EMERGENCY MEDICINE AND CRITICAL CARE DEFINING THE DIFFERENCE

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Objectives

- Definition of Emergency Services (99281-99285)
- Definition of Critical Care Services (99291 & 99292)
- Split/Shared and Teaching Physicians
  - Emergency Visit
  - Critical Care
- Medical Necessity
  - Documentation needs
  - Care vs. location
- Coding Cases
According to CPT, an Emergency department is defined as “an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention”

- Must be open 24 hours a day
- Time does not apply
- No distinction between new and established
- May be billed as split/shared services
Appendix C of the CPT Manual offers some clinical examples of typical encounter types that support each level of service.

CPT 99285
- ED visit for a patient with active, upper gastrointestinal bleeding.
- ED visit for a patient with a sudden onset of “the worst headache of their life”, stiff neck, nausea and inability to concentrate.
- ED visit for an acute febrile illness in an adult, associated with shortness of breath and altered level of consciousness.
**Split Shared/ED services**

- Physician must document their face-to-face portion of the encounter
  - May be billed by either the MD or NPP
  - No face-to-face by MD, must be billed with NPP’s NPI number
  - The NPP and the MD must clearly identify themselves in the record
  - Physician must document one or more elements of the encounter (history, exam and medical decision making)
  - “Seen and agree” or “agree with above” are examples of documentation that would not qualify
  - “Incident-to” is not reportable in the hospital setting (inpatient or outpatient) which includes the Emergency Department
Teaching visits in the ED

- Care provided by interns, residents and fellows
  - Per Transmittal 1780 “an individual who participates in an approved graduate medical education program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting”
  - Medical student is never considered to be an intern or resident and no service performed by them qualifies as billable to Medicare
Teaching visits in the ED

- Three scenarios:
  - Teaching physician performs and documents all requirements of the E/M service
  - Resident performs the elements of the E/M and provides the documentation; Teaching physician documents their presence and involvement in the management
  - Resident performs the E/M service and documents their work; Teaching physician independently performs the E/M service and documents the work
Teaching visits in the ED

• Services may be reported in the following situations:
  o Personally by a teaching physician who is not a resident
  o By a resident seeing a patient in the “physical presence” of a teaching physician who documents their presence during the key portion of the service
  o Jointly by a teaching physician and resident, seeing patients at a different time during a visit – physician must perform key portions of the service and documenting their involvement
  o Resident admits the patient late at night and teaching physician evaluates the patient later (including the next calendar day)

• Code must be reported with modifier
  o GC - This service has been performed in part by a resident under the direction of a teaching physician.
CPT definition “direct delivery by a physician(s) or other qualified health care professional of medical care for a critically ill or critically injured patient”

- Critical Illness/injury: One that 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
  - 99291 – 30 to 74 minutes
  - 99292 – each additional 30 minutes

- CMS adds that “the 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”
• High complexity medical decision making to “assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or prevent further life-threatening deterioration of the patient’s condition.”

• Examples of system failure:
  o Central nervous system failure
  o Circulatory failure
  o Shock
  o Renal failure
  o Hepatic failure
  o Metabolic failure
  o Respiratory failure
Services included in Critical Care:

- the interpretation of cardiac output measurements (CPT 93561, 93562)
- pulse oximetry (CPT 94760, 94761, 94762)
- chest x-rays, professional component (CPT 71010, 71015, 71020)
- blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data-CPT 99090)
- gastric intubation (CPT 43752, 91105)
- transcutaneous pacing (CPT 92953)
- ventilator management (CPT 94002-94004, 94660, 94662)
- peripheral vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600)
CPT 99291 & 99292

Separately reportable from Critical Care:

- CPR (92950) (while being performed)
- Endotracheal intubation (31500)
- Central line placement (36555, 36556)
- Intraosseous placement (36680)
- Tube thoracostomy (32551)
- Temporary transvenous pacemaker (33210)
- Electrocardiogram - routine ECG with at least 12 leads; interpretation and report only (93010)
- Elective electrical cardioversion (92960)
CPT 99291 & 99292

- **NOT** meeting medical necessity:
  - Services that do not meet critical care service definition
  - Services provided for a patient who is not critically ill or injured
  - Patients located in the critical care, intensive care or specialized care unit but did not receive critical care services based on the definition and criteria
  - Must be both the treatment of vital organ failure **AND** prevention of further life threatening deterioration
  - Report with another appropriate E/M code
    - Subsequent Hospital care (99231-99233)
    - Outpatient Office visit (99201-99215)
    - Emergency Services (99281-99285)
CPT® Clinical Examples

- Clinical Examples of Critical Care from Appendix C of the CPT Manual
  - 13 year old with hypovolemic shock secondary to diarrhea and dehydration
  - Patient who sustained a liver laceration, cerebral hematoma, flailed chest, and pulmonary contusion after being struck by an automobile
  - Patient with septic shock following relief of ureteral obstruction by a stone
  - Female who, following a hysterectomy, suffered a cardiac arrest with pulmonary embolus
According to Medicare, Emergency Department service codes and Critical Care service codes cannot be reported on the same day by the same provider.

- This includes physicians of the same specialty in the same group
- Many commercial payers will also deny
- CMS Transmittal 1548

**Pediatric patients (under 24 months) report codes**

- 99466 and 99467

**Pediatric critical care interfacility transport supervision**

- 99485 and 99486
Documentation

• To support critical care there must be documentation of:
  o The time spent performing CC services
  o The “unbundled” associated procedures and the amount of time performing them
  o A summary of the critical illness and interventions

• Concern of imminent organ failure
  o Providers should indicate what patient was at risk for

• Guidelines state “both the illness or injury and the treatment must meet CC requirements”

• ED providers should document time in and time out
  o Treat multiple patients at the same time
Split/Shared Critical Care Services

- Split/Shared cannot be reported for critical care
- Each critical care code must represent the evaluation, treatment and management of the patient by an individual provider
NPP and Critical Care

- Nurse Practitioners and Physician Assistants may bill critical care with their own National Provider Identifier (NPI)
- Services must be under their scope of practice and licensure services for the state where the services are performed
- Medicare Claims Processing Manual (Pg. 68)
Same Group Critical Care Services

• Same type of practitioner (physician or NPP) in the same group
  o Combine time for a group total to be billed for the calendar day
  o Example: ED physician #1 critical care time of 40 minutes, later same day ED physician #2 critical care time of 55 minutes
    • Total critical care billed for group for the day is 95 minutes
  o Cannot use combined time to meet the first unit of critical care. Each provider must separately meet the minimum 30 minute requirements (Medicare Claims Processing Manual, pg 73)
Teaching Physician and Critical Care

• Time spent by a resident, in absence of the teaching physician cannot be billed by the teaching physician
• Time spent teaching may not be counted towards critical care time
• Time spent by the resident and teaching physician together with the patient OR the teaching physician alone with the patient can be counted for time based codes such as critical care
What to look for

• High level E/M services in the ED require:
  o Comprehensive history and exams with moderate or high medical decision making (99284 vs. 99285)
  • Unable to get a history due to acute illness/injury a statement it was unobtainable supports comprehensive history
  • Any portion of documentation not captured (history, exam and decision making) will make the code invalid

• Critical Care codes:
  o A patient may be critically ill or in a critical care unit but does not automatically support critical care codes
  o Management and time are factors too
# What to look for

<table>
<thead>
<tr>
<th>TOTAL DURATION OF CRITICAL CARE CODES</th>
<th>CODE TO REPORT</th>
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<tbody>
<tr>
<td>Less than 30 minutes</td>
<td>99232 or 99233 or other appropriate E/M code</td>
</tr>
<tr>
<td>30–74 minutes</td>
<td>99291 x 1</td>
</tr>
<tr>
<td>75–104 minutes</td>
<td>99291 x 1 and 99292 x 1</td>
</tr>
<tr>
<td>105–134 minutes</td>
<td>99291 x 1 and 99292 x 2</td>
</tr>
<tr>
<td>135–164 minutes</td>
<td>99291 x 1 and 99292 x 3</td>
</tr>
<tr>
<td>165–194 minutes</td>
<td>99291 x 1 and 99292 x 4</td>
</tr>
<tr>
<td>194 minutes or longer</td>
<td>99291–99292 as appropriate (per the above illustrations)</td>
</tr>
</tbody>
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Critical Care crosses midnight

- Critical Care that crosses midnight and meet the 30 minute threshold
  - Report 99291
  - DOS is calendar date when face-to-face visit began
- Non-continuous critical care performed after midnight. CPT 99291 is reported for the new 30 minutes on the next DOS.
Not necessarily Critical Care

- Daily Vent Management
- Management of dialysis/care related to dialysis for ESRD patient receiving hemodialysis
- Patient admitted to CCU when no other beds are available
- Patient admitted to ICU for observation and monitoring vitals
- Patient admitted to ICU due to hospital rules requiring the needed treatments for the patient must be performed in a critical care setting
Possible Critical Care

- Some diagnoses may be routine in the ED but depending on the interventions and time documented could support critical care coding
  - Elderly patient with acute congestive heart failure
  - Patients with new onset of uncontrolled atrial fibrillation
  - Extended management of severe asthma exacerbation
  - Individuals with supraventricular tachycardia
- There must be an indication of acute interventions to prevent life-threatening deterioration of the patient’s condition
- Provider must document the complexity to support critical care
Documentation counts

- Provider evaluates and treats a patient in the Emergency Department and performs critical care interventions totaling 20 minutes.
- History is comprehensive, Exam is expanded and MDM is high.
- Critical Care is not met due to services being less than 30 minutes.
- Emergency Department services require all 3 of 3 elements for a code assignment.
- Time is not a factor of codes 99281-99282.
- Code supported would be 99283.
Patient was seen in the Emergency Room at 22:35 by ED doctor in with severe chest pain and difficulty breathing. A comprehensive history and examination and EKG tests were performed. IV medications were administered and patient was stabilized. Patient was observed in the ED pending assessment for admission. ED doctor attends to other patients and receives notice that the patient decompensated and loss consciousness at 00:43. ED doctor returns to the patient and CPR is initiated and ET tube is placed. ED provider documents 105 minutes of critical care for the first intervention and 90 minutes of critical care minus procedures.
Coding Case #1

Which codes support this case?

• 99291 and 99291-25, 31600 & 92950
• 99285 and 99291-25, 31600 & 92950
• 99291-25, 99292, 31600 & 92950
• 99285-25, 31600 & 92950

• 99285 and 99291-25, 31600 & 92950
An elderly patient with a history of seizure disorder and history of stroke was found unresponsive with snoring respirations. Patient does not respond to painful stimuli. There was no other information available from the nursing home or family. Provider documents that history was unobtainable due to unresponsiveness. Comprehensive exam was documented. EKG, Chest x-ray and CBC were performed. Chest x-ray was independently viewed by me showing no infiltrates. Patient developed generalized seizure activity and received Ativan and Dilantin IV. Seizure activity ceased. Patient was still unresponsive and Cardizem was administered. Heart rate dropped and patient remained in Afib. Blood pressure was stabilized and the patient was admitted. 85 minutes of critical care was documented excluding procedures.
Coding Case #2

Which codes support the case?

- 99291
- 99285 and 71010-26
- 99285
- 99291 and 99292, 71010-26
- 99291
Patient presents to the ED following a gunshot wound to the chest. Upon arrival to the ED initial resuscitation and complex decision making, including imaging studies, coordination with specialists for emergency surgery and communication with family. Patient is unable to provide any history which was documented. A 7 organ system exam was performed including constitutional, a detailed respiratory exam, detailed cardiovascular exam, gastrointestinal, skin neurologic and musculoskeletal. CPR was performed, a central line and chest tube were placed and the patient was stabilized prior to transfer to the operating room. 115 minutes of critical care time was documented and 45 minutes of that was spent performing procedures.
Coding Case #3

Which codes support this case?

• 99291-25, 99292, 36556, 92950 & 32551
• 99291, 99292
• 99285, 36556, 92950 & 32551
• 99291-25, 36556, 92950 & 32551

• 99291-25, 36556, 92950 & 32551
Thanks For Participating

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