

# Internal Medicine Coding Alert

## Prove Patient Is Critical Before Coding 99291

Remember to count bundled services toward critical care time

When your internist treats a patient with a serious injury or medical condition, coders should be on the lookout for critical care services the physician might provide. After all, critical care codes sport higher relative value units (RVUs) than standard E/M codes.

But be careful you don't miscode a claim in your zeal to use the high-RVU critical care codes. You'll have to prove that the patient needed critical care services before considering 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) or +99292 (... each additional 30 minutes [list separately in addition to code for primary service]), or you'll likely receive a denial for your claim.

Establish Critical Illness or Injury First

According to CPT, a patient must be critically ill or injured for critical care services.

Critical illness or injury is defined as impairment of one or more vital organ systems such that there is risk of imminent or unstable life-threatening deterioration in the patient's condition.

Critical care involves high-complexity medical decision-making to assess and support the functionality of vital organ systems -- all in an effort to prevent the patient from deteriorating further, says **Shelley Bellm, CPC**, coder at Colorado Mountain Medical.

Translation: Critically ill or injured patients require immediate medical attention, or they will get worse -- or die, says **Michael Lemanski, MD**, billing director at Baystate Medical Center in Springfield, Mass.

Check out this definition: "Critical care includes the care of critically ill and unstable patients who require constant physician attention, whether the patient is in the course of a medical emergency or not," Medicare says. But "constant physician attention" does not necessarily mean constant physical contact between the patient and the physician.

When you report critical care time, Medicare wants you to report "the time the physician spent working on the critical care patient's case, whether that time was spent at the immediate bedside or elsewhere on the floor, but immediately available to the patient."

So 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 would be reported as critical care, even if it does not occur at the bedside," Medicare says.

According to Lemanski, examples of possible critical care scenarios include patients:

- with acute myocardial infarction, especially those requiring thrombolysis
- with respiratory failure from acute pulmonary edema, chronic obstructive pulmonary disease (COPD), etc.
- who are unresponsive due to overdose, stroke, seizure, etc.

**Note:** For a list of more conditions that may warrant critical care, see "Chart Critical Care With This Checklist" on page 13.

Consider this example: The internist meets a 67-year-old established patient with COPD at the hospital. The patient is in severe respiratory distress with an acute exacerbation of his underlying lung disease.

Despite multiple rounds of nebulizers, treatment with steroids, and additional supplemental oxygen, the patient develops worsening respiratory distress and ultimately suffers a respiratory arrest and requires intubation. The physician documents that she spent 45 minutes outside of separately billable procedures caring for this critically ill patient.

On the claim, you would report the following:

- 99291 for the critical care
- modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) linked to 99291 to show that the critical care and intubation were separate services
- 31500 (Intubation, endotracheal, emergency procedure) for the emergency intubation
- 799.1 (Respiratory arrest) and 491.21 (Obstructive chronic bronchitis; with [acute] exacerbation) linked to 99291 and 31500 to prove medical necessity for the encounter.

#### Observe Critical Care Bundles

As shown in the above example, some services are separately reportable from critical care.

In addition to CPR, here are the other services that you may report separately from 99291 and 99292 when your internist performs them:

- endotracheal intubation
- pericardiocentesis
- central venous catheter placement.

However, the following services are bundled into 99291 and 99292:

- interpretation of cardiac output measurements
- interpretation of pulse oximetry
- interpretation of data stored in computers
- transcutaneous pacing
- ventilator management
- some vascular access procedures
- gastric intubation.

Suppose you're looking at encounter notes indicating that the physician provided critical care. During the session, the physician performed a central venous catheter placement (36556, Insertion of non-tunneled centrally inserted central

venous catheter; age 5 years or older) and pulse oximetry (such as 94760, Noninvasive ear or pulse oximetry for oxygen saturation; single determination). On the claim, you should report the central venous catheter placement separately, but you should consider the oximetry work part of the critical care.

#### Document Total Critical Care Time

Remember that critical care encounter time does not need to be continuous, says **Caral Edelberg, CPC, CCS-P, CHC**, president of Medical Management Resources for TeamHealth in Jacksonville, Fla.

When compiling critical care time, you should count the total time the physician provided his undivided attention in the care of the critically ill or injured patient on a single date of service, she says.

"That would include time spent documenting the critical care patient's record, speaking with family or other healthcare providers, treating the patient, giving orders for treatment, etc.," Edelberg says.

Noting these actions in the medical record is vital to the health of your critical care claim, because it will help support critical care services and medical decision-making, in addition to meeting the time documentation requirements for 99291.

Critical care time does not, however, include time the physician spends treating other patients, or time spent performing other billable procedures for the critically ill patient. So if the physician performs CPR, which is separately billable, the internist cannot count that time toward total critical care minutes.

Example: The internist provides 45 minutes of critical care for a patient in the morning. The patient's condition stabilizes, and the physician tends to other patients at the facility. Later that afternoon, the patient's condition deteriorates and the internist returns to provide 20 more minutes of critical care.

In this instance, the physician provided 65 minutes of noncontinuous critical care. On the claim, report 99291.

#### Drop Location Concerns for Critical Care

Remember that critical care can occur wherever the physician performs critical care on a patient -- the patient does not need to be in the intensive care unit or emergency department. What drives critical care is the patient's condition, not the location, Edelberg says.

However, "if the care were provided in an unusual location (such as an office or clinic), the provider may be required to provide documentation to the payer explaining the unusual place of service for such a high-acuity treatment," she says.

Best bet: If you have that rare claim in which the internist performs critical care outside of the hospital setting, contact the insurer and explain the situation before filing the claim.

Conversely, suppose the physician treats a patient in a location where critical care is common, such as the ICU. This is not a guarantee that critical care occurred; you'll have to check the encounter notes before deciding whether to use 99291-99292.

According to Medicare: "Services for a patient who is not critically ill and unstable but who happens to be in a critical care, intensive care, or other specialized care unit are reported using subsequent hospital care codes (99231-99233) or hospital consultation codes (99251-99255)."