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# Coding & Billing Quarterly

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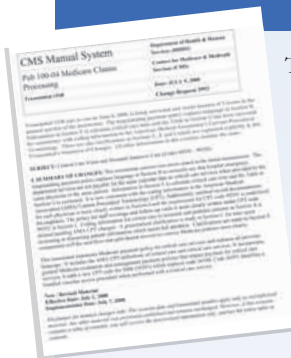
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## CMS Transmittal 1548



The CMS has published a number of policies on adult critical care coding, billing and documentation. The most recent policy, transmittal 1548, was issued on July 9, 2008 and is the policy from which your office or billing service

should work. This document can be found at [www.cms.hhs.gov/transmittals/downloads/R1548CP.pdf](http://www.cms.hhs.gov/transmittals/downloads/R1548CP.pdf).

Transmittal 1548 explains:

- the definition of critical care in the AMA's CPT 2009, and how to bill for critical care services; and
- CPT code **36591**, which replaced code **36540**, is for collection of blood specimen from a completely implantable venous access device. Code **36591** identifies a bundled vascular access procedure when performed with a critical care service. Note that this is on the list of services included in critical care.

The good news is that transmittal 1548 really doesn't establish new policy, it merely reiterates and, in some cases, clarifies the coding, billing and documentation of standard clinical practice. While key sections of the

(continued on page 4)

## Notes from the Editor

### *Components of Critical Care Reporting*



This issue of the *ATS Coding & Billing Quarterly* focuses on adult critical care. Correct coding billing and documentation of critical care services continues to be a source of confusion for many physician practices.

The primary CPT codes for reporting adult critical care services are:

- |              |                                                                                                                          |
|--------------|--------------------------------------------------------------------------------------------------------------------------|
| <b>99291</b> | <b>Critical care, evaluation and management</b> of the critically ill or critically injured patient; first 30-74 minutes |
| <b>99292</b> | each additional 30 minutes<br>(List separately in addition to code for primary service)                                  |

This edition provides 10 tips from a coding expert on how to improve your critical care billing practices, sample critical care documentation notes and a review of key CMS policy documents on critical care billing. If you are looking for information on pediatric critical care services or how to report remote critical care services, please see the December 2008 issue of the *ATS Coding & Billing Quarterly*, which is available on the Society's Web site at [www.thoracic.org/go/ats-coding-and-billing](http://www.thoracic.org/go/ats-coding-and-billing).

For those interested in learning more about billing and coding in pulmonary, sleep and critical care medicine, I recommend attending the day-long postgraduate course "Billing, Coding and Pay for Performance," which will be held on Saturday, May 16, during the 2009 ATS International Conference in San Diego.

Sincerely,

Alan L. Plummer, MD  
Editor



## EXPERT ADVICE:

### 3. Use ventilator codes when appropriate.

When appropriate, the critical care physician has the opportunity to utilize ventilator management CPT codes, rather than those for critical care services. For example, when all organ systems are truly stable, the patient is intubated and is tolerating the weaning program directed by the provider, you may wish to report ventilation management, **94002** or **94003**. There are no formal documentation requirements associated with ventilator management services, but providers should consider including the following items in their documentation: the reason for ventilatory support, pertinent physical findings, type of support, current settings, patient's response and ongoing plan.

### 4. Most importantly, document the total time you spent providing critical care in your medical record.

The time documentation is critical—without it, you won't be reimbursed for critical care. The calendar day begins and ends at midnight, and the rules are very specific for reporting time. Time does not have to be continuous. If you spent from 11:40 p.m. to 12:35 a.m. with a patient on the night of January 21, and into the morning of January 22, you would report the appropriate evaluation and management codes for January 21, not a critical care code, since the time spent providing critical care was less than 30 minutes. Report **99291** for the services provided on the second day (January 22), since the time spent was greater than 30 minutes. It is never a good practice to report critical care time as 40 minutes spent with every patient. Appropriate time documentation for example, would be to report one of the following: "I spent less than 42 minutes," "I spent from 9:37 a.m. to 10:19 a.m.," or "I spent 42 minutes of critical care time."

### 5. Read the CPT definition of critical care every year.

It is advisable to read the critical care introductory guidelines in CPT every year in December for the following year and review with all physicians and staff reporting and billing critical care codes. Providers should also be aware of critical care policies published by their Medicare carriers, as well as any commercial/HMO carriers with whom they participate.

### 6. Critical care providers from different specialties treating the same patient need to coordinate code selection.

For two providers in different specialties performing critical care on the same day for the same patient, it is important to communicate—and ultimately report two different primary diagnosis codes relevant to your respective specialties and why you are both seeing the patient. For example, the pulmonologist would report acute respiratory failure as the primary diagnosis and the cardiologist would report congestive heart failure. In addition, only one provider may bill for critical care for the same period in time, so there can be no time overlap when billing provider critical care services.

Critical care billing expert Mary Mulholland, MHA, BSN, RN, CPC, of the University of Pennsylvania Health System, offers 10 tips on how to correctly report critical care services and conditions.

### 1. Document the instability or critical nature of the condition(s) being treated.

Describing the patient's instability lends weight to the medical necessity for selection of a critical care code. Be sure to note which organ system(s) is failing, or failed, as well as the impact on associated systems.

Include comments on co-morbid conditions contributing to primary or secondary organ failure, and to the critical nature of the patient's status. Clearly identify just how critically ill the patient is. Documentation of the need for intubation, higher oxygen requirements, IV pressors and blood products—as well as co-morbid clinical conditions inhibiting the patient's inability to be weaned—demonstrate critical instability.

Explain the status of the problems you are managing by using terms like "acute," "severe," "worsening" and "the patient continues to require support." Demonstrate medical necessity by reporting the most specific ICD-9-CM codes possible (*please see table on page 3 for a sampling of appropriate diagnosis codes*).

### 2. Don't use the term "stable" in your documentation!

Reviewers may misinterpret the patient's actual clinical status. The fact that the patient is stable on high doses of IV vasopressors, for example, only means that the patient is "stable" because he/she is receiving supportive medications/treatments.

If the modality were to be withdrawn, the patient would not be "stable." Be sure to document the reason why you are unable to discontinue specific therapy (e.g. IV vasopressors rate decreased and patient became acutely hypotensive; the patient is fatigued and his CO<sub>2</sub> increased; he is unable to tolerate weaning program at this point, but you will return to prior settings and check arterial blood gases in 30 minutes). In these circumstances, your documentation demonstrates patient instability and your efforts to prevent further deterioration in the patient's condition.

# 10 Tips on Critical Care Coding

## 7. The floor nurse cannot request a consultation.

If a consultation is requested by a floor nurse, and you provide 30 minutes of critical care, you should report a subsequent hospital visit. Highmark Medicare's consult policy specifically states a consultation must be requested by another physician or appropriate source (e.g., a C.R.N.P. or P.A.). It is not within the scope of practice for an R.N. to request a consultation.

If the consultation is provided and meets the criteria for critical care (critical instability documented and less than 31 minutes of time spent providing critical care), code **99291** may be reported, rather than a consult code (**99241-99245**).

## 8. A group practice is a single entity.

Three different people from the same group seeing a critically ill patient on the same day must be reported by adding their times together. Provider A does one hour, B provides a half-hour, and C provides another half-hour. Bill the critical care under one provider—in this example, Provider A for **99291**, **99292** x 2. The initial critical care service (**99291**) must be met by a single initial provider. Some practices believe cumulative billing for critical care services on one calendar day balances out at the end of the year, or the practice can develop an internal accounting system to track the productivity of each provider.

## 9. You can report critical care and an E/M on the same day, but it will trigger a payment review.

If you report a **99233** service, and the patient's condition worsens on the same day, and you are required to provide critical care services thereafter, can you bill **99291**? Yes, if you provide an E/M service in the morning and the patient becomes critically ill later in the day, you can report critical care in addition to **99233**. You must have medical necessity for each service, and it is recommended that you have different diagnosis codes when possible. You should always include the date and time in all of your notes. Reporting both services will trigger an edit for a pre-payment review of the claim. The carrier will request your documentation to verify the timing of the services provided on the same calendar date. When you date and time your notes, you can bullet-proof your claim because you have clearly demonstrated the timing of each service.

Furthermore, you most likely will be paid for each service after submitting both of your notes. When you report services in this circumstance, you must append modifier **25** to the E/M for your morning hospital visit. In addition, you must write a separate note for the critical care service (**99291**). Some providers do not bother billing the **99233-25** for the morning visit, but you should go ahead and bill both appropriately.

## 10. Critical care services to a pediatric patient six years or older are reported with the critical care codes, 99291, 99292.

Critical care services to a neonate or pediatric patient of any age provided in an outpatient department, such as an emergency room, are reported with the critical care codes, **99291**, **99292**. If the same physician/provider provides critical care services to a neonate or pediatric patient in both the outpatient and inpatient settings on the same day, report only the appropriate neonatal or pediatric critical care code (**99468-99476**). Critical care services provided by a second pediatrician of a different specialty not reporting a 24-hour global code can be reported with the critical care codes, **99291**, **99292**.

### Selected ICD-9-CM Diagnosis Codes Supporting Critical Care Medical Necessity\*

070.41	Acute hepatitis C with coma
276.1	Hyponatremia/other electrolyte disturbance
276.2	Metabolic acidosis/other acid base disturbances
276.5	Hypovolemia
348.5	Cerebral edema
401.xx-404.xx	Malignant hypertension
402.91	Hypertensive urgency
410.xx	Acute myocardial infarction
415.0	Acute cor pulmonale
427.31	Atrial fibrillation
428.1	Congestive heart failure
433.xx	Cerebral vascular accident (CVA)
570	Hepatic necrosis
572.2	Hepatic encephalopathy
799.02	Hypoxemia
799.1	Respiratory arrest
518.5	Respiratory failure (including ARDS), following trauma and surgery
518.81	Acute respiratory failure
518.82	Other pulmonary insufficiency, NEC, such as ARDS — acute respiratory distress syndrome
518.83	Chronic respiratory failure with no acute component
518.84	Acute and chronic respiratory failure
518.89	Other diseases of the lung, NEC, such as broncholithiasis
584.x	Acute renal failure
786.05	Severe shortness of breath
786.51	Tachypnea, substernal chest pain
793.1	Abnormal chest x-ray
960.xx-989.xx	Poisonings
991.x	Hypothermic injury
992.x	Heat injuries
993.x	Barotrauma
995.6x	Anaphylactic shock
995.91	Sepsis
995.92	Severe sepsis with acute or multiple organ dysfunction

\*Codes **800** through **959.9** (except **930-939**) clearly indicate that the critical care service was unrelated to surgery.

(continued from page 1)

transmittal are excerpted below, physicians and their billing staff are strongly encouraged to read transmittal 1548 in its entirety.

## Critical Care Defined

Critical care is the direct delivery by a physician(s) 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.

Critical care involves high-complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and/or respiratory failure.

Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life-threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.

Providing medical care to a critically ill, injured or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit or the emergency department. However, payment may be made for critical care services provided in any location, as long as this care meets the critical care definition.

When all these criteria are met, Medicare will pay for critical care service reported with CPT codes **99291** and **99292**.

## Critical Care Services and Medical Necessity

As described above, critical care services encompass both the treatment of 'vital organ failure' and 'prevention of further life-threatening deterioration in the patient's condition.' Therefore, although critical care may be delivered in a moment of crisis, or upon being called to the patient's bedside emergently, this is not a requirement for providing critical care service. The treatment and management of a patient's condition, while not necessarily emergent, shall be required, based on the threat of imminent deterioration (i.e., the patient shall be critically ill or injured at the time of the physician's visit).

## Do Not Report Critical Care Services

Do not report a critical care service just because the patient is critically ill or injured. The example provided is a dermatologist treating a rash on a critically ill patient in the ICU, should not be reported as critical care. To this point, each physician providing critical care services to a patient during the critical care episode of an illness or injury must be managing one or more of the critical illness(es) or injury(ies) in whole, or in part.

If you have any questions regarding transmittal 1548, please contact your carrier at its toll-free number, which may be found on the CMS Web site at [www.cms.hhs.gov/MLNProducts/downloads/CallCenterToll-NumDirectory.zip](http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterToll-NumDirectory.zip). If you can't find what you are looking for, send us an e-mail at [CodingQuestions@thoracic.org](mailto:CodingQuestions@thoracic.org).



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## Critical Care Notes

Below are sample critical care notes that fulfill key documentation requirements of Medicare and other payers:

### Sample of Longer Note:

03/18/2009 46-year-old male diabetic has been living in a nursing home. Presented to ER with severe respiratory distress. Initially intubated, but weaned from ventilator, extubated and transferred to floor. Returned to MICU in acute distress, required re-intubation. Overnight vent settings: A/C mode, 12 breaths/min, 550 ml tidal volume, 30% oxygen, and 5 cm of PEEP. ABG: pH 7.43, PO<sub>2</sub> 93, and PCO<sub>2</sub> 41. Will require prolonged ventilator support and enteral nutrition. To OR today for tracheostomy and PEG tube.

PE: VS: BP 134/100, HR 61, afebrile, SpO<sub>2</sub> 99% (FiO<sub>2</sub> 0.30). ENT: trachea midline, ET: tube in place. Heart: NSR. No gallops or murmurs. Lungs: scattered rhonchi bilaterally. Abdomen: no organomegaly. No masses or tenderness. Extremities: no clubbing, cyanosis or edema. GU: urine output has been adequate. Lab: Electrolytes normal, BUN 21, creatinine 0.7, LFT's wnl. WBC 16.7, HGB 8.

### Impression and Plan:

The patient is critically ill with acute respiratory failure. Acute Respiratory Failure (**518.81**). Continue respiratory support at current vent settings. Repeat ABGs. Will attempt to wean in am pending ABG results.

### Anemia d/t chronic disease (**285.29**)

Start Procrit to stimulate his bone marrow. Check CBC.

### Nutrition:

Restart tube feeds in a.m. Monitor electrolytes and replace as necessary.

### Discharge Plan:

Pending respiratory status will look at a potential placement in a long-term acute care facility.

Critical care billing time is 35 minutes and doesn't include time for separately billable procedures.

Signed and Dated

### Sample of Shorter Note:

3/18/2009 5:30 PM, Dr. A. Sudden hemoptysis, bronch by Dr. B w/ large L mainstem clot, ? tracheal erosion, family: no OR. PE: 100 systolic, decreased BS on L, RRR, abd: more tense & firm on R, ext-change. Assess: worse resp failure, massive hemoptysis, ? tracheal erosion. Hypotension better: ? propofol vs. drop Hgb. Plan: AM bronch, no CPR per my d/w family. 35 min crit care time.