Billing and coding for critical care

For Vanderbilt Medical Center

Carolyn Buppert, NP, JD
Law Office of Carolyn Buppert
www.buppert.com

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

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

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

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

“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

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

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

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

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"

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^2 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

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

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

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

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")

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

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

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 arrythmias. Cardiologist visits for 30 minutes
  - Cardiologist bills CPT 99291
  - While global fee paid to surgeon covers ICU visits by surgeon, arrythmias 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

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

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?