Trauma Surgery & Acute Care Open

# Acute Care Surgery Billing, Coding and Documentation Series Part 1: Basic Evaluation and Management (E/M), Emergency Department E/M, Prolonged Services, Adult Critical Care Documentation and Coding

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## SUMMARY

This series of reviews has been produced to assist both the experienced surgeon and coder, as well as those just starting practice that may have little formal training in this area. Understanding this complex system will allow the provider to work 'smarter, not harder' and garner the maximum compensation for their work. We hope we have been successful in achieving that goal and that this series will provide useful information and be worth the time invested in reading it by bringing tangible benefits to the efficiency of practice and its reimbursement.

## INTRODUCTION

Acute care surgeons, like most physicians are focused on providing quality clinical care and often may avoid the administrative, bureaucratic and business aspects of their practice by deferring them to professional billing or coding specialists either within or outside their institutions. As a result of eschewing the business and administrative component of practice, many surgeons have little education and familiarity with the rules, nuances and other vagaries of coding and billing or how their documentation of clinical services impact their ability to garner the commensurate and appropriate reimbursement for the valuable work that they do.

Likewise, the coding staff are not clinicians and therefore cannot necessarily infer, or correctly interpret, the actual services rendered by the clinician without specific documentation and use of essential terms and phrases along with other critical information to justify the application of a particular code.

Although in some models a coder may be dedicated to surgeons of a unique specialty such as Trauma/Acute Care Surgery, in many, they are 'generalists' with no such specialization. Therefore, they also may not be intimately familiar with Acute Care Surgery practice and the proper application of the codes and modifiers that generate optimal payment and the steps necessary to avoid denials.

Some surgeons do prefer to include their determination of the proper diagnosis (ICD-10 or International Statistical Classification of Diseases and Related Health Problems, revision 10) and procedure (current procedural terminology, CPT) codes in the medical records for coders to acknowledge and submit. This is, in some instances, facilitated by the availability of drop-down lists in the electronic medical record (EMR). Others rely on the coding staff to determine the codes that correspond to the services documented. In either case, close communication between the surgeon and the coding/billing staff is key and should be maintained. This avoids confusion and repeated requests for more information or revision of records which are time-consuming, annoying and inefficient for both the surgeon and the coding staff. It should also serve to reduce the number of claim denials.

The following series of articles is the work product of the American Association for the Surgery of Trauma Ad Hoc Committee on Reimbursement and Coding. The compendium of reviews is meant to serve as a basic primer on documentation and coding for both surgeon and coder, either of whom may not be familiar with the necessary elements required to attain maximal efficiency in a constantly changing landscape of rules, and the interpretation of them, by different payers. Better understanding of this daunting process can ultimately lead to maximal reimbursement.

The series is presented in three parts:

- Basic Evaluation and Management (E/M), Emergency Department (ED) E/M, Prolonged Services, Adult Critical Care Documentation and Coding.
- Postoperative Documentation and Coding, Documentation and Coding in Conjunction with Trainees and Advanced Practitioners, Coding Select Procedures.
- Coding of additional select procedures, Modifiers, Telemedicine coding, Robotic surgery.

Each section gives pertinent information on the documentation and coding process. Examples of some clinical scenarios and templated notes are provided, along with additional resources for further reading.

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## E/M DOCUMENTATION AND CODING

### Introduction

E/M services are the mainstay of clinical practice. Proper and complete documentation of services is essential for quality patient care, medicolegal reasons and appropriate reimbursement for the services rendered.

The CPT code range for E/M services is a medical code set maintained by the American Medical Association. The CPT code range for E/M (99201–99499) contains CPT codes for office/other outpatient services, hospital observation services, hospital inpatient services, consultations, ED services and critical care, among many other services. A detailed listing can be found at https://coder.aapc.com/cpt-codes/.

Medicare establishes a relative value unit (RVU) for each CPT code to determine reimbursement. The RVU has three components: physician work, practice expense and malpractice. The physician work RVU, or wRVU, is a method used to quantify and compare the productivity of physicians which neutralizes variables such as fee schedules or geographical costs. Physicians employed by a medical group, hospital or academic institution are commonly compensated using a productivity formula based on wRVUs. Since these formulas have significant bearing on earnings, it is advisable to be knowledgeable about how the compensation formula works and specifically how wRVUs are tabulated.

### E/M components

There are three key components of E/M and its documentation:

- History (Hx).
- Physical examination (PE).
- Medical decision making (MDM).

In certain circumstances, time may be used instead of Hx, PE, or MDM. If more than 50% of the provider's time was spent in face-to-face counseling and coordination of care of the patient (outpatient) or services were provided on the hospital ward (inpatient) with at least a face-to-face encounter, consider using time-based billing to choose the appropriate E/M code submitted.

### Rules for documentation of an E/M encounter

The rules for documentation in these types of notes can be found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf.

There are two pathways for documentation. The 1995 versus the 1997 guidelines differ in their examination documentation requirements, and a note must use *either* the 1995 or the 1997 rules throughout the note, not a mixture of both. However, the 1997 documentation guidelines for extended history of present illness (HPI) may be used in conjunction with other elements from the 1995 documentation guidelines for an E/M note.

One should also know the institutional norms for documentation. If the institution uses coders and has a convention of using either the 1995 or 1997 rules, one should be familiar with those and have close communication with the coders regarding proper documentation according to the correct set of rules.

Consistency, using *either* the 1995 or 1997 rules throughout the E/M note, and adhering to any institutional requirements and practices, is key to avoiding any confusion and the repeated need for revision of notes or denial of claims.

In the interest of brevity, only the 1997 rules will be discussed. For more detailed information on both sets of rules, see the references above or www.cms.gov or consult with your coding staff.

### Recent rule changes

The following rule change instituted in 2019 for established office patients should be noted:

A provider may review some elements previously documented in the chart and indicate the review and any changes. For example, a form completed by the patient prior to, or at the time of, an initial encounter that contains information on chief complaint (CC), HPI, review of systems (ROS), and past, family, and/or social history (PFSH) may be reviewed by the provider and documented as such in the E/M note thereby fulfilling the requirements for that portion of the current encounter's documentation. Likewise, documentation that a review of the provider's notes done in an earlier encounter was performed will also suffice to meet requirements. The EMR provides the ability for 'cutting and pasting' from other notes or documents easing the process of complete documentation, however this should be used sparingly, and with precision, to avoid lengthy notes containing extraneous or outdated, inaccurate information, that are cumbersome to read and interpret.

CMS (Centers for Medicare and Medicaid Services) has been discussing more radical change of the documentation rules that may be initiated for 2021. The changes under consideration reportedly attempt to decrease the burden of documentation for E/M encounters which has been recognized as a factor contributing to physician 'burnout'.

### Selection of the appropriate code for E/M documentation

Considerations include:

- Inpatient or outpatient?
- New patient or established patient?
- What type of encounter—admission/consult versus subsequent hospital day versus discharge date versus ED service?
- Predominantly counseling and/or coordination of care?

The amount of supporting documentation required can be analyzed from Hx and PE, starting with recognition of the level of MDM. The MDM supporting documentation required should give guidance.

There are four levels of complexity for E/M encounters: problem-focused; expanded problem-focused; expanded problem-detailed; expanded problem-comprehensive. Each requires increasing amounts of information be documented to support the claim for that level of complexity. Components of the documentation are noted previously and include the following:

### History

Documentation of history including CC and then elements of HPI, ROS, and PFSH (see table 1).

*Chief Complaint*—A CC must be provided with each admission note. It is typically a succinct statement of the symptom or reason for the encounter.

*History of Present Illness*—The HPI section describes the development of the present illness and includes the following elements:

- Location
- Quality

**Table 1** Elements required for history

| Type of history | CC | HPI | PFSH | ROS |
|---|---|---|---|---|
| Problem focused | Required | Brief | n/a | n/a |
| Expanded problem focused | Required | Brief | n/a | Problem pertinent (one system) |
| Detailed | Required | Extended | Pertinent (1 of 3) | Extended (2–9 systems) |
| Comprehensive | Required | Extended | Complete (3 of 3) | Complete (10 systems) |

CC, chief complaint; HPI, history of present illness; PFSH, past, family, and/or social history; ROS, review of systems.

- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated signs and symptoms

There are two types of HPI—brief and extended.

- ***Brief HPI*** is comprised of one to three elements of the HPI.
- ***Extended HPI*** is comprised of four or more elements of the HPI.
  - 1995 guidelines—at least four elements of HPI or associated comorbidities (as of 2013, may use update of three chronic or inactive conditions).
  - 1997 guidelines—at least four elements of HPI or the status of at least three chronic or inactive conditions.

*Review of Systems*—inventory of systems to identify signs or symptoms the patient is experiencing/has experienced, designated by the following list:

- Constitutional symptoms
- Eyes
- Ears, nose, mouth, throat (count as one system)
- Cardiovascular
- Respiratory
- Gastrointestinal
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic

**Problem-pertinent ROS** is the system directly related to the problem in the HPI. (one system reviewed).

**Extended ROS** is about the problem identified in the HPI and a limited number of additional systems (pertinent positives and negatives for two to nine systems).

**Complete ROS** directly related to the problem in the HPI plus other systems, with at least 10 organ systems reviewed.

One should document positives and negatives for the most relevant systems and then can state 'all other systems are negative'. Without such a blanket statement implying that all 12 systems were reviewed, specific information must be documented for at least 10 systems.

## Past, family, and/or social history

The grouping of PFSH is another portion of the history and is often referred to as PFSH.

**Past Medical History** comprises both medical and surgical conditions. It reviews the patient's previous illnesses, operations, injuries, and treatments.

**Family History** reviews diseases or medical events in the patient's family.

**Social History** reviews age-appropriate past and current activities. (eg, marital status, frequency and quantity of alcohol intake, illicit substance use, tobacco use, living situation/support system). For a new patient in either the outpatient or inpatient setting, at least one item from each of the areas of PFSH is required.

**Pertinent PFSH** is a review of the history related to the problem in the HPI and includes at least one item from any of the three areas.

**Complete PFHS** is a review with at least one element in two or three of the PFSH areas, depending on the category of E/M service. (All three areas if a new patient; two areas if ED services, hospital subsequent day service, or established outpatient visit).

## Guidelines for use of PFSH and ROS

- At least one item from two of the PFSH areas must be documented to qualify as a complete PFSH for established patient office visits or subsequent day inpatient visits.
- At least one item from each of the three areas must be documented to claim the highest level new patient visits, both inpatient and outpatient.
- An ROS or PFSH from an earlier encounter may be reviewed and updated in the record, describing what, if any change has occurred.
- Ancillary staff or the patient himself/herself may record ROS and/or PFSH on a form and the physician may review it and confirm that review in the note.

If, for any reason, there is an inability to obtain any portion of the history, this should documented along with the reason in order to obtain full credit for the category. (eg, 'the PFSH or ROS was not able to be obtained due to the patient being intubated and sedated'.)

## Physical examination

The most profound differences between the 1995 and 1997 guidelines for E/M documentation pertain to PE (see table 2).

**Problem-focused**—limited examination of the body area or organ system affected.

**Table 2** 1997 documentation guidelines: examination

| Type of examination | Number of organ system or body areas | Description |
|---|---|---|
| Problem-focused | At least one organ system | One to five elements identified by a bullet in at least one organ system |
| Expanded problem-focused | At least one organ system | At least six elements identified by a bullet in at least one organ system |
| Detailed | At least 2 elements each in six organ systems<br>OR<br>At least 12 elements in two or more organ systems | **'2 in 6'** At least two elements identified by a bullet in at least six organ systems<br>**'12 in 2'** Alternatively, may include at least 12 elements identified by a bullet in two or more organ systems |
| Comprehensive | Two elements from at least nine organ systems or complete examination of single organ system | At least nine organ systems or complete examination of single organ system |

**Expanded problem-focused**—limited examination of the affected body or organ system and any other symptomatic or related body areas or organ systems.

**Detailed**—extended examination of the affected body areas or organ systems and other symptomatic or related body areas or organ systems.

**Comprehensive**—general multisystem examination or complete examination of a single organ system or organ systems (1997 guidelines).

The 1997 documentation guidelines describe two types of comprehensive examinations that can be performed during a patient's visit: general multisystem examination or single organ examination. The CMS guidelines for 1997 give some specific examples and regulations for this.

## 1997 guidelines organ systems

- Constitutional
- Eyes
- Ears, nose, mouth, and throat
- Neck
- Respiratory
- Cardiovascular
- Chest (breasts)
- Gastrointestinal (abdomen)
- Genitourinary (male)
- Genitourinary (female)
- Lymphatic
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric

## Documenting to achieve the highest level of service

The chart below (table 3) summarizes the documentation necessary to garner the highest level of reimbursement for E/M services using either the 1995 or 1997 rules for a new patient H&P (History and Physical) in the hospital or office. These will not apply to ED visits for patients who are not admitted.

A new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty who belongs to the same group practice, within the past 3 years See table 4.

An established patient is one who has received professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years. See Table 4.

**Table 3** Minimum requirements for highest-level billing in a new patient (inpatient/outpatient)

| Sections | 1995 | 1997 |
|---|---|---|
| CC | | |
| HPI | Four elements or status update of three chronic conditions | Four elements or status update of three chronic conditions |
| PFSH | One element from all three categories | One element from all three categories |
| ROS | One element from least 10 of 14 systems | One element from least 10 of 14 systems |
| PE | One element from at least eight organ systems<br>OR<br>One complete single specialty system examination | At least two bullets in at least nine organ systems |

Always document *why* it is not possible to obtain information regarding a specific element of history or examination to receive credit for addressing that element, body area or organ system.
CC, chief complaint; HPI, history of present illness; PE, physical examination; PFSH, past, family, and/or social history; ROS, review of systems.

**Table 4** Current codes for office encounters

| New patient visit | Typical time (minutes) | Established patient visit | Typical time (minutes) |
|---|---|---|---|
| 99201 | 10 | 99211 | 5 |
| 99202 | 20 | 99212 | 10 |
| 99203 | 30 | 99213 | 15 |
| 99204 | 45 | 99214 | 25 |
| 99205 | 60 | 99215 | 40 |

## Initial hospital care (99221 to 99223)

These codes are used to bill for initial hospital services otherwise known to physicians as H&Ps (see table 5). When admitting a patient to the hospital as an inpatient, these are the codes that should be used. More detailed information about use and documentation regarding these and many other CPT codes can be found at https://www.pinterest.com/hospitalist/evaluation-and-management-em-cpt-free-coding-lectu/

## Hospital progress notes

There are three levels of inpatient services that are analyzed by information in the progress note. These range from 99231 to 99293 with increasing complexity (see table 6).

## Claims require only two of the three components be documented to justify level of service

A useful tool for determining the proper code to be submitted based on number and complexity of service components rendered can also be found by accessing Resource 1.

## Discharge summary documentation

The Joint Commission mandates that discharge summaries contain certain components. These are: reason for hospitalization; significant findings; procedures and treatment provided; patient's discharge condition; patient and family instructions; and attending physician's signature. The definition of each component is listed below.

1. **Reason for hospitalization**—CC and/or HPI.
2. **Significant findings**—primary diagnoses.
3. **Procedures and treatment provided**—hospital course and/or hospital consults and/or hospital procedures and their outcomes, significant laboratory results or diagnostic imaging findings.
4. **Patient's discharge condition**—documentation that gives a sense for how the patient is doing at discharge or the patient's health status on discharge.
5. **Patient and family instructions** (as appropriate)—as discharge medications and/or activity orders and/or therapy orders and/or dietary instructions and/or plans for medical follow-up.
6. **Attending physician's signature**—an electronic or physical signature of the attending physician on the discharge summary.

Table 5 Initial hospital service codes

| Level | E/M code | History | Physical examination | MDM | Time |
|---|---|---|---|---|---|
| 1 | 99221 (1.92 wRVU) | Detailed | Detailed | Straightforward/low | 30 min. |
| 2 | 99222 (2.61 wRVU) | Comprehensive | Comprehensive | Moderate | 50 min. |
| 3 | 99223 (3.86 wRVU) | Comprehensive | Comprehensive | High | 70 min. |

E/M, evaluation and management; MDM, medical decision making; wRVU, work relative value unit.

Important changes to E/M rules and requirements are planned for 2021. Not uncommonly, CMS and CPT rule language and definitions will differ and private payers may, or may not, adopt either thereby adding to the coding conundrum and complexity.

The following are resources which give additional information on this section:

- https://thehappyhospitalist.blogspot.com/2008/11/how-to-bill-critical-care.html (accessed May 18,2020)
- https://www.pinterest.com/hospitalist/evaluation-and-management-em-cpt-free-coding-lectu/ (accessed May 18, 2020)
- https://ngsmedicare.com/ngs/wcm/connect/ngsmedicare/3632a905-b697-4266-8fc0-2aa2a84fedb2/1074_0317_EM_Documentation_Training_Tool_508.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_69MIG982N05UD0QGR5I7CS200069MIG982N05UD0QGR5I7CS2000-3632a905-b697-4266-8fc0-2aa2a84fedb2-lGlLe2y
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf (accessed May 18, 2020)
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Fast-Facts/Medical-Records-Documentation (accessed May 18,2020)
- https://blog.cureatr.com/what-should-be-included-in-a-hospital-discharge-summary (accessed May 18, 2020)
- Kind AJH, Smith MA. Documentation of Mandated Discharge Summary Components in Transitions from Acute to Subacute Care. https://www.ahrq.gov/downloads/pub/advances2/vol2/advances-kind_31.pdf (accessed May 18, 2020).
- https://www.doctors-management.com/ama-to-revise-cpts-e-m-codes-in-2021-following-cms/ (accessed May 18, 2020)
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf (accessed May 18, 2020),
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf (accessed May 25, 2020)
- https://www.cms.gov/Medicare/Prevention/PrevntionGen-Info/Downloads/bp102c15.pdf (accessed May 25, 2020)
- www.medicalbillingcptmodifiers.com/2015/02/cpt-code-99223-and-99233.html (accessed May 25, 2020)
- https://www.cgsmedicare.com/partb/mr/PDF/99233.pdf (accessed May 25, 2020)
- https://emuniversity.com/Level3HospitalProgressNote.html (accessed May 25, 2020)
- https://myheart.net/cardiology-coding-center/99233-cpt-code-level-3-hospital-followup-note- dummies-guide-2017–2018/ (accessed May 25, 2020)

Table 6 Inpatient hospital service codes (daily visits)

| Level | E/M code | History | Physical examination | MDM | Time |
|---|---|---|---|---|---|
| 1 | 99231 (0.76 wRVU) | Focused | Focused | Straightforward/low | 15 |
| 2 | 99232 (1.39 wRVU) | Expanded | Expanded | Moderate | 25 |
| 3 | 99233 (2.0 wRVU) | Detailed | Detailed | High | 35 |

E/M, evaluation and management; MDM, medical decision making; wRVU, work relative value unit.

- www.medicalbillingcptmodifiers.com/2015/02/cpt-code-99223-and-99233.html (accessed May 25, 2020)
- https://www.cgsmedicare.com/partb/mr/PDF/99233.pdf (accessed May 25, 2020)
- https://emuniversity.com/Level3HospitalProgressNote.html (accessed May 25, 2020)
- https://myheart.net/cardiology-coding-center/99233-cpt-code-level-3-hospital-followup-note- dummies-guide-2017–2018/ (accessed May 25, 2020)

## EMERGENCY DEPARTMENT EVALUATION AND MANAGEMENT

### Introduction

Acute Care Surgeons deliver many of their services in the ED either singularly or often in conjunction with a number of other providers from the same or different specialties. Therefore it is incumbent on all providers to be aware of coding rules and options and for coders to communicate before submitting claims to avoid denials and audits but also to assure appropriate credit and reimbursement to each provider.

### Basic principles

Any provider can use the ED codes (99281 to 99285), as long as the service is provided in the ED setting. There is not a requirement for the provider to be an ED physician to use these codes.

When an ED physician requests another physician to see the patient in the ED, both physicians should report an ED code, unless the patient is admitted. If the patient is admitted, the ED provider chooses a code from 99281 to 99285 and the physician admitting the patient through the ED will report an initial hospital care code (99221 to 99223) or critical care code (99291 to 99292).

The same qualifiers and documentation requirements govern level of service which can be claimed for both hospital E/M and ED E/M services. The reimbursement (wRVU) is, of course, greater for critical care than either the ED or hospital admission E/M. If critical care is billed, be mindful of the need for more detailed and specific documentation to support the claim.

It is generally more advantageous for the surgeon to bill critical care in the ED rather than inpatient hospital visit codes when admitting patients to their service. Obviously this is predicated on the service qualifying as such (see Adult Critical Care section).

### ED E/M Codes

#### 99281 (wRVU 0.45) ED visit for the E/M of a patient,

Requires these three key components: a problem-focused history; a problem-focused examination; and straightforward MDM. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor.

#### 99282 (wRVU 0.88) ED visit for the E/M of a patient,

Requires these three key components: an expanded problem-focused history; an expanded problem-focused examination; and MDM of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

#### 99283 (wRVU 1.34) ED visit for the E/M of a patient,

Requires these three key components: an expanded problem-focused history; an expanded problem-focused examination; and MDM of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.

#### 99284 (wRVU 2.56) ED visit for the E/M of a patient,

Requires these three key components: a detailed history; a detailed examination; and MDM of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function. Average fee payment - $110 to $120

#### 99285 (wRVU 3.80) ED visit for the E/M of a patient,

Requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history; a comprehensive examination; and MDM of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

### Prolonged service codes may not be used with ED E/M codes

### Multiple Physician Coding (Concurrent Care)

Critically ill or critically injured patients may require the care of more than one physician medical specialty. Medically necessary critical care services provided on the same calendar date to the same patient by physicians representing different medical specialties that are not duplicative services are payable. This is referred to as 'concurrent care'. Concurrent care exists where more than one physician renders services more extensive than consultative services during a period of time. The medical specialists may be from the same group practice or from different group practices. Concurrent care by more than one physician is payable if certain requirements are met. It applies only if the care meets critical care requirements, is medically necessary and is not duplicative. Note that concurrent critical care services provided by each physician must not be provided during the same instance of time, that is, simultaneously. Medical record documentation must support the medical necessity of critical care services provided by each physiciadures included in critical care time and not sepan or qualified non-physician provider (NPP). Each physician must accurately report the service(s) they provided to the patient in accordance with any applicable global surgery rules or concurrent care rules.

The question then arises: can two physicians bill for critical care services on the same patient if it is rendered at the same time, or simultaneously? Although the Medicare Claims Processing Manual clearly states that two physicians cannot provide critical care services to the same patient at the same time, many physician evaluations occur at the same time, especially when critically ill patients require a multidisciplinary approach as is often the case with trauma team activations. It is not clear how often claims are denied when two different physicians of different specialties provide critical care services at the same time. However, appeals of any denials will more than likely be rejected unless documentation can somehow present the care of the different providers as *not* being simultaneous.

#### The following are resources which provide additional information on this topic

- https://www.aapc.com/practice-management/rvu-calculator-results.aspx?c=99291%2c99292%2c99221%2c99222%2c99223%2c%2c%2c%2c%2c%2c&u=1%2c1%2c1%2c1%2c1%2c%2c%2c%2c%2c%2c (accessed May 18, 2020)
- www.medicalbillingcptmodifiers.com/2013/01/emergency-department-cpt-codes-99281.html (accessed May 18, 2020)
- https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/Downloads/clm104c12.pdf (accessed May, 2020)
- https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/bp102c15.pdf (accessed May 18, 2020)

#### Prolonged services

Codes +99358, prolonged E/M service before and/or after direct (face-to-face) patient care (eg, review of extensive records

and tests, communication with other professionals and/or the patient/family); first hour (list separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient E/M service) and +99359, prolonged E/M service before and/or after direct (face-to-face) patient care (eg, review of extensive records and tests, communication with other professionals and/or the patient/family); each additional 30 minutes (list separately in addition to code for prolonged physician service) report non face-to-face prolonged services, but these are not recognized by Medicare and many other payers.

Time counted towards prolonged services need not be continuous, but it must occur on the same service date. Do not consider time spent discussing the patient's case with other physicians, time reviewing data or tests without the patient present, or other activities not involving direct patient contact towards prolonged services.

Documentation must explain why the physician provided prolonged services. Rules state 'to support billing for prolonged services, the medical record must document the duration and content of the E/M code billed'. A notation that the physician spent an extra 40 minutes with the patient, for instance, is not adequate. The medical record must support specifically medical necessity for the extra time spent.

**Note:** Prolonged services codes (+99354 to +99357) are 'add on' codes and may be combined with other E/M services to report extended, face-to-face patient/provider visits. To report prolonged services, the physician must document at least an additional 30 minutes of face to face beyond the time reference of the chosen E/M service level. Do not report prolonged service codes in addition to any E/M services (such as observation services) that do not include a time reference.

Additional information on this topic may be found in these resources.

- https://www.aapc.com/blog/4615-go-beyond-the-basics-of-time-based-em-coding/ (accessed May 18, 2020)
- https://www.aap.org/en-us/Documents/coding_prolonged_services.pdf (accessed June 3, 2020)

## ADULT CRITICAL CARE DOCUMENTATION AND CODING

### Introduction

Critical care constitutes a large part of Acute Care Surgery practice. Not only is the provision of critical care difficult and complex, so too is the process of coding for services and documentation to justify those codes. In both instances, the difficulty and complexity is a result of the acuity and multiplicity of patient conditions along with a team approach to care involving a number of providers from different specialties and at various levels of training and expertise. Further contributing to the intricacy of this process is the fact that oftentimes the operating surgeon is also the primary critical care provider. This piece explores some of those issues and methods to avoid and address them, as well as the rules governing the documentation and coding of critical care services.

### Critical Care: Definition

Critical care is a time-based service that, according to CMS definitions, 'involves high complexity decision making to assess, manipulate, and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition a critical illness or injury'. 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'.

Examples of vital organ system failure cited by CMS include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

### Qualifying Providers

Any physician or qualified NPP can bill critical care.

### Service Venue

It is not required that the patient be located in the intensive care unit (ICU) at the time of the services to bill critical care. When the appropriate conditions and services are present, critical care may be provided and billed on the wards, ED, or anywhere else within the institution. However, the provider must be physically present in proximity to the patient during the billed time, dedicated to their sole care and immediately available.

### Credit for NPP Services

The time spent by an NPP in providing a service *cannot* be credited to the physician. Critical care billing represents time as an individual qualified provider and cannot be used as a split/shared service. Resident time cannot be billed as critical care time. The substance of an attested resident note can be used as justification and details of a critical illness diagnosis and services, but the physician time must stand alone for total time by the specific provider and represents personal effort and services. In general, the note documenting critical care services delivered by a particular provider should stand alone and describe the services delivered by that provider that justify the critical care charge.

### Qualifiers of Time

The first block of critical care time must be 30 minutes or more. That 30 minutes or more starts the 'critical care clock'. The time during which care is rendered may be discontinuous and aggregated on a calendar date. The billing provider must be physically present in the proximity of the patient (on the ward/floor or ICU, as appropriate) and engaged in activities devoted to the specific patient.

Time spent performing or supervising procedures that are separately billed must be subtracted from time comprising total critical care time, even if still present at bedside. It is good practice to ensure it is clearly documented whether a procedure is included in your total critical care time versus separately billed.

> Note: *You must clearly state the total critical care time, how the patient is critically ill and what critical services are being provided. It is helpful to state what is included in the time and whether procedures or other events are excluded.*

Time spent in educational discussions with residents/students and not directly related to patient care cannot be included.

Even if related to the care of the patient, time off of the ICU/floor where the patient is located is not included. (eg, telephone calls from home, documentation in the office in another area, etc).

### Required Elements of Documentation

There are three elements required in documentation for a critical care note:

1. Critical illness diagnosis.
2. Performance of critical care services.

3. Meeting the threshold for initial block of critical care time and documentation thereof.

Maintaining the patient in an ICU due to lack of other bed availability, need for frequent nursing care or because hospital policy requires it due to specific treatment (eg, insulin drip or specific medication dosing) does not justify critical care billing.

> Note: *Though CMS does not actually require documentation of a physical exam to support critical care, it is obviously helpful for medicolegal documentation, communication, and continuity of care. If documentation doesn't rise to the level of the requirement of critical care, the note would then drop to an E/M Subsequent Hospital Care level, but if absolutely no exam is present, the service becomes* non-billable.
>
> ***Example of Critical Care statement:*** *I spent a total of* 55 *min of critical care time on this date, including* exam, review of labs and studies, discussion with consultants, ventilator management, and direction of blood product administration, documentation and decision-making. *This time is exclusive of procedures and separate from other providers. The patient is critically ill due to* acute hypoxic respiratory failure and hemorrhagic shock.

## Activities comprising critical care time

- PE.
- Review of labs and studies.
- Discussion with consultants and care teams.
- Family counseling/discussions (if patient unable to participate and discussion is necessary for history or determining treatment decisions, NOT just routine updates).
- Documentation.
- Procedures included in critical care time (see below).

## Procedures included in critical care time and not separately billable (CPTs)

- Interpretation of cardiac output measurements (93561, 93562).
- Gastric intubation (91105).
- Ventilator management (94656, 94657, 94660, 94662).
- Temporary transcutaneous pacing (92953).
- Review of chest X-rays (71010, 71020).
- Vascular access procedures (36000, 36410, 36415, 36600)—these do not include central line placement (36556).

Billing claims for any of these procedures will automatically be rejected by the edit process and not allowed to be submitted together (known as the codes being bundled or 'hitting up against each other').

Occasionally two separate access sites to the central circulation are required. One site is used for the measurement of cardiovascular function, the other dedicated to the administration of medications or fluids. This could result in charges for two 36556s or one 36556 and one 93503.

Arterial catheters (36620) allow monitoring of the systemic arterial, not the central venous, circulation. Arterial catheter placement should never be considered to be bundled with procedures for monitoring the central circulation (36555, 36556 or 93503). Ultrasound-guided vascular access (76937–26) to facilitate placement of arterial and central venous catheters is not bundled with arterial catheter placement (36620), central venous catheter placement (36555, 36556), or pulmonary artery catheter placement (93503).

Relevant CPT codes for critical care follow in table 7

**99291 (wRVU 4.50):** Critical Care, E/M of the critically ill or critically injured patient; first 30 minutes to 74 minutes.

**Table 7** Critical care time coding guide

| | Codes |
|---|---|
| Less than 30 min | 99232 or 99233 or other appropriate E/M code |
| 30 min to 74 min | 99291×1 |
| 75 min to 104 min | 99291×1 and 99292×1 |
| 105 min to 134 min | 99291×1 and 99292×2 |
| 135 min to 164 min | 99291×1 and 99292×3 |

E/M, evaluation and management.

**99292 (wRVU 2.25):** Critical Care, E/M of the critically ill or critically injured patient; each additional block of time up to 30 minutes (use of 99291 is a prerequisite to use of this code).

## Multiple billing providers within the same specialty and practice documentation for critical care time on the same date

Critical care time becomes additive for care billed under one National Provider Identifier (NPI) number.

According to CMS guidelines, when two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service, only one physician in the specialty group may report CPT code 99291 with or without CPT code 99292, and the other physician(s) must report their critical care services with CPT code 99292.

**Example**: Physician A writes a critical care note for 57 minutes. Physician B documents critical care services at a later time on the same date for a separate 35 minutes. The total critical care time is 92 minutes and is billed under one physician's NPI number as 99291 and 99292 for that date.

For the provider of a like specialty, 99291 should be used only once on a single calendar date. The 99291 code must be submitted before the 99292 code can be used for each subsequent block of 30 minutes. Thus, code 99292 could be used for multiple blocks, as appropriate.

The 99291 code can be submitted for the same calendar date by a provider of a *different* specialty (NPI) as long as it is for a separate block of time or management of a different critical care issue.

For more information on this topic see these additional resources:

- https://thehappyhospitalist.blogspot.com/2008/11/how-to-bill-critical-care.html (accessed May 18,2020)
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2997CP.pdf (accessed May 18, 2020)
- American Medical Association. *Current Procedural Terminology*. Professional Edition. Chicago, IL: American Medical Association; 2017.
- https://www.sccm.org/Communications/Critical-Connections/Archives/2017/Common-Confusing-Issues-When-Reporting-Critical-Ca (accessed May 18, 2020)
- https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd (accessed May 19, 2020)
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM5993.pdf (accessed May 25, 2020)

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