Critical Care billing and coding summary handout

**Overview:**

Critical care billing is based on time evaluating and managing a single critically ill or injured patient.

CPT code 99291 is used for the first 30-74 minutes and CPT code 99292 for the next 15-30 minute time intervals. Critical illness or injury is defined as an illness or injury that impairs one or more vital organ system such that there is a high probability of imminent or life-threatening deterioration in the patient’s condition.

**What is needed in the chart:**

Documentation of evidence of organ system failure and high probability of imminent or life-threatening deterioration. Critical care billing does not require all the parts of HPI/PMHx/PE elements as level 1-5 E/M codes, but there does need to supporting documentation to demonstrate the failing organ system, or risk of organ system failure and a summary of events that occurred during that time, such as case discussed with consultant, patient re-assessed at this time and management decisions.

The chart should include a statement that the physician provided care to a single patient who had a critical injury/illness with high probability of imminent or life-threatening deterioration. This statement should include total time involved in critical care, specific time is better than a time range (i.e. I spent 40 minutes providing critical care, excluding other separately billable procedures and teaching).

**What is included/bundled into critical care time:**

Time at the bedside providing direct patient care, time reviewing labs/imaging, time documenting in the chart, time gathering information and discussing care with consultants and patient’s family. The following procedures are also included:

Interpretation of cardiac output measurements

CXR

Pulse ox

Blood gas

Collection and interpretation of physiologic data (ECG, BP, labs, etc)

OGT/NGT

Temporary transcutaneous pacing

Vent management

Vascular access (not CVC)

**What is billed separately:**

 All other procedures, (i.e. EKG interpretation, CVC placement, intraosseous placement, intubation, cardioversion, tube thoracostomy, temporary transvenous pacemaker, CPR)

 Teaching/education

 Delegated tasks

**Other tips:**

Critical care time does not need to be continuous but needs to total > 30 minutes. For example, a patient with a STEMI who goes immediately to the cardiac catheterization lab has a critical illness with a vital organ system failure, but the physician’s total time caring for the patient is 15 minutes, then they cannot bill critical time. Critical care time is based on the attending physician’s total time evaluating, managing, providing care, and documenting care to the critical patients. The physician must devote full attention to the patient during the critical care time (they physician can manage multiple critically ill patients in the same time frame, but bill for the time focused on each individual patient). The physician does not need to be at bedside for all of the critical care time but must be immediately available to render care for the patient during the critical care time.

Time spent by resident alone does not count for attending critical care time, the attending must be present for critical care time. The teaching attending may refer to the resident’s chart regarding history, physical exam and assessment, but still must document a statement explaining the patient was critically ill and the treatment and management provided.

The critical care time clock starts over at midnight, however a single, continuous, episode of critical care can span midnight.

When specialty teams such as trauma team, stroke team, cath lab, etc. assume care the ER providers critical care time stops

**Common examples:**

Central nervous system failure (CVA, meningitis, epilectus)

Circulatory failure, (CHF, Ventricular tachycardia)

Shock-like conditions (Cardiogenic shock)

Renal Failure (Acute tubular necrosis)

Hepatic Failure (Hepatic encephalopathy)

Metabolic (DKA)

Respiratory failure

Postoperative complications (Hypotension, malignant hyperthermia)

Overwhelming infection (Septic shock, meningitis, HIV infection with complications)

 Other vital system functions (Compartment syndrome)

* 1. Example of unacceptable teaching physician documentation: “I came and saw (the patient) and agree with (the resident)”.
	2. Example of acceptable teaching physician documentation: "Patient developed hypotension and hypoxia. I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."

Why - $$$$, get paid for what you did

Also, legal record (your chart is your life raft in the sea of litigation as one attending used to say)

CPT code 99291 (critical care, evaluation and management of critically ill or injured patient 30-74 minutes) and 99292 (every additional 30 minutes, after the initial 15 minutes of that time frame have passed)

Care to single patient at that time (can go back and forth between multiple critically ill patients), exclude time for other billable procedures (i.e. CPR, intubation, cardioversion, CVC placement)

Need to indicate a total time in minutes, not just stating 30-74 minutes

Definition – Direct delivery of medical care to a critically ill or critically injured patient (critical illness or injury 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)

Service must be medically necessary

High complexity decision making, typically requires the interpretation of multiple physiologic parameters and/or application of advanced technology

Services included in CC: Interpretation of cardiac output measurements, CXR, pulse ox, blood gas, collection and interpretation of physiologic data (ECG, BP, labs, etc), OGT/NGT, temporary transcutaneous pacing, vent management, vascular access (not CVC), all else is billed separately, should document time it took to perform those non-bundled procedures

Also includes time at bedside, time reviewing labs/imaging, discussing care w/ other medical staff, documenting, gathering info/discussing treatment options w/ pt’s family

Need supporting documentation (do not need all the E/M parts, such as full HPI, ROS, FHx, PMHx, etc), but need pertinent documentation to demonstrate at risk/failing organ system, need to document a time and summary of events that occurred during that time, doesn’t need to be specifically times (example- phone call w/ Dr… about pt for 10 minutes, plan for…)

Clock starts over at midnight (can bill 99291 on 2 days) 30-74 minutes of time (total, does not need to be continuous), can include before and after midnight if continuous critical care episode

Can bill aggregate time as long as both physicians are in same group (15 min from provider 1 + 20 min from provider 2)

From <https://crashingpatient.com/philosophy/emergency-department-billing.htm/> (accessed 8/19/2020

Critical Care

Unstable or patients requiring treatment or they will become unstable

Patients should be admitted, transferred, or expire

<30 min=E&M level >30 min=CCT

Time Spent: Documenting

Interpreting Stuides

Consultation

Talking with patient and Family

Talking with EMS

Performing Bundled procedures

Review of tests/films, talking with consultants, eval and treatment, charting all count

Must write number of CCT minutes

Services Bundled in Crit Care Time

CO Output Interpretation

Chest X-rays

Blood Gases

Interpretation of data stored in computer

Gastric Intubation

Transcutaneous Pacing

Blood Draw

Pulse Ox

Vent Management

Family Psychotherapy

Time spent reviewing test results on the patient, discussing care with other medical staff about the patient, documenting the medical record for the patient and talking to the family (if the patient cannot give an adequate history due to incompetence or inability to communicate) are all considered part of critical care time. Time spent discussing emergency treatment options with family is also considered as time in critical care including DNR status (regular updates and emotional support do not count). Time supervising or teaching is not included and delegated care of any kind is not included. 1) Interpretation of cardiac output measurements 2) Reading chest x-rays 3) Blood gases 4) Blood drawn for specimen (new this year) 5) Data retrieval 6) NGT 7) Pulse oximetry 8) Transcutaneous pacemaker 9) Ventilator management 10) Vascular access procedure 11) Family medical psychotherapy