Part B Insider (Multispecialty) Coding Alert

E/M Coding: You Must Meet Both the "Critical" Illness and the Time Thresholds to Accurately Report Critical Care

Review these strategies to avoid auditors' scrutiny.

Critical care coding is often the target of payer audits -- and mistakes can cost you. Because the critical care codes are unlike the other E/M codes that you report every day, these can be misunderstood by those unfamiliar with the rules that do apply. Check out these tips on what "critical" actually means and which services are, and are not, bundled into the critical care codes.

Insurers May Not Agree That Your Patient Was Critically Ill or Injured

Whether the patient was critically ill or injured is perhaps the most important question you'll need to answer on any critical care claim. You must be able to establish that the patient is critically ill or injured to report 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]), reports **Michael A. Granovsky, MD, FACEP, CPC**, President of Logixhealth, a national emergency department coding and billing company based in Bedford, MA.

CPT® defines critically ill or injured as "an injury or illness that acutely impairs one or more vital organ systems such that there is high probability of imminent or life threatening deterioration in the patient's condition," Granovsky explains.

In addition, minimal time thresholds of care, at least 30 minutes must be clear from the medical records, says Granovsky.

He offers these examples of patients that insurers would consider critically ill or injured:

- An acute asthma exacerbation patient requiring multiple nebulizer treatments and close monitoring with perhaps the use of third line agents such as magnesium;
- An MVA victim with concerning internal injuries, altered mental status or significant fractures; and
- Unstable vital signs, severe hypernatremia, severe dyspnea, or a hypertensive crisis.

There Is A Good Chance That the "High Probability" Clause Will Be Questioned

Although most critical patients will be actively critically ill or injured, some may just be unstable to the point that they will very likely become so without immediate treatment.

When determining whether or not a patient is critically ill or injured, the physician should consider the likelihood that they would have a clinically significant deterioration if nothing was done in the next hour. If the probability for imminent or life threatening deterioration is high, critical care may be an appropriate consideration. For example consider a patient with an allergic reaction with severe laryngeal swelling that threatens to close off his airway, but is not yet fully decompensated and requiring intubation, says Granovsky.

Where Can the Physician Provide Critical Care?

Place of service is not restricted in CPT® other than to identify typical areas of a facility where it may occur. While most critical care will occur in a critical care area (ICU, ED, etc.), the physician can provide 99291 services in any place of service the patient requiring it presents. In fact, according to the Medicare database, about 25 percent of all critical care services were provided in the emergency department setting, Granovsky explains.

Don't Forget the Services That Are Bundled into 99291 and +99292

The CPT® critical care preamble includes a specific list of services that are bundled in to code 99291 and should not be reported separately. These include:

- The interpretation of cardiac output measurements (93561, 93562);
- Pulse oximetry (94760, 94761, 94762);
- Chest x-rays, professional component (71010, 71015, 71020);
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data (99090);
- Gastric intubation (43752, 43753);
- Transcutaneous pacing (92953);
- Ventilator management (94002-94004, 94660, 94662); and
- Peripheral vascular access procedures (36000, 36410, 36415, 36591, 36600).

Best bet: When your physician provides any of the above services during a critical care session, do not report them separately.

Non-bundles: However, you can report the below services separately from 99291 and +99292, as they are not bundled into critical care:\

- CPR (92950);
- Endotracheal intubation (31500);
- Tube thoracostomy (32551);
- EKG interpretations (93010, 93042); and
- Central venous catheter placement (36555, 36556).

Consider this example: A patient presents to the ED with worsening shortness of breath. The physician examines the patient and finds him to have elevated blood pressure and tachycardia. The patient is started on a Cardizem drip to control his heart rate. Labs, chest x-ray, and an EKG are ordered. Multiple re-evaluations are performed. The physician interprets both the x-ray and EKG, and the patient is diagnosed with CHF and atrial fibrillation. The EKG interpretation takes the physician four minutes, and the rest of the encounter took 46 minutes.

In this example, the physician spent 46 minutes providing critical care services to this patient (this time excludes time spent interpreting the EKG). On the claim you would:

- report 99291 for the 46 minutes of critical care.
- report 93010 (Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only) for the EKG.
- link ICD-9 codes 786.05 (Shortness of breath), 428.0 (Congestive heart failure, unspecified) and 427.31 (Atrial fibrillation) to 99291 and 93010 to prove medical necessity for the services.

On this claim, you would not code the chest x-ray interpretation, as it is included in the critical care code, says Granovsky.

Of note: Be sure to deduct the time spent providing these separately billable procedures (such as the EKG) from your critical care time reported, warns Granovsky.

Is It 30 or 31 Minutes to Qualify For Critical Care?

The 2014 CPT® book introduction discusses time threshold requirements for code sets that contain a time basis for code selection. It reads, "The following standards shall apply to time measurement, unless there are code or code-range-specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary. A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed."

In the case of code 99291, there is specific language in CPT® that states 30 minutes both in the code descriptor itself and in the time threshold chart in the critical care section preamble. So for 99291, CPT® describes a threshold of at least

30 minutes, when the midpoint would have been passed, Granovsky explains.