Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Can You Identify Critical Care Without A Doubt? 3 Expert Q&As Will Increase Your Certainty

You shouldn't report 99291 and 99292 just because the patient is in the ICU

Do you jump the gun and report critical care codes whenever you see "ICU" or "CCU" on the medical chart? You could be shooting yourself in the foot.

Time is crucial to reporting the correct critical care code, but so is the severity of the patient's condition.

Before assigning a critical care code - 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and 99292 (...each additional 30 minutes) - you need to confirm the patient's critical condition and look for documentation of the physician's time.

Not sure how to get it right every time? Learn all you need to know from the expert answers to these three pressing critical care coding questions:

1. How can I clearly identify a critical care patient?

Answer: Discerning whether a patient received critical care can be tricky, especially given that a patient may receive critical care services in a unit not designated as "critical care." For example, "the patient may not be in the ICU, but may be in life-threatening condition that merits critical care treatment," says **Catherine Brink, CMM, CPC,** president of **HealthCare Resource Management Inc.** in Spring Lake, NJ.

Or a physician may treat a patient in the intensive care unit (ICU), but the patient may not require critical care, adds **Marvel Hammer, RN, CPC, CHCO,** president of **MJH Consulting** in Denver, CO. Physicians and coders over-used critical care codes in the past because they inaccurately believed that any treatment in an ICU or critical care unit (CCU) qualified for critical care services codes, Hammer explains.

Critical condition is a must: Never assume you can code for critical care services just because the patient is in an ICU or CCU, Hammer says. The patient must be "critically ill or critically injured," according to CPT. A patient in critical condition suffers from impairment of "one or more vital organ systems" and faces "a high probability of imminent or life threatening deterioration," CPT states. "Examples of vital organ system failure include ... central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and/or respiratory failure."

Therefore, a physician administering critical care will engage in high complexity decision making to sustain the patient's life and prevent further deterioration in the patient's condition.

What to look for: For critical care, the physician's documentation should state how the patient's condition is life threatening, Brink says. For example, documentation may state the patient went into cardiac arrest, or respiratory failure, and needed to be put on a ventilator.

Watch out: On the day following initial critical care, physicians often report the patient is "stable," but this documentation doesn't tell anything about the severity of the patient's condition. A physician may say the patient is now "stable," but if he went into cardiac arrest the night before, his condition may still be critical, Brink says. Instead of simply writing "stable," physicians should document more details, such as "patient is responding to medication" or "patient is still on ventilator," she adds. These details give a more accurate description of whether the patient's condition still merits critical care codes.

Don't forget: A patient with a life-threatening problem doesn't necessarily merit critical care codes every single day, Brink says. For instance, a physician may render critical care services on day one and two, subsequent hospital care (99231-99233) on day three, and then the patient's condition may deteriorate on day four and warrant critical care treatment again.

2. Can I report an initial hospital care code and a critical care code for services a physician provides to the same patient on the same day?

Answer: Most payers, including Medicare, allow you to report only one E/M code for all the services a physician provides to the same patient on the same date of service - but critical care codes are the exception to this rule, says **Mary I. Falbo, MBA, CPC,** president of **Millennium Healthcare Consulting Inc.** in Lansdale, PA.

Example: Suppose your physician admits a patient and provides initial hospital care in the morning. Then the patient suffers a myocardial infarction in the afternoon, prompting the physician to perform one hour of critical care. You should report the appropriate level initial hospital care code (99221-99223) for the morning service and 99291 for the afternoon critical care service.

Add modifier -25: If you report critical care along with another E/M code, correct coding dictates you should append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the other E/M code you report, Falbo says. So based on the example above, you would report 99291 for the critical care and then modifier -25 with the other E/M service (99221-99223).

Pay attention to diagnoses: To justify both services on the same day, link a more specific diagnosis code to the critical care code, Falbo says. Based on the example above, you might report 786.50 (Chest pain, unspecified) for the initial hospital care and 410.01 (Acute myocardial infarction; of anterolateral wall; initial episode of care) for the critical care.

Documentation gets you paid: Payers frequently ask to see documentation before paying for critical care and another E/M service on the same day, Hammer says. Make sure your physician's documentation can back up your claims.

3. Can I report multiple blocks of critical care time, or must the physician's time be continuous?

Answer: You should use critical care codes 99291 and 99292 "to report the total duration of time" a physician spends providing critical care, according to CPT. And "the time does not have to be continuous," Falbo says.

Add up all reported times: Your physician needs to document the start and stop time of every critical care session with the patient, Brink says. Critical care services include both face-to-face patient time and time spent elsewhere on the floor or unit tending to the patient's care. However, CPT states the physician must be "immediately available to the patient." Critical care does not include time the physician spends in other units or off the floor tending to the patient's care needs.

Example: If the physician's notes state he spent 90 minutes on critical care in the morning and another 30 minutes in the afternoon, you should report a total of 120 minutes of critical care services with 99291 (for the first 74 minutes) and two units of add-on code 99292 (for the additional 46 minutes).

Don't round up: "The key thing is that you can't round up," Falbo says. CPT dictates that you use 99291 for the first 30-74 minutes of critical care. So if the physician performs a total of less than 30 minutes of critical care, you cannot report 99291 for the service, Brink says. Instead, you would report the service with the appropriate level E/M code, most often an initial or subsequent hospital care code, she adds.

When to subtract time: CPT lists many procedures that are bundled into critical care services. However, if your physician performs a non-bundled procedure during the critical care period, be sure to subtract the time spent on the non-bundled procedure from the total amount of critical care time.

For example, a Swan-Ganz catheter (93503 - Insertion and placement of flow directed catheter [eg, Swan-Ganz] for monitoring purposes) is not bundled with critical care, Falbo says. If the physician reports he spent 70 minutes in critical care, and spent 10 minutes of those critical care minutes performing the catheterization, you are left with 60 minutes of reportable critical care time - still enough to qualify for a 99291, she says.

The physician needs to document his critical care start and stop times, as well as the catheter procedure, so that you can calculate the proper amount of critical care time. The payer is reimbursing you separately for the non-bundled procedure, so documentation is crucial to prove you didn't "double-dip" on the time spent on the non-bundled procedure, she concludes.