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Part B Insider (Multispecialty) Coding Alert

Pulmonology Coding: Let CMS's Vent Management Rules Guide Your Code Selections

Documentation determines choice between E/M and ventilation management coding.

You may be missing out on deserved reimbursement dollars for your pulmonologist's respiratory failure treatments if you do not pay attention to the method of ventilation management, location of care, and Medicare's rules regarding E/M codes and critical care services. Here's a lowdown on how to choose the right ventilation management code to decrease your claim denials while getting the most payment for performed services.

1. Make a choice between E/M and Ventilator Management

If your pulmonologist has been called to a critical care unit and she performs both ventilator management and an E/M, take a close look at the documentation to decide which one to report. National Correct Coding Initiative edits prohibit you from billing ventilator management with an E/M code because ventilation management is bundled with all of the E/M codes (99201-99499), meaning that you cannot report both on the same calendar day.

However, if your pulmonologist performs ventilator management as part of a more expansive E/M service, you should report the E/M instead. You should report the encounter based upon the content of decision making the physician documents. If the physician performs the components of an E/M service (history, exam, medical decision making [MDM], counseling) beyond what ventilator management requires, report the E/M code and not the ventilator management code.

However, if your pulmonologist's service focuses mainly on vent management, and he did not address or document all of the necessary elements in the key components warranting an E/M service, you should report a vent management code instead.

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 more appropriate E/M code such as 99223 (Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components...) or, potentially, a critical care code (99291-99292).

According to the Medicare Physician Fee Schedule, 99223 is reimbursed at $204.19, a payment which may better reflect the encounter's complexity. The initial day of vent management (94002) earns the provider only $94.57, and does not require such an extensive encounter as 99223.

Beware: If the physician has provided and/or documented only ventilator care and no other medical care, then you should report only the ventilator management codes.

2. Location and Method are Pivotal to Vent Management Reporting

If you choose to report vent management instead of an E/M, you should select one of the following codes.

Inpatient setting: You can report either 94002 (Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day) or 94003 (... hospital inpatient/observation, each subsequent day).

Long-term setting: If your physician provides ventilator management services for a patient admitted in a long-term care facility, report 94004 (...nursing facility, per day) for each day she provides care.

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Caution: For 94002-94004, Medicare requires a face-to-face encounter between the reporting physician and the patient to report ventilator management.

Also, look at when he administered the treatment. Choose the correct code based on whether you're reporting the first day of inpatient/observation ventilation or subsequent days. If your pulmonologist just sets the patient up on the ventilator without documenting any other aspect of the patient's treatment, you should use 94002 for mechanical ventilation.

Method: You should also know the physician's method for administering ventilation management to pick the right procedure code. For example, if your physician decides to perform pressure ventilation, you can report 94660 (Continuous positive airway pressure ventilation (CPAP), initiation and management). But if the physician initiates negative pressure ventilation, you should use 94662 (Continuous negative pressure ventilation (CNP), initiation and management).

The primary documentation that the physician should include for ventilator management services is the indication and the ventilator settings/adjustments. 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.

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

You should report 94002 for the first day of the ventilation and 94003 for subsequent days. You should primarily report 518.81 (Acute respiratory failure) for the acute respiratory failure, and 428.0 (Congestive heart failure, unspecified) for the congestive heart failure.

3. Make Sure to Exhaust All Diagnostic Possibilities

Look deep into your pulmonologist's documentation to arrive at the right diagnostic codes to link to your ventilator procedure code. Sometimes, this may confuse you as your pulmonologist may not clearly indicate the exact diagnosis. Here are some of the most common diagnoses to support respiratory management:

- 518.81 -- Acute respiratory failure
- 518.83 -- Chronic respiratory failure
- 518.84 -- Acute on chronic respiratory failure
- 492.8 -- Other emphysema
- 491.21 -- Obstructive chronic bronchitis with [acute] exacerbation
- 482.x -- Other Bacterial Pneumonia
- 515 --Post-inflammatory pulmonary fibrosis
- 415.19 -- Other pulmonary embolism and infarction
- V44.0 -- Tracheostomy status
- 428.0 -- Congestive heart failure, unspecified
- 162.5 -- Malignant neoplasm of lower lobe, bronchus or lung
- 340 -- Multiple sclerosis
- 799.1 -- Respiratory arrest.

The patient's condition should reveal acute or chronic respiratory failure. Your pulmonologist may have used the generalized term "respiratory failure" in his documentation when a patient has significant difficulty in breathing. Make sure to clarify from your physician whether you should report 518.81 for acute respiratory failure, or if she wants you to assign 518.84 for acute on chronic respiratory failure.

Example: Your pulmonologist treats a patient with end-stage COPD who has consistently altered carbon dioxide and

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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.

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 help 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 with the proper respiratory failure code. If the patient has respiratory failure associated with pneumonia (for example, 486, Pneumonia, organism unspecified) or heart failure (428.0), report the appropriate ICD-9 codes in addition to the correct respiratory failure code.

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