

APS Update

ER Newsletter

Volume 5

September 2008

Issue 9

ICD-9 2009 Update: Implementing 346.xx Changes

ICD-9 2009 will premiere with about 30 new migraine codes, expanding the 346.xx series to its highest degree of specificity ever. To make this coding transition as painless as possible, documentation is key, so the coder will need to determine the appropriate 5th digit. The changes go into effect October 1, 2008.

For each new migraine code, there are 4 fifth digit options to indicate the presence of status migrainosus, which is a prolonged migraine that increases the patient's stroke risk. The new and revised fifth digit options include:

- ◆ 0- Without mention of intractable migraine without mention of status migrainosus
- ◆ 1- With intractable migraine, so stated, without mention of status migrainosus
- ◆ 2- Without mention of intractable migraine, with status migrainosus
- ◆ 3- With intractable migraine, with status migrainosus

There are many changes for 346.0x (classic migraine). According to ICD-9 2008, you use 346.0x to describe migraines with auras or migraines preceded or accompanied by transient focal neurological phenomena. The revised version of 346.0x will also include the following migraine types:

- ◆ Classic migraine
- ◆ Basilar migraine
- ◆ Migraine-triggered seizures
- ◆ Migraine with acute-onset aura
- ◆ Migraine with aura without headaches
- ◆ Migraine with prolonged aura
- ◆ Migraine with typical aura
- ◆ Retinal migraine

(cont)

APS Medical Billing
5700 Southwyck Blvd.
Toledo, OH 43614
419-866-1804 / 800-288-8325
www.apsmdbill.com

(cont)

Until now, 346.2x (variants of migraine) was something of a catchall for other migraine types. ICD-9 2009 will instruct that 346.2x also includes the following migraine variants:

- ◆ Cyclical vomiting
- ◆ Ophthalmoplegic migraine
- ◆ Periodic headache syndromes in child or adolescent

The first new code ICD-9 2009 adds to the series is 346.3x (Hemiplegic migraine). This is a rare migraine type in the most severe form. Symptoms include temporary paralysis, hemiplegia or sensory changes on one side of the body. This classification encompasses both familial and sporadic migraines.

New subcategory 346.4x (Menstrual migraine) covers menstrually related migraines and pure menstrual migraines.

346.5x (Persistent migraine aura without cerebral infarction) will give you several new options when coding for persistent migraines.

Following 346.5x, which will be used for patients with persistent migraine aura *without* cerebral infarction, is its opposite 346.6x (Persistent migraine aura *with* cerebral infarction).

346.7x brings a variety of new coding possibilities for chronic migraines. This coding subcategory is used to describe transformed migraines (TM). Use 346.7x codes when the migraine occurs on more days than not for greater than 3 months in the absence of medication overuse.

346.9x (Migraine, unspecified) subcategory are used when documentation does not support using any of the above subcategories.

Latest Info on Critical Care Updates

CMS has released a flurry of transmittals regarding critical care in the last few months: 1473 on April 1, 1530 on June 6, 1545 on June 27, & now 1548 released on July 9. The latest states you cannot report critical care services and an ED E/M by the same physician on the same date of service for the same patient.

Medicare makes an allowance for reporting critical care with other E/M services, such as inpatient (99221-99223) or outpatient office (99201-99215) but does not make an allowance for reporting 99291 with the 9928x ED service codes. According to Transmittal 1548, Section H, page 20: "Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient." Medicare has offered no explanation as to why the ED is singled out for this special exclusion. The American College of Emergency Physicians (ACEP) is making a formal inquiry.

To capture valuable critical care time each time the physician provides it, doctors need to be diligent about documenting encounter specifics. The transmittal, effective July 7, makes especially clear points on documenting family counseling time & coding for concurrent critical care. According to the transmittal, "CPT codes 99291 & 99292 include pre- and post-services work." Routine daily updates or reports to the family members and/or surrogates are considered part of this service. So if the physician meets for 3 minutes with a patient's wife to give her an update, you cannot count this as critical care. The exception is if the patient is unable or too cognitively impaired to give a medical history or make treatment decisions, you can count time spent consulting the family toward critical care. In short, if the physician spends family time with the family for the sake of the patient, it counts toward critical care time. But if the family time is for the sake of the family, it is not critical care.

When recording family counseling time for critical care the provider must document four items:

- ◆ That "the patient is unable or incompetent to participate in giving history and/or making treatment decisions"
- ◆ The necessity to have the discussion (eg, no other sources were available, or because the patient was deteriorating rapidly)
- ◆ Medically necessary treatment for which the discussion was needed
- ◆ A summary in the medical record that supports the medical necessity of the discussion.

(cont)

(cont)

For any given period of time spent providing critical care services, the physician must devote his full attention to the patient and cannot provide services to any other patient during the same period of time. What's not included is also important, CPR, chest tubes, wound repair, etc, are separately billable when you provide them and critical care. It's important the physician understands what 'separately billable' means so that the critical care time that is documented is accurate and includes/excludes services correctly.

PQRI Participation Up, Satisfaction Down, MGMA Finds

Many practices have begun participating in the Physician Quality Reporting Initiative in the past six months. The motive, however, is not the additional payment but rather the opportunity to learn how the reporting system works. The Medical Group Management Association has indicated that many of its member practices have said that 1.5% is not sufficient to invest in the reporting effort but that their members believe that PQRI is the first step in a true pay for performance effort by CMS and that being in on the ground floor may help them to understand the program better and possibly even have some influence in the future of the program.

CMS has reported that total amounts to be paid on participants in the program during the second half of 2007 will be \$36 million. Only half of those who submitted PQRI information during that period qualified for payments, on average \$600 per physician.

A major complaint about the program to date has been the lack of feedback from CMS. In particular, practices that participated during the second half of 2007 did not receive any feedback about their eligibility for the bonus, or the potential size of the bonus until July, 2008.

CMS has responded to many of the issues raised by including an expanded list of services to be included in the effort for future periods and by beginning to address many of the administrative difficulties, especially the ability of practices to view their performance on the program online. It would appear that PQRI will continue to expand in scope and that CMS is investing in the program for the future.