

Effectively using E/M codes for trauma care

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rauma typically involves every organ system and requires both the medical and surgical expertise of the attending surgeon. As trauma care has evolved, intensive, nonoperative care has been used more frequently to manage many trauma patients. Consequently, coding for the care of trauma patients is now a more complicated process because it involves knowing not only the major surgical procedure codes, but also how to use evaluation and management (E/M)codes effectively. E/M coding remains an area of difficulty for some surgeons due to the numerous rules and guidelines. Furthermore, Medicare's

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*Department of Health and Human Services. Centers for Medicare & Medicaid Services. Evaluation and Management Services Guide. Available at: http://www.cms. gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ Downloads/eval_mgmt_serv_guide-ICN006764.pdf. Accessed April 17, 2013. decision to not reimburse consultation codes has made coding for E/M services in trauma care even more complicated for those surgeons using the consult codes.

This column provides coding guidance and clinical scenarios on the appropriate use of E/M codes during the care of injured or critically ill patients, including the use of critical care codes, the coordination/counseling guide as a coding alternative to the tradition documentation guidelines ("bullets"), and modifiers for coding during the global surgical period.

ATLS and E/M documentation

Most surgeons are familiar with and have completed an Advanced Trauma Life Support[®] (ATLS[®]) course. The initial assessment and management tool includes a brief primary survey combined with the opportunity to take a patient's history that includes allergies, medications, past illnesses, pregnancy, last meal, and events/ environment related to the injury (AMPLE), followed by a head-to-toe secondary physical exam. Typically, the emergency medical technicians and nurses also capture the past and social history of the patient during their assessment, and this information may be incorporated into the surgeon's initial assessment and management document. If the surgeon performs and fully documents this initial evaluation and secondary survey the service will typically qualify for one of the highest levels of E/M encounters.*

To capture one of the highest level E/M codes, the level of care that must be documented requires a comprehensive history and physical exam and a level of decision making that is of moderate or high complexity. The 1995 guidelines require a general multisystem examination or a

CODING AND PRACTICE MANAGEMENT CORNER

TABLE 1. DOCUMENTATION GUIDELINES FOR E/M CODES FREQUENTLY USED IN TRAUMA PATIENTS: INITIAL EVALUATION

HISTORY									
Type of history	History of present illness (HPI)	Review of systems (ROS)	Past, family, and or social history (PFSH)	d/ Cl	PT code initial iospital care	CPT code hospital consult	Initial observation care	Observe/ discharge same date	Emergency department (ED) visit
Detailed	Extended (4)	Extended (2–9)	Pertinent (1)	99221	99253	99218	99234	99284
Comprehensive	Extended (4)	Complete (10)	Complete 9922 (2–3) 9922		99222/ 99223	99254/ 99255	99219/ 99220	99235/ 99236	99285
			EX	AMIN	NATION				
Type of examination	Body areas/ organ systems		CP ⁻ ir hosp	T code nitial ital care	CPT code hospital consult	Initial observation care	Observe/ discharge same date	ED visit	
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) Twelve elements from at least two body areas/organ systems		9	9221	99253	99218	99234	99284	
Comprehensive (8 of 12)	ve A general multisystem examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)		99 9	9222/ 9223	99254/ 99255	99219/ 99220	99235/ 99236	99285	
	At least two e body areas/or	lements each rgan systems	from nine						
		Μ	EDICAL	DECI	SION N	IAKING			
Type of decision making	Number of diagnosis or management options	Amount and/or complexity of data to be reviewed	Risk o complica and/o morbid or morta	of itions or lity ality	CPT code initial hospital care	CPT code hospital consult	Initial observation care	Observe/ discharge same date	ED visit
Low complexity	Limited	Limited	Low		99221	99253	99218	99234	99282
Moderate complexity	Multiple	Moderate	Modera	ate	99222	99254	99219	99235	99283/ 99284
High complexity	Extensive	Extensive	High	1	99223	99255	99220	99236	99285

complete examination of a single organ system in order to constitute a comprehensive exam. The 1997 multisystem examination requires two bullets from each of the nine organ systems to constitute a comprehensive history and physician exam (see Table 1, this page).

The sickest trauma patients may be unable to provide

history, social, family, and other required E/M information. In these instances, to qualify for the highest level E/M (99223 or 99255), the surgeon must document that the information was unobtainable and document high-complexity medical decision making.

However, if the surgeon does not document the patient's

history, physical examination, or decision making, the level of E/M cannot be justified. Good documentation is important.

Typically the trauma admission forms will cover the multisystem exam, because it is generally recommended that trauma patients receive a comprehensive evaluation. The creation of a standardized evaluation form

TABLE 2. RISK MODIFIED FOR TRAUMA PATIENTS

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Moderate	 Acute illness with systemic symptoms, for example, pyelonephritis, pneumonitis, colitis Acute complicated injury, for example, head injury with brief loss of consciousness 	 Physiologic tests under stress, for example, cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk factors, for example, arteriogram, cardiac catheterization Obtain fluid from body cavity, for example, lumbar puncture, thoracentesis, culdocentesis 	 Minor surgery with identified risk factors Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine Intravenous fluids with additives Closed treatment of fracture or dislocation without manipulation
High	 Acute or chronic illnesses or injuries that pose a threat to life or bodily function, for example, multiple trauma, acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure An abrupt change in neurologic status, for example, seizure, transient ischemic attack, weakness, sensory loss 	 Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography 	 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

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for the history and physical, whether as an admission or consultation, is recommended.

Complexity of decision making helps to determine the level of CPT code billed

When the surgeon fully documents the standard initial ATLS trauma evaluation, the level and complexity of medical decision making may become the critical element in determining the final level of coding. The levels of E/M services recognize four increasingly complex levels of medical decision making (straightforward, low complexity, moderate complexity, and high complexity). Medical decision making refers to the

complexity of establishing a diagnosis and/or selecting a management option based on three components: (1) the number of diagnoses or treatment options; (2) the amount and/or complexity of data to be reviewed; and (3) the level of risks of complications and/or morbidity or mortality.

Typically, trauma care requires extensive treatment options and data review. As such, the complexity of a medical decision may boil down to the level of risk. The 1995 guidelines for the upper two levels of risk are provided in Table 2 on this page. The surgeon would also need to document high complexity for either the number of diagnoses or treatment options or the amount or complexity of data reviewed to capture the highest level charge.

Coding the initial encounter

Care of trauma patients generally involves one of three management options: evaluation in the emergency department (ED) followed by admission to the hospital to the general surgery trauma team or to another specialty's service; observation as an outpatient in the hospital or in the ED area; or discharge from the ED with either follow up in the office or transfer to another hospital.

In most trauma cases, the surgeon will typically determine that the patient requires admission to the inpatient hospital or observation through the general surgery or trauma service.

TABLE 3. 2013 TOTAL INITIAL OBSERVATION, HOSPITAL, SAME-DAY OBSERVATION AND DISCHARGE, AND OUTPATIENT CONSULTATION FACILITY AND NONFACILITY RVUs

2013 TOTAL FACILITY RVUs						2013 TOTAL NONFACILITY RVUS			
СРТ	Initial observation care	СРТ	Initial hospital care	СРТ	Observe/ discharge same date	СРТ	Outpatient consultation	СРТ	ED visit
99218	2.84	99221	2.92	99234	3.86	99241	1.37	99281	0.60
99219	3.87	99222	3.96	99235	4.83	99242	2.58	99282	1.18
99220	5.31	99223	5.82	99236	6.24	99243	3.52	99283	1.76
						99244	5.20	99284	3.37
						99245	6.36	99285	4.93

Because Medicare has stopped reimbursing for consult codes, and some commercial payors have followed suit, it is critically important that surgeons report the disposition of the patient.

When admitting Medicare patients to the hospital, surgeons should bill an initial hospital care code (99221-99223) and not an ED visit code. Medicare also requires that the admitting physician append modifier AI to the initial hospital visit code (9922X-AI). If the patient is admitted to the hospital as an inpatient and the surgeon sees the patient on the hospital unit on the same day of admission, this additional work should be summed into the one initial inpatient admission service code (99221-99223). However, if the patient also receives critical care services on the day of admission, these services are separately reportable. Subsequent hospital care visits per day are coded using Current Procedural Terminology (CPT)[†] codes 99231–99233; day of discharge is coded using CPT code 99238. For trauma services in which multiple physicians may play

different roles (one covers admits, one covers the intensive care unit [ICU]), it will be important to coordinate coding practices.

For payors that follow CPT rules, if a patient is admitted after an ED consultation and is not seen on the unit on the date of admission, only report the outpatient consultation codes (99241–99245). If the surgeon sees the patient on the hospital unit on the date of admission, report all E/M services related to the admission with the initial inpatient admission service code (99221–99223); documentation is key in this situation. If after admission the E/M documentation does not meet the criteria for an initial inpatient admission, the visit should be coded as subsequent hospital care (99231–99232). Do not report both an outpatient consultation and inpatient admission (or observation care) for services on the same day related to the same inpatient stay.

If the patient is admitted to the general surgery service for observation, codes 99218–99220 are reported for the first day of observation. For subsequent observation services, performed on a date other than the initial day of observation care, CPT codes 99224–99226 should be reported. CPT code 99217 is reported when a patient is discharged from observation on a date other than that of initial or subsequent observation care, if a face-to-face encounter occurred on that date. Code 99217 should not be reported in conjunction with a hospital stay.

For patients who receive hospital outpatient observation services and are discharged on the same date of service or who are admitted to the hospital as an inpatient and discharged the same day, the surgeon should report CPT codes 99234–99236. For Medicare patients, the patient must be admitted for at least eight hours but less than 24 hours to report CPT codes 99234–99236. Table 3 on this page describes the 2013 total facility and nonfacility relative value units (RVUs) for total initial observation, hospital, sameday observation and discharge, and outpatient consultations.

In some cases, a patient presents to the ED, and general surgery is consulted, but the patient is not admitted to the hospital. If the patient is a Medicare beneficiary, the surgeon should bill the appropriate level of ED code (99281–99285). Non-Medicare patients are considered

[†]All specific references to CPT (Current Procedural Terminology) codes and descriptions are © 2012 American Medical Association. All rights reserved. CPT and CodeManager are registered trademarks of the American Medical Association.

TABLE 4. 1	2013	TOTAL	INITIAL	HOSPITAL	AND	OUTPATIENT	CONSULTATION
FACILITY	AND	NONFA	CILITY F	RVUs			

	2013 TOTAL	2013 TOTAL NONFACILITY RVUs			
СРТ	Initial hospital care	СРТ	ED visit	СРТ	Outpatient consultation
00221	2.02	99281	0.60	99241	1.37
99221	2.92	99282	1.18	99242	2.58
00222	2.06	99283	1.76	99243	3.52
99222	3.90	99284	3.37	99244	5.20
99223	5.82	99285	4.93	99245	6.36

outpatients until admitted to the hospital, and therefore, the outpatient consultation codes may be reported (99241–99245) if the payor recognizes those consult codes. If the surgeon does not see the patient in a face-to-face visit but advises the ED physician by telephone, the surgeon may not bill for this service. Table 4, this page, describes the 2013 total initial hospital and outpatient consultation for facility and nonfacility RVUs.

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Critical care codes

Critical care codes are E/M codes that may be billed independently or in addition to the typical E/Mcodes often used for trauma patients. However, distinguishing between critical care services and other E/M services can be confusing. The critical care surgeons provide to severely injured patients typically fits the criteria of critical care. However, it is important to note that just because a patient is critically ill or in a critical care unit does not automatically determine whether a service can be billed

*Department of Health and Human Services. Centers for Medicare & Medicaid Services. Evaluation and Management Services Guide. Available at: http://www.cms. gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ Downloads/eval_mgmt_serv_guide-ICN006764.pdf. Accessed April 17, 2013. as critical care. Critical care services require direct personal management by the surgeon. Additionally, the determination of critical care is based not only upon the severity of the illness but on time. Table 5 on page 61 illustrates how to correctly report critical care services.

CPT defines critical care as:

The direct delivery by a physician(s) or other qualified health care professional 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. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life-threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of attention described above.*

Critical care codes 99291 and 99292 are used to report the total time a physician spends providing critical care services on a single date of service, even if the time spent is not continuous. Although the time does not need to be continuous, it must be measured in increments from greater than 30 minutes up to 74 minutes for CPT code 99291, and each 30-minute increment thereafter using CPT code 99292. If a patient is in an intensive care area, but either the time spent is less than 30 minutes or the level of care does not meet the above criteria, the surgeon should use the appropriate level of E/M code for the encounter, such as 99233. For example, if a surgeon delivered critical care in one 60-minute increment, followed by three 20-minute increments throughout the day (120 minutes total time), this care would be coded as 99291 \times 1, and 99292 \times 2. The physician's progress note must document the care delivered

TABLE 5. TOTAL DURATION AND CORRECT CODES FOR REPORTING CRITICAL CARE SERVICES

TOTAL DURATION	CODE TO REPORT
CARE CODES	
Less than 30 minutes	99232 or 99233 or other appropriate E/M code
30–74 minutes	99291 x 1
75–104 minutes	99291 x 1 and 99292 x 1
105–134 minutes	99291 x 1 and 99292 x 2
135–164 minutes	99291 x 1 and 99292 x 3
165–194 minutes	99291 x 1 and 99292 x 4
194 minutes or longer	99291–99292 as appropriate (per the above illustrations)

on the unit and the time spent with the patient or family.

In some instances, a surgeon may need to accompany a critically ill patient during transport between facilities. Critical care codes (99291 and 99292) are used if the patient is 24 months of age or older. For pediatric patients, codes 99466 and 99467 are used to report "the physical attendance and direct face-to-face care by a physician during the interfacility transport of a critically ill or critically injured pediatric patient 24 months of age or younger. Codes 99485 and 99486 are used to report the control physician's non-faceto-face supervision of interfacility transport of a critically ill or critically injured pediatric patient 24 months of age or younger."*

As noted previously, 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 E/M service and critical care may be reported.

For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period. This critical care time may include coordinating care with other physicians, obtaining a history from others when the patient cannot give a comprehensive history, or discussing a specific treatment issue with family members when the patient is unable to participate.

Counseling, coordination of care It is a misconception that an E/M encounter must meet each of the documentation guidelines or "bullets" for the associated service. Even if the documentation guidelines for the history, physical exam, or decision making are unmet, the work and time spent may be reported and are reimbursable as "counseling and coordination of care." CPT defines these activities as follows:

When counseling and/or coordination of care dominates (more than 50 percent) the en-

counter with the patient and/or family (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time shall 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 (for example, foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.*

When counseling or coordination of care occupies more than half of a given E/M visit, the surgeon may use that total time to determine the level of E/M code. In many cases, the work involved in coordinating multiple procedures between other specialists, talking with family members, and planning rehabilitation treatment falls on the trauma surgeon. 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 may

^{*}Department of Health and Human Services. Centers for Medicare & Medicaid Services. Evaluation and Management Services Guide. Available at: http://www.cms. gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ Downloads/eval_mgmt_serv_guide-ICN006764.pdf. Accessed April 17, 2013.

TABLE 6. USING TIME AND PROLONGED SERVICES

CODE	TYPICAL TIME FOR CODE	THRESHOLD TIME TO BILL 99356	THRESHOLD TIME TO BILL 99356 AND 99357				
	Initial h	ospital services					
99221	30	60	105				
99222	50	80	125				
99223	70	100	145				
Subsequent hospital visits							
99231	15	45	90				
99232	25	55	100				
99233	35	65	110				
Inpatient consults							
99251	20	50	95				
99252	40	70	115				
99253	55	85	130				
99254	80	110	155				
99255	110	140	185				

report those services with code 99233. This code is separately reportable if the patient is not in the global period for a procedure performed by the surgeon. The surgeon must document the total time, must indicate that greater than 50 percent of time was spent counseling/coordinating care, and must summarize the counseling/coordination of care work. Use the add-on prolonged service CPT codes (99356 and 99357), in addition to the standard E/M code, when the face-toface time exceeds the time allotted for E/M services at any level, by more than 30 minutes. (See Table 6 on this page.)

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Standard times are also important when reporting E/M services in which the surgeon spends more than the typical time for an E/M encounter. This situation frequently occurs in trauma, where the surgeon is present during the evaluation and stabilization process waiting for computed tomography scans, test results, and so on, but the severity of illness and intensity of care delivered do not rise to the critical care level. Remember, the longer the visit/work time, the longer the percentage of time counseling and coordinating care. Wait time increases work time and, thus, will add to the amount of counseling/care coordination that must be met.

For example, if the time for an initial hospital service takes greater than 125 minutes, report code 99222 for the hospital visit, then code 99356 for the first 30–60 minutes of additional care and code 99357 for each additional unit of 30 minutes.

It is important to note that time has no relevance in the ED when reporting 99281–99285 codes alone.

E/M services not related to the global period

Typically surgical procedures have global periods of 0, 10, or

90 days. E/M work typically performed in the global surgical period is inherent in the payment for a 10- or 90-day global surgical procedure. However, there are some exceptions to that rule, which allow separate payment if the appropriate modifier and diagnosis code(s) are used to report the service(s).

Modifier 24 (unrelated evaluation and management service by the same physician or other qualified health care professional during the postoperative period) is appended to an E/M service during the global period to indicate that the diagnosis or cause for the E/M service is unrelated or not typically seen in relation to the operation. An example would be if a patient has a splenectomy for a ruptured spleen (CPT 38100, splenectomy; ICD-9 865.04, massive parenchymal disruption of spleen), and over the next several days the surgeon manages the patient on a ventilator due to his concurrent flail chest (CPT

To capture one of the highest level E/M codes, the level of care that must be documented requires a comprehensive history and physical exam and a level of decision making that is of moderate or high complexity.

99291-24, critical care, first 30 minutes; ICD-9 807.4, flail chest).

Modifier 25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) is appended to an E/M service to indicate that on the same day as a procedure, the physician performs an E/M service that is a significant, separate, identifiable service from the procedure. Modifier 25 is only used when the procedure performed on the same day is a minor procedure and has a 0- or 10day global period. For example, a surgeon provides critical care for a patient following multiple traumas with head injury and pelvic fracture and places a central line to provide pressors and total parenteral nutrition. These activities would be coded using CPT 36556, insertion of nontunneled central venous catheter; ICD 9 958.4, traumatic shock; ICD 9 263.0, malnutrition of moderate degree; and CPT 99291-25, critical care, first 30 minutes; ICD 9 851.0, cerebral cortex contusion with prolonged loss of consciousness, ICD 9 808.43, multiple closed pelvic fractures.

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 either the same or the following day.

Clinical scenarios

Case 1: A 65-year-old male involved in a motor vehicle accident (MVA) is brought to the ED with a fractured pelvis and small bleed from the spleen. The general surgeon consults.

The patient presents hypotensive but responds to an initial fluid challenge and has acceptable vital signs. Due to poor IV access, the surgeon inserts a central venous catheter using ultrasound guidance. The surgeon then evaluates the patient with a standard ATLS initial, secondary survey, and a contrast CT scan of abdomen and pelvis, along with the standard blood, urine, and electrocardiogram tests. The patient has pain upon palpation of his pelvis. Suspicious of a pelvic fracture, the surgeon performs a focused abdominal scan for trauma (FAST) with image documentation. The FAST exam shows a small amount of blood around the spleen but no other free fluid in the abdomen. The CT scan shows a small tear of the spleen with a small amount of blood and a contained retroperitoneal hematoma caused by a pelvic fracture, but no arterial blush is seen. The surgeon then communicates with the patient's family, the orthopaedic surgeon on call, and the patient's primary care physician and enters orders

for admission to the intensive care unit. The surgeon sees the patient later that afternoon and evening; the patient is stable and requires no vasopressors or operations. However, the patient does require a blood transfusion and adjustment of his pain medications. The patient remains stable and is subsequently moved to a regular floor and is discharged to a rehabilitation facility after a seven-day hospital stay.

The surgeon was in direct attendance with the patient in the ED for 120 minutes—critical care, including care coordination and communication with family. Reportable procedures include:

Day 1

- 99291-25, Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes
- + 99292-25, Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
- + 99292-25, Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
- •99223-25-AI, Initial hospital care



- 36556, Insertion of nontunneled centrally inserted central venous catheter; age 5 years or older
- + 76937-26, Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)
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- 76705-26, Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)
- 76775-26, Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited
- 76604-26, Ultrasound, chest (includes mediastinum), real time with image documentation

Days 2 to 6 •99232, Subsequent hospital care

Day 7

•99238, Hospital discharge day management; 30 minutes or less

Codes 99291 and 99292 are used to report the total duration of time spent providing critical care services. CPT code 99223 is used to report the hospital

admission and includes evaluation and admission to hospital, including later rounding on patient in ICU (noncritical care) on day of admission, accounting for the face-toface time of the subsequent care delivered later that day and complexity of the medical decision making. The critical care and hospital admission are separately reportable. Although the surgeon was called in to consult. the consult codes are not reported because the surgeon decided to admit the patient to his service. The AI modifier is necessary to alert the Centers for Medicare & Medicaid Services (CMS) that the surgeon is the admitting physician. The 25 modifier (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) is necessary on the E/M services because a nontunneled centrally inserted central venous catheter, a minor procedure with a 0-day global period, was performed; however, the E/M services are separately reportable.

The ultrasound procedures require the 26 modifier (*professional component*) because the surgeon may only bill for the physician component of the service. In addition, any add-on codes must follow the primary code on the claim form.

Case 2: A 45-year-old male is brought to the ED in shock with a gunshot wound to the chest.

The trauma surgeon meets the ambulance in the ED and performs the ATLS, primary and secondary surveys, initial resuscitation, and complex medical decision making, including imaging studies, coordination with specialty services for an operation with multiple teams, and communication with family. The patient is unable to provide a comprehensive history. The surgeon documents that the history is unobtainable and high-complexity medical decision making. The surgeon places bilateral chest tubes for hemopneumothoraces and performs a FAST exam, which shows free fluid in the abdomen. The surgeon directs the management of ventilation and blood product administration. The surgeon spends 60 minutes performing critical care in the ED and then takes the patient to the operating room, where he or she performs a laparotomy to pack and control a liver injury. At the same session, a thoracic surgeon performs a thoracotomy with wedge resection of a bleeding lung and a pericardial window. The patient then goes to the intensive care unit, where the surgeon spends another 60

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minutes supervising critical care. Reportable procedures include:

Day 1

- 47361, Management of liver hemorrhage; exploration of hepatic wound, extensive debridement, with or without packing of liver; ICD-9
 864.14 (laceration of liver, major with open wound into cavity)
- 32551-50, Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure); ICD-9 860.5 (traumatic pneumohemothorax with open wound into thorax)
- 76705-26, Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up); ICD 9 958.4 (traumatic shock)
- 76775 -26, Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited
- 76604-26, Ultrasound, chest (includes mediastinum), real time with image documentation
- 99291-25, Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes
- + 99292-25, Critical care, evaluation and management of the critically

ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service); ICD-9 958.4 (traumatic shock)

•99223-25-57, Initial hospital care

Management of the liver hemorrhage is reported with CPT code 47361. CPT code 32551 is used to report the placement of the chest tubes, and the 50 modifier (bilateral procedure) is required because chest tubes were placed bilaterally. It is important to note that some payors that do not follow Medicare rules may require the reporting of bilateral procedures on two lines (32251 and 32251-50). The ultrasound procedure requires the 26 modifier (professional component) because in the facility the surgeon may only bill for the physician component of the service. Addon codes must follow the primary code on the claim form.

Critical care codes 99291 and 99292 are used to report the total duration of time that a physician spent providing critical care. CPT code 99223 is used to report the hospital admission and includes evaluation and admission to hospital, including later rounding on patient in ICU (noncritical care) on day of admission, accounting for the face-to-face time of the subsequent care delivered later that day and complexity of the medical decision making. The critical care and hospital admission are separately reportable.

If you have additional coding questions, contact the ACS Coding Hotline at 800-227-7911 between 7:00 am and 4:00 pm Mountain time, excluding holidays, or go to *www.facs.org/ ahp/pubs/tips/index.html.* ◆

Editor's note

Accurate coding is the responsibility of the provider. This summary is only intended as a resource to assist in the billing process.