Codify by AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Heed New Transmittal When Documenting, Compiling Critical Care Time

Medicare clears up counseling, concurrent care rules

If coders can learn to spot critical care indicators, and doctors are diligent about documenting encounter specifics, you can capture critical care each time the physician provides it.

To help coders with this process, CMS released transmittal 1530 on June 6.

This document puts all critical care coding guidance in one easy-to-access place, says **Carol Pohlig, BSN, RN, CPC, ACS**, senior coding and education specialist at the **University of Pennsylvania**.

The transmittal, effective July 7, makes especially clear points on documenting family counseling time and coding for concurrent critical care.

Keep it handy when you-re coding for 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and +99292 (- each additional 30 minutes).

Use CMS -Approved- List

The transmittal spells out exactly what interactions with the patient's family you can count toward overall critical care time, Pohlig confirms.

According to the transmittal, -CPT codes 99291 and 99292 include pre- and post-service work. Routine daily updates or reports to family members and/or surrogates are considered part of this (included) service.- So if the physician meets for 3 minutes with a patient's wife to give her an update, you should not count this as critical care time.

Exception: When the patient is unable or incompetent to give a medical history or make treatment decisions, you can count time spent consulting with the family toward critical care. You can also include time spent discussing treatment decisions, if the physician has to ask a family member for
patient information.

You-ll need to be sure to document the family counseling time properly, Pohlig warns. When recording family counseling time for critical care, the transmittal states that the provider must document the following:

- that -the patient is unable or incompetent to participate in giving history and/or making treatment decisions;

- the necessity to have the discussion (e.g., -no other source was available to obtain a history- or -because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family-);

- medically necessary treatment decisions for which the discussion was needed; and

- a summary in the medical record that supports the medical necessity of the discussion.-

Show Physicians the Value of Documentation

The physician also needs to be diligent about documenting the other critical care components. Often, the physician does

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not provide enough information on encounter forms to justify critical care coding.

Bottom line: To report 99291, the physician needs to spend a minimum of 30 minutes providing critical care to the patient. If the physician performs activities that count toward that time, but does not include them in the documented time, then appropriately coding critical care is virtually impossible. This problem has hamstrung many potential 99291 claims.

-Some physicians I talk to say they don't know what's included in critical care, which makes counting up the time very difficult for coders,- said -**Caral Edelberg, CPC, CCS-P, CHC,** president of **Medical Management Resources for TeamHealth** in Jacksonville, Fla. during a recent audioconference on documenting hospital services (www.audioeducator.com).

Key: Documentation must support that critical care services were medically necessary and reasonable. You can report critical care services for the time the physician spent evaluating, providing care and managing the critically ill or injured patient's care. The physician must spend the time at the immediate bedside or elsewhere on the floor or unit, provided the physician is immediately available to the patient.

For example, you may report time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor as critical care, even when the service does not occur at the bedside, if this time represents the physician's full attention to the critically ill/injured patient's management .

Don't miss: For any given period of time spent providing critical care services, the physician must devote his full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

Best bet: Educate your physicians on what's included in critical care time, and encourage them to write down any activity they perform toward patient treatment.

Overlapping Time a No-No on Concurrent Care

Transmittal 1530 also spells out Medicare's concurrent care coding rules. Physicians from different specialties can provide critical care on the same calendar date to the same patient, provided the services are not -duplicative.-

-The medical specialists may be from the same group practice or from different group practices,- the transmittal states. Provided the physicians are not billing for the same time block, they can each report critical care they provide for the same patient, Pohlig confirms.

-Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient,-according to the transmittal.

Exception: Medicare may cover concurrent care by more than one physician (generally representing different physician specialties) if the requirements in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, section 30 are met. For instance, if a cardiologist and internist provide critical care services that warrant the physician's sub-specialty (cardiology) and internal medicine expertise, then medically necessary concurrent critical care for the same time period may be payable.

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