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Internal Medicine Coding Alert

Four Key Strategies for Billing Critical Care Services

Coding for critical care is misunderstood in many internal medicine practices, says **Laura Driscoll,** principal with IMPACT Medical Consulting in Atlanta, GA.

Driscoll has seen some practices that never bill for their critical care servicesand are missing out on significant reimbursement as a result.

She has also encountered physicians who bill for critical care every time they step into a CCU at a hospital.
I once knew a critical care intensivist who always used the critical care codes and wondered why he was identified by the payer for over-utilization, she states. Critical care is not related to the location, rather it is based on the type of service provided.

Here are the four key strategies for knowing when to bill a service as critical care, what documentation is necessary, and how to correctly report the codes to ensure payment.

1. Know what is (and is not) critical care. CPT defines critical care as the care of the unstable critically ill or unstable critically injured patient who requires constant physician attendance (the physician need not be constantly at bedside per se but is engaged in physician work directly related to the individual patients care). Critical care services are provided to, but not limited to, patients with central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic or respiratory failure, postoperative complications, or overwhelming infection.

Critical care is generally considered to be provided to patients who either have life-threatening health problems or a serious illness that requires the constant attention of the physician to avoid a poor outcome, says Driscoll.
CPT does not require that these services be delivered in a critical care unit or emergency room at a hospital, she adds. Critical care can be delivered in a physicians office or any site of service.

Conversely, just because a patient is in the critical care unit does not justify the use of critical care codes when a physician sees that patient.

In fact, CPT specifically states that services for a patient who is not critically ill but happens to be in a critical care unit are reported using the subsequent hospital care codes (99231-99233) or hospital consultation codes (99251-99263) as appropriate.

If the care provided is critical care, the ICD-9 code reported should indicate a serious health problem. Although this is not always the case, an ICD-9 code indicating respiratory failure, or another serious health problem should be the first clue that critical care service should be considered.

Coders should also consider the physicians documentation. Did he or she indicate critical care services provided-45 minutes or make some other notation indicating continuous care?

The disposition of the patient would also be another clue. Did the patient require treatment in the hospitals ED or admission to the critical care unit or intensive care unit?
However, in most cases, physician documentation will be the main indication that critical care should be coded, says Driscoll. Even an ICD-9 code indicating serious illness and a record of the patient being admitted to the critical care unit is not enough information to justify the coding of critical care services.

Whether or not a service was critical care vs. a high-level visit E/M service is largely up to the subjective judgment of the

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physician.

It should be emphasized to the internists that they must provide specific documentation of critical care services, including notes on how much time was involved. (See below.)

2. Critical care codes are time-specific. These codes are based on time, notes Driscoll. Code 99291 is for the first hour and 99292 is for each additional half hour. Therefore, coding for critical care requires that the physician document how much time was spent on critical care, otherwise the codes cannot be used. (See chart on coding for critical care, page 26.)

The code 99291 also cannot be used unless the time spent exceeds 30 minutes beyond the original E/M service, she explains. The first 30 minutes of critical care are considered included in the visit E/M.

Likewise, code 99292 cannot be used until the first hour and 15 minutes of critical care has been provided. The additional half hour is not counted unless at least 15 minutes of critical care are performed beyond the first hour, according to CPT.

Tip: As CPT indicates, the time at the patients bedside does not have to be continuous to be reported as critical care. The total time may be cumulative over the course of one calendar day, says Driscoll. The physician must keep specific documentation of the time spent with the patient (i.e., 10 minutes of critical care provided from 4:00 to 4:10 p.m., returned to patients bedside at 4:30 and provided care until 4:45, returned to evaluate condition and order treatment at 5:00 and remained until 5:20). Otherwise, the coder will not know, or be able, to code the critical care service.

3. Know which procedures are included and which are not included. When providing critical care, some procedures are deemed to be included in the critical care service while others are not. (See related article on page 25.) Coders should check the CPT manual for which procedures should not be coded separately and should also consider Medicare CCI edits.

In addition, it is important to subtract the time it takes to perform the procedures that are billed separately from the total critical care time. Because the procedures are reported separately, the time it takes to perform them cannot be used to justify a critical care code. This is another reason that specific physician documentation is a must.

4. E/M documentation guidelines do not apply to these codes. It is also important for physicians to know that documentation for critical care E/M codes does not follow the usual E/M format, says Driscoll. The physician should provide a detailed summay of the service. Again, the main thing to be included in documentation is an indication of the severity of the patients medical condition and the amount of time spent.

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