Essential Rules for Critical Care Coding and Billing	
Questions	**Answers**
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Where can I ask questions after the webinar?	The online member forums, where over 100,000 AAPC members have access to help each other with all types of questions. *Forum Posting Instructions* 1.Login to your online account 2.In the middle of the page you will see "discussion forums" 3.Click on "view all" – top right hand side 4.Select "general discussion" under "medical coding" unless you see a topic that suits you more – 5.On the top left side of the forum box, you will see a blue button, "new thread" – click on that 6.Type your question and submit 7.Check back in that location for answers as you please

If a patient has severe anemia and needs a blood transfusion is this a condition that might meet critical care?	It's possible that this patient may require critical care, yes.
What documentation is expected for facility coding? Does the nurse need to document how much time?	This presentation focuses on professional fee billing of Critical Care. Some rules may differ when billing for the facility.
Relating to time billing for cc - if a provider bills critical care time as 75 minutes....how would you code that?	75 minutes of critical care by a single provider would usually be billed as 99291 + 99292, assuming other criteria are met.
If there is documentation that is obviously supporting the provider provided critical care but they do not document the time is it ok to have the provider do a late entry?	CMS allows addenda/late entries into medical records. However, a FEW contractors say this info must only be info that wasn't available at the time of the service, and not info that you realized you left out and is is only necessary for billing. Check with your local contractor.
Do you add -25 modifier to cc code when separate billable prcedure is done?	This will be covered in detail in a few slides. UPDATE: In most cases yes. Medicare states that ALL pre-operative CC be billed with Modifier 25. For other payers, you would follow standard CPT coding rules that state it would be attached to an E/M code (like CC is) billed on the same day as a minor procedure.
Is that the same if you are billing two providers, one 30 and other 45?	This will also be covered in detail a bit later in the presentation. Let me know if you have additional questions after those slides. UPDATE: It depends on the provider types of the two individuals (eg 2 MDs, 2 PAs, 1 MD and 1 PA…).

So, relating to 99291 and 99292 for 75 minutes....code 99291 would be the first thirty minutes; your understanding is that medicare would pay for ONE minute of 99292?	99291 is for the first HOUR of care. See the slides being discussed right now. UPDATE: When 75 total minutes have been reached, you have actually provided 15 MINUTES of additional care past what code 99291 pays for (the first hour of CC), and so are eligible to bill the first unit of 99292. True, you are only 1 minute past the THRESHHOLD for billing 99292, but that threshhold is set at the midway point (15 minutes into an additional 30 minutes).
If a patient is being treated for critical care and within 10 mins passes away and the physician goes out to speak with the family, would that time spent with the family be counted as critical care time?	CPT would allow this. As discussed in prior slides, CPT allows family counseling to count when the counseling is to provide an update on the patient's condition. MEDICARE, however, says the discussion has to focus on the patient's ongoing treatment, where you're having to ask for history from the family or ask them to make treatment decisions. UPDATES don't count as CC time for Medicare. So after the patient expires, family updates are not countable as CC time.
Do most payers follow Medicare or CPT guidelines for CC?	Most follow CPT rules, but some adopt a hybridized approach.
How would you deal with a PA and MD from same team billing for separate time....PA 30 and MD 45?	This specific type of situation will be covered in the final section. UPDATE: The PA would bill 99291 and the MD would bill 99292.

One thing I learned was in the description of 99285 it says "components within the constraints imposed by the urgency of the patient's clinical conditiona and/or mental status" so in the situation of 10 minutes and then patient passes away would this be a situation this could apply?	Only the Hx and Exam components are allowed that caveat. The MDM must still be HIGH as required by 99285. Assuming this, then yes, some critical care of less than 30 minutes could be billed as 99285, IF provided in the ED.
What if a patient codes in the ICU? 40 minutes spent with patient. Can CPR be billed seperately from the CC code, or would you bill only CC?	BOTH can be billed, but you can't count the CPR time as CC time since it is being separately paid.
What if the doc billing critical care, isn't doing the surgery? Would you still use the mod 25 and mod 24?	No, it wouldn't be necessary if the provider billing CC doesn't have an active global package.
Our trauma docs are on call 24 hours...if they do rounds and see a patient and record a 99233... then later on the same date the patient codes or declines and the dr returns and records 45 mins critical care. Can I bill the 99233 and 99291 for the same physician on the same date of service?	YES. As stated earlier, though, Medicare will deny it initially so that you can send the documentation on appeal.
How about specialist rendering critical care in ER, stabilize the patient, and decide to admit and do a separately reportable H&P on the same day. Can we bill 99291 and 9922x-25?	Per CPT, YES. But this was one point that Medicare differed on. Medicare will allow a non-critical E/M to be billed on the same day as CC, but only when the non-critical E/M occurred FIRST, and was not an ED visit.
Will we be able to print these questions after the webinar?	A full transcript will be provided.

I've got verbiage in a "Coding for chest medicine" manual that states: "Critical Care of less than 15 minutes beyond the first 74 minutes may not be reported separately." Is that incorrect? That conflicts with an earlier slide.	That is a direct quote from ERRONEOUS Medicare verbiage. I will explain that in more detail in the official transcript. If that statement was correct, it would mean that Medicare would in effect have different time threshhlds than CPT. Yet Medicare repeats the same times from the CPT CC chart in their manual. UPDATE: See Attachment A for the full explanation of this erroneous Medicare quote.
For a non teaching Dr. can they simply state "Critical Care time total was 40 minutes"?	If the other portions of their note establish that this was a critical patient, that high complexity MDM was required. etc., then yes.
The CMS PATH Guidelines state, "For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service of from 20 to 30 minutes may be paid only if the teaching physician is physically present for 20 to 30 minutes. Do not add time spent by the resident in the absence of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary." The resident time can only be counted if the teaching physician was present during that time. Where can I find the updated information that states the resident time can be counted if the teaching physician is available on the floor? Thank you.	There is no new rule. What I stated doesn't contradict this. My point is that there will be times when the resident is alone with the patient that you will STILL bill CC because the work that the TP is doing elsewhere on the floor/unit in-and-of-itself counts as CC time.

How about 1st trauma provider renders 74 minutes and the second trauma surgeon rendering additional 30 minutes?	First doc bills 99291, second bills 99292. UPDATE: This was initially typed as 99291 and 99291 in error in the live session.
Our cardiologist was called for a consult on a patient that is in ICU and spent an hour with this patient is it appropriate to use 99291 for this consult?	If the CC billing/coding requirements are met, then YES this E/M code would be billed IN PLACE OF whatever other E/M code would have otherwise applied.
What if the physician is on the floor/unit but is addressing issues with another patient?	Then this time could not be counted as CC time.
Our problem with splitting the bill is our carriers won't pay for the 99292 alone....it won't even leave our system. Do you have any other suggestions besides billing under one provider?	Medicare contractors should pay this no problem. If they don't, send them the quotes I provided from CMS that states this is allowed and correct. If your system won't allow it to be billed the RIGHT WAY, the only COMPLIANT answer is to change your system, not to bill it in an alternative but INCORRECT way.

How can you bill a 99292 on a separate claim with it is an add-on code?	Because this is the ONE case in which Medicare said this was allowed and the correct way to bill for multiple providers within the same group and specialty performing CC on the same patient on the same day. Please see the specific Medicare language in the presentation quoting Medicare on this. This language can also be seen here: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf .It DOES break a CPT rule, though, and is only used for Medicrae patients, or for other payers who provide similar instruction.
Claims billed with only add-on 99292 code, wouldnt they be denied for no primary procedure code?	For non-Medicare payers, YES. But for Medicare, see the specific Medicare language included in the presentation where Medicare said in this ONE case this is allowed and CORRECT for their patients. See also the link pasted in the response above.
If a provider is supplying comfort care to the patien who is critically ill, can you still be out a critical care code?	To bill CC, you don't just need to have a critical patient. The situation must require HIGH complexity MDM and usually require interpretation of multiple physiologic parameters and application of advanced technologies. These may not be present if just providing comfort care.
How about 1st trauma provider renders 74 minutes and the second trauma surgeon rendering additional 30 minutes ANSWER: First doc bills 99291, second bills 99291?? 99291 and 99292 or two 99291s?	My apologies. First provider bills 99291, and second bills 99292, not 99291. UPDATE: The initial answer to this question has been corrected in the transcript above.

Do you add -25 to 99291 when performing separate billable procedure?	In most cases yes. Medicare states that ALL pre-operative CC be billed with Modifier 25. For other payers, you would follow standard CPT coding rules that state it would be attached to an E/M code (like CC is) billed on the same day as a minor procedure.
ATTACHMENT A	

Medicare did indeed have what many realized was an erroneous statement in their critical care instruction. This phrase "CC of less than 15 minutes beyond the first 74 minutes is not separately payable" used to appear in the Claims Processing Manual before the recent revisions to the critical care section. Taken literally, the phrase “Critical care of less than 15 minutes beyond the first 74 minutes is not separately payable” would mean that you could not add a 99292 until you had reached the threshold time of 89 minutes.

The confusion lies in the fact that code 99291 is really for the first hour of critical care, as its descriptor used to say years back. However, since critical care, like many other time-based CPT codes, can be billed when at least half or more of the time in the code description is spent, the actual threshold to be able to bill the code is 30 minutes. Code 99292 is for “each additional 30 minutes,” but this is understood to mean each additional 30 minutes over the first hour/60 minutes. It too, though, may be billed when only half of that, 15 minutes, is spent above the “first hour,” which means the threshold for reporting 99292 is 75 minutes.

This meant that the actual range for the “first-hour” critical care code 99291 is 30-74 minutes, and years ago the descriptor for 99291 was changed from “first hour” to the actual “30-74 minutes” range. This clarified when to use

descriptor for 99291 was changed from "first hour" to the actual "30-74 minutes" range. This clarified when to use 99291, but muddied when to use 99292, which continued to have its "each additional 30 minutes" descriptor. Now that 99291 no longer just said "first hour" people wondered "30 more minutes above and beyond what…?" The table finally solved everything, and provides an easy method for determining the correct coding.

What Medicare almost certainly meant to say in their Claims Processing Manual, and in the Medlearn Matters article based on it, was "Critical care of less than 15 minutes beyond **the FIRST HOUR** (or 60 minutes) is not separately reportable" instead of saying "30-74 minutes." As I mentioned before, that phrase if taken literally would mean that the threshold time for code 99292 is 89 minutes, but we know Medicare didn't really mean that because they have for years reproduced the CPT critical care table in their manual showing that 99292 is reportable once you reach 75 minutes. It's a good thing that this phrase was omitted from the new cc section in the Claims Processing Manual, but it is regrettable that it still appears in a Medlearn Matters article, and other publications originally based on that section of Medicare's manual as it is only inevitable that people will stumble across that sentence from time to time and wonder "Whaaat…?"