Internal Medicine Coding Alert

Learn New Standards for Proper Critical Care Coding

Critical care reimbursement for 2001 has increased by more than 10 percent over last years levels, but changes to critical care guidelines in CPT 2001 put stricter standards on what can and cannot be claimed.

Last years national average payment rate for 99291 (critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) was $186.34, but the rate for 2001 has been raised to $211.20, or 5.52 relative value units (RVUs). Similarly, the 2000 payment rate for 99292 (... each additional 30 minutes [list separately in addition to code for primary service]) was $91.89, while this years rate has been increased to $104.45, or 2.73 RVUs.

Last year, HCFA reduced the RVUs for critical care work by 10 percent because of its concerns with the CPT 2000 guidelines, particularly that the language might lead physicians to report emergency department or other high-level E/M services as critical care.

We had always contended that the CPT 2000 definition adequately described critical care service and was appropriate, but HCFA decided that the definition was too loose, says **Brett Baker,** senior associate for Managed Care and Regulatory Affairs with the American College of Physicians/American Society of Internal Medicine (ACP/ASIM) based in Washington, D.C.

Baker says the issue is the CPT 2000 definition of critical illness, which HCFA felt did not sufficiently distinguish critically ill patients from patients whose care was described by other E/M services with less work intensity.

The revised definition in CPT 2001 now aims to clarify that critical care codes are reserved only for the treatment of critically ill, injured or postoperative patients, such that there is a high probability of imminent or life-threatening deterioration in the patients condition, and that critical care involves high-complexity decision making . . . to prevent further life-threatening deterioration of the patients condition.

Some Billing Wasnt Warranted

For example, HCFA said that many patients diagnosed with congestive heart failure, regardless of severity, met the CPT 2000 definition of critical illness and that some physicians were billing such cases as critical care when it wasnt warranted.

Congestive heart failure covers a whole spectrum of disease, says **Madhuresh Kumar, MD,** an internist at Martin Memorial Medical Group in Stuart, Fla.

Sometimes the pathology is there, but the patient is stable and the physician is only continuing to monitor the situation. But at the other end of the spectrum, you may have a situation where hardly any blood is being pumped through the heart, the lungs are swollen like a sponge, and the patient is hooked up to two or three IVs, says Kumar. There are different degrees of heart failure. Physicians generally draw the line between what is and isnt critical care by their need to be physically present.

If I need to be at the patients bedside for more than a half-hour, I bill critical care [99291]. If Im there less than 30 minutes, I bill a hospital visit [99231, subsequent hospital care, straightforward medical decision making where the physician typically spends 15 minutes at the bedside and on the patients floor, or 99232, subsequent hospital care, moderately complex decision making where the physician typically spends 25 minutes at the bedside and on the patients floor, or 99233, subsequent hospital care, high-complexity decision making]. Either way, I always document what has been involved, says Kumar.

Critical Care Outside the CCU

Further new language defining critical care in CPT 2001 states, critical care is usually, but not always, given in a critical care area ...

Scott Manaker, MD, a practicing internist at the University of Pennsylvania Hospital in Philadelphia and an adviser to the ACP/ASIM panel on coding and reimbursement, says the new phrasing was added because the prior definition did not fully describe the range of settings where critical care is carried out.

Critical care is not always confined to the hospital critical care unit [CCU], says Manaker. Sometimes legitimate critical care situations arise outside the critical care area, like in a nursing home or even in a physicians office.

For example, an internist is called to a nursing home after a patient has taken a turn for the worse. Once there, the internist evaluates the problem and determines the patient is undergoing acute respiratory failure. The internist spends 45 minutes attending to the patient before an ambulance is called to transfer the patient to the critical care unit. This should be billed as critical care (99291). A similar situation could arise in the office setting, where a patient suffers a heart attack or stroke.

These are critical care situations. Regardless of where they occur, if I spend more than a half-hour attending to the patient, I will bill the service as critical care, says Manaker.

Billing E/M and Critical Care

Another new addition to the introductory notes for critical care in CPT 2001 states: Critical care and other E/M services may be provided to the same patient on the same date by the same physician.

Kumar says this situation would likely arise when an internist made a routine hospital visit to a patient during morning rounds (99232) and was called back in the afternoon after the same patient had a sudden downturn.

Again, if I had to spend more than a half-hour at the patients bedside to stabilize the situation, I would consider it critical care, says Kumar.

Both visits can be billed. The earlier visit is billed 99232, and the critical care visit later in the day is billed 99291-25. Modifier -25 is appended to the critical care visit to show that these are two separately identifiable services by the same provider on the same date.

If the claim is denied, it should be appealed. There is a very good chance the claim will be paid on appeal when the documentation is reviewed.

Some Codes Cant Be Billed Separately

Some new codes among the services cant be billed separately when reporting critical care. These services include interpretation of cardiac output measurements (93561, 93562); chest x-rays (71010, 71015, 71020); pulse oximetry (94760, 94761, 94762); blood gases and information stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090); gastric intubation (43752, 91105); temporary transvenous pacing (94662); and vascular access procedures (36000, 36410, 36415, 36540, 36600).

Apart from the services listed above, however, any other services performed should be billed separately. CPT 2001 added codes that describe services already included in the definition of critical care, for example, another chest x-ray code and another gastric intubation code, says Baker. The exception is pulse oximetry. HCFA decided in 2000 that it wouldnt pay for pulse oximetry separately. In 2001, HCFA agreed to pay separately only when it is the sole service provided on a visit. It wont be paid separately when done during an E/M visit, which includes critical care.

Critical Care Time Can Be Added

Critical care codes 99291 and 99292 can be used to report the total time spent providing critical care, even if the time spent by the internist on that date is not continuous.

Manaker cites the example of an internist spending 20 minutes stabilizing a patient with acute respiratory failure. The internist was called back several hours later when the pressure suddenly dropped on the patients respirator.

For example, the internist spends another 20 minutes stabilizing the patient. As long as the internist clearly documents the acute situation, the total time spent can be added together and billed as critical care [99291], says Manaker.

CPT 2001 says the time that can be reported as critical care is the time spent engaged in work directly related to the individual patients care, whether the time was spent at the immediate bedside or elsewhere on the floor or unit.

For example, time spent on the unit or at the nursing station on the floor reviewing test results or imaging studies, discussing the critically ill patients care with other medical staff or documenting critical care services in the medical record would be reported as critical care even though it does not occur at the bedside.

Physicians find various ways to document the time they spend in various critical care situations, which very often includes a number of patients, says Manaker. Its my personal feeling that stopwatch care is not good care, but thats the situation we have to deal with.

Generally, physicians providing hospital care are advised to note the start and stop time for each patient. However, providing care isnt like punching the clock at a factory. Again, internists should review their notations at the end of each hospital session and fill any gaps or lapses while theyre still fresh in their minds.

Dont Shoot the Breeze

CPT 2001 says that time spent with family discussing treatment, etc., may be reported as critical care, provided that the conversation bears directly on the management of the patient. The quoted phrase is more new language geared to narrow the physicians focus when he or she is calculating time spent providing critical care services.

Again, its all part of the ongoing debate, where auditors are concerned that doctors are simply shooting the breeze with family members and counting it as critical care time, and where physicians are concerned that its important and necessary to spend this time with surrogate decision-makers, says Manaker.

However, time spent in activities that occur outside of the unit (e.g., telephone calls, whether taken at home or in the office, or elsewhere in the hospital) may not be reported as critical care because the physician is not immediately available to the patient.