

Facility Coding for Critical Care under CMS Outpatient Prospective Payment System Rules

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Critical care is the highest level of facility visit service provided in an outpatient setting—emergency department (ED), observation and clinics. The relatively high monetary value of this service, coupled with specific Current Procedural Terminology (CPT) and Centers for Medicare and Medicaid Services (CMS) documentation requirements, often leads to coding compliance concerns. Consequently, many outpatient facilities are under-reporting critical care and leaving money on the table. However, with proper background and better visibility into CPT and CMS rules, EDs can code critical care appropriately and optimize ED reimbursement and compliance. On top of these tremendous challenges, the health care industry confronts the most sweeping reform in its history. The provisions included within the law will make it necessary for hospitals to transform the way they deliver care to reduce costs, enhance efficiency, improve coordination among disparate providers, and deliver high quality care. Further, adding millions of newly covered individuals will put a strain on certain resources while fundamentally changing how hospitals are paid for services provided to these individuals.

In an ED, any high-acuity presenting problem has the potential to result in the need for critical care services. Under CMS Outpatient Prospective Payment System Rules (OPPS), facilities are directed to follow CPT critical care guidelines, which define critical care as the direct delivery, by a physician, of medical care for a critically ill or injured patient. According to CMS, a critical illness or injury results in a “high probability of sudden, clinically significant or life-threatening deterioration in the patient’s condition, which requires the highest level of physician preparedness to intervene urgently.” CPT says the care of such patients involves high-complexity decision-making to assess, manipulate and support vital system functions, to treat organ system failure and/or to prevent further life-threatening deterioration of the patient’s condition.

The CPT descriptor for critical care services, reported with CPT codes 99291 and 99292, requires documentation in the clinical record of:

- The patient’s criticality
- The intensity of service and interventions provided
- At least 30 minutes of critical care, not including separately billable procedure time

CMS Facility Critical Care Coding Rules

OPPS rules state that the time reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-

to-face care of a critically ill or injured patient. This care should be reported only once per calendar date, even if the time is not continuous or if multiple staff members are simultaneously engaged in care. In line with CMS guidelines, critical care lasting less than 30 minutes is reported instead as an ED visit, consistent with internal hospital guidelines.

Importance of Timing

Determining facility critical care time requires calculation. The coder or nurse needs to determine the critical care start and stop times and the total time in hours/minutes, and then subtract the time spent performing separately billable procedures from this total.

The patient may present to the ED requiring critical care or critical care may start at any point during the encounter after a specific clinical event or deterioration in the patient’s condition. The clinical record may have the initiation of critical care noted along with the time this occurred.

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Critical care time stops when the care no longer meets medical necessity or the CPT definition of critical care. This stop time may occur at the end of the ED encounter (at hospital admission, facility transfer, or death) or at some point during the encounter after the patient stabilizes and the intensity of critical care service is no longer required. Examples of the latter situation may include the point at which no new treatment is required, monitoring frequencies have decreased or a physician's service is no longer required at the bedside.

Once the total critical care time is calculated, procedure time must be subtracted. In an ideal world, documentation would contain start and stop times for every procedure. In the real world, however, coders seldom see this so they must evaluate the record to determine the duration of each procedure. There are a few strategies coders can employ to determine these times:

- Query the clinical staff and have them provide the actual duration of the procedures performed during critical care for a specific encounter
- Use time stamps in the record to accurately estimate procedure time
- Query clinical staff and develop a list of procedures often associated with critical care and their average performance times
- Conduct time-motion studies and determine how long, on average, it takes clinicians to perform specific procedures

While facility and physician critical care time may differ because of varying factors, a physician's documentation of critical care can make the job of discerning the presence of facility critical care easier for the coder. However, nursing documentation must be reviewed to assess accurate facility critical care time when the physician's documentation is used.

Critical Care Documentation

To support the tasks of accurately reporting critical care and standing up to audit scrutiny, nurses and physicians must be complete in their documentation. Documentation should include thorough notes for all care and interventions and time notations for all procedures, including those that are separately reported and billed. Notes need also to support the criticality of the patient's condition and interventions to treat or prevent further deterioration in the patient's condition. All clinical nursing care and patient responses should be documented, including initial assessment, progress notes, treatments and interventions, and discharge/admit/transfer notes. All entries should be signed by the nurse and all interventions should have a physician's order which helps to establish medical necessity for the service provided.

Coders can have difficulty recognizing facility critical care when there is less than optimal nursing documentation. In lieu of specific critical care notes, coders can evaluate the record for the presence of specific clinical conditions, procedures, medications and other interventions that are frequently reported during critical care episodes. Coders may also review the physician's documentation or query the MD or nurse to verify that critical care was provided.

To optimize coding, facilities should establish internal policies for critical care documentation, provide nursing documentation education and offer feedback when documentation is insufficient.

The frequency of critical care reporting varies significantly depending on the ED patient population, practice patterns in a given ED, documentation quality, and knowledge level of providers and coders. In an average acuity ED, facility critical care frequency usually does not exceed 1% for outpatients and 6% for all ED patients—including discharges, transfers and admissions.

With improved understanding of the rules, hospitals can educate their clinical staff and coders to increase the accuracy of coding and optimize reimbursement for critical care services.

Candace Shaeffer manages all aspects of LYNX coding policy. Prior to stepping into her current role, Shaeffer held the position of vice president, Coding Operations/Quality Management at LYNX. Shaeffer has also assisted with clinical product development, marketing and beta test implementation for E/Map. She has more than 20 years of clinical expertise, extensively in the emergency department setting, as well as 16 years of nursing management experience. Before joining LYNX in 1997, Shaeffer was a case manager for CCU, ICU and Telemetry patients at Swedish Medical Center. She is a member of the American College of Emergency Physicians' Coding and Nomenclature Advisory Committee and both the Washington State and National Associations for Healthcare Quality. She is on the clinical faculty of the Health Informatics and Health Information Administration Program at the University of Washington, writes articles for the HCPRO monthly APC Publications and teaches for the ACEP Coding & Reimbursement Seminars. Shaeffer received her BSN from the University of Washington and her MBA from Seattle University. 