's done, documenting all the ventilator settings and how to monitor the patient including measuring arterial blood gases.

Do this: You should report 94656 for the first day of the ventilation and 94657 for subsequent days. You should report

518.81 (Acute respiratory failure) for the acute respiratory failure and 428.0 (Congestive heart failure, unspecified) for the congestive heart failure.
If the physician initiates only continuous positive airway pressure (CPAP) on an intubated patient, you should select 94660, Pohlig says. But if the physician initiates negative pressure ventilation, you should use 94662. The most frequent use for 94660 is in the outpatient setting for the patient with sleep apnea on whom the physician initiates nasal CPAP to use during sleep, Plummer says.

2. Support Your Coding With Proper Diagnoses

Linking the right ICD-9 code to your ventilator procedure code can be tricky because your physician's terminology may not clearly indicate the exact diagnosis. Dig into the details of the documentation to figure out which code is best.

You have three diagnosis codes to choose from when reporting respiratory failure:

• 518.81--Acute respiratory failure
• 518.83--Chronic respiratory failure
• 518.84--Acute on chronic respiratory failure

Look for: "The patient's condition should reveal acute or chronic respiratory failure," Pohlig says. Sometimes physicians use the term "respiratory failure" as a general phrase when a patient has difficulty breathing. Your challenge is figuring out whether the physician intended for you to report 518.81 for acute respiratory failure, or if she actually intended you to assign 518.84 for acute on chronic respiratory failure.

Best bet: "It becomes more confusing when the patient has chronic respiratory failure with an acute episode. It is likely that patients who are being hospitalized for their respiratory failure are experiencing some form of acuity," Pohlig says. The key to using the right diagnosis code for respiratory failure is deciphering from your physician's documentation how quickly the patient normalizes his lung function between episodes of the respiratory disease.

Example: Your physician treats a patient with end-stage emphysema who has consistently altered carbon dioxide and oxygen levels. The physician diagnoses the oxygen-dependent patient with chronic respiratory failure (518.83). The patient presents in the emergency department for an exacerbation of emphysema, which severely deteriorates the patient's already compromised condition, causing acute respiratory failure.

Do this: In this case, you would report 518.84 for acute on chronic respiratory failure. The documentation on an arterial blood gas determination of an elevated PaCO2, elevated bicarbonate level and a low pH helps to substantiate the diagnosis of acute on chronic respiratory failure.

If the patient has acute decomposition of chronic bronchitis, you should also code 491.21 (Chronic bronchitis, with [acute] exacerbation) with the proper respiratory failure code, Plummer says. If the patient has respiratory failure associated with pneumonia (for example, 486, Pneumonia, organism unspecified) or heart failure (428.0, Congestive heart failure, unspecified), report the appropriate ICD-9 codes in addition to the correct respiratory failure code.

3. Choose Between E/M and Vent Management

If your physician performs ventilator management and an E/M, you'll have to look at the documentation to see which you should report. Because of National Correct Coding Initiative edits, you can never bill ventilator management with an E/M code, such as 99221 (Initial hospital care ...) or 99291 (Critical care ...).

Rule of thumb: Base your coding on the level of assessment and decision-making your physician documents. Choose either the E/M or the ventilation management, depending on the medical record. If your physician's service focuses on vent management and he did not document all of the necessary elements in the key components warranting an E/M service, you should report a vent management code, Pohlig says.

If, however, your physician performs and documents the necessary items of the key components, expanding beyond

issues merely related to the ventilation, select an E/M code.

Beware: Ventilation management and critical care coding often go hand-in-hand. You can't separately report both a critical care code and a ventilation management code, however.

Bonus: Subsequent-day ventilation management pays less than subsequent hospital care (levels 2 and 3). It is up to you and your physician which code you report, but the documentation must support the selected code and the medical necessity of the service.

Keep an eye out: Codes 94656 and 94657 were referred to the CPT Editorial Panel after the October RUC meeting, and three new ventilation management codes and one new monthly home ventilator management code have been developed and referred back to the RUC for survey and assignment of work values, Plummer says.