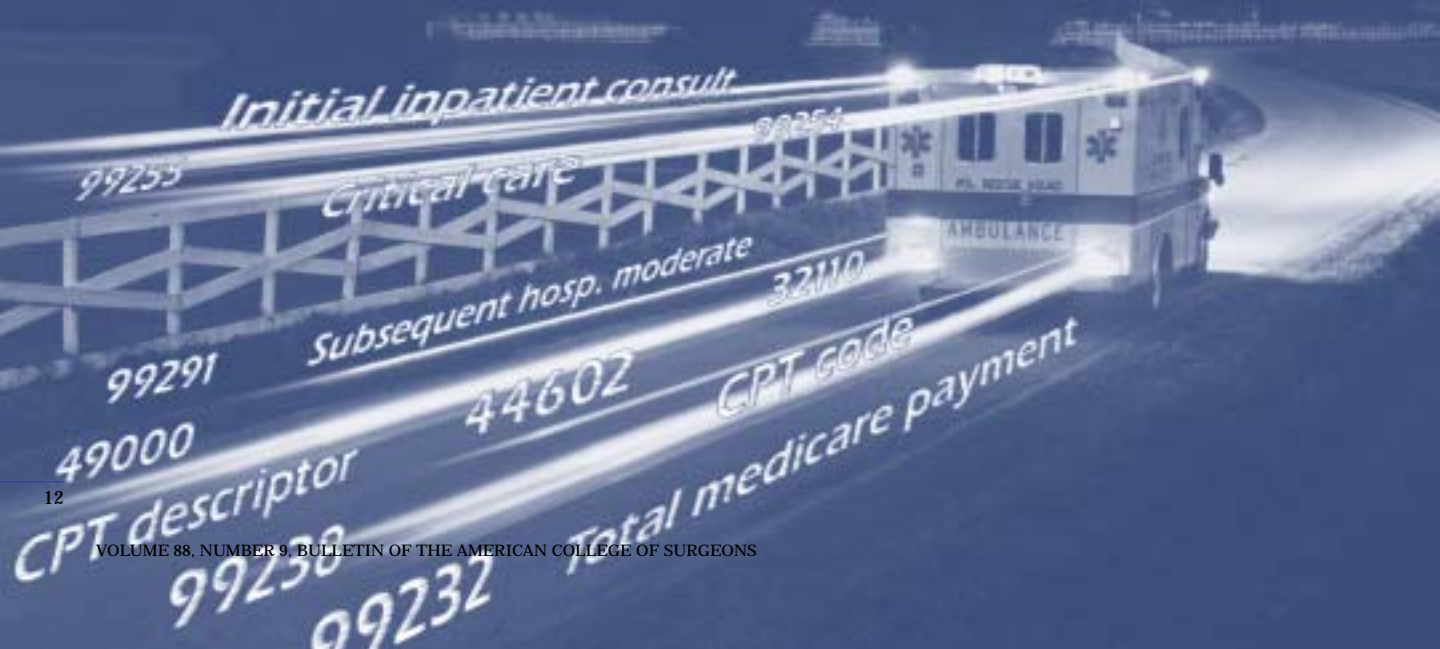


Trauma services: Coding for optimal practice management

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Trauma is a common condition treated regularly by most practicing surgeons of all specialties in all parts of the country. Many trauma centers have surgeons on staff who specialize solely in the care of the trauma patient, along with multispecialty trauma teams to help and assist. At the other extreme, a solo general surgeon often functions as the trauma surgeon, the intensivist, and even the triage officer in more rural areas. Trauma occurs with multiple simultaneous presentations to the emergency room at the most inopportune times, frequently in the dead of night. Proper attention to the coding aspects of patient care is essential, especially if the surgeon expects to be reimbursed fairly.

Trauma involves every organ system, and requires the medical as well as the surgical expertise of the attending surgeon. Thanks to modern diagnostic and therapeutic methods, trauma care has evolved, and an intensive care/nonoperative management mode is being used more frequently. Therefore, efficient coding of the care for trauma patients involves knowing about more than just the major surgical procedure codes. Full knowledge of the extent and application of evaluation and management (E/M) codes is essential for the surgeon caring for trauma patients. Therefore, it behooves surgeons who care for trauma patients, from the traumatologist to the solo general surgeon, to learn to use all of the coding tools available to ensure fair and adequate reimbursement for the services they provide.

In practice management audits performed across the U.S., we have found that surgeons (particularly general surgeons) typically undercode E/M visits, and underuse several important coding tools. This article reviews important aspects of these E/M codes, including the proper use of the critical care and consultation codes, of modifiers for coding during the global surgical period, and of the little-used but powerful "coordination/counseling guide" as a method of judging time for appropriate coding.

Finally, to borrow a phrase from the Advanced Trauma Life Support® Course (ATLS®), we will then "put this all together" and present four clinical trauma vignettes that will exemplify these coding lessons and demonstrate the typical reimbursement resulting from correctly using the E/M coding system.

Lesson #1

The ATLS initial survey followed by a secondary survey usually qualifies for coding at an upper-level encounter.

Most surgeons are familiar with and have completed an ATLS course. Basic to that program is the concept of an initial survey, including an AMPLE history (Allergies, Medications currently used, Past illnesses/Pregnancy, Last meal, and Events/Environment related to the injury), followed by a head-to-toe secondary survey. Most emergency medical technicians and nurses also capture the past and social history of a patient in their assessment process. Assuming that the surgeon performs and *fully documents* this initial evaluation and secondary survey, that service should qualify for one of the highest levels of E/M encounters. The level of care that must be documented, using the 1995 E/M guidelines, requires a detailed or comprehensive history and physical exam, plus the patient must require a level of decision making that is at the moderate or high level of complexity.*

This documentation process need not be hard or arduous. Surgeons are allowed to incorporate into their evaluation and history taking all of the information available to them, including the ambulance run sheet, nursing history and evaluation forms, and so on. The surgeon may incorporate this information by either copying/dictating the information, or with a note indicating that they have reviewed it. Remember, however, that if the history taking, physical examination, or decision making is not documented by the surgeon, it didn't occur. Therefore, good documentation by the use of trauma flow sheets (like the ones in the ATLS manual), dictation templates, or other methods is most important. To assist surgeons in coding, Table 1 (p. 14) contains the *Current Procedure Terminology* (CPT)[†] codes and documentation guidelines for the most common and appropriate initial care codes.

*1995 Evaluation and Management Guidelines. Web site: <http://cms.hhs.gov/medlearn/1995dg.pdf>

†All specific references to CPT terminology and phraseology are: CPT only 2002 © American Medical Association. All rights reserved.

Lesson #2

Complexity of decision making determines whether to code the higher or highest-level code. Most multiple-trauma or emergency procedures qualify for the highest level of decision making.

Assuming that the initial evaluation is completed and documented, what factors determine whether to use the highest-level code? As the lowest section of Table 1, below, indicates, the history and physical examination components are the same for both of the upper level codes, meaning that decision making becomes the criti-

cal element determining the level of coding.

Decision making has three components: (1) the number of diagnosis or treatment options; (2) the amount and/or complexity of data to be reviewed; and (3) the risk complication and/or morbidity or mortality. In general, the number of treatment options and amount of data to be reviewed is extensive for most badly injured patients. This leaves the level of risk as the final arbiter of level of coding. The Table of Risk from the 1995 guidelines for these upper two levels of risk is provided in Table 2, page 15. As that table indicates, a patient presenting with multiple trauma or requiring emergency surgery

Table 1: Initial evaluation codes for trauma

1995 documentation guidelines for evaluation/management services					
History					
Type of history	History of present illness (HPI)	Review of symptoms (ROS)	Past, family, and/or social history (PFSH)	CPT code Hospital, initial	CPT code Hospital consult
Detailed	Extended (4)	Extended(2-9)	Pertinent (1)	99221	99253
Comprehensive	Extended (4)	Complete (10)	Complete (2-3)	99222/99223	99254/99255
Examination					
Type of examination	Body areas	Organ systems		CPT code Hospital, initial	CPT code Hospital consult
Detailed	An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).			99221	99253
Comprehensive (8 of 12)	A general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).			99222/99223	99254/99255
Medical decision making					
Type of decision making	Number of diagnosis or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	CPT code Hospital, initial	CPT code Hospital consult
Low complexity	Limited	Limited	Low	99221	99253
Moderate complexity	Multiple	Moderate	Moderate	99222	99254
High complexity	Extensive	Extensive	High	99223	99255

would qualify for the level of risk being graded as high, thus qualifying the E/M code to be at the *highest* level, assuming the history and physical examination meet the previously mentioned circumstances.

Lesson #3

For patient entry into the trauma system, the surgeon should usually code as a consultant.

Patients enter the trauma system by many routes, but in most cases the end result is one of three management options:

1. Evaluation in the emergency room (ER) followed by admission to the hospital.
2. Observation in the outpatient/ER area.
3. Discharge from the ER with follow up in the office.

In most areas of the country, an ER physician will be involved with the initial triage and perhaps subsequent care of the trauma patient. When the surgeon is called to see the trauma patient, he or she then becomes a consultant to the emergency room physician as long as three simple guidelines are followed. To qualify as a consultation, the encounter must meet the following criteria: (1) the surgeon's assistance must be requested by another physician (or another appropriate source); (2) the request for and need for the consultation must be documented in the patient's medical record; and (3) the consultant must prepare a written report and provide it to the physician requesting the opinion. Because both physicians use a common medical record, such as trauma flow sheets or ER progress notes, it is easy for them to appropriately document the care given and the ra-

Table 2: Table of Risk—Modified for trauma patients

1995 Documentation Guidelines

Level of risk	Presenting problem(s)	Diagnostic procedure(s) ordered	Management options selected
Moderate	<ul style="list-style-type: none"> • Acute illness with systemic symptoms, such as pyelonephritis, pneumonitis, colitis • Acute complicated injury, such as head injury with brief loss of consciousness 	<ul style="list-style-type: none"> • Physiologic tests under stress • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors • Obtain fluid from body cavity 	<ul style="list-style-type: none"> • Minor surgery with identified risk factors • Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors • Prescription drug management • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	<ul style="list-style-type: none"> • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, such as multiple trauma, acute myocardial infarction (MI), pulmonary embolus, severe respiratory distress, peritonitis, acute renal failure • An abrupt change in neurologic status, such as seizure, transient ischemic attack (TIA), weakness, or sensory loss 	<ul style="list-style-type: none"> • Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors 	<ul style="list-style-type: none"> • Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous, or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

tionale for the consultation, and to communicate back to the requesting physician (the ER physician) in written form. The codes used are for an office or other outpatient consultation (codes 99241-99245).

Incidentally, a surgeon may report consultations even if he or she initiates diagnostic and/or therapeutic services during or subsequent to the consultation. Any specifically identifiable CPT code performed on the date of the consultation should be reported separately, using modifier 25.

The use of a consultation code by the surgeon (as opposed to an initial hospital care code) is an important concept because there is a small, but not insignificant, difference in the reimbursement amounts for these codes compared with others the surgeon might use. Table 3 (right) gives the average 2003 Medicare payment for the highest level of the codes the surgeon might consider reporting for these two types of codes. In the case of a surgeon who first performs a consultation and then admits the patient to the hospital, from the Medicare standpoint, the surgeon would charge for the consultation performed, but not charge for the admission (in other words, would not use any of the Initial Hospital Care codes in addition to the Consultation codes). For other insurers, local policies usually follow Medicare policy, but may be different, and the surgeon should consult other insurance carriers' payment policy for advice.

Table 3: Initial encounter for trauma patients

CPT code	2003 MFS descriptor	Medicare payment
99221	Initial hospital care	\$ 65.85
99222	Initial hospital care	109.25
99223	Initial hospital care	151.92
99253	Initial inpatient consult	96.01
99254	Initial inpatient consult	137.95
99255	Initial inpatient consult	189.81

Lesson #4:

Proper use of the critical care codes can be rewarding.

Many surgeons don't know whether to use a critical care code, or the standard E/M codes. In general, the level and length of care that they deliver to a patient justify the use of these codes. There are some important differences in these codes and the usual E/M codes. We will focus on two: the definition and time.

Critical care is defined in CPT as follows:

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient.

- A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.
- Critical care involves high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition.
- Examples of vital organ system failure include, but are not limited to:
 - central nervous system failure,
 - circulatory failure,
 - shock,
 - renal, hepatic, metabolic and/or respiratory failure.[‡]

Care given by the trauma surgeon to critically ill patients often fit these criteria.

It is important to note that the determination of critical care is based not only upon the severity of the illness but on time as well. The surgeon must be present at the bedside or immediately available to the patient to qualify for critical care. Time includes the following: coordinating care with other physicians; obtaining a history from others when the patient cannot give a full and comprehensive history; or discussing

[‡]American Medical Association: *Current Procedural Terminology (CPT) 2003*. Chicago, IL: American Medical Association, 2003.

the course of treatment with family members when the patient is unable to participate.

The time does not have to be continuous, but must be measured in increments from at least 30 minutes up to 74 minutes for the base code (code 99291) and 30-minute increments thereafter, using code 99292. Assuming that a surgeon delivered critical care in one 60-minute increment, followed by three 20-minute increments throughout the day, this care would be coded as 99291 \times 1, and 99292 \times 2. The surgeon needs to document the care delivered and the time he or she was in attendance with the patient.

Some other important facts to remember about using the critical care codes include:

- If a patient is in an intensive care area, but either the time spent is less than 30 minutes, or the level of care doesn't meet the above criteria, then the surgeon should use the appropriate level of hospital visit or consult code for the encounter.

- In some instances, surgeons may need to accompany a critically ill patient during transport between facilities. The critical care codes (99291 and 99292) are used for coding this care if the patient is 24 months or greater in age. For patients less than two years old, use the pediatric transport codes (99289 and 99290).

- For any given period of time spent providing critical care services, the surgeon must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

- Critical care and other E/M activities may be provided and coded for on the same patient on the same day. Thus, if a patient was seen earlier in the day and then deteriorated clinically and required subsequent critical care, both the earlier E/M service and later critical care may be reported.

Lesson #5

Use appropriate modifiers to report E/M services not related to the global period of a surgical procedure.

Many surgical procedures have global periods of zero, 10, or 90 days. E/M work related to the global surgical procedure is included in that work value and payment for a given code. However, there are some exceptions to that rule,

which allow payment if the appropriate modifier and diagnosis code are used to report those services.

Modifier -57, Decision for surgery is added to an E/M code if the surgeon sees the patient and then, based upon the evaluation of the patient, decides to proceed with surgery within that day.

Modifier -24, Unrelated E/M service in the global period is used if the surgeon performs an E/M service that is unrelated to a 10- or 90-day global surgical procedure done in the global period. An unrelated diagnosis and diagnosis code must be included with the E/M service that describes the problem for which the E/M service is being performed. For example, when seeing a patient during the global period of a small bowel repair due to injury (ICD-9-CM code 863.30) and who also is diagnosed and treated for a urinary tract infection, it is possible to code for an office visit (code 99212-24) with an ICD-9-CM code different from the one used for the small bowel repair (ICD-9-CM code 599.0, *Urinary tract infection, site not specified*).

Modifier -25, Separate E/M service on same day as surgical procedures is used when the surgeon performs a separate E/M service on the same day as a minor procedure.

This situation typically occurs when the patient undergoes insertion of a central venous catheter (36489) or a chest tube (32020). An unrelated diagnosis should be included with the separate E/M service that describes the problem for which the E/M service is performed.

Lesson #6

Time can be an ally. Use the "Counseling and coordination of care" section of the E/M guidelines to properly code for some of the work provided in caring for trauma patients.

Several codes are useful when time is a factor in determining the level of coding. In many cases, the work involved in coordinating multiple surgeries between other specialists, talking with family members, planning rehabilitation treatment, and so on, falls upon the trauma surgeon as part of the post-trauma phase of care. Many surgeons fail to code appropriately for this

work, because they believe that any E/M encounter must meet the documentation guidelines, or “bullets.” However, even if the bullets or documentation guidelines for the history, physical exam, or decision making are unmet, the work and time spent may be reported and charged for based upon the time spent in that activity.

This aspect of E/M coding, which is called “counseling and coordination of care,” is explained in CPT as follows:

When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital...), then time may be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members... The extent of counseling

and/or coordination of care must be recorded in the medical record.

The standard times for various E/M encounters are included in Table 4, below. As an example, if a hospitalized patient requires 35 minutes of time for that day’s care, which includes at least 18 minutes of counseling and coordination of care, then the surgeon could report those services as a 99233. Of course, this is permissible only if the patient is not in the global period of an operation that the surgeon performed.

These standard times are also important for reporting E/M services in which the surgeon spends more than the typical time of an E/M encounter. This frequently occurs for trauma, where the surgeon is present during the sometimes-long evaluation and stabilization process, but the severity of illness and intensity of care delivered do not rise to the critical level.

Use the prolonged service codes when the face-to-face time for the E/M service exceeds

Table 4: Time-based codes for trauma

CPT code	2003 CPT descriptor	Standard Medicare payment	Coordination/ time (minutes)	Counseling >50% time
99214	Office/outpatient visit, est.	\$ 56.65	25	13
99215	Office/outpatient visit, est.	91.23	40	20
99222	Initial hospital care	109.25	50	25
99223	Initial hospital care	151.92	70	35
99232	Subsequent hospital care	54.07	25	13
99233	Subsequent hospital care	76.88	35	18
99253	Initial inpatient consult	96.01	55	28
99254	Initial inpatient consult	137.95	80	40
99255	Initial inpatient consult	189.81	110	55
99354	Prolonged service, office	89.76	60	
99355	Prolonged service, office	89.02	Each 30	
99356	Prolonged service, inpatient	87.18	60	
99357	Prolonged service, inpatient addtl. 30 min	87.55	Each 30	

Table 5: Common trauma operations and the average Medicare payment

CPT code	CPT descriptor	Medicare payment
20103	Exploration, penetrating wound, leg	\$ 323.60
49000	Exploratory laparotomy	688.32
38100	Splenectomy	813.90
44602	Small bowel repair, trauma	863.77
44120	Resection small bowel, trauma	943.12
32110	Thoracotomy with hemorrhage control	1,365.73

the time allotted for the highest-level service (level 5) by over 30 minutes. Hence, if the time for an initial inpatient consultation takes greater than 140 minutes, report code 99255 for the consult, then code 99356 for the first 30-60 minutes of additional care, and code 99357 for each additional unit of 30 minutes. To report these services in the office setting, use the appropriate E/M service code, code 99354 (30-60 minutes), and code 99355 (each additional 30 minutes).

Putting it all together

Combining good trauma care of the patient with proper coding by the surgeon.

Finally, let's look at four vignettes and the associated coding to see how these six lessons are properly used (see following pages). We have included the average Medicare reimbursement for 2003 for each of the codes mentioned to give an idea of how well the proper coding would be reimbursed. Remember that the geographic adjustment factor used by Medicare will result in different payments. For comparison purposes, we have also compiled common surgical procedures used in the trauma patient in Table 5, left. You will see

how in many cases, proper use of the CPT code book and coding guidelines will help reimburse the surgeon for work that he or she is already doing.

Conclusions

Often surgeons don't fully capture the value of all that they do for patients because of inefficient use of the current CPT codes and modifiers. Trauma care involves both nonoperative and operative care. Wise use of the existing E/M codes by surgeons can result in improved reimbursement for those caring for these challenging patients. The American College of Surgeons continues to lead the way in educating surgeons on proper coding and to help ensure proper reimbursement for the tremendous surgical care delivered by Fellows of the College.

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Vignette #1: Motor vehicle accident (MVA) Fractured pelvis—ICU care, no surgery

- 74-year-old male in MVA with fracture of pelvis and associated large pelvic hematoma—surgeon consulted by ER physician as part of trauma protocol.
 - Other medical problems: Diabetes, HPTN, and COPD.
 - Complete ATLS initial, secondary survey performed by surgeon.
 - Stabilized in ER—fluid, blood transfusions, other.
 - Central line inserted—36489.
 - CT scans of head/abdomen/pelvis.

- Initial evaluation completed in ER, treatment decision made. Level of care coded: 99255, *Complex consult*.
 - Admission to ICU: patient stabilized in ICU, after transfusions, vasopressors, IV fluids given, labs rechecked, and so on.
 - Time of surgeon in attendance, critical care: 2.5 hours critical care time. Level of care coded: 99291, plus 99292 × 3.
 - Follow serial labs, exams.
 - Hypotensive episode; surgeon evaluates patient and recommends repeating labs, giving

Coding/reimbursement for Vignette #1

Day	CPT code	Description	Modifier	Medicare payment	Total time	Diag. code	Diagnosis
1	99255	Initial inpatient consult	57	\$ 189.81	70	808.43	Multiple closed pelvic fractures with disruption of pelvic circle
1	99291	Critical care	25	200.11	60	808.43	
1	99292	Critical care, addtl.	25	100.06	30	958.4	Traumatic shock
1	99292	Critical care, addtl.	25	100.06	30		
1	99292	Critical care, addtl.	25	100.06	30		
1	99292	Critical care, addtl.	25	100.06	30		
1	99292	Critical care, addtl.	25	100.06	30		
1	99292	Critical care, addtl.	25	100.06	30		
1	36489	Central line insertion		85.34			
2	99291	Critical care		200.11	60		
3	99233	Subsequent hosp. complex		76.88			
4	99233	Subsequent hosp. complex		76.88			
5	99233	Subsequent hosp. complex		76.88			
6	99232	Subsequent hosp. moderate		54.07			
7	99232	Subsequent hosp. moderate		54.07			
8	99232	Subsequent hosp. moderate		54.07			
9	99232	Subsequent hosp. moderate		54.07			
10	99231	Subsequent hosp. low		32.74			
11	99231	Subsequent hosp. low		32.74			
12	99238	Discharge day management		<u>69.16</u>			
		Total Medicare payment		\$1,857.30			

fluid and blood, and repeating CT scans.

- Transfer to radiology for arteriogram of pelvic hematoma.
- Hematoma not bleeding.
- Transfer back to ICU with labs, serial exams by surgeon during remainder of day.
- Total fluid given: Six liters. Total blood transfused: Four units.
- Time of surgeon in attendance, after initial episode, same day: Three discontinuous increments of 30 minutes each, critical care time. Level of care coded: *99292* × 3.
- Total time estimate of surgeon in attendance, day one: 4.5 hours critical care time, including time for discussion of condition of patient with family members.
- Day two: Patient requires intubation and ventilator/fluid management and critical care of one hour total time.

- Total time estimate of surgeon in attendance, day two: One hour of critical care time. Level of care coded: *99291*.

- Days three to five: Patient observed in ICU; patient more stable but requiring decision making of high complexity, but not of critical care standards.

- Total daily time of surgeon in attendance, days three to five: Less than 60 minutes each day. Level of care coded: *99233 level of care* × 3.

- Days six to nine: Patient on floor. Level of care coded: *99232 level of care* × 4.

- Days 10 to 11: Patient continues recuperation on floor. Level of care coded: *99231 level of care* × 2.

- Day 12: Patient ready for discharge home; discharge planning performed. Level of care coded: *99238*.

Vignette #2: MVA Chest, facial, and abdominal trauma—ICU care, and surgical operation

- 32-year-old female in MVA with multiple rib fractures, complex facial lacerations, and abdominal trauma; surgeon consulted by ER physician as part of trauma protocol.

- Complete ATLS initial, secondary survey performed by surgeon.

- Stabilized in ER: Evaluation with CT scan of head, chest, and abdomen, other X rays and labs, administration of IV fluids, and so on. CT scan reveals moderate hematoma of liver. Level of care coded: *99255, Complex consult, modifier -57*.

- Patient stabilized after two hours, admitted to hospital, with patient taken to OR (after stabilization) for surgical repair of facial lacerations.

- Patient has complex repair of 5 cm laceration of scalp and 5 cm laceration of cheek and mouth.

- Patient transferred to ICU for further care and observation of chest/abdominal trauma.

- Total time estimate of surgeon in attendance, day one: Two hours noncritical care

time. Level of care charged/level of care coded: *99255*.

- Day two: Patient requires placement of chest tube for pneumo-hemothorax, hypotensive episode treated with fluids and blood transfusion, and repeat CT scan obtained to rule out increased hemorrhage from liver. Surgeon in attendance and providing critical care.

- CT scan shows no change, patient becomes stable with transfusion and fluid administration.

- Total time estimate of surgeon in attendance, day two: 90 minutes critical care time, not related to repair of facial laceration. Level of care coded: *99291, plus 99292* × 1, *modifier -24*.

- Day three: Patient improved and transferred to floor for further care of chest and abdominal trauma, serial lab, exams, and X rays.

- Total daily time of surgeon in attendance day three: Less than 60 minutes. Level of care coded: *99233, (not related to repair of facial laceration), modifier -24*.

Coding/reimbursement for Vignette #2

Day	CPT code	Description	Modifier	Medicare payment	Total time	Diag. code	Diagnosis
1	99255	Initial inpatient consult	57	\$ 189.81	70	873.59	Open wound of face, other and multiple sites, complicated
1	13121	Repair, complex, scalp, other; 2.6 cm to 7.5 cm				873.51	Open wound of cheek, complicated
1	13132	Repair, complex, forehead, cheeks, chin, mouth, other; 2.6 cm to 7.5 cm				873.59	Open wound of face, other and multiple sites, complicated
2	32020	Tube thoracostomy		212.62		860.4	Traumatic pneumo-hemothorax without mention of open wound into thorax
2	99291	Critical care	24, 25	200.11	60	864.05	Liver injury without mention of open wound into cavity, unspecified laceration
2	99292	Critical care, addtl.	24, 25	100.06	30	864.05	Liver injury without mention of open wound into cavity, unspecified laceration
3	99233	Subsequent hosp. complex	24	76.88		864.05	
4	99232	Subsequent hosp. moderate	24	54.07		864.05	
5	99232	Subsequent hosp. moderate	24	54.07		864.05	
6	99231	Subsequent hosp. low	24	32.74		864.05	
7	99233	Subsequent hosp. complex	24	76.88		864.05	
8	99238	Discharge day management	24	69.16		864.05	
		Total Medicare payment		\$1,066.41			

- Days four to five: Patient improves, chest tube removed and recuperation continues. Level of care coded: *99232 level of care × 2, modifier -24.*

- Day six: Further improvement. Level of care coded: *99231, modifier -24.*

- Day seven: Family arrives from out of town; surgeon holds conference with family

- on patient's condition, and so on. Total time for counseling/coordination of care: 20 minutes. Level of care coded: *upcoded to 99233 level, modifier -24.*

- Day eight: Patient discharged home. Discharge planning performed. Level of care coded: *99238, modifier -24.*

Coding/reimbursement for Vignette #3

Day	CPT code	Description	Medicare payment	Total time
1	99255	Comprehensive hospital consult	\$189.81	
2	99232	Subsequent hosp. moderate	54.07	
3	99238	Discharge planning	69.16	
8	99215	Office/outpatient visit, est.	<u>91.23</u>	45
		Total Medicare payment	\$404.27	

Vignette #3: MVA Chest, facial, and abdominal trauma—minor

- 32-year-old female arrives with history of being in MVA with ejection from vehicle, contusions to chest, minor facial abrasions, dental injuries, and abdominal pain and bruising. Surgeon consulted by ER physician as part of trauma protocol.

- Complete ATLS initial, secondary survey performed by surgeon.

- Stabilized in ER. Evaluation with CT scan of head, chest, and abdomen, other X rays and lab, administration of IV fluids, and so on.

- Patient appeared relatively stable after evaluation, and decision made to place the patient in regular hospital bed for continued monitoring by serial exams and laboratory/X ray studies.

- Total daily time of surgeon in atten-

dance, day one: 1.5 hours. Level of care coded: *99255, Comprehensive hospital consult.*

- Day two: Patient appears stable based upon history, physical exam, and lab values; diet/ambulation started. Dental consult obtained. Level of care coded: *99232.*

- Day three: Patient felt to be stable for discharge home with follow-up in office in one week. Discharge planning. Level of care coded: *99238.*

- One week follow-up: Patient seen back for history and exam, requires 45 minutes total physician time, of which 20-plus minutes is for counseling/ coordinating dental repair, counseling recuperation from injury, and return to work issues. Level of care coded: *upcode to 99215.*

Vignette #4: Fall at home with multiple trauma, subdural hematoma, long bone fracture

- 74-year-old male arrives at ER with history of falling off of ladder at home, with right femoral fracture, broken ribs, small hemothorax, and numerous small abrasions. Patient has period of unconsciousness at home. Surgeon consulted by ER physician as part of trauma protocol.

- Complete ATLS initial, secondary survey performed by surgeon. CT scan of head reveals small subdural hematoma.

- No abdominal trauma detected, hemothorax stable, and orthopaedics and neurosurgery consult on patient.

Coding/reimbursement for Vignette #4

Day	CPT code	Description	Medicare payment	Total time
1	99255	Comprehensive hospital consult	\$189.81	
1	99356	Prolonged service, inpatient	87.18	
2	99291	Critical care	200.11	
3	99233	Subsequent hosp. complex	76.88	
4	99233	Subsequent hosp. complex	76.88	20
5	99233	Subsequent hosp. complex	76.88	
6	99233	Subsequent hosp. complex	76.88	
7	99231	Subsequent hosp. low	<u>32.74</u>	
		Total Medicare payment	\$784.64	

- Patient stabilized. Trauma surgeon coordinates care plans among other surgeons, and patient admitted to ICU for observation.

- Total daily time of surgeon in attendance, day one: 2.5 hours. Level of care coded: *99255, Comprehensive hospital consult, plus 99356 × 1, Prolonged service, inpatient.*

- Day two: Patient has deterioration of neurological exam, CT scan ordered.

- Patient has subdural hematoma, increased in size on CT scan, and is unstable.

- Patient stabilized by trauma surgeons and neurosurgery reviews patient, CT scans, neurosurgery makes decision to operate on subdural.

- Consultation and coordination of care by trauma surgeon between orthopaedics and neurosurgery, necessitating taking patient to surgery for neurosurgery operation, and delaying orthopaedic operation.

- Total time estimate of trauma surgeon in attendance, day two: 90 minutes critical care time, including discussions with family members about patient's condition, and for coordination of care discussions with neurosurgery and orthopaedics. Level of care coded: *99291.*

- Day three: Patient stabilized from neurosurgical procedure, 30 minutes of time for coordination of care with neurosurgery and orthopaedics, orthopaedic surgery planned for day four. Level of care coded: *upcoded to 99233.*

- Days four to six: Patient recuperating from neurosurgery and orthopaedic procedures, trauma surgeon continues to coordinate care with orthopaedic/neurosurgeon, and counsel with family members. 20+ minutes counseling/coordination time documented daily in chart. Level of care coded: *upcoded to 99233.*

- Day seven: Patient transferred to neurosurgical service; trauma surgeon completes final recommendations and signs off. Level of care coded: *99231.*



Dr. Mabry is a general surgeon practicing in Pine Bluff, AR, and assistant professor, department of surgery, University of Arkansas for Medical Sciences. He is a Regent of the College and a member of the General Surgery Coding and Reimbursement Committee.

