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.
“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 × 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
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
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
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
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)
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
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?