Coding Complexities of Critical Care

Jill Young, CPC, CEDC, CIMC
Young Medical Consulting, LLC
East Lansing, Michigan

Disclaimer

- This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational a guide and should not be considered a legal/consulting opinion
- CPT® is a registered trademark of the American Medical Association

A Physician's Perspective

- Critical care is
  - "Taking care of sick people
  - It's harder
  - The mortality is higher
  - It's more complicated
  - It requires more monitoring of the patient
  - It involves more interaction with families
  - It frequently is more about what NOT to do to the patient than what to do."

CPT®'s Descriptor

- Critical care is defined as the direct delivery by a physician(s) 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.

CPT's Descriptor

- 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.

CPT's Descriptor

- Critical care is usually, but not always, given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department.
- However, payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care.

CMS' Reference

- MCM-Pub 100-04: Chapter 12, Section 30.6
- Transmittal 1548
  - July 2008
- MedLearn Matters #5593
  - Revised July 2008

CMS' Additional Descriptor

Critical Care Services and Medical Necessity

- Critical care services must be reasonable and medically necessary. As explained above, critical care services encompass both the treatment of "vital organ failure" and "prevention of further life threatening deterioration in the patient's condition."

Medicare's Definition of Medical Necessity

- "Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, are
  - provided for the diagnosis, direct care, and treatment of a medical condition
  - meet the standards of good medical practice in the local area
  - aren't mainly for the convenience of the patient or doctor."

http://www.cms.hhs.gov/apps/glossary/default.asp?Letter=M&Language=English

SS Act - Medical Necessity

- Sec. 1862. **[**42 U.S.C. 1395y**]**
- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code.

CMS' Additional Descriptor

- Therefore, delivering critical care in a moment of crisis, or upon being called to the patient's bedside emergently, is not the only requirement for providing critical care service.
- Treatment and management of a patient's condition, or the threat of imminent deterioration; while not necessarily emergent, is required.

PHYS-022
National Coverage Provision

1. Clinical Condition Criterion

- There is a high probability of sudden, clinically significant, or life threatening deterioration in the patient's condition that requires the highest level of physician preparedness to intervene urgently.

NCP: Retired 9-1-11

PHYS-022
National Coverage Provision

2. Treatment Criterion

- Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition.

NCP: Retired 9-1-11

Critical Care Time

- Total time of critical care should be documented
  - No particular format required
    - Recommend start and stop times
- Includes any time the physician devotes their full attention to the critical patient on the unit floor*

Critical Care Time

- Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient.
- Time may be aggregated throughout the day
  - Must show this in documentation

AAPC
Credentialing the Business Side of Medicine

Critical Care Time

- Time spent with family and surrogate decision makers in person or on the phone is included if the following criteria are met:
  - Patient unable to participate in giving history and/or making treatment decisions
  - Discussion necessary for determining treatment decision
- CPT® indicates this time is spent on the floor or unit

AAPC
Credentialing the Business Side of Medicine

Critical Care Time

- For family discussions the physician should document:
  - Patient's inability to participate in care/decisions
  - Necessity of discussions
  - Medically necessary treatment decisions
  - Summary in the medical record
    - Supports medical necessity of visit
  - Time

Critical Care Time

- Routine daily updates or reports to family members and/or surrogates are considered part of this service.

Critical Care Time

- For Medicare Part B physician services and paid under the physician fee schedule critical care is not a service that is paid on a “shift” basis or a “per day” basis.

Selection of Proper Code(s)

- Critical care, evaluation and management of the critically ill or critically injured patient;

  99291 - first 30 – 74 minutes

  +99292 - for each additional 30 minutes

Proper Use of 99291

Medicare Claims Processing Manual

- Physicians in the same group practice, same specialty must bill and be paid as though each were the single “physician”.
- This “physician” can only report one 99291 per patient on each calendar day

Reporting of Critical Care Services

Total Duration of Critical Care	Appropriate CPT 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 x1 and 99292 x 2
135 - 164 minutes	99291 x 1 and 99292 x 3
165 - 194 minutes	99291 x 1 and 99292 x 4

MedLearn Matters 5993

CMS Time Based Codes

- In 2010 clarified that for time based codes
  - units are reported once the midpoint of time is passed
- Prolonged Care codes are an exception
- Verify with your carrier* their definition

Proper Use of 99292

- "Code 99292 is used to report <u>additional block(s)</u> of time up to 30 minutes each beyond the first 74 minutes of critical care."
  - Defined by CMS & CPT ®

Clarified in Transmittal 1548 Dated July 9, 2008

Proper Use of 99292

- The service may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty in order to meet the duration of minutes required for CPT® code 99292.

Critical Care and Other E&M Services Same Day

- Critical care and inpatient hospital or office/outpatient E&M "may" be payable
  - "earlier on the same day"
    - CMS
  - Critical care and other E&M services may be provided on the same patient on the same date by the same physician.
    - CPT®

Critical Care and Other E&M Services Same Day

- If critical care services required in the Emergency Department
  - Only critical care codes may be reported

Documentation Tips

- Make it clear the patient is critical
- Primary diagnosis documentation should reflect most severe/critical illness(s)
- At first critical care encounter give a brief past, family and social history
- Notation of testing done and relevant findings or abnormalities
- Document a physical exam appropriate for critical illness
- Special notation of abnormalities caused by primary diagnosis

Modifier 25

- Services not bundled into the critical care codes may be separately payable if the critical care was a significant, separately identifiable service
- Do not include time spent performing the pre, intra, and post procedure work of these unbundled services in critical care time.

Modifier 25

- Pre-operatively two reporting requirements
  - Modifier 25 indicating separate service
  - Documentation showing critical care was unrelated to the injury or procedure performed
    - ICD-9-CM code 800.0-959.9 (except 930.0-939.9)

Modifier 24

- Post-operatively two reporting requirements
  - Modifier 24 indicating unrelated service
  - Documentation showing critical care was unrelated to the injury or procedure performed
    - ICD-9-CM code 800.0-959.9 (except 930.0-939.9)

Teaching Physician Criteria

- Time spent by the resident and teaching physician together can be counted
  - or the teaching physician alone with patient
- Documentation can be a combination of resident and physician's note

Non-Physician Practitioners

- Critical care cannot be a split/shared service
- Non-physician practitioners may bill for critical care services if:
  - Within the scope of practice and licensure requirements for the State in which the qualified NPP practices
  - Collaboration, physician supervision and billing requirements must also be met.

Critical Care and Other Procedures

- CPT® New in 2011
  - For reporting by professionals, the following services are included in critical care when performed during the critical period by the physician(s) providing the critical care
- CMS
  - The following services when performed on the day a physician bills for critical care

Procedures Included in Critical Care

- The interpretation of cardiac output measurements (93561, 93562)
- Chest x-rays, professional component (71010, 71015, 71020)
- Blood draw for specimen (36415)
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data 99090)

Procedures Included in Critical Care

- Gastric intubation (43752, 91105)
- Pulse oximetry (94760, 94761, 94762)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94002 – 94004, 94660, 94662)
- Vascular access procedures (36000, 36410, 36415, 36591, 36600).

Documentation of Procedures

- Recommended items of report:
  - Clinical indication for procedure
  - Name of procedure
  - Type of anesthesia, if used
  - Detailed account of procedure
    - Approach
    - Specimen or item(s) removed
    - Closure
    - Outcome

Documentation of Procedures

- Recommended items of report: ***(cont'd)***
  - Blood loss
  - Condition of patient post-procedure
  - Special instructions or comments
  - Time spent
  - Name of performing provider
    - Any resident assistant

Diagnostic Coding

- Specific enough to accurately describe patient's critical illness(s)
- Include appropriate clinical information
- Should be revised to reflect emergence new problems requiring treatment
- Should reflect improving or deteriorating patient's condition

"Critical" Diagnoses

- Acute respiratory failure
- Respiratory arrest
- Cardiac arrest
- Acute renal failure
- Uncontrolled atrial fibrillation

Sepsis and Septicemia

- The terms *septicemia* and *sepsis* are often used interchangeably by providers, however they are not considered synonymous terms.
- The following descriptions are provided for reference but do not preclude querying the provider for clarification about terms used in the documentation

ICD-9-CM Official Guidelines 2011

Sepsis and Septicemia

- **Systemic inflammatory response syndrome (SIRS)** generally refers to the systemic response to infection, trauma/burns or other insult (such as cancer) with symptoms including fever, tachycardia, tachypnea and leukocytosis
- **Sepsis** generally refers to SIRS due to infection

ICD-9-CM Official Guidelines 2011

Sepsis and Septicemia

- **Severe sepsis** generally refers to sepsis with associated acute organ dysfunction
- **Septicemia** – generally a systemic disease associated with the presence of pathological microorganisms or toxins in the blood which can include bacteria, viruses, fungi or other organisms

ICD-9-CM Official Guidelines 2011

SIRS, Sepsis and Severe Sepsis

- Required a minimum 2 codes
  - A code for underlying cause (i.e. infection, trauma)
  - A code from 995.9x SIRS subcategory
- Underlying cause sequenced before SIRS code

ICD-9-CM Official Guidelines 2011

SIRS, Sepsis and Severe Sepsis

- Sepsis and Severe Sepsis require a code
  - For the systemic infection (038.11, 112.5 etc)
  - Either 995.91 sepsis or 995.92 severe sepsis
  - If casual organism not documented
    - 038.9 unspecified septicemia

ICD-9-CM Official Guidelines 2011

SIRS, Sepsis and Severe Sepsis

- Severe sepsis requires additional code for associated acute organ dysfunction(s)
- If patient has sepsis with multiple organ dysfunctions follow instructions for coding severe sepsis
- Either the term sepsis or SIRS must be documented to assign a code from subcategory 995.9

ICD-9-CM Official Guidelines 2011

SIRS, Sepsis and Severe Sepsis

- Due to the complex nature of sepsis and severe sepsis, some cases may require querying the provider prior to assignment of the codes.

ICD-9-CM Official Guidelines 2011

Sequencing of Septic Shock

- Septic shock generally represents a type of acute organ dysfunction
  - Circulatory failure
- Sequence first the code for systemic infection

ICD-9-CM Official Guidelines 2011

Sequencing of Septic Shock

(cont'd)

- Next code SIRS due to infections process with organ dysfunction (995.92)

  and

- and septic shock (785.52)
- Any additional codes for other acute organ dysfunctions should also be assigned.

ICD-9-CM Official Guidelines 2011

Septic Shock Without Documentation of Severe Sepsis

- Septic shock indicates the presence of severe sepsis.
- Code 995.92, Severe sepsis, must be assigned with code 785.52, Septic shock, even if the term severe sepsis is not documented in the record.

ICD-9-CM Official Guidelines 2011

ICD-9-CM Sepsis Guidelines

- Sepsis/SIRS with Localized Infection
- Bacterial Sepsis and Septicemia
- Acute Organ dysfunction that is not clearly associated with the sepsis
- Septic shock
- Sequencing of septic shock
- Septic shock without documentation of severe sepsis
- Sepsis and septic shock complicating abortion

ICD-9-CM Official Guidelines 2011

ICD-9 Sepsis Guidelines

- Negative or inconclusive blood cultures
- Newborn sepsis
- External cause of injury codes with SIRS
- Sepsis and severe sepsis associated with noninfectious process
- Methicillin resistant staphylococcus aureus (MRSA) conditions

ICD-9-CM Official Guidelines 2011

Human Immunodeficiency Virus

- Code only confirmed cases of HIV infection/illness.
  - Confirmation does not require positive lab
  - Provider's statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

ICD-9-CM Official Guidelines 2011

Selection and Sequencing of HIV Codes

- Patient admitted for HIV-related condition
- Patient with HIV disease admitted for unrelated condition
- Whether the patient is newly diagnosed
- Asymptomatic human immunodeficiency virus

ICD-9-CM Official Guidelines 2011

Selection and Sequencing of HIV Codes

(cont'd)

- Patients with inconclusive HIV serology
- Previously diagnosed HIV-related illness
- HIV Infection in pregnancy, childbirth and the puerperium
- Encounters for testing for HIV

ICD-9-CM Official Guidelines 2011

Templates

- Necessary information on a Critical Care Form/Note
  - Paper note should have 2 parts
  - Electronic health record approved template
  - Diagnosis
    - Most critical condition of patient
    - Other co-morbidities/diagnosis

Templates

- Necessary information on a Critical Care Form/Note ***(cont'd)***
  - Start and stop times
  - Procedures performed along with amount of time spent performing them
  - Note should detail
    - Patient's condition
    - Intensity of services

AAPC
Credentialing the Business Side of Medicine

NAME OF PATIENT	MOST CRITICAL ILLNESS	OTHER DIAGNOSES
	1.	3.
	2.	4.
DOS		5.

S TART/STOP TIMES OF CARE:	
HISTORY: PFSH: ROS: EXAM:	NOTE ON PATIENT: *This patient required my constant attention because:*

TESTING:
LABS:

X-RAY:

BLOOD GAS:

O2 SAT: EKG:

OTHER:

PROCEDURES :
Indicate dx #

- ☐ Intubation _____
- ☐ Pulse oximetry _____
- ☐ Temporary transcutaneous pacing _____
- ☐ Ventilator management _____
- ☐ Vascular access procedure _____

Type _____

FAMILY MEETING OR CONFERENCE CALL (on floor or unit):

☐ To obtain necessary information ☐ To discuss treatment options

Summary of meeting:

PROCEDURES:

TIME PROCEDURE DX #_____

- _____ CPR _____
- _____ Art Line Placement _____
- _____ Central Line Placement _____
- _____ Swan-Ganz _____
- _____ Bronchoscopy _____
- _____ Other _____

Tell The Story

- Why is the patient being seen?
  - What is different?
  - From yesterday or what has recently changed
- What did the provider find wrong with the patient and how did it require their “full attention”
- What did the provider do “for” the patient?
- How much time was spent?

THANK YOU!!