Rational Physician Coding for Critical Care and Other Timed Services

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www.EMuniversity.com
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Goals

- Identify the types of patient encounters which may be coded based on time
- Understand how to calculate and report time spent
- Learn the documentation required for these encounters
Time-Based Services

- Critical Care
- E/M encounters (optional)
- Prolonged Services
- Discharge Services

Critical Care

- Critical care is the direct delivery by a physician of medical care for a critically ill or injured patient
- Any physician or NPP can bill for critical care
- Critical care does necessarily have to take place in the intensive care unit
What is a Critical Illness?

- “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.”

Organ System Failure

- Circulatory failure
- Shock
- Renal failure
- Hepatic failure
- Metabolic failure
- Respiratory failure
- Overwhelming sepsis
Critical Care Physician Services

- Critical care services require direct personal management by the physician
- They are life and organ-supporting interventions that require frequent, personal assessment and manipulation by the physician
- Withdrawal of, or failure to, initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life-threatening deterioration in the patient's condition

Services Included with Critical Care

- Cardiac output measurement
- CXR interpretation
- Pulse oximetry
- ABG’s
- EKG interpretation
- Gastric intubation
- Transcutaneous pacing
- Ventilator management
- Peripheral venous access

Anything NOT included in this list should be billed separately (Modifier 25 must be added to the critical care service)

Examples
- Endotracheal intubation (31500)
- CPR (92950)
- Swan Ganz catheter (93503)
- Central line (36556)
Coding for Critical Care

Two time-based codes

- **99291** First hour $206.00
- **99292** Add’l 30 min $103.00

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**99291**

- Reported for 2,636,587 encounters in 2004 for $528,971,410
- Used to bill for the first hour of critical care
- May be billed only once per calendar date
- Time threshold of 30 minutes
99292

- Used to bill for each additional 30 minutes of critical care beyond the first hour on any given calendar date
- Time threshold is 15 minutes
- May only be submitted with 99291
- May be billed multiple times per day

**Critical Care is a Time-Based Service**

<table>
<thead>
<tr>
<th>Total Duration of Critical Care</th>
<th>CPT 4 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Less than 30 minutes</td>
<td>99231-99233 or 99251-99255</td>
</tr>
<tr>
<td>b) 30 - 74 minutes</td>
<td>99291 x 1</td>
</tr>
<tr>
<td>c) 75 - 104 minutes</td>
<td>99291 x 1, 99292 x 1</td>
</tr>
<tr>
<td>d) 105 - 134 minutes</td>
<td>99291 x 1, 99292 x 2</td>
</tr>
<tr>
<td>e) 135 - 164 minutes</td>
<td>99291 x 1, 99292 x 3</td>
</tr>
<tr>
<td>f) 165 - 194 minutes</td>
<td>99291 x 1, 99292 x 4</td>
</tr>
</tbody>
</table>
Calculating Critical Care Time

- Total time spent at the bedside or in the unit on any single calendar date
- Time spent DOES NOT need to be continuous
- Include time spent on documenting the encounter and discussing the case with other providers
- Include time spent discussing treatment options with surrogate decision-makers
- Must “carve out” time spent performing separately billable procedures

Critical Care Documentation

- Must document time spent
- There are no specific requirements for documenting the history or exam
- MDM must be high complexity
- The note should clearly convey the “criticality” of the encounter
A Day in the Life of Critical Care

- You admit a patient with CHF
- Later that day you are paged stat and find the patient somnolent, hypotensive and hypoxic
- You spend 25 minutes stabilizing the patient on the floor and transfer him to the ICU
- You spend another 21 minutes in the ICU
- As you are writing your note, the patient codes and requires ETI and CPR which takes 20 minutes
- You spend an additional 31 minutes in the unit documenting the encounter, coordinating care with other physicians and discussing the treatment plan with his wife
- How would you code and document this encounter?

Services Provided

- Admission H&P
- Endotracheal intubation
- CPR
- Critical Care
  - 25 minutes on the floor
  - 20 minutes documenting/discussing with MD
  - 31 minutes following the code
- 76 minutes of total critical care time
# Coding for this Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99223</td>
<td>(Level 3 H&amp;P)</td>
<td>$154.00</td>
</tr>
<tr>
<td>31500</td>
<td>(ETI)</td>
<td>$116.00</td>
</tr>
<tr>
<td>92950</td>
<td>(CPR)</td>
<td>$192.00</td>
</tr>
<tr>
<td>99291-25*</td>
<td>(first hour)</td>
<td>$206.00</td>
</tr>
<tr>
<td>99292-25*</td>
<td>(16 minutes)</td>
<td>$103.00</td>
</tr>
<tr>
<td><strong>Total Services</strong></td>
<td></td>
<td><strong>$771.00</strong></td>
</tr>
</tbody>
</table>

*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other Service*

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**Critical Care Note**

**Interval History**

CTSP stat following admission earlier today for CHF exacerbation. Pt found unresponsive and hypoxic with severe respiratory acidosis. BP was down to 80’s systolic. Pt placed on 100% NRB with gradual improvement in pulse ox. Transferred to ICU for dobutamine and bumex gtt. Patient went into PEA in the ICU requiring ETI and CPR. Pulse restored following 2 doses of epinephrine.

**Physical Exam**

Intubated, unresponsive. BP 101/80, 22, 82, 98.6; lungs have bibasilar crackles; heart is RRR with a positive S3; extremities show 3+ edema.

**Assessment:**

1. Cardiogenic shock
2. Severe mixed acidosis
3. Respiratory failure
4. ARF

**CXR:**

Severe pulmonary vascular congestion

<table>
<thead>
<tr>
<th>Value</th>
<th>Value</th>
<th>Value</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>136</td>
<td>101</td>
<td>87</td>
<td>124</td>
</tr>
<tr>
<td>3.8</td>
<td>12</td>
<td>11</td>
<td>31</td>
</tr>
<tr>
<td>2.8</td>
<td></td>
<td></td>
<td>289</td>
</tr>
</tbody>
</table>

**Plan**

1. Continue Dobutamine gtt
2. Continue Bumex gtt
3. Recheck renal profile stat
4. 2 amps of bicarb now
5. Consult renal
6. Repeat labs in a.m.
7. Patient’s wife was updated at the bedside
8. Patient remains a full code

**Critical Care Time:** 76 minutes excluding time spent on ETI and CPR
Critical Care Coding Pearls

- Add up TOTAL time spent on each calendar date even if the time is not continuous
- Critical care and other E/M services and procedures may be provided on the same day by the same physician
- Critical care does not have to be provided in the ICU
- Services which are not bundled into critical care should be billed separately
Time-Based E/M Services

- Most types of E/M encounters have times assigned to each level of care
- Physicians have the option of coding based on time or based on the key components

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99251</td>
<td>20</td>
</tr>
<tr>
<td>99252</td>
<td>40</td>
</tr>
<tr>
<td>99253</td>
<td>55</td>
</tr>
<tr>
<td>99254</td>
<td>80</td>
</tr>
<tr>
<td>99255</td>
<td>110</td>
</tr>
</tbody>
</table>

Coding Based on Time

Must spend the entire allotted time for the encounter in face-to-face contact with the patient or on the ward taking care of patient business

Over half of the time spent must have been devoted to “counseling and/or coordination of care”

Must document the time spent as well as the nature of the counseling and/or coordination of care
E/M Services Based on Time

- Strictly optional
- Time does not need to be continuous on any given calendar date
- Time spent nature of the counseling and/or coordination of care must be documented
- When coding based on time, there are no specific requirements for documentation of the history, physical exam and MDM
Prolonged Services

- Prolonged services codes (99354, 99355, 99356, 99357)
- Used to report extra time spent beyond the usual time required for any given E/M service
- These services are reported and billed in addition to the E/M encounter
- May be used in either the outpatient (99354, 99355) or inpatient (99356, 99357) settings

What is a Prolonged Service?

- A service is only prolonged when it goes at least 30 minutes beyond the typical time allotted for that E/M encounter
- If you do not spend at least 30 minutes beyond the usual time for that encounter, you cannot bill for prolonged services
Calculating Time for Prolonged Services

- Clock starts ticking only *after* you have used up the time allotted for an E/M encounter
- Time must be face-to-face with the patient or on the floor taking care of patient business
- Add up all time spent on any given calendar date even if not continuous

Outpatient Prolonged Services

99354
- First 60 min
- Threshold = 30 min
- Once per calendar date
- $98.19

99355
- Each add’l 30 min
- Threshold = 15 min
- May be reported multiple times
- $97.00

- Both of these codes should be reported only in conjunction with outpatient E/M codes
- No modifier is required
Inpatient Prolonged Services

- 99356
  - First 60 min
  - $90.12
  - Threshold = 30 min
  - Once per calendar date

- 99357
  - Each add’l 30 min
  - $90.96
  - Threshold = 15 min
  - May be reported multiple times

- Both of these codes should be reported only in conjunction with inpatient E/M codes
- No modifier is required

Documentation Required

- Normal documentation rules apply to the primary E/M encounter which is being performed
- No specific requirements for documenting the extra time spent on prolonged services
- Must document the nature of the prolonged services and total time spent
Example of Prolonged Services

- In the morning you perform and document a level 2 progress note (99232) on patient with USA.
- The encounter takes about 20 minutes.
- Later that day, you spend an additional 36 minutes with the patient discussing the risks and benefits of performing angioplasty vs. medical management.
- What would be the best way to code for these services?

Optimal Coding This Encounter

<table>
<thead>
<tr>
<th>E/M Code</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>PF</td>
<td>PF</td>
<td>SF/Low</td>
<td>15</td>
</tr>
<tr>
<td>99232</td>
<td>EPF</td>
<td>EPF</td>
<td>Moderate</td>
<td>25</td>
</tr>
<tr>
<td>99233</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High</td>
<td>35</td>
</tr>
</tbody>
</table>

Initial time spent = 20 min which would allow us to bill only for a 99231 ($32.00) if coded based on time vs. $54.50 for a 99232 if coded based on key components.

Then add in 36 minutes spent later in the day for a total of 56 minutes. This allows us to add the code for prolonged services (99356 = $90.12) to the original encounter which brings the final reimbursement to $144.62.
Documenting Prolonged Services

Addendum

I came back to discuss the risks and benefits of cardiac catheterization vs. medical therapy for USA and CAD. All questions were answered to the patient’s satisfaction. He is going to discuss the situation with his wife and let me know later today whether he will accept cardiac cath in the a.m.

Total time spent in the course of two visits today was 56 minutes.
Discharge Services

- Final physical exam of the patient
- Discussion of the hospital stay
- Finalizing discharge medications
- Arranging for outpatient follow-up or placement
- Writing prescriptions, referrals, orders
- Documenting the discharge summary

Inpatient Discharge Services

- Time-based codes
  - 99238 ≤ 30 minutes $70.03
  - 99239 > 30 minutes $95.53

- Include all time spent performing discharge services on the date of discharge, even if time is not continuous
- Time spent does not need to be face-to-face
Documenting Discharge Services

- No defined documentation requirements
- Principal diagnoses
- Brief description of hospitalization including principal procedures performed and results of pertinent diagnostic testing
- Disposition and follow-up care
- Discharge medications
- No requirement to document the time spent for the 99238 code, but you must document time for the 99239 code.

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