Acute Care Surgery Code for Reimbursement: Critical Care Documentation

R. Lawrence Reed, MD, FACS

Editorial Review: *Stephanie A. Savage, MD, MS*

Clay Cothren Burlew, MD

- **<u>Critical Care Codes</u>**
    - 99291 covers the first hour (defined as anything between 30 and 74 minutes) of total critical care time spent on the patient during the course of a day
        - Currently valued at 4.5 work RVUs (7.76 total RVUs)
    - 99292 covers every subsequent 30 minutes of total critical care time spent on the patient during the course of the day. (There is a minimum of 15 minutes that must be spent before this charge can be applied.)
        - Currently valued at 2.25 work RVUs (3.47 total RVUs)
- For purposes of reimbursement, Critical Care documentation requires 2 key elements:
    - Evidence supporting the fact that the patient is critically ill, and
    - The total time spent by the physician (and others in his group and specialty) delivering critical care on the patient during the day.
- Documentation of critical illness can often be established by identifying key physical, laboratory, imaging, etc. data that defines critical illness.
    - According to the Medicare Claims Manual, "*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*."
    - Thus, the following phrases can often be helpful:
        - "The patient's current chest imaging demonstrates diffuse bilateral infiltrates, which, coupled with his low PaO_2/F_IO_2 and lack of evidence of hypervolemia, is consistent with Acute Respiratory Distress Syndrome (ARDS)."
- "Clearly, the patient needs continuous mechanical ventilation to sustain life."
- "Mr./Ms. _____ is in critical condition requiring constant attention."
    - "The patient's hemodynamics continue to demonstrate instability with (hypotension/tachycardia/bradycardia/severe hypertension)."
    - "The patient continues to demonstrate severe respiratory failure with hypoxia/hypercarbia requiring continuous mechanical ventilation and supplemental oxygen."

- Documentation for critical care E&M codes should also include what you did for the patient during the time you stated you cared for the patient, excluding the time spent on bedside procedures. For example:
    - "While immediately available to the patient, I examined (him/her) and reviewed (his/her) recent events, ICU flow sheet data, laboratory analyses, and imaging studies."
    - "I transfused the patient with 4 units of packed red blood cells over the past 24 hours, along with fresh-frozen plasma & cryoprecipitate. Continuous assessment

and supplementation is necessary to prevent uncontrolled hemorrhage, hypovolemia, with potential subsequent organ failure and death."
    - "The patient requires continuous infusions of vasoactive agents (epinephrine and dobutamine) to maintain his systolic arterial blood pressure in the 90s. Otherwise, he would progress into circulatory shock, organ failures, and death."
    - "The patient is hypokalemic, hypocalcemic, and hypomagenesemic. We will administer supplements of these electrolytes in order to forestall further deterioration with potential circulatory disturbances, organ failure, and death."
    - The overall picture is that of overwhelming sepsis with septic shock, unresponsive to current broad-spectrum antibiotic management. We will continue to evaluate for potential septic sources to control while providing hemodynamic circulatory support in efforts to prevent organ failure and death."
- The phrases listed above and similar phrases can be automated as SmartText, AutoText or other macro facility in your electronic medical record. Most of these systems also have "wildcard characters" (such as "**" or "_") that can be quickly located with a function key (i.e, F2 or F3) to complete for variable terms (such as "his" vs "hers", or to enter a specific value for electrolytes, vital signs, etc.
- Documentation elements typically applied in other E&M encounters (i.e., history of present illness, physical examination, and medical decision-making) are not specifically required for critical care documentation.
    - Providing data that does not establish the critical nature of the patient's current condition is not helpful and could actually be detrimental to billing 99291/99292.
        - For example, if most of the physical examination represents normal findings, that documentation could dilute statements that establish the patient's critical illness.
- The documentation structure to employ for critical care is not based around the HPI, physical exam, medical decision-making. Rather one should use:
    - A list of organ and system problems, (but only list the organs and systems with problems):
        - Respiratory system
        - Circulatory system
        - Gastrointestinal system
        - Hepatic function
        - Renal function
        - Neurologic system
        - Immunologic system
        - Hematologic system
        - Nutritional status
        - Integumentary system (all epithelial surfaces should be include, cutaneous and well as gastrointestinal epithelial surfaces if problematic)
        - Urologic system (i.e., urinary drainage conduits, as opposed to renal filtration and excretion)

        - Musculoskeletal system
    - With each derranged organ or system, describe
        - The nature of the problem based upon clinical findings, laboratory and imaging studies, consultant opinions, etc.
        - What you are doing about it with respect to previous and current therapy, responses to those interventions, and future plans.
- Finally, document your total time managing the patient during the day.
    - i.e., "I spent 48 minutes in the critical care of this patient, excluding time spent on procedures"
    - All time spent with the patient and – very importantly – the time you spent writing the note should be included in your time determination.