Billing for Critical Care

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Multidisciplinary Intensive Care Unit Care

- Medical and nursing directors
  - co-responsibility for ICU management
- Team approach
  - doctors, nurses, R/T, pharmacist
- Use of standards, protocols, guidelines
  - consistent approach to all issues
- Coordination and communication for all aspects of care
- Emphasis on practitioner certification, research, education, ethical issues, patient advocacy

Critical Care Practice Pattern

- Open
- Closed
- Transitional
Open Units

**Definition:**
Any attending physician with hospital admitting privileges can be the physician of record and direct ICU care. (All other physicians are consultants)

**Disadvantage:**
- Lack of a cohesive plan
- Inconsistent night coverage
- Duplication of services

Closed Units – UF Medical ICU

**Definition:**
An intensivist is the physician of record for ICU patients. (other physicians are consultants), All orders & procedures carried out by ICU staff

**Advantage:**
- Improved efficiency
- Standardized protocol for care

**Disadvantage:**
- Potential to lock out
- Increase physician conflict

Transitional Units-UF Surgical ICU

**Definition:**
Intensivists are locally present - co-manage care between ICU staff and surgical teams
ICU staff is a final common pathway for orders and procedures

**Advantage:**
- Reduce physician conflict, standard policies and procedures usually present

**Disadvantage:**
- Confusion and conflict regarding final authority & responsibilities for patient care decision
Three components to be documented for the provision of critical care services

- Clinical Criteria
  - “Instability” of the patient
    - “What did you see”
- Treatment Criteria
  - Complexity of Medical Decision Making
    - “What did you do”
- Time

Clinical Criteria
“Instability” of the patient
“What did you see”

...impairs one or more vital organ systems such that there is a high probability of sudden clinically significant or life threatening deterioration in the patient condition.
## Treatment Criteria
Complexity of Medical Decision Making
“What did you do”

- Critical care services require direct personal management by the physician.
- They are high complexity decision making to assess, manipulate and support vital systems function(s) to treat...vital organ system failure.
- And / or to prevent further life threatening deterioration of the patient’s condition

## Components of CC Billing

### Physician Time in Critical Care Services

- Progress note must contain documentation of the total time involved providing critical care services.
- Cannot provide services to another patient during the same period of time
- 99291 must be met by single MD or NPP
- MD's/NPP's in same group with same specialty may not each provide 99291

99292 may represent aggregate time by a single physician...or physicians in the same group practice with same medical specialty
- Each aggregated visit must meet the definition of CC in order to combine the times
Components of CC Billing

...time involved with family members or other surrogate decision makers...may be counted toward critical care time only when...

...the patient is unable or incompetent to participate in giving history &/or making treatment decisions.

Components of CC Billing

...the discussion is absolutely necessary for treatment decisions under consideration that day

...the necessity of the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly, I needed to discuss treatment options with family immediately."

...the treatment decisions for which the discussion was needed, and

...a summary in the notes supports the medical necessity of the discussion

Correct reporting of critical care services:

<table>
<thead>
<tr>
<th>Total Duration</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 minutes (less than ½ hour)</td>
<td>Appropriate E/M codes</td>
</tr>
<tr>
<td>30-74 minutes (1/2 hr.- 1 hr. 14 min.)</td>
<td>99291 x 1</td>
</tr>
<tr>
<td>75-104 minutes (1 hr. 15 min.-1 hr. 44 min.)</td>
<td>99291 x 1 AND 99292 x 1</td>
</tr>
<tr>
<td>105-134 minutes (1 hr. 45 min.-2 hrs. 44 min.)</td>
<td>99291 x 1 AND 99292 x 2</td>
</tr>
<tr>
<td>135-164 minutes (2 hrs. 15 min.-2 hrs. 44 min.)</td>
<td>99291 x 1 AND 99292 x 3</td>
</tr>
</tbody>
</table>
Most Common Complex Organ Dysfunctions

- Sepsis
- Shock
- Multi-organ failure
- Acute kidney injury
- Acute respiratory insufficiency/failure
- Delirium
- Coma
- Liver failure
- Hypotension
- Hypovolemia
- Hyponatremia/hypernatremia
- Metabolic acidosis

SEPARATE IDENTIFIABLE E&M SERVICES
Example of the – 25 Modifier
Critical Care & CVP/ A Line

- 99291-25 (J69.0) for aspiration pneumonia
- 36556 (CVP) for acute respiratory failure with hypoxia (J96.01)
- 36620 (A-line) for severe sepsis with shock (R65.21)
- 00001 (knife insertion) for lustful longings (F52.9)
“......62-year-old female admitted with acute subarachnoid hemorrhage, negative cerebral arteriogram, increased lethargy and hemiparesis with fever.”

SAH

• ...because of the **imminent** neurologic instability and the **potentially life threatening** risk she faced from vasospasm, a CVP was placed. She was started on: hypertensive therapy with norepinephrine to reach a MAP of 110; hypervolemic therapy to attain a CVP of 10.

ICU progress note: 11/01/2016

Co: status 5 days post MVA with multiple trauma
Pt has returned from OR
CV: Mean arterial BP stable, swan gazz inserted, readings: PAP 40/20; CI/2.0 Norepinephrine started.
GU: Urinary output minimal, significant metabolic acidosis requiring HCO3, Mannitol given
Hem: moderate amount of bleeding from operative site, PTT slightly increased, FFP given
Plan: Continue to treat for shock, will not wean ventilator until cardiovascular status is stable.
Met with mother for 30 minutes to discuss findings, assessment, prognosis, treatment plan and will continue with full support
Time “I” spent in the provision of critical care with mgmt of shock, resp failure, renal insuff is 55 minutes and did not include time for procedures.
Total time spent in the provision of care is 85 min
Dr. Oller
Which Procedures are Included in CC Codes?

Included = Bundled

- Mechanical Ventilator Management
- NG Tube Placement
- Arterial Blood Gases interpretation
- Temporary Pacing

Which Procedures are Separately Billable?

- BRONCHOSCOPY, DIAGNOSTIC W/LAVAGE 31624
- INSERT CATH, ART, PERCUT, SHORT-TERM 36620
- INSERT NON-TUNNEL CV CATH => 5 Y/O 36556
- REPLACE CV CATH, COMPLETE, NON-TUNNELED, W/O SUBQ PORT OR PUMP 36580
- INTUBATION, ENDOTRACHEAL 31500
- CARDIOVERSION, ELECTIVE, EXTERN 92960
- Tracheostomy
- Chest Tube
- Cardio-Pulmonary Resuscitation
- Moderate/Deep Sedation
- Direct laryngoscopy

If you bill a procedure, your critical care code will require a 25 modifier to indicate it is a separately identifiable E/M on same day as a procedure.

Billing screen in Epic
Ultrasound and Ultrasound Guidance

CVL/Art Line/IV – 76937
FAST – 76700
Chest – 76604
Thoracentesis – 76942
Chest Tube/Pigtail – 75989

26 modifier (professional component) required since the equipment is owned by the hospital.
Requires additional credentialing.

Transthoracic echocardiogram (TTE)
Transesophageal echocardiogram (TEE)

93308 – TTE
Echocardiography, transthoracic, real time with image documentation (2D), includes M-mode recording, when performed, follow-up or study.

93318 – TEE
Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis.

26 modifier is required.

Non-Critical Care E/M Codes

• If you do not meet the requirements for billing critical care codes, you may bill subsequent hospital visit codes.
  • 99231
  • 99232
  • 99233

You may bill a subsequent hospital visit and a critical care code in the same day. If a non-critical care service is billed earlier in the day and the patient later requires critical care services, you may bill both. However, each service must be documented separately. The non-critical care code will require a 25 modifier.
Billing in the Global Period

The global period for most major procedures is 90 days.

Critical care services may be billed within the global period for reasons unrelated to the operation.

The primary ICD-9 (diagnosis) code should not be the same as the code billed with the operation.

24 modifier may be required if you are a surgical critical care intensivist within a surgical group and are providing care for a patient of your group.