

# PULMONOLOGY CODING ALERT

Your practical adviser for ethically optimizing coding, payment, and efficiency in pulmonology practices

2009, Vol. 10, No. 12 (Pages 89-96)

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## Eliminate VAP Uncertainty With Clear Diagnosis Parameters and E/M Options

▶ **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 pulmonologist 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](http://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, pulmonologists 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 pulmonologist provides, observes **Becky Zellmer, CPC, MBS, CBCS**, medical billing and coding supervisor for SVA Healthcare in Milwaukee.

**Option 1:** For instance, if the pulmonologist 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. *Note: See Pulmonology Coding Alert, Vol. 10, No. 10 for more on ventilator management coding and reimbursement comparisons between these and other E/M codes.*

**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 MedLearn Matters article MM5993.*

**Treatment:** Most patients with suspected VAP will receive broad spectrum antibiotics (extended spectrum penicillins, cephalosporins, or quinilones), says Gordon. Since a ventilator-assisted patient would be a hospital inpatient or long-term care resident, the facility, rather

## CONTACT INFORMATION

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## Avoid Unnecessary Ire from CMS: 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 “non-reimbursable 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., says **Alan L. Plummer, MD**, professor of medicine in the division of pulmonary, allergy, and critical care at Emory University School of Medicine in Atlanta. “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 broncho-alveolar lavage with a new or enlarging infiltrate chest X-ray, relates Young. Search for another diagnosis if cultures are negative. For more on VAP diagnoses, refer to the cover page article in this issue. □

than the pulmonologist, 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](http://www.thoracic.org/sections/publications/statements/pages/mtpi/guide1-29.html). □

## Master Pulmonary Diagnoses Coding With These Proven Tips

► **Focusing on acute conditions, exacerbations can whip these claims into shape.**

Correctly reporting asthma, acute bronchitis, chronic obstructive pulmonary disease (COPD), obstructive bronchitis, and emphysema depends on the pulmonologist's documentation in the patient's medical record. Making sure the documentation supports the patient's diagnosis and that you code for any associated acute conditions will ensure that you're correctly reporting pulmonary diagnoses.

### Check for Manifestations When Choosing Asthma Code

You can find all the asthma codes in the 493 category of the ICD-9 codes. Look to 493.2x for asthma with airflow limitation. Airflow limitation may occur in asthmatic patients with persistent disease or those patients with asthma of long duration.

The three asthma codes with airflow limitation demonstrated by pulmonary function testing you'll choose from are:

- 493.20 — *Chronic obstructive asthma; unspecified*
- 493.21 — *... with status asthmaticus*
- 493.22 — *... with (acute) exacerbation.*

COPD can be associated with asthma. When your physician diagnoses both COPD and asthma together, you'll refer to his documentation in the medical record to

*(Continued on next page)*

settle on a code from the three codes listed above. Thus, you would use these three codes for asthma with airflow limitation or for asthma with the nonspecific diagnosis of COPD. When assigning 493.2x, follow these guidelines:

If your physician documents status asthmaticus with airflow limitation with or without COPD, you should report this diagnosis first. Assign the fifth digit of “1” in this case (493.21), not the fifth digit of “2” (493.22), says **Cheryl Klarkowski, RHIT**, coding specialist with Baycare Health Systems in Green Bay, Wis.

Assign only an asthma code with the fifth digit “1.” “Status asthmaticus” refers to a patient’s failure to respond to therapy administered during an asthmatic episode and is a life-threatening complication that requires emergency care. It supersedes any type of COPD, including that with acute exacerbation (493.22) or acute bronchitis. It is inappropriate to assign an asthma code with fifth digit “2” (... *with acute exacerbation*) together with an asthma code with fifth digit “1” (... *with status asthmaticus*).

**Warning:** Most payers may reject unspecified codes, such as 493.20, when ICD-9 provides a more specific code. When possible, ask your physician whether the patient has status asthmaticus or an acute exacerbation to avoid using the unspecified code as a “catch-all” code for all types of asthma with airflow limitation or COPD. Remember that if the patient doesn’t exhibit either manifestation, your only option is to use 493.20.

### Use 491.22 for Obstructive Bronchitis with Acute Bronchitis

Another common condition that is associated with airflow limitation is chronic obstructive bronchitis. When your physician documents chronic obstructive bronchitis with an episode of acute bronchitis, you should report 491.22 (*Chronic bronchitis; obstructive chronic bronchitis; with acute bronchitis*), Klarkowski says. You shouldn’t report 466.0 (*Acute bronchitis*) for the obstructive chronic bronchitis since 491.22’s code descriptor specifies acute bronchitis.

**Tip:** If your physician documents that a patient has acute bronchitis with chronic obstructive bronchitis that is causing an acute exacerbation, the combined bronchitis (chronic with acute bronchitis) supersedes the exacerbation (491.21, ... *with [acute] exacerbation*) or the acute condition alone (466.0), according to ICD-9-CM Guidelines. Therefore, you should still report 491.22 for

the acute bronchitis with chronic obstructive bronchitis. But if the documentation states that the patient has chronic obstructive bronchitis with acute exacerbation but doesn’t mention acute bronchitis, you should report 491.21.

If the patient has emphysema in addition to chronic obstructive bronchitis, you should use code 491.20 (...*without exacerbation*) unless the patient has an exacerbation (491.21) or acute bronchitis (492.22).

**Exception:** If your physician diagnoses COPD and there are no other manifestations or conditions that document chronic bronchitis or emphysema, you should use 496 (*Chronic airway obstruction, not elsewhere classified*).

### Report COPD Dx after Confirmation

Before a COPD diagnosis code is confirmed, be sure the documentation includes a listing of signs, symptoms, and conditions to report as the reason for work-up.

“Unfortunately, almost all the diseases of the lungs manifest themselves in a very similar fashion: shortness of breath and cough,” says **Pierre Edde, MD**, founder of [www.pesbilling.com](http://www.pesbilling.com) in Uniontown, Pa. “By themselves, they are not specific for any disease entity. Therefore, clinical evaluation, based on a detailed history including tobacco use past or present, is of prime importance. Once clinically suspected, radiographical and physiological evaluations will complement the workup in order to make a diagnosis.”

When billing for these studies, the physician may report only the sign or symptoms that prompted the test. Do not report a “suspected” or “possible” diagnosis (for

## You Be the Coder

### Rest Home Service Versus CPO

**Question:** *A new patient who resides in an assisted living facility was treated for emphysema, hypertension, and new onset cough by the visiting physician. Can we still report this with 99339 or 99340?*

Michigan Subscriber

**Answer:** Found on page 95. □

instance, COPD) before it is confirmed. Airflow limitation documented by pulmonary function testing must be present before you can confirm COPD in a patient with a smoking history.

Your physician should document the tests he orders, such as X-rays (71010-71035) and pulmonary function tests (PFTs, 94010-94060). Make sure the physician includes enough detail in the medical record to support confirmation of the COPD diagnosis, particularly noting the pulmonary function tests (94010 or 94060). □

## Don't Overlook 3 Key Coding Opportunities for Pulmonology Claims

### ► You could be turning away your rightful reimbursement for scores of services.

Medicare coding rules are complex and challenging, and sometimes it's difficult to know which services you can rightfully report. But if you're up to speed on these key coding practices, you'll be raking in deserved pay:

**1. Mine those modifier 59 opportunities.** Some coders assume that if the Correct Coding Initiative (CCI) forbids reporting two codes on the same date, that's the end of the story. But in fact, you may be missing out on some legitimate cases where CCI allows you to use modifier 59 (*Distinct procedural service*) to override an edit.

Always scan the CCI edits to see which code pairs can be overridden when appropriate. Of course, you should use modifier 59 only when the services are separate, distinct, and medically necessary.

**Example:** The need for separate pulmonary function testing (for instance, 94060, *Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration*) and simple pulmonary stress testing (94620, *Pulmonary stress testing; simple [e.g., 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry]*) is a CCI edit that permits separate reporting, but only when it is medically necessary to override the edit. In this example, you would report 94060, 94620-59, when permitted.

**2. Keep modifier 50 in mind.** Many procedures are inherently unilateral, and you won't receive full reimbursement for bilateral versions of those procedures unless you append modifier 50 (*Bilateral procedure*).

**Watch out:** Coders often forget modifier 50 when the pulmonologist performs bilateral thoracenteses on a patient on the same day. To report bilateral services, append modifier 50 to 32421 (*Thoracentesis, puncture of the pleural cavity for aspiration, initial or subsequent*) on a single line item with a unit of "1", advises **Carol Pohlig, BSN, RN, CPC, ASC**, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia. When appropriate, this will yield 150 percent of the Medicare allowable rate: 100 percent for the initial procedure and 50 percent for the second. Remember, bilateral surgeries are defined as procedures performed on both sides of the body during the same operative session or on the same day (such as 31622, *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing [separate procedure]*). Procedure codes containing the terms "bilateral" or "unilateral or bilateral" in their definitions are not subject to bilateral pricing (meaning 150 percent reimbursement), says Pohlig. Additionally, not all procedures qualify for bilateral payment. Check the payment policy indicators for each code in the Physician Fee Schedule at [www.cms.hhs.gov/PFSlookup/02\\_PFSSearch.asp](http://www.cms.hhs.gov/PFSlookup/02_PFSSearch.asp).

**3. Appeal when you feel you've been wronged.** Because many practices fear being labeled "trouble-makers" or even worse yet, non-compliant with the False Claims Act's regulations, they accept Medicare payers at their word — and this isn't always a good idea.

If your MAC denies your claim or requests a refund, research the issue before you take the payer's word for it.

"At the outset, I would caution against rolling over with regard to 'alleged' overpayments," says **Robert Liles, Esq.**, a health care fraud defense attorney with Liles Parker in Washington, D.C. "If it is a clear overpayment, sure, give the money back. However, if the claims were properly submitted, fight it!" he says.

You should appeal any time you feel your payer has wrongly denied your claim or incorrectly requested a refund. Medicare payers "are getting to be almost as bad as third-party payers," Liles says. "There seems to be a knee-jerk reaction to certain claims and they are automatically denied, regardless of their merit." □

## READER QUESTIONS

### Learn How to Code Multiple Xolair Injections

**Question:** Often, asthma patients must receive multiple administrations of Xolair and I am not sure how many times I can report 96372 for one encounter. Could you provide an example?

Wyoming Subscriber

**Answer:** To help guide you through your next encounter with Xolair, consider this case scenario: An established patient with atopic asthma reports to the pulmonologist for a scheduled Xolair injection session. Under direct physician supervision, the nurse practitioner gives the patient three separate injections of Xolair (each shot is 50 mg).

On the claim, you would report the following:

- 96372 (*Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular*) for the first Xolair injection.
- 96372 appended with modifier 76 (*Repeat procedure or service by same physician*) for the second injection

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- 96372-76 for the third injection
- 493.00 (*Extrinsic asthma; unspecified*) linked to all the injection codes for the patient's condition
- J2357 (*Injection, omalizumab, 5 mg*) x 30 for the supply of Xolair.

### Don't Get Stumped by Observation Care

**Question:** I am not sure when to use observation care versus subsequent hospital care. Can you shed some light on which conditions may point to the need for one or the other?

Minnesota Subscriber

**Answer:** By definition, a physician admits someone to observation because she's trying to determine whether the patient's condition requires extended treatment in an inpatient setting. Use these two examples to help you choose an appropriate code:

**Example 1:** A 68-year-old patient with bronchiectasis and a pleural effusion undergoes thoracentesis at the hospital. A few hours later, the patient is admitted to observation because a post-thoracentesis chest X-ray demonstrates a mild- to moderate-size pneumothorax. The pulmonologist performs a detailed history and a detailed examination along with straightforward medical decision making, then places the patient on mask oxygen therapy and schedules a repeat chest X-ray that night.

On the claim, report 99218 (*Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity*) for the observation with ICD-9 codes 494.0 (*Bronchiectasis without acute exacerbation*), 511.9 (*Unspecified pleural effusion*), and 512.0 (*Spontaneous tension pneumothorax*) appended to prove medical necessity.

**Example 2:** A 65-year-old patient with moderate airflow limitation due to chronic bronchitis and

### Newsletter Question or Comment?



If you have a question or comment about the contents of this publication, please contact the editor, Liisa Sullivan, at [liisa.sullivan@verizon.net](mailto:liisa.sullivan@verizon.net).

emphysema is admitted to observation for acute bronchitis. The pulmonologist performs a comprehensive history and a comprehensive examination along with medical decision making of high complexity. Initially, the saturation is satisfactory and the provider starts the patient on antibiotics and bronchodilators by inhalation. Within two hours, the patient's condition begins to deteriorate, the saturation falls, and the pulmonologist decides to admit the patient to the hospital.

This is a hospital care service, not an observation. On the claim, report 99223 (*Initial hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical*

*decision making of high complexity*) for the initial evaluation with 491.22 (*Obstructive chronic bronchitis; with acute bronchitis*) to describe the acute bronchitis, complicating the patient's chronic bronchitis and emphysema.

**Watch out:** The physician may not always have control over what type of stay the patient requires. If the patient does not meet the payer's guidelines for acuity, you may downgrade the intended inpatient stay to an observation stay. If this happens and the physician learns of it in a timely manner, the physician may report the appropriate observation care code instead of the inpatient care code.

## You Be the Coder

(Question on page 92)

### Rest Home Service Versus CPO

**Answer:** The domiciliary or rest home service done by the physician in this example is an E/M service and should not be confused with codes for care plan oversight (CPO) of a patient in a home, domiciliary, or rest home, which includes an assisted living facility (99339-99340). Instead, use E/M service codes for new-patient domiciliary, rest home, or custodial care services (99324-99328), depending on the level of the service.

In your example, suppose the physician visited the new patient in the assisted living facility and was able to assess the patient's medical condition from a detailed history and detailed examination and proceeded to treat and manage the patient using moderate medical decision making. It would be appropriate to report this as 99326 (*Domiciliary or rest home visit for the evaluation and management of a new patient ...*).

If the physician provides a higher level of service than the above example, then use the other applicable new-patient codes for this category from 99325-99328.

**Beware:** Medicare and other insurers typically do not recognize codes 99339-99340. They consider these services "bundled" and not separately payable to any provider. □

### Can You Bill Incident To Using 1 NPI?

**Question:** *Is there any circumstance in which a group can bill all services and all providers (including other physicians) under just the medical director? I know we can bill nonphysician practitioner (NPP) services incident to another physician. What about to other physicians?*

California Subscriber

**Answer:** No, you cannot always bill services for all providers under a group's medical director. One reason is because you may not bill one doctor incident to another doctor. Incident to rules don't apply here because they pertain to care rendered by an NPP incidental to the plan of care established by the physician. The NPP must have an identifiable relationship with the physician (such as a leased or direct employee of the group practice).

**Bottom line:** It is never acceptable to bill services provided by one physician under another physician's name or national provider identifier (NPI). Physician billing under the name of a physician who did not perform the service will lead to denials or refund requests with citations that the service was "reported under the wrong provider's name." Report the service under the NPI of the performing physician.

You can, however, report NPP services incident to a physician instead of the NPP's using the physician's NPI if the visits meet all the requirements of incident to services. The NPP could be a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist — as

(Continued on next page)

long as the NPP meets state and federal guidelines to provide the service. The NPP must be “licensed by the state under various programs to assist or act in the place of the physician,” according to the *Medicare Benefit Policy Manual*, Chapter 15.

**Best bet:** Check your state and local Medicare regulations for NPP qualifications. If the NPP does not meet one or both sets of guidelines, don’t bill incident to for physician-level services (such as 99212-99215, *Office or other outpatient visit ...*).

**Keep in mind:** In order to bill the service under the medical director’s NPI, there has to be a plan of care for the patient’s condition (and the plan of care may have been developed by the patient’s regular physician and not necessarily the medical director). Plus, the medical director must be physically on site in the office suite when the NPP is providing the service you are billing. However, if the patient’s attending physician is also present in the suite during the service, it is always advisable to report the service under the attending physician’s NPI instead of the medical director. This will prevent patient complaints and questions about the service being billed under a physician that the patient has never met.

— *The answers to the Reader Questions and You Be the Coder were provided and reviewed by Alan L. Plummer, MD, professor of medicine in the division of pulmonary, allergy, and critical care at Emory University School of Medicine in Atlanta; and Carol Pohlig, BSN, RN, CPC, ASC, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia.* □

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