Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Critical Care: 99291 vs. 99292: Check for Documentation of Time Before Selecting A Code

Critical care coding can be easy with these quick tips.

Whether your providers perform critical care services once a year or once a day, if you only look for the place of service and not the patient's condition, you'll set yourself up for inappropriate billing of critical care codes.

Read on to know more about when you can bill critical care services and other associated services provided to the same patient on the same day.

Assess Patient's Criticality

Ensure that the patient's condition qualifies as critical. CPT® guidelines state that "critical care is the direct care provided by a physician to critically ill or injured patient" and "the critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition." CMS states that "Critical care services must be medically necessary and reasonable" and if services provided are not in accordance to the definitions of critical care services, then an appropriate E/M code should be used to report the services provided (e.g., CPT® codes 99231-99233, Subsequent hospital care, per day...). For more details, check www.cms.gov/manuals/downloads/clm104c12.pdf.

When your physician provides critical care services, you report these services provided with 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) for the first 30-74 minutes of services provided.

For any additional time that your physician provides these services, you would use +99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes [List separately in addition to code for primary service]) for every additional 30 minutes.

Calculate Accurately Time Spent on Providing Critical Care

When your physician provides critical care for a patient, the notes need to show more than support for the patient's critical status. Critical care services are time based.

Vital: To accurately report critical care, the documentation should indicate the total amount of time the physician devoted their full attention to the patient providing critical care services. Ideally, coding experts would love to see a short explanation of the critical nature of the patient, the critical interventions and other activities that totaled up to XX minutes to make a bullet proof chart. But at a minimum you should include something along the lines of "Critical care time XX minutes not including separately billable procedures."

Official guidance: Many policy resources suggest the physician should document their total attention time (see the sidebar "Let Official CMS and MAC Guidance Direct Your Critical Care Coding" on page 228) and physicians should document to that standard. The time range indicated in the code descriptor is for the coder to use to select the correct CPT® code based on the total time documented by the physician.

Keep in mind: During this time the physician must devote full attention to the particular patient. This time may be spent at the patient's immediate bedside or elsewhere on the unit, so long as the physician is immediately available to the patient. So you need to document all the time spent that comes under the purview of critical care, for example, at bedside, discussion of the case with other staff, time spent with family recording history or making management decisions and reviewing results.

Time spent performing allowed billable services should not be included (e.g., insertion of an arterial line). Time spent performing bundled services (reading an ECG, starting an IV, or looking at x-rays or CT) should be included in the critical care time, if performed on the patient's floor/unit.

Don't Miss Other Billable E/M services

You will need to know when you can report E/M services and critical care services provided by your physician to the same patient on the same day. When the provider performs both an E/M service (outpatient or inpatient service) and critical care on the same calendar day, both services may be reported, as long as the E/M service preceded the critical care service. Providers are advised to retain documentation for discretionary contractor review should claims be questioned for both hospital care and critical care claims.

Example: A patient hospitalized with severe episodes of abdominal discomfort and diarrhea was seen in the morning for a level 2 subsequent hospital visit. The patient had earlier undergone paracentesis and was placed on diuretics for the management of ascites. The patient's condition deteriorated and the gastroenterologist suspected spontaneous bacterial peritonitis. The patient was moved to the ICU requiring 60 minutes of critical care time. You can code 99232 (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components...) with the modifier 59 (Distinct procedural service) along with 99291 for the day's efforts.