Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Bust These 2 Critical Care Myths to Maximize Your Income

Here's what you need to have when reporting critical care to Part B payers.

If you meet two important critical care requirements in the time and documentation departments, your claim will succeed even if the physician is not in the emergency department or other critical care area.

Myth 1: You Can Only Provide Critical Care in the Emergency Room

If you think that your physician has to be in an emergency department (ED) or other critical care area, you may be missing out on well-deserved reimbursement for codes 99291 and +99292. In reality, a physician can provide critical care just about anywhere he meets the patient and provides the service.

In other words, no matter the setting, you should base critical care based on time only, for the critically ill or critically injured patient, meaning there is a high probability of imminent or life-threatening deterioration of the patient's condition.

In black and white: "While critical care is usually given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department, payment may also be made for critical care services that you provide in any location as long as this care meets the critical care definition," CMS says in MLN Matters article MM5993. If you provide medical care to a critically ill, injured, or postoperative patient, you can report a critical care code if both the illness or injury and the treatment provided have a high probability of imminent or life threatening deterioration, CMS says.

Myth 2: Documentation Is Secondary to Setting

Even though the critical care may have occurred in a nontraditional setting, the service is still a viable critical care claim as long as you meet documentation requirements.

Whether a service meets critical care requirements depends on treatment, level of care performed, gravity of the patient's condition, and the physician's documentation and notes. In critical care, setting is secondary to documentation.

Heed this advice: To lock up reimbursement for your critical care claims, check out this short list of tips on documentation:

Note a start and stop time for the critical care services. Also document time spent on all care management services provided in that time. In addition, you should give details about all the services the physician provides. These services would include the usual E/M components. Other services that may (or may not) be part of a carrier's critical care package include:

- interpretation of cardiac output studies

chest x-rays
blood gases
electrocardiogram
blood pressures
hematological testing
gastric intubations.

Try This Critical Care Scenario

Now that you've busted the above two myths, try your hand at the following critical care scenario.

Example: A patient with macro nodular cirrhosis of the liver presents to the hospital where the physician treats him for severe gastrointestinal bleeding. The patient is hemorrhaging heavily, and the physician needs to perform bedside care and management before deciding whether he will conduct an endoscopy to find the bleeding's origin and stop it.

Solution: The physician documents 47 minutes of critical care, during which time he:

lavages blood from the patient
conducts tests and analyzes results
consults with other physicians.

On your claim, you should:

report 99291 for the critical care services
attach 578.9 (Hemorrhage of gastrointestinal tract, unspecified) and 571.5 (Cirrhosis of liver without mention of alcohol) to 99291 to show the payer why critical care was medically necessary.

What you need: The physician documented the 47 minutes of critical care services, so you need to include this with your claim. Also, make certain that the physician gives the details about what he performed.