

## Part B Insider (Multispecialty) Coding Alert

### Part B Coding Coach: Are You Documenting Your Critical Care Time Accurately?

Check out these resources to see if your policies are in order.

Every coder knows critical care is a time-based code. But there can be some confusion about what documentation is required to justify the time reported. Where do you turn for definitive direction?

**Key resources:** The most obvious places to look are the CPT® book and the Medicare Claims Processing Manual. Per CPT®, "Time spent with the individual patient should be recorded in the patient's record" and the CMS manual tells us that "the physician's progress note(s) **shall document the total time** that critical care services were provided". CMS transmittals also tell us that the use of "Shall" denotes a mandatory requirement, says **Todd Thomas, CPC, CCS-P**, President of ERcoder, Inc. in Edmond, OK.

Physicians and coders should also be aware that the CMS manual also indicates that "The physician's progress note(s) in the medical record should demonstrate that time involved in the performance of separately billable procedures was not counted toward critical care time", he adds.

Good, Better, Best Documentation Principles

CPT® code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) does not use numerical documentation requirements for history, physical exam and medical decision making for code selection the way other E/M codes do. Instead the critical care codes are determined by the physician's total attention time. However, that doesn't mean that those E/M elements can be omitted in a critical care chart. These elements will be needed to indicate that the patient has a critical illness or injury that 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.

**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, I 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 I like to see something along the lines of "Critical care time XX minutes not including separately billable procedures", says Thomas.

Many policy resources suggest the physician should document their total attention time (see sidebar) and Thomas urges ED physicians to 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, he says.

**Red flag:** Auditors are increasingly leery of generic documentation that is not specific to the patient or encounter. Using the 30-74 minutes language that is included in some templates and EMRs seems to fit the CPT® code descriptors, but be careful on relying on solely an attestation.. "If I am going toe to toe with an auditor, I want documentation that complies with coding guidelines and CMS policy to ensure that there is no room for the auditor to argue that the ED chart does not accurately reflect the service that was provided and/or the code that was reported," advises Thomas.

Teaching Physicians Have More Documentation Homework

There is more specific instruction in the teaching physician section in the CMS critical care transmittal 1548 from July 2008, says Thomas. This update seems to hold the teaching physician documentation of critical care to a higher standard than just a blurb with the teaching physician time.

It reads, "The teaching physician medical record documentation must provide substantive information including:

- (1) the time the teaching physician spent providing critical care,
- (2) that the patient was critically ill during the time the teaching physician saw the patient,
- (3) what made the patient critically ill, and
- (4) the nature of the treatment and management provided by the teaching physician."

**Example:** Check out this example of acceptable teaching physician documentation: "Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."

It's important to remember that a resident's work and time providing critical care services cannot be used by the teaching physician to support reporting critical care. Some Medicare carriers have been refusing to allow payment for 99291 when the only teaching physician note in the chart is "Critical care time XX minutes", Thomas warns.