Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Get Burned By Critical Care Coding Errors

Hint: A stay in ICU doesn't always justify a critical care code

There's more to determining critical care status than the patient's diagnosis, and if you don't look at the big picture, you could risk reimbursement denials and even attract an audit. Use our guidelines to focus in on when to use critical care codes--and learn how to ensure you have all the supporting documentation you need.

Look Closely At CPT's Definition of Critical Care

Before you use critical care codes 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and +99292 (... each additional 30 minutes [List separately in addition to code for primary service]), you should review how CPT defines a critical care patient.

Definition: According to CPT, the patient must have "a critical illness or injury [that] acutely impairs one or more vital organ systems" and requires the physician to perform "decision making of high complexity to assess, manipulate and support central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, postoperative complications, overwhelming infection, or other vital system functions to treat single or multiple organ system failure, or to prevent further deterioration."

A physician needs to document that the patient is critically ill, which requires that the patient has at least one organ system that is failing and that the patient's life is in jeopardy, advises **Alan L. Plummer, MD**, professor of medicine, Division of Pulmonary, Allergy, and Critical Care at **Emory University School of Medicine in Atlanta**. Without documentation of these criteria, you can't report critical care codes.

Alternatives: If your physician's services do not meet the criteria for critical care services, then you should not report 99291 or 99292. You'll have to use another appropriate E/M service code (such as subsequent hospital care codes, 99231-99233 or inpatient consultation codes, 99251-99255), depending on the level of service the physician provided.

Critically Ill Doesn't Equal Critical Care

Just because your physician is providing care to a critically ill patient, don't automatically assume you can code his services using critical care codes.

Example: If a physician makes rounds in an intensive care unit (ICU), you shouldn't assume this is critical care because you may not meet the time requirements for critical care. A patient who is intubated for acute respiratory failure (518.81), and is improving or even stable, may not be considered critically ill, particularly if the physician's service does not require his constant attention toward the care of the patient. Because the requirements for critical care have not been met, you cannot report critical care codes for the physician's services in this case.

Rule of thumb: A patient does not have to be in the intensive care unit (ICU) to be critically ill, and similarly, not every patient in ICU is critically ill, advises **Pierre Edde, MD, FAASM** (Fellow of the American Academy of Sleep Medicine), director of the sleep and respiratory services at **Uniontown Hospital in Pennsylvania** and founder of www.PCSbilling.com.

Be clear: The word "stable" is often confusing for physicians and coders alike, says **Carol Pohlig, BSN, RN, CPC**, senior coding and education specialist at the **University of Pennsylvania** department of medicine in Philadelphia. "The patient may be 'stable' due the interventions provided. Remove the intervention and the patient may severely decline."

For example, a patient may "consistently require" supportive ventilation due to acute respiratory failure. As long as the patient's condition warrants the physician spending more than 30 minutes directing his attention to the care of that single patient, you can report critical care codes, Pohlig advises.

Remember to Specify Time

The critical care codes are time-based codes, so you need to look at the physician's documentation to determine which code you should report. For the first 30 to 74 minutes of critical care your physician provides, report 99291. For each additional 30 minutes, you'll add 99292. If the physician spends less than 30 minutes providing critical care to the patient you have to choose another appropriate E/M code. "The time has to be documented or the service will be denied," Edde cautions.

Note: Critical care does not have to be continuous, but you should make sure your physician records the time he or she spends with the patient in the patient's chart and explains everything he or she did during that time. Critical care works on a calendar day. "The time can be spent intermittently throughout the day, so long as it is documented," Plummer says. "Documentation can be total time (eg., 35 minutes) or start/stop time (eg., 0800-0835)."

Remember: Time your physician spends performing separately reportable procedures does not count as critical care. Also, the physician's critical care time should not overlap with critical care time reported by anyone else on the same day. "It is important to make sure that there is no overlap of services," Pohlig warns.

Tip: The physician has to provide his or her "full attention" to the patient, but that doesn't mean that critical care time only includes the time the physician spends at the patient's bedside. Use these additional coding tips to ensure you correctly report critical care services every time:

• Time spent in the ICU nursing station reviewing test results or imaging studies, discussing the critically ill patient's condition with other medical staff, and documenting critical care services all qualify as critical care.

• If the patient is unable to make decisions for himself/ herself, then discussions with the family also count as critical care time.

• If the patient is fully cognitive and is able to make decisions, then discussing the patient's condition with the family in the presence of the patient counts as critical care time, but the same discussion held without the patient present does not count as critical care time.

• Tasks such as reading x-rays in the radiology department or talking to family on the phone from the office, however, do not count toward critical care time, Plummer cautions.