

# Billing and coding for critical care

For Vanderbilt Medical Center

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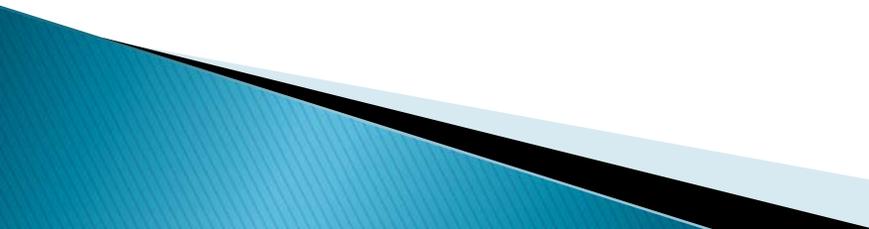
# Objectives

- ▶ Describe the services in critical care that nurse practitioners perform that are billable
  - ▶ Discuss what is covered by the global fee for surgery, and therefore is not billable
  - ▶ Discuss how nurse practitioner services and documentation meshes with resident services and documentation, as these relate to billing
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# Critical care service, defined

- ▶ “Critical care is high complexity decision making to assess, manipulate, and support vital system function to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition.”
  - CMS Transmittal 1530 (June 6, 2008)

# Critical care CPT codes (99291 and 99292) include

- ▶ Interpretation of cardiac output measurements, chest x-rays, pulse oximetry, blood gases, and information data stored in computers
  - ▶ Gastric intubation
  - ▶ Temporary transcutaneous pacing
  - ▶ Ventilatory management
  - ▶ Vascular access procedures
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# If billing CPT 99291, 99292

- ▶ Do not separately bill for
  - Interpretation of cardiac output measurements
  - Chest x-ray, professional component
  - Blood draw
  - Blood gasses
  - Gastric intubation
  - Pulse oximetry
  - Temporary transcutaneous pacing

# What may be billed separately from CPT 99291, 99292

- ▶ Endotracheal intubation
  - ▶ Insertion/placement of Swan-Ganz
  
  - ▶ Use modifier -25
  - ▶ Don't count the minutes spent performing these procedures
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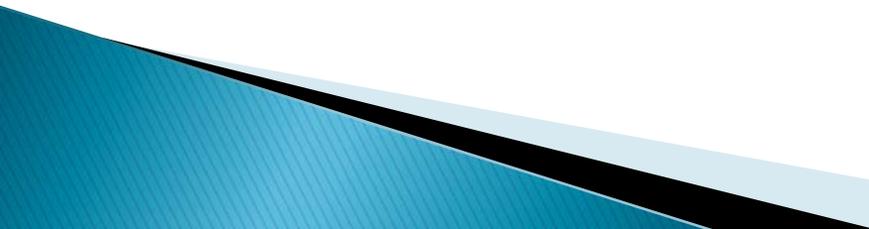
# Criteria for billing CPT codes 99291 and 99292

- ▶ Select a code based on time spent at bedside or on the unit
- ▶ Select CPT 99291 when spending at least 30 minutes and up to 74 minutes
- ▶ Select CPT 99292 when spending 75–104 minutes (Bill CPT 99291 and 99292)
- ▶ When spending 105–134 minutes, bill CPT 99291 and 99292 x 2

# Criteria for billing CPT codes 99291 and 99292

- ▶ CPT 99291 may be billed only once per day per specialty
  - Physicians in the same group may add their minutes together and bill under one physician
  - NPs in the same group may add their minutes
  - NPs and MDs may not add their minutes

# Examples

- ▶ Physician A spends 40 minutes, Physician B in same group spends 30 minutes
    - Bill CPT 99291 under Physician A
  - ▶ Physician A spends 40 minutes, NP B in same group spends 30 minutes
    - Bill CPT 99291 under Physician A
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# “Time spent” means

- ▶ Time spent evaluating, providing care and managing the patient at the bedside or on the unit
- ▶ Examples
  - Time spent examining the patient
  - Time spent writing orders
  - Time spent reviewing lab test results
  - Time spent discussing patient’s care with other staff in the unit

# Requirements regarding time spent

- ▶ Services must be “physician services”
  - Federal definition of physician services: Diagnosis, therapy, surgery, consultation, and home, office and institutional visits
    - 42 CFR §410.20
- ▶ Time billed must represent the NP’s full attention to the management of the critical care patient

# Additional rules

- ▶ More than one physician/NP may provide critical care if the service is not duplicative and the services are medically necessary
- ▶ Report 2 different diagnosis codes relevant to the respective specialties and why both providers are seeing the patient
  - Example: Pulmonologist reports diagnosis of acute respiratory failure; cardiologist reports diagnosis of congestive heart failure

# What is not billable (not counted in time spent)

- ▶ Activities off the unit, including telephone calls (with one exception)
- ▶ Time spent performing procedures which are billed and paid separately
  - Example: Endotracheal intubation -- In your note, specify that the time spent on the procedure was not counted toward critical care time

# What is not billable (not counted in time spent)

- ▶ Review of literature (even if performed at bedside)
  - ▶ Teaching sessions with residents, whether in rounds or in other venues
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# Reimbursement for critical care codes

- ▶ CPT 99291      \$184.94
- ▶ CPT 99292      \$92.42

# Other issues to be covered in this talk

- ▶ When critical care codes may be used
  - ▶ How to code time spent by teams, including nurse practitioners and physicians
  - ▶ How to document medical necessity of critical care services
  - ▶ What is covered under the global fee for surgery, and therefore is not billable as critical care
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# When are services billable as critical care?

- ▶ What is critical care?
  - Critical care is high complexity medical decision making delivered to a critically ill or injured patient.
- ▶ “Critical care is defined as the direct delivery by a physician of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition.”
  - CMS Transmittal 1530 (June 6, 2008) and Transmittal 1548 (July 9, 2009)

# Examples of vital organ system failure

- ▶ CNS system failure
- ▶ Circulatory failure
- ▶ Shock
- ▶ Renal, hepatic, metabolic and/or respiratory failure
  - CMS Transmittal 1530 (June 6, 2008)

# Does critical care have to be in an ICU?

- ▶ No. Critical care usually is given in an ICU or ED, but may be provided in any location as long as the care meets the definition of critical care.
- ▶ “Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology, critical care may be provided in life-threatening situations when these elements are not present.”
  - CMS Transmittal 1530 (June 6, 2008)

# Critical care = high complexity decision making for a critical illness/injury

- ▶ Both the illness or injury and the treatment being provided must meet the requirements
- ▶ Is this critical care?
  - NP treats viral conjunctivitis for a patient in trauma unit with blunt force trauma to abdomen
  - NP evaluates and treats a patient who has collapsed and ceased to breathe while in the hospital cafeteria
  - NP performs examination and initiates treatment for sepsis for a patient in burn unit

# Services must be medically necessary

- ▶ Critical care services must be medically necessary and reasonable, or Medicare and other payers will deny claims for payment
  - The progress note must justify why the services are necessary and reasonable

# Examples of situations which may warrant critical care

- ▶ 81-year-old male admitted to ICU after AAA resection. Is 2 days post-op. Requires fluids and pressors to maintain adequate perfusion and arterial pressures. Remains ventilator dependent
- ▶ 67-year-old woman 3 days s/p mitral valve repair developed petechiae, hypotension, and hypoxia requiring respiratory and circulatory support

# Situations where medical necessity is lacking

- ▶ Patient has been diagnosed as terminal with no hope of recovery. Patient is in ICU. Surgeon performs a hysterectomy
- ▶ Patient has no history of hypothyroidism and TSH is normal. Physician initiates Synthroid therapy
- ▶ Patient's traumas have healed. Patient is still in ICU. NP's documentation for daily visit: "Doing well"

# Situations not considered critical care: Chronic management

- ▶ Management of dialysis for ESRD patient receiving hemodialysis
  - Not critical care unless evaluation/management is separately identifiable from chronic long term management of dialysis
- ▶ Daily ventilator management for patient on chronic ventilator therapy
  - Not critical care unless the E/M is separately identifiable from the chronic long term management of ventilator dependence

# Ventilator management

- ▶ Do not bill ventilator management codes (94002–94004, 94660 and 94662) in addition to critical care (99291–99292)
  - ▶ If ventilated patient's organ systems are truly stable, and you won't be billing critical care codes, you may report CPT 94002 or 94003
  - ▶ No formal documentation requirements but address ventilator settings in your note
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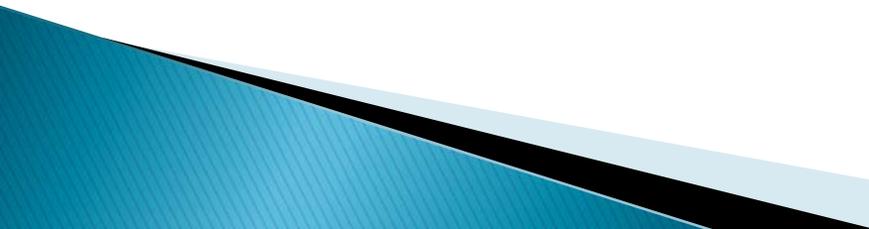
# What about physician services which don't meet criteria for critical care?

- ▶ If service is medically necessary, bill using CPT codes for subsequent hospital visits (CPT 99231, 99232 or 99233)
  - Use these codes if providing non-critical care services which are medically necessary to a patient in critical care setting
  - Use these codes if provide less than 30 minutes critical care on a given date

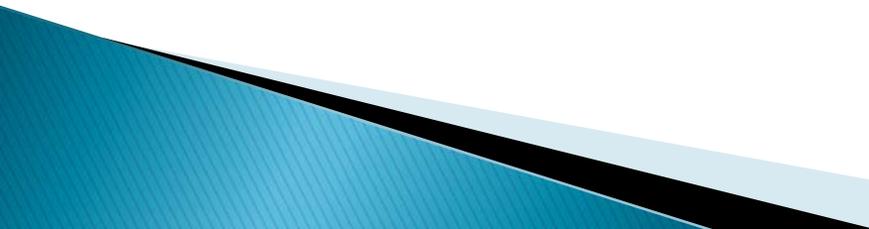
# Documentation requirements



# How to document medical necessity

- ▶ Describe the patient's instability
  - ▶ Note which organ system is failing or failed, as well as the impact on associated systems
  - ▶ Comment on co-morbid conditions contributing to organ failure and to the critical nature of the patient's status
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# How to document medical necessity

- ▶ Document the need for intubation, higher oxygen requirements, IV pressors and blood products
  - ▶ Document co-morbidities that inhibit the patient's ability to be weaned
  - ▶ Explain the status of problems you are managing by using such terms as “acute,” “severe,” “worsening,” and “the patient continues to require support”
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# How to document patient's instability

- ▶ Be cautious about using the term “stable” in your documentation
  - If patient is stable on high doses of IV vasopressors, the patient is “stable” because he is receiving supportive medications

# How to document patient's instability

- ▶ Document why you are unable to discontinue specific therapy
  - “IV vasopressors rate decreased and patient became acutely hypotensive”
  - “Patient is fatigued and his CO<sup>2</sup> increased”
  - “He is unable to tolerate weaning program at this point but will return to prior settings and check ABGs in 30 minutes”

# Documenting time spent

- ▶ Document in the progress note the time spent for each encounter
  - Good
    - “I spent 42 minutes of critical care time.”
  - Best
    - “I spent from 9:40 to 10:20 a.m. on the unit providing critical care”
  - Coders need the start time to determine the provider for whom CPT 99291 will be billed

# Documenting time spent

- ▶ No two physicians or NPs may bill for the same block of time
  - ▶ Ideally, providers will coordinate the timing of their services to avoid overlapping times
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# Remember that there are multiple purposes for documentation

- ▶ Documentation is evidence that the standard of care was met
- ▶ Documentation supports the hospital's selection of DRG
  - Example:
    - Simple pneumonia is DRG 090
    - Pneumonia with complications/comorbidity is DRG 089, for which reimbursement is 62% greater

# Additional issues for today's discussion

- ▶ Authority for NP billing of critical care
  - ▶ Shared/split visits not applicable in critical care
  - ▶ NPs and residents
  - ▶ Billing for time spent counseling
  - ▶ Global fee considerations
  - ▶ Audits
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# Medicare says NP services in critical care may be billed

- ▶ When the services meet the definition and requirements of critical care
- ▶ When the services are within the scope of practice of an NP under state law
- ▶ When the billing requirements for the CPT code are met
- ▶ When the NP is collaborating with a physician
  - CMS Transmittal 1530 (June 6, 2008) and Balanced Budget Act of 1997

# Split/shared visits

- ▶ Split/shared E/M services are **not** applicable in critical care
  - CMS Transmittal 1530 (June 6, 2008)
- ▶ Shared visit rules apply in other areas of hospital
  - *Medicare Claims Processing Manual*, Ch. 12 §30.6.1

# The rule on shared visits

- ▶ If NP and MD are members of the same group practice, practice may combine the E/M services performed by NP and MD and bill under physician's name, as if one clinician provided the service
  - MD must have a face-to-face visit with the patient that day, in hospital
  - MD must document the visit
  - **Not** applicable to critical care

# NPs and residents

- ▶ NP documentation stands alone and supports billings under the NP's name/provider number
  - ▶ Rules on teaching physicians do not apply to NPs
  - ▶ Cannot combine resident's documentation and NP documentation for billing purposes
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# Family counseling/discussion

- ▶ May count time spend counseling toward billable time if obtaining history or discussing treatment options and patient is unable to participate in giving a history and/or making treatment decisions

*and*

the discussion is necessary for determining treatment decisions

# Telephone calls to family

- ▶ May count this time if obtaining history or discussing treatment options if patient is unable to participate in giving a history and/or making treatment decisions

*and*

the discussion is necessary for determining treatment decisions

# Family counseling/discussion

- ▶ Do not count time spent on routine daily updates or reports
  - ▶ Do not count time talking with family about other matters
    - Only time spent on history and treatment options may be counted
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# What to document regarding family discussions

- ▶ That the patient is unable to participate in giving history and/or making treatment decisions
  - ▶ The necessity for the discussion (“patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family”)
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# What to document regarding family discussions

- ▶ The medically necessary treatment decisions for which discussion was needed and
  - ▶ A summary that supports the medical necessity of the discussion
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# Example of good documentation of counseling

- ▶ “10 a.m. to 10:45 a.m. -- Discussed with patient’s son the pros and cons of surgical re-exploration later today versus watchful waiting, in light of declining Hct. Patient is ventilated and heavily sedated.”

# Global fees for surgery

- ▶ What is included depends on the surgery
  - Major surgery: 90-day global period
  - Minor surgery: 10-day global period

# What is included in global fee

- ▶ ICU visits by surgeon
- ▶ Preoperative visits
- ▶ Intra-operative services
- ▶ Postoperative visits related to recovery from the surgery, for pain management, and required because of complications
- ▶ Dressing changes; local incision care; removal of sutures, drains, etc.
  - *Medicare Claims Processing Manual*, Ch. 12, §40.1

# What is not included in global fee

- ▶ Initial visit/consultation
- ▶ Services of other MDs
- ▶ Visits unrelated to the surgical diagnosis
- ▶ Treatment of underlying condition
- ▶ Diagnostic tests
- ▶ Clearly distinct surgical procedures
- ▶ Treatment for post-op complication which requires return to OR

- *Medicare Claims Processing Manual, Ch. 12, §40.1*

# Trauma and burn cases

- ▶ Pre-operative and post-operative critical care may be billed in addition to a global fee if
  - the patient is critically ill
  - the patient requires the full attention of the physician and
  - the critical care is unrelated to the anatomic injury or general surgical procedure performed
    - CMS Transmittal 1530 (June 6, 2008)

# Trauma and burn cases

- ▶ If these criteria are met, use CPT 99291 or 99292 and modifier -25
  - Modifier -25 denotes a significant, separately identifiable E/M service by the same physician on the same day of service
- ▶ Document that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed
  - ICD codes in range 800.0 to 959.9 (except 930.0–939.9) are acceptable documentation

# CPR

- ▶ Global period is 0 days
  - ▶ May bill CPR (CPT 92950) in addition to CPT codes for critical care
  - ▶ Use -25 modifier on critical care or E/M code
  - ▶ Don't count minutes spent
  - ▶ Only the MD or NP who performs the resuscitation bills CPT 92950
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# Example scenarios

# Example #1

- ▶ Intensivist spends 29 minutes (11:00 to 11:29 a.m.) at bedside.
- ▶ NP spends 29 minutes (2:00 to 2:29 p.m.) at bedside  
No CPT 99291 may be billed  
Bill CPT 99231, 99232, or 99233 depending upon the level of history, examination and medical decision-making

# Example #2

- ▶ Physician sees a critically ill patient for 30 minutes in the a.m. Eight hours later NP sees the patient, who is stable but has developed an unrelated system problem
  - Bill CPT 99291 under the MD's name

# Example #3

- ▶ NP and MD see the patient jointly upon arrival to the ICU (30 minutes). Patient is near death. NP documents a limited exam and straightforward decision-making but also spends an additional 60 minutes with the family discussing end-of-life issues. Four hours later MD sees patient for 30 minutes. Patient still has organ system failure but has stabilized.
  - Bill CPT 99291 under MD

# Example #4

- ▶ NP spent 45 minutes with a critically ill patient. MD performed a billable procedure. Resident performed a procedure with no attestation included. NP intubated patient
  - Bill CPT 99291 under NP's name
  - Bill the MD's procedure under the MD's name
  - Bill the intubation under the NP's name
  - No bill may be generated for the resident's procedure

# Example #5

- ▶ Patient S/P AAA repair, POD #2, having arrhythmias. Cardiologist visits for 30 minutes
  - Cardiologist bills CPT 99291
  - While global fee paid to surgeon covers ICU visits by surgeon, arrhythmias are not necessarily a condition normally treated by surgeon in post-op care

# Audits: Who is looking over the NP's shoulder?

- ▶ Medical coders at Vanderbilt
  - ▶ Medical center's compliance team
  - ▶ Medicare auditors
  - ▶ Blue Cross auditors
  - ▶ All insurers' auditors
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# What's an audit?

- ▶ Payer requests medical record for a specified patient on a specified date
  - ▶ RN reviewers check for
    - Documentation of medical necessity
    - Documentation that supports the CPT code billed
  - ▶ If errors are found, payer declines to pay the bill or demands repayment of monies already paid, plus interest and fines
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# Things that will inspire “further review”

- ▶ Submitting claims for more than 12 hours by a physician or NP for one or more patients on the same calendar date
- ▶ Several physicians submitting multiple units of critical care time for a single patient
  - “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.” (CMS transmittal 1530)

# Things that will inspire “further review”

- ▶ Patient is non-critical. Physician or NP sees patient and bills 99233. Later that day, patient becomes critical. Same physician or NP bills 99291. Reporting these codes on one day will trigger a pre-payment review. Carrier may request documentation. Claim will be paid if notes are timed such that the auditor understands the situation

# Examples of audits involving NPs

- ▶ Medicare demanded \$185,000 from NP with own practice
  - NP did not document medical necessity for E/M services
  - NP did not justify high-level codes billed
- ▶ Blue Cross demanded \$45,000 from neurology practice of MD and NP
  - MD and NP did not justify use of high-level codes

# Many NPs have passed audits

- ▶ NP was audited for billing many high-level codes and passed the audit, because his documentation supported medical necessity and the choice of code

# Thank you for attending

Questions?

