Critical Care
What Makes this so Difficult

Presented by
Medical Revenue Solutions, LLC
An Independent Healthcare Audit Organization

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Disclaimer

The speaker has no financial relationship to any products or services referenced in this program. The program is intended to be informational only. The speaker is not an authoritative source by law. Attendees are advised to reference payer specific provider manuals, on-line or otherwise, for verification prior to making changes to their coding, documentation and/or billing practices.
Focus of Today's Critical Care Discussion

- Definition of Critical Care
- Who can provide critical care services
- Where critical care services can be provided
- CPT codes 99291 & 99292
- Documentation and time requirements
  - Please note where possible in this presentation Critical Care will be designated by CC in all slides.
Medical Definition of CRITICAL

• From Merriam-Webster Medical Dictionary
  • a: relating to, indicating, or being the stage of a disease at which an abrupt change for better or worse may be anticipated with reasonable certainty <the critical phase of a fever>
  • b: being or relating to an illness or condition involving danger of death <critical care> <a critical head injury>
AMA Definition of Critical Illness or Injury

The AMA’s CPT has redefined a critical illness or injury as follows:

- “A critical illness or injury acutely impairs one or more vital organ systems such that the patient’s survival is jeopardized.”

- Note: The term “unstable” is no longer used in the CPT definition to describe critically ill or injured patients.
Critical Care is when the provider is treating the patient’s critical problem “with high complexity decision making to assist, manipulate, and support vital systems to treat a single or multiple vital organ system failure and/or prevent further life threatening deterioration of the patient’s condition”.

Critical Care is a provider judgement call based on the presenting problems or issues.
Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient’s condition.

Providing medical care to a critically ill patient should not be automatically determined to be a critical care service for the sole reason that the patient is critically ill. The physician service must be medically necessary and meet the definition of critical care services as described previously in order to be considered covered.
Organ System Failure

- Central nervous system failure
- Circulatory failure
- Acute renal failure
- Shock
- Acute hepatic failure
- Acute metabolic failure
- Respiratory failure
Any time a provider does anything for any other patient it must be carved out of the CC time. Constant attendance is not required for the billing of CC.

CC is a time based code and in that it must show the time in the provider note. So it does not have to be continuous during the 24 hour period. However when the provider is performing CC he/she must only be performing services that contribute to the care of that particular patient.

If the provider is involved with the family or caregivers in many cases it is due to the fact the patient is unable to participate in their care. This is still considered “Full Attention”.

Exclusive Care or Full Attention
Critical services are defined as a physician’s direct delivery of medical care for a critically ill or critically injured patient. It involves decision making of high complexity to assess, manipulate, and support vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition.

*In this context physician is considered also a qualified health care professional per CPT.
Critical Care Split/Shared between Physicians

- Two physicians in the same group can share services as long as each has his/her own time that is appropriate for CC and that the patient meets the CC guidelines during all of the time billed for.
  - Example is a hospitalist that has the day shift and provides an hour of CC to a patient. When he/she leaves and another hospitalist takes over provides an additional hour of CC time.
    - Physician A – 99291
    - Physician B – 99292 x 2
Critical Care Shared with a NPP

- According to CMS a physician and a NPP can not split/share a service based on time.
- Critical care services are reflective of the care and management of a critically ill or critically injured patient by an individual physician or qualified NPP for the specified reportable period of time and shall not be representative of a combined service between a physician and a qualified NPP. (Novitas)
Both providers are in the same group, same specialty.

- 8:00 am to 9:00 am Dr. Jordan see’s the patient that is critical, and generates a service for 99291.
  - Dr. Jordan - 99291
- 4:00 pm to 5:00 pm Dr. Jordan’s Nurse Practitioner, Nancy see the patient that is still critical.
  - Nancy, NP - 99291

Per CMS Physicians and NPP’s cannot split/share CC services. In this scenario NPP’s have different Taxonomy codes, there services are billable under their NPI, “as long as all the requirements for critical care services are met.” per WPS GHA Provider Outreach & Education
Taxonomy Codes

- Nurse Practitioner 50
- Certified Nurse Midwife 42
- Physician Assistant 97

- Complete listing at:
  https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf
According to the SCCM billing guidelines the following is acceptable:

- A PA and NP can combine time.
- When physicians and NPPs bill for critical care on the same patient, the time should be billed according to insurance payer guidance. Most commercial payers will allow for the combination of physician and NPP time when billing for critical care.

NOTE: Be sure and verify this with any and all payors before billing.
Can nonphysician providers (NPP) [e.g., physician assistants and nurse practitioners] bill for critical care services?

According to Medicare guidelines, NPPs can provide critical care services under the following conditions:

- The services provided must be within the scope of practice and licensure requirements for the state in which the NPP provides the services.
- For physician assistants, general physician supervision requirements must be met.

With these conditions met, NPPs can bill using codes 99291 or 99292 under their provider number.
Teaching physician care must meet all of the criteria for CC as well as the following:

- Time teaching can not be counted towards CC.
- The documentation must support both the physician and resident were present and involved for the CC time billed. Only the teaching physician’s time is counted for CC services.
- A combination of the documentation from the attending and resident must support the medical necessity of CC and the time billed.
- Documentation must meet the standards for billing a teaching service.
Critical Care During a Trauma

- Critical Care can be billed during a trauma.
- Not all traumas will qualify for critical care.
- Not all traumas will qualify for a Trauma Team activation.
- Not all Trauma Team activations will qualify for critical care.

- See the attachment at the end of the presentation from the University of Missouri, Columbia. It is their Trauma Team Activation Criteria. Each of you should look in your state to see what that criteria is. It will help you with the use of CC.
CC Documentation in a Trauma

The following comments are based on the perception that the patient qualifies for critical care.

• The CC/trauma note by the lead provider running the trauma does not have to be in the format of a regular E/M note.

• Many providers use a narrative of the issues and problems and nature of the condition as a basis for their note.

• The note should include all of the basics that are listed in the CPT book for critical care.

• The note should further show the involvement of the provider as to what he is directing and what he is performing.
CC Documentation in a Trauma

- If the provider leading the trauma is busy with the details of the trauma and he/she is not able to pull away to perform any of the procedures that are included, some other provider should perform and bill for them. However the note by the TT leader as well as the supporting documents by the hospital scribe should support this. In other words if the leader stopped doing what he/she was doing to perform a procedure what would happen to the patient.

- All of the trauma is based on medical necessity.

- What providers are called into the trauma is based on the diagnosis and condition of the patient.
CC Documentation in a Trauma

- As you consider if your practice should bill for CC during a trauma, take a look at the resources that should be available to help you with this process.

- Most hospitals have a designated TT on the hospital side. During the trauma, the hospital team is responsible for keeping track of all that happens and the time. All tests, procedures, readings, etc. are time-stamped by the hospital staff person running the trauma board. This is how the hospital keeps track of what is being done by whom and when.

- This report that is run by the hospital can help the provider performing the CC track all that was done and the time involved.
99291

- Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes. Meaning 30 minutes or more of direct care provided by the physician or other qualified health care professional to a critically ill or injured patient.

- All time counted in CC is spent exclusively* with the patient or family/caregivers at the bedside or on the unit. The time spent for CC does not have to be face-to-face time with the patient. It can be spent reviewing test results, imaging studies, discussing care with other providers.

  *Exclusively means that the provider can not be caring for any other patient while providing critical care.
99292

- Critical care, evaluation and management of the critically ill or critically injured patient; each additional **30** minutes (List separately in addition to code for primary service)

- This is an add on code and does not stand on its own. You must bill 99291 with this code.
99291 & 99292 includes the following

- Professional Services for the interpretation of
  Blood gases
  Chest films (71010, 71015, 71020)
  Measurement of cardiac output (93561-93562)
  Other computer stored information (99090)
  Pulse oximetry (94760-94762)
  Professional services for:
  Gastric intubation (43752-43753)
  Transcutaneous pacing, temporary (92953)
  Ventilation assistance and management, includes CPAP, CNP (94002-94004, 94660, 94662)
  Venous access, arterial puncture (36000, 36410, 36415, 36591, 36600)
99291 & 99292 excludes the following

Critical care services provided via remote real-time interactive videoconferencing (0188T, 0189T)

Inpatient critical care services provided to child 2 through 5 years of age (99475-99476)

Inpatient critical care services provided to infants 29 days through 24 months of age (99471-99472)

Inpatient critical care services provided to neonates that are age 28 days or less (99468-99469)

Other procedures not listed as included performed by the physician or other qualified health care professional rendering critical care

Patients who are not critically ill but in the critical care department (report appropriate E&M code)
RVU’s 99291

- The information provided is for the National RVU’s.

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**RVU’s 99292**

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Facts about Critical Care

- CC can be provided in settings other than the intensive care unit.
- CC may be provided in addition to other E/M services by the same provider on the same date under qualifying circumstances.
- CC is a 24 hour code. 99291 is billed once and 99292 is billed each additional 30 minutes by using units.
- The total time spent in CC must be notated in the chart for confirmation if audited.
- CC may be provided on multiple days even if there are no changes to the treatment plan as long as all the requirements for critical care services are met.
Facts about Critical Care Continued . . .

- Not allowable on a Medicare ASC claim. These codes represent physician and nonphysician practitioner professional services or services billable only by another type of entity. Physician and nonphysician practitioner professional services must be billed on a separate claim from the ASC services.

- Critical Care codes 99291 and 99292 may require the use of applicable modifiers. Modifier usage may be payor specific, refer to their coding and billing policies.
Facts about Critical Care Continued . . .

- When CC time crosses midnight to the next calendar day (Noridian)
  - What happens if the critical care services extend over the midnight hour into another calendar day?
- CPT coding principles require that when a time-dependent service is performed continuously and crosses over midnight the time should be accrued for, and reported as occurring, on the pre-midnight date; however, once the service is disrupted (i.e., becomes non-continuous), that creates the need for a new initial service on the post-midnight date.
Crossing Midnight

- Physician provides CC starting at 11:50 pm on 9/1/16 and ends at 12:45 am on 9/2/16.
  - 9/1/16 – 99291 (55 minutes)

- Physician provides CC starting at 11:40 pm on 9/1/16 and is called away at 12:05 am on 9/2/16 due to another urgent patient. Returns at 12:20 am on 9/2/16 to resume CC and times out at 1:15 am on 9/2/16.
  - 9/1/16 – E/M (CC was less than 30 minutes, 25 minutes)
  - 9/2/16 – 99291 (55 minutes)
Time

- 99291 and 99292 are time based codes. To be reported as Critical Care the time spent must be at least 30 minutes. Anything less is reported by other E/M services.
- The chart documentation must reflect the total time the provider spent in giving his/her full attention to this patient in CC.
- Any of the procedures that are performed that are included in the charge for CC must be carved out of the time billed for CC. The providers note should reflect that these procedures were not counted in the CC time.
Time continued...

Time includes:

- Patient care at the bedside
- Review of test results or imaging studies at the nurse’s station for example
- Discussing the patient care with other medical staff
- Discussion with family and decision makers as appropriate
- Documentation in the medical record
## Time Grid for Critical Care

### Table 1
**Reporting of Critical Care Services**

<table>
<thead>
<tr>
<th>Total Duration of Critical Care</th>
<th>Appropriate CPT Codes</th>
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<tr>
<td>Less than 30 minutes</td>
<td>99232 or 99233 or other appropriate E/M code</td>
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<tr>
<td>30 - 74 minutes</td>
<td>99291 x 1</td>
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<tr>
<td>75 - 104 minutes</td>
<td>99291 x 1 and 99292 x 1</td>
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<td>105 - 134 minutes</td>
<td>99291 x1 and 99292 x 2</td>
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<tr>
<td>135 - 164 minutes</td>
<td>99291 x 1 and 99292 x 3</td>
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<tr>
<td>165 - 194 minutes</td>
<td>99291 x 1 and 99292 x 4</td>
</tr>
<tr>
<td>194 minutes or longer</td>
<td>99291 – 99292 as appropriate (per the above illustrations)</td>
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Critical Care and E/M on Same Day

- Billing for both CC and other E/M services on the same day by the same provider are acceptable.
- To be covered the lesser service is provided prior to the patient needing the CC services.
- These visits are separately documented in the chart. The time for the separate E/M visit provided first is not counted toward the CC services.
- The medical record must support the reasonableness of the separate services.
End of Life Services

- Services provided by Palliative Care can not be submitted with CC.
- These services and diagnoses do not meet the definition of CC.
- Hospice can not submit CC for the same reason.
- Both Hospice Services and Palliative Services can be performed in the ICU but not as CC. By nature neither specialty is providing any CC service.

If for any reason CC is performed on a patient in Palliative or Hospice these services and notes need to be reviewed at the hospital level prior to submission. Neither of these programs cover CC.
What if it is Not Critical Care

Providers need to understand what other options are available.

- Anyone can use an emergency department code
- Prolonged care is an option to add on to a visit code
- Outpatient Visit codes can be used in the ED with a prolonged service code
- Very rarely would a TT activation be a consultation
Physician Jones admits a patient with septic shock to the ICU. Her initial treatment involves intubation and placement of a central line and arterial line. The patient receives mechanical ventilation, volume resuscitation and antibiotics; a norepinephrine infusion is initiated and titrated for mean arterial pressure management. Ventilator titration is performed, as well as electrocardiography, arterial blood gas measurement, central venous oxygen saturation determination, and chest radiography interpretation. Finally, time is spent documenting time spent in critical care management as well as ICU admission. The total time spent was 119 minutes with 45 minutes devoted to procedures.

Physician Assistant Smith is covering the ICU that evening. The patient develops acute respiratory distress syndrome and is managed with low tidal volume ventilation. The patient also develops acute kidney injury, requiring placement of a temporary dialysis catheter, and she is managed using continuous hemodialysis. The total critical care management time spent was 90 minutes, including 30 minutes of procedural time. How would the critical care time be most appropriately billed?
Answer - Commercial

- **Physician Jones**
  - Critical care time, 74 minutes – 99291
  - Arterial line – 36620: arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
  - Central line – 36556: non-tunneled central venous catheter > 5 years of age
  - Intubation – 31500: endotracheal intubation, emergency

- **Physician Assistant Smith**
  - Critical care time, 60 minutes – 99292 x 2
  - Temporary dialysis catheter placement – 36556: non-tunneled central venous catheter >5 years of age. Append modifier -59 to second central line code to avoid risk of denial by the payer as a duplicate code.
Answer - Medicare

- **Physician Jones**
  - Critical care time, 74 minutes – 99291
  - Arterial line – 36620: arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
  - Central line – 36556: non-tunneled central venous catheter > 5 years of age
  - Intubation – 31500: endotracheal intubation, emergency

- **Physician Assistant Smith**
  - Critical care time, 60 minutes – 99291
  - Temporary dialysis catheter placement – 36556: non-tunneled central venous catheter >5 years of age. Append modifier -59 to second central line code to avoid risk of denial by the payer as a duplicate code.
Critical Care & Global Surgical Package

- Complications unrelated to the surgery
- Unrelated postoperative conditions
- CPT or CMS surgical package definition
- Work Comp payor and/or state specific
Critical Care Payer Audits

- Amount of time billed
- Diagnosis
- Other services provided
- Procedures
- Multiple Critical Care billing for the same date of service
Critical Care 99291 and 99292 – Noridian September 7, 2016

Summary of State Findings

- **99291/99292** – 1,418 services reviewed: **32.55%** error rate
  - The error rate is calculated by dividing the dollar amount of charges billed in error (minus any confirmed under-billed charges) by the total amount of charges for services reviewed.

Top Denial Reasons

- Improper documentation of time
- Missing or illegible signature
- Failure to submit documentation within allotted timeframe
References

- 100-04 Chapter 12 section 100.1 (teaching physician guidelines)
- 100-08 Chapter 3, section 3.3.2.4 (signature requirements)
- MLM article MM6698 (signature requirements for medical review)
- 100-04 Chapter 12 section 30.6.12 (definition of critical care)
- 100-04 Chapter 12 section 30.6.12.H (CC and E/M on same day)
- 100-04 Chapter 12 sections 30.6.12.E,F,G (counting time and units)
References...continued

- IOM 10004, Chapter 12, Section 30.6.12J. (Critical Care)
- Society of Critical Care Medicine  
  http://www.acep.org/Content.aspx?id=30466
- AMA CPT for Professionals 2015
- WPS Medicare, JMAC 5
- University of Missouri, School of Medicine
The Final Word…

What has been discussed in this presentation may or may not apply to your practice. Be sure you check with your hospital and office policies to see if these services are allowed as discussed.

You also need to be sure and review the state scope of practice as well as your payer regulations for the most current rules and regulations in your area.

Thank you,

Sarah Reed, CPC
QUESTIONS

This presentation was presented by:
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Senior Managing Consultant

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