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Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Ventilator Management vs. E/M Codes: This Guide Helps You Make the Call

Boost reimbursement by 70 percent on subsequent care days with 9400x in lieu of low-level E/M code.

Prolonged ventilation is on the rise, due, in part, to improved intensive care unit survival. Brush up on your ventilator management coding skills to ensure that you don't miss out on deserved reimbursement when dealing with this growing area of respiratory medicine.

Time and Place Define Ventilator Management Options Start by knowing the four choices you have for reporting ventilator management and the rules governing each.

Hospital care: Code ventilator management for inpatients in the hospital setting by the day using one of the following codes:

• 94002 -- Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

• 94003 -- ... hospital inpatient/ observation, each subsequent day.

Long-term care: If the doctoris providing ventilator management services in a long-term care facility, report 94004 (... nursing facility, per day) for each day she provides care.

Important: For 94002-94004, Medicare requires a face-to-face encounter between the reporting physician and the patient to report ventilator management, says **Alexander White, MD, MS, FCCP,** of the department of pulmonary and sleep medicine at New England Sinai Hospital in Stoughton, Mass.

There is no specific time requirement the physician must meet to report 94002-94004; however, the physician should still note in the patient's chart the time he spent providing the service, notes **Becky Zellmer, CPC, MBS, CBCS,** medical billing and coding supervisor for SVA Healthcare in Milwaukee.

Weigh Choice Between Ventilator Management and Hospital Care

You cannot report ventilator management codes in conjunction with any E/M code (99201-99499) on the same day. So it pays to know which code achieves maximum potential reimbursement when your doctor performs both ventilator management and E/M services on the same day.

Example: The physician treats a newly admitted patient for acute respiratory failure (518.81). Since initial inpatient care of ventilated patients involves more than the initiation of mechanical ventilation, set aside ventilator codes in favor of a high-level E/M code such as 99223 (Initial hospital care, per day, for the evaluation and management of a patient ...) or, potentially, a critical care code (more on that later).

According to the 2009 MedicarePhysician Fee Schedule, 99223 is reimbursed at $180.33, a payment which better reflects the encounter's complexity. The initial day of vent management (94002) earns the provider only $87.64.

Caveat: If the physician is providing only ventilator care and no other medical care, then ventilator management codes only should be used, states White, coauthor of "Prolonged Mechanical Ventilation: Review of Care Settings and an Update on Professional Reimburse-ment," in the February 2008 edition of CHEST (Vol. 133, No. 2).

Using the ventilator management code for subsequent care (94003), however, can pay off when a ventilated patient has

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stable or resolving medical conditions. It may be more advantageous to bill ventilator management in a patient who would otherwise just require the lowest-level hospital follow-up code, says White.

Example: When the patient's condition and current treatments include management of the ventilator, the physician may opt for 94003 (subsequent day of ventilator management) to achieve a payment of $63.48, instead of 99231 (Subsequent hospital care, per day, for the evaluation and management of a patient ... Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit) and its corresponding payment of $37.15.

How to decide: If the main service is checking and adjusting the vent settings, use a ventilator code, says **Denae M. Merrill, CPC, CEMC,** HCC coding specialist for The Coding Source and owner of Merrill Medical Management in Saginaw, Mich. On the other hand, if the doctor performs ventilator management during the course of a more extensive E/M visit and the E/M components could support a higher-level code, you may want to go with an E/M code to reflect the more comprehensive service with increased reimbursement, she sums up.

Don't Pass Up Critical Care Pay

Missing an opportunity to report critical care services can mean your practice misses out on well-deserved earnings. When a patient suffers, for instance, from hemoptysis (786.3), severe sepsis (995.92), or shock (639.5), and requires critical care to manage the critical illness or injury in addition to ventilator management, report one of the following critical care codes (as long as the documentation demonstrates the critical condition and all coding requirements are met):

• 99291 -- Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes, or

• +99292 -- ... each additional 30 minutes (List separately in addition to code for primary service). These codes reflect the provision of complex services and, as a result, are reimbursed at higher levels than either E/M codes or ventilator management codes, relates White.

It breaks down like this:

• 99291 (initial 30-74 minutes of critical care) earns $212.07,

• +99292 (each additional 30 minutes of critical care) is reimbursed at $106.04, while

• an initial day of ventilator management (94002) earns only $87.64.

Resource: Read the full article at www.chestjournal.org/content/133/2/539.full.

Connect the Dots: If you're wondering if you have covered all your diagnosis possibilities when coding a patient's ventilation management services (94002-94005), here's a quick refresher.

According to "Prolonged Mechanical Ventilation: Review of Care Settings and an Update on Professional Reimbursement," in the February 2008 edition of CHEST (Vol. 133, No. 2), common diagnoses for patients who require prolonged mechanical ventilation in an acute or long-term care setting include:

• 518.81-518.84 -- Respiratory failure/insufficiency

• 492.8 -- Other emphysema

• 491.21 -- Obstructive chronic bronchitis with [acute] exacerbation

• 482.x -- Pneumonia

• 515 -- Postinflammatory pulmonary fibrosis

• 415.19 -- Other pulmonary embolism and infarction

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- V44.0 -- Presence of a tracheostomy
- 428.0 -- Congestive heart failure, unspecified
- 162.5 -- Malignant neoplasm of lower lobe, bronchus or lung
- 340 -- Multiple sclerosis.

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