

ESSENTIALS OF CRITICAL CARE DOCUMENTATION AND CODING

RON STUNZ, MD, FACEP

WWW.CBIZMMP.COM



MMP
EMERGENCY MEDICINE



PHYSICIAN BILLING — PRACTICE MANAGEMENT

The core competency that defines emergency medicine as a specialty field is centered in our ability to bring to bear critical interventions on patients presenting with organ or life threatening illness and injury. While we routinely handle debilitating ankle sprains, patiently help a young child through his first finger laceration as painlessly as possible, or reassure a middle-aged man that his chest pain is not from a heart attack, our ultimate value to our hospital and our community is our availability and competence in the delivery of complex, skilled intervention to those who would suffer extreme morbidity or mortality were we not present.

Our timely interventions in severe infectious, ischemic, traumatic, surgical and other emergent scenarios obviously have a direct impact on patient outcome. Not so obvious, but only slightly less important in the prevailing climate of rising and scrutinized healthcare costs, what we do well in the first hour of a patient's presentation can significantly reduce downstream costs for care.

Evaluation and Management	CPT E/M Code	RVU
Limited/Problem Focused	99281	0.56
Expanded H&P/Low Complexity	99282	1.09
Expanded/Moderate Complexity	99283	1.70
Detailed/Moderate Complexity	99284	3.17
Comprehensive/High Complexity	99285	4.72
Critical Care (30-74 Minutes)	99291	5.88
Critical Care/Additional 30 Minutes	99292	2.94

It is thus not surprising that provision of critical care is the most highly compensated level of Evaluation and Management (E/M) codes for our specialty. The accompanying table shows the Relative Value Units (RVU's) for emergency medicine E/M levels. Worth remembering is the statistic that E/M coding and billing accounts for 80-85% of the revenue stream for a typical practice, and that critical care (99291 and 99292) is reimbursed about 25% higher than a comprehensive E/M code (99285) which might be coded for an uncomplicated hospital admission. The question of whether compensation for the provision of critical care is adequate and truly reflective of the skill required or the real impact on outcome and cost remains open to some debate. That question aside, it is clear that critical care represents not only the best argument for our specialty's presence, but also, relatively speaking, our best reimbursed activity.

What remains surprising is the tendency of many emergency physicians to fail to recognize that, in many circumstances, the care they have provided constitutes critical care and their subsequent failure to submit a billing request for this level of service. Typically, these circumstances are the product of the very competence that should be rewarded: the experienced provider manages a serious and complex case with alacrity and comes to view such activity as routine. A recurrent example would be an elderly patient presenting with acute congestive heart failure whose diagnosis is often immediately apparent and whose management is often relatively predictable and formulaic. Too often, the chart of such patients does not reflect the time spent in reassessment, discussions with the patient, family members and consultants, reviewing studies and prior patient records, and the physician does not request critical care coding and billing for the encounter. Similarly, unclaimed critical care scenarios are seen in the setting of extended ED management of asthma, otherwise healthy young adults with supraventricular tachycardia, or patients with new onset uncontrolled atrial fibrillation.

DEFINITIONS FOR CRITICAL CARE

Current Procedural Terminology (CPT) is relatively explicit and detailed in its descriptions of critical care services. Three components are required for codes 99291 and 99292: a critical illness, which "...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 intervention,

involving “...high complexity decision making to assess, manipulate, and support vital organ system failure;” and, time, defined as “...time spent engaged in work directly related to the individual patient’s care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.” In order for critical care services to be coded and billed, documentation to support all three components of the definition must be present in the medical record, accompanied by the physician’s attestation that critical care was provided.

Further nuances have importance for each of the three components of critical care. Critical illness may be somewhat problematic and situational in its formal definition, but, paraphrasing Supreme Court Justice Potter Stewart on another subject, “I can’t define it, but I know it when I see it.” Emergency physicians are trained and skilled in the recognition of clinical scenarios in which the patient’s potential for severe clinical deterioration is either actively evolving or imminently likely to occur. Certainly, examples cited by CPT in its guidelines, “...central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure,” are usually readily apparent and well-defined clinical scenarios in which critical intervention is mandatory in a timely fashion. Other presentations, in which overt organ failure has not occurred, but in which a high probability of such failure is possible, and prevention of which requires active physician management, represent cases in which, situationally, the critical care services codes are justified and sustainable.

In terms of physician intervention, it is noteworthy that all three verbs used by CPT to define the care provided, “assess, manipulate and support,” are active rather than transitive. The implication is that the physician is taking an active role in management of the case, and this should be manifested by documentation evidence of therapeutic intervention. Whether cases ending with simple assessment, in which therapeutic intervention on the part of the emergency physician is neither feasible nor indicated, meet the requirements of the CPT definition remains a question in coding and billing circles. An elderly patient presenting with transient neurologic symptoms certainly has the potential for deterioration, although such deterioration is generally not so temporally imminent as to mandate even hospital admission in many cases, and therapeutic manipulation may not be emergently prescribed in the ED. For a similar patient with evidence of an active ischemic stroke with fixed deficits for whom no pharmacologic intervention is warranted or necessary by the emergency physician, is the definition of critical care met? While such patients clearly require significant time for coordination of care and interpretation of studies, the absence of manipulative and supportive interventions may argue against the notion that critical care was actively provided. CPT states: “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.” (Emphasis added). Thus, in the absence of active care by the physician, some ambiguity may exist in certain clinical scenarios.

To elaborate further on the common scenario of acute ischemic stroke, in the absence of pharmacologic intervention, the question becomes: in the absence of such intervention, what distinguishes the case in which critical care services are requested and billed from a similar case coded 99285, a comprehensive E/M service? For 99285 billing, CPT concludes its definition by stating: “Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.” This is certainly concordant with the presentation of acute ischemic stroke.

The Medical Decision Making documentation requirement for 99285 must attest to “high complexity,” a characterization entirely sustainable even in the absence of therapeutic intervention by the provider. It is apparent that, at least in this context, the gradation between a comprehensive level of E/M service and critical care service is ill-defined and open to interpretation both by the provider and the coder.

The time component of critical care service is inherently somewhat approximate. There is no requirement that the physician carry a stopwatch. Few critical care encounters occur uninterruptedly, and in a busy emergency department, the physician is often buffeted by overlapping and conflicting obligations to a number of patients. Thus, an approximation or a range of time spent in the provision of critical care is sufficient for coding and billing purposes.

For code 99291, critical care time is defined as 30 to 74 minutes spent, including direct bedside time, documentation time, time for discussion with other medical staff, time spent in the interpretation of laboratory or imaging studies, review of old records, and time spent discussing the care of an incompetent or unconscious patient with family members. As noted, this time need not

be continuous. Frequent contributors to bedside time that often go undocumented are the recurrent physical reassessments that are regular concomitants to critical care. Brief notes covering these revisits are important not just for accurate coding and billing, but are crucial elements from a medico-legal, risk management perspective.

A number of procedures and services are incorporated into the coding and billing for critical care time and may not be separately billed. These include interpretation of chest x-rays, pulse oximetry and blood gasses, passage of a nasogastric tube, temporary pacing, ventilator management and peripheral vascular access. Procedures not specifically listed in the CPT manual as included in critical care services can and must be separately billed. The two most commonly performed, separately billable procedures performed in the setting of a critically ill patient are endotracheal intubation and the establishment of central venous access. The time spent performing these separately billable procedures must be subtracted from the total amount of critical care time claimed by the physician. Thus, for example a 60-minute total time for critical care in which intubation required five minutes and the insertion of a central line another five minutes, the time submitted would be 50 minutes.

Critical care may not be billed for patients under the physician's care for less than 30 minutes. As an example, a patient with a coronary artery lesion who is expedited from the ED to the cardiac catheterization laboratory within 25 minutes of arrival does not qualify for critical care services, even though such care may well have been provided. Code 99291 covers minutes 30 to 74 of the patient's ED time. Subsequent to this time, incremental intervals of 30 minutes are billed using 99292 for each additional half hour. Longer time frames require progress notes justifying the time spent in direct patient care.

Documentation of a request for critical care time by the physician should include a statement covering the nature of the illness, and a listing of those components of care requiring the provider's time, with a notation that time spent on separately billable procedures has been subtracted from the total time claimed. Templated records, such as the T-System, contain acceptable statements covering the documentation requirements. Newer electronic records typically incorporate macros, wherein a single mouse click can generate several sentences covering the critical care services. With all templated records, whether paper or electronic, care must be taken that the documentation is patient-specific, meeting the requirements of medical necessity. The Center for Medicare and Medicaid Services (CMS) has specifically stated that it looks askance at macro-generated "cookie cutter" charts that all look alike.

Finally, in terms of documentation requirements, critical care charting is not governed by the same rules that apply to high level E/M codes. A "comprehensive" E/M service (99285) requires four elements in the HPI, 10 elements in ROS, two of three elements in past medical/family or social history, and eight areas in the physical examination. These component elements are waived for critical care services (99291).

Critical care is relatively highly compensated, and because of this audits from third-party payors should be anticipated. Such audits may focus on any of the three principal components of critical care services: the severity of the illness itself, the care provided, or the amount of time claimed by the provider.

Audits typically are triggered by a physician's relatively high percentage of claims. A skilled coding and billing service, by identifying records where critical care time may have been provided but was not submitted for, helps assure appropriate physician compensation, and, conversely, will help the physician in the avoidance of audits by avoiding submission of critical care codes when not clearly justified by the medical record. While well trained coders are taught to use judgment in submission of claims by the physician for critical care services, it is worth keeping in mind that coders are likely to be influenced by statements from the physician, and may be reluctant or insufficiently clinically experienced to adjudicate those records containing inappropriate requests by the physician. Furthermore, regardless of who codes the record, the provider, under fraud and abuse statutes, bears the ultimate responsibility for the codes submitted.

In conclusion, emergency physicians should, on the one hand, not undervalue their services and remember to properly submit claims for critical care in all appropriate clinical circumstances. On the other hand, overreaching for critical care services in marginal cases could potentially prove costly.

Ron Stunz, MD, FACEP, is the medical director for MMP. Dr. Stunz is a member of the Pennsylvania ACEP emergency medicine practice committee and the governmental affairs committee. Nationally, he serves on the pay for performance task force of the Emergency Department Practice Management Association (EDPMA). He is the former chairman of the Department of Medicine of the Bryn Mawr Hospital and the former chairman of the Department of Emergency Medicine of Main Line Health, in suburban Philadelphia.

About MMP

Medical Management Professionals, Inc. (MMP) was founded in 1993 and is a provider of billing and practice management services to emergency medicine physicians. It currently serves more than 70 emergency medicine practices with more than 1000 emergency physicians combined. MMP's flexible solutions range from billing-only services to full-practice management services.

For additional information please call **1.877.541.9690** or email **emergency@cbizmmp.com**