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Internal Medicine Coding Alert

Heed New Transmittal When Documenting, Compiling Critical Care Time

Medicare clarifies rule for family counseling, concurrent care

If coders can learn to spot critical care indicators, and doctors are diligent about documenting encounter specifics, you can capture critical care each time the internist provides it.

To help coders with this process, CMS released transmittal 1530 on June 6 (www.cms.hhs.gov/Transmittals/downloads/R1530CP.pdf). This document puts all critical care coding guidance in one easy-to-access place, says **Carol Pohlig, BSN, RN, CPC, ACS,** senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia.

The transmittal, effective July 7, makes especially clear points on documenting family counseling time and coding for concurrent critical care. Keep it handy when you're coding for 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and +99292 (... each additional 30 minutes [list separately in addition to code for primary service]).

Use CMS List of Approved 'Counseling' Activities

The transmittal spells out exactly what interactions with the patient's family you can count toward overall critical care time, Pohlig says.

According to the transmittal, "CPT codes 99291 and 99292 include pre- and post-service work. Routine daily updates or reports to family members and/or surrogates are considered part of this (included) service." So if the internist meets for three minutes with a patient's wife to give her an update, you should not count this as critical care time.

Exception: When the patient is unable or incompetent to give a medical history or make treatment decisions, you can count time spent consulting with the family toward critical care. You can also include time spent discussing treatment decisions, if the internist has to ask a family member for patient information.

You'll need to be sure to document the family counseling time properly, Pohlig says. When recording family counseling time for critical care, the transmittal states, the provider must document:

• that "the patient is unable or incompetent to participate in giving history and/or making treatment decisions;

• the necessity to have the discussion (e.g., 'No other source was available to obtain a history' or 'Because the patient was deteriorating so rapidly, I needed to immediately discuss treatment options with the family);

• medically necessary treatment decisions for which the discussion was needed; and

• a summary in the medical record that supports the medical necessity of the discussion."

Show Physicians the Value of Documentation

The internist also needs to be diligent about documenting the other critical care components. Often, the physician does not provide enough information on encounter forms to justify critical care coding.

"Critical care is commonly performed but underreported. I believe many (physicians) often miss critical care coding opportunities," says **Caral Edelberg, CPC, CCS-P, CHC,** president of Medical Management Resources for TeamHealth in Jacksonville, Fla.

Bottom line: To report 99291, the physician needs to spend a minimum of 30 minutes providing critical care to the patient. If the physician performs activities that count toward that time, but does not include them in the documented time, then appropriately coding critical care is virtually impossible. This problem has hamstrung many potential 99291 claims, Edelberg says.

"Some physicians I talk to say they don't know what's included in critical care, which makes counting up the time very difficult for coders," Edelberg said during a recent audioconference on documenting hospital services (http://www.audioeducator.com).

Key: Documentation must support that critical care services were medically necessary and reasonable. You can report critical care services for the time the physician spent evaluating, providing care and managing the critically ill or injured patient's care. The physician must spend the time at the immediate bedside or elsewhere on the floor or unit, provided the physician is immediately available to the patient.

For example, you may report time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor as critical care, even when the service does not occur at the bedside, if this time represents the physician's full attention to the critically ill/injured patient's management.

Don't miss: For any given period of time spent providing critical care services, the physician must devote his full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

Scenario: Edelberg said that sometimes, many doctors won't initially think they provided critical care. "But then if you ask them what they did during the encounter they say: 'Well, I spent 30 minutes stabilizing the patient, 7 minutes discussing the patient with the family, and 20 minutes recording the details of the encounter," Edelberg said.

Based on the above description, the physician might have provided critical care. If, however, the physician records none of this information in the medical record, the coder cannot count these activities toward total critical care time.

What's not included is also important. CPR, chest tubes, wound repair, etc., are separately billable. "However, it's important the physician and coders understand what 'separately billable' means so that the critical care time that is documented is accurate and includes/excludes services correctly," Edelberg said.

(For a list of procedures that are included in critical care, check out the explanation in CPT 2008 under the "Critical Care Services" subhead.)

Best bet: Educate your physicians on what's included in critical care time, and encourage them to write down any activity they perform toward patient treatment. That way, the coder will have all the information she needs to make the critical 99291 decision.

Overlapping Time a No-No on Concurrent Care

Transmittal 1530 also spells out Medicare's concurrent care coding rules. Physicians from different specialties can provide critical care on the same calendar date to the same patient if the services are not "duplicative."

"The medical specialists may be from the same group practice or from different group practices," the transmittal states. If the physicians are not billing for the same time block, they can each report critical care they provide for the same patient, Pohlig says.

"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," according to the transmittal.

Example: Internist A and B both work for Internal Medicine Practice C. Dr. A provides a patient suffering from acute pulmonary edema and hypotension with 45 total minutes of critical care (from 9-9:30 a.m. and from 11-11:15 a.m.). Later in the day, Dr. B checks up on the patient and ends up providing another 35 minutes of critical care (from 3:15-3:50 p.m.).

Medically necessary critical care time can be noncontinuous. Therefore, Drs. A and B should both be able to report their time, if both internists clearly state the timeframes they provided critical care. Because a claim for 99292 requires 99291, you should report the critical care service on one claim. To account for both physicians' time (total of 80 minutes), you would enter one unit of 99291 and one unit of 99292 under each internist's NPI using the same group identification number.

Check Manual for Concurrent Care Exceptions

Medicare may cover concurrent care by more than one physician (generally representing different physician specialties) if the requirements listed in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, section 30 are met.

For instance, if a cardiologist and internist provide critical care services that warrant the physician's sub-specialty (cardiology) and internal medicine expertise, then medically necessary concurrent critical care for the same time period may be payable.

Note: For more information on critical care coding, check out "Prove Patient Is Critical Before Coding 99291" in Internal Medicine Coding Alert 2008, Vol. 11, No. 2.