Chapter 15
Billing and Coding

Dixan Gonzalez, Martha Ruiz, and Javier Pérez-Fernández

Introduction

Critical care billing and coding is instrumental in the financial sustainability of intensive care services. Whether care is delivered in a private, fee-for-service model, or in a single-payer system (state or country level) adequate coding and billing is needed not only to provide financial support for the system and its individual components but also to determine the budget required for any given period.

Critical care spends more than 30 percent of the financial resources of a hospital system while typically accumulates less than 15 percent of the hospital beds [1]. Moreover, technology and specialization of care as well as aging of the population are factors that impact the cost of care of those patients admitted to the ICUs, prolonging their length of stay and allowing more and more costly tests and procedures [2].

Amid those important factors, every country and even sometimes every area in each country presents different challenges related to financing and provision of services in the ICUs. While some provide critical care services in the setting of a bundle-care model, others continue experiencing the so-called fee-for-service model with separation of charges and compensation for the institution and the clinician (physician or advance practitioner).

In addition, there is much confusion and information regarding documenting and billing for critical care, what entitles and what needs to be there. Organizations such as the American Medical Association or the Society of Critical Care Medicine have published guidelines and define terminology for providers to allow critical care time documentation and billing according to the Centers for Medicare and Medicaid Services requirements [3, 4].

D. Gonzalez · M. Ruiz
Passage Health International LLC, Oakland Park, FL, USA

J. Pérez-Fernández (✉)
Department of Critical Care Services, Baptist Hospital of Miami, Miami, FL, USA

J. Hidalgo et al. (eds.), *Critical Care Administration*,
https://doi.org/10.1007/978-3-030-33808-4_15

This chapter will aim to simplify billing and coding aspects for critical care providers and will make references to the updated information available online by Centers for Medicare and Medicaid Services [4].

Disease-Related Group

Medicare Severity Diagnosis Related Group (MS-DRG) is also known as DRG. It is an inpatient prospective payment system and determines how hospitals get paid. Attempts to reflect the hospitals case mix, including the type of patients the hospital treats, severity of medical issues, and the number of resources needed to be used to treat those patients. It is based on ICD 10 [5].

DRGs apply to inpatient services offered but lately have included some outpatient surgeries [5].

For a hospital to get paid, in a simplified way, depends on two main factors, the DRG assigned to the patient (reason for hospitalization) and the hospital payment rate per case. In addition, there is weight factor associated with the DRG based on the average amount of resources to take care of that particular patient (based on average DRG data). The higher the weight factor, the more the payments for a particular DRG. In general, many factors influence the payment rate per case, also known as base payment rate. It includes labor and nonlabor portion. Location area for the institution is factored into the labor portion according to a cost of living adjustment.

Although clinicians are not directly affected by DRG-associated reimbursement, accurate and complete documentation will make a better justification for patient's ICU admission and treatment and provide better financial return to the institution. The International Classification of Diseases-10 (ICD 10) has made imperative for providers to maintain accurate and specific documentation. Inpatient hospital depends in a great portion on that. In addition, The Affordable Care Act requires providers not only to demonstrate medical necessity but also document the patient encountered in detail.

Critical Care Services

In the United States, Medicare has determined strict criteria for billing critical care services. Most private insurances follow Medicare rules, with only few exceptions and pilot projects in which bundle services are in place. Even on those, documentation criteria must be met.

Critical care treatment is billed using the Current Procedural Terminology (CPT) codes 99291 and 99292 of the evaluation and management services bill (E&M) **(1,2)**. In order to meet criteria, the patient must be critically ill or injured with impairment of one or more vital organs and/or there is a high probability of immi-

nent or life-threatening deterioration of his/her condition. Critical care involves high complexity decision-making. In addition, critical care must be medically necessary and reasonable.

According to Centers for Medicare and Medicaid Services, critical care must encompass the treatment of a vital organ and/or prevention of further life- threatening deterioration of the patient's condition. A patient that is admitted to the ICU after surgery might not qualify for critical care services unless there is a real potential deterioration risk. Typical examples of organs involved that have that potential include central nervous system failure, circulatory failure, shock, or renal, hepatic, metabolic, or respiratory failure.

It is important to mention that just because a patient is critically ill or is admitted to a critical care area does not justify that critical care services are or need to be provided. Examples of situations in which patients admitted to ICU do not warrant critical care services include:

- Daily management of patient on chronic ventilator
- Management of dialysis care related to a patient receiving dialysis for end-stage renal disease
- Patients admitted to ICU because of no other beds available
- Patients admitted to ICU for close observation and monitoring of vitals
- Patients admitted to ICU because hospital rules require certain treatments to be administered in the ICU

Critical care codes are based on a patient's condition and the intensity of services provided and not the location of the service. Following this statement, critical care services could be billed in the medical-surgical ward, ED, recovery area, and of course ICU among others.

Critical Care Time

Critical services, as a difference to other E&M codes, are time-based, representing the time spent by the clinician evaluating, treating, and managing the patient. The time might be spent bedside or elsewhere in the unit or in the grounds nearby as far as the clinician is immediately available to the patient (as an example cannot be seeing other patients on the floor). That determines how time need to be accounted for patient-care interventions such as reviewing test results, discussing care with nursing staff or other physicians (including phone conversations while on the unit), completing orders or documentation, arranging transfers, and even discussing care with family members (only if the patients are unable to make informed decisions and those are needed for treatment purposes) [6].

Code **99291** is applied to the first 30–74 minutes and **99292 for each** 30 minutes. If less than 30 minutes are spent, then an E&M evaluation code must be used. Total time per day must be documented. The time must be continuous or intermittent and aggregated in time increments spread over a calendar day. Time for procedures that

Table 15.1 Services bundled into adult critical care codes (with CPT codes)

Interpretation of cardiac output measurements (93561–93562) Chest x-ray, professional component (71010, 71015, 71020) Blood gas interpretation (99090)
Interpretation of data stored (ECG, vital signs, laboratory, etc.) (99090) Nasogastric or orogastric intubation (43752–43753)
Pulse oximetry (94760–94762)
Temporary transcutaneous pacing (92953)
Vascular access (noncentral) (36000, 36410, 36415, 36591, 36600)

Table 15.2 Reporting critical care services

Less than <30 minutes	Appropriate E&M code
30–74 minutes	99291
75–104 minutes	99291 × 1 and 99292 × 1
105–134 minutes	99291 × 1 and 99292 × 2
135–164 minutes	99291 × 1 and 99292 × 3
165 minutes and longer	99291 × 1 and 99292 as appropriate

require different billing (i.e., intubation, line placements) must be carved out from the total time. Some procedures are included in the critical care service and must not be reported separately (Table 15.1).

Initial critical care time, billed as code 99291, must be met by a single practitioner, in a single period of time, or be cumulative by the same practitioner on the same calendar date. An example of correct reporting of critical care services is seen below (Table 15.2).

Subsequent critical care visits performed on the same calendar date are reported using CPT code 99292. The service may represent aggregate time met by a single practitioner or practitioner in the same group with the same medical specialty in order to meet the duration of minutes required for CPT code 99292. The aggregated critical care visits must be medically necessary, and each aggregated visit must meet the definition of critical care in order to combine the times.

It is also important to clarify that two practitioners cannot bill critical care at the same time. So, if a critical care physician and a neurologist are seeing a patient between 09:00 and 10:00, only one of them can bill critical care time for that hour. However, if the critical care physician sees the patient at 09:00 and the neurologist sees the patient at 10:00, both can bill critical care time as long as they are managing different conditions (very important to have clear documentation of accurate diagnosis).

Billable services that can be carved out of the critical care time are summarized below (Table 15.3). When documenting critical care time, it is important to describe these services as a separated procedure and explain that the time spent on these is not accounted into the critical care time billed.

Table 15.3 Separately billable services (with CPT codes)

Insertion of Swan-Ganz catheter	93503
Temporary transvenous pacer	33210
Thoracentesis (with or without imaging guidance)	32554–32555
Pleural drainage (insertion of catheter with or without image)	32556–32557
Placement of central vascular access	36556
Tracheostomy	31600–31603
Endotracheal intubation	31500
Arterial puncture	36600
Arterial catheterization	36620
Pericardiocentesis	33010–33011
Cardiopulmonary resuscitation	92950

Shared Time-Split Time

A split/shared E&M service performed by a practitioner of the same group practice (or employed by the same employer) cannot be reported as critical care services. The critical care service reported should be billed under an individual practitioner.

Once the initial critical care visit (99291) has been documented, critical care services times are additive (99292) even when performed by different practitioners in the same group. According to CMS when "more than one member of a physician group provides ICU (99291 and 99292) care to the same patient in the same day… the physicians should bill as if all of the services were provided by one of the members of the group" [4].

To add critical care time, practitioners must work in the same group, but if they have different taxonomic backgrounds (i.e., physician/nurse practitioner), shared billing can be applied in some areas although it is recommended to insert the appropriate provider identification number (NPI) with the submitted claim [7]. This has changed from previous CMS guidelines and it is applicable to some regions. Thus, practitioners must know and be familiar with the regulations applicable by your different payers.

Teaching Time

In academic centers it is common that patients are initially evaluated and managed in some medical aspects by residents and fellows to a later evaluation by the attending practitioner. Teaching practitioners can report critical care time only if that time has been devoted entirely to the patient together with the resident and fellow. If the teaching practitioner is not present, then critical care time cannot be billed based on

the resident or fellow documentation. It is however accepted a combination of teaching practitioner documentation and the resident or fellow documentation to support the services provided (linked documentation). In that case, the teaching practitioner must document a statement that he/she personally spent the time providing critical care. That statement should include documented time, rationale for the services, and the teaching practitioner medical plan of care. In addition the teaching practitioner should apply the modifier GC (this service has been performed in part by a resident under the direction of a teaching physician).

Nonphysician Practitioner (NPP) Billing

The Balanced Budget Act of 1997 recognized NPPs as healthcare providers. NPP direct billing is typically subject to a decreased Medicare allowable down to 85% of the physician's rate [8]. There are three particular scenarios, incident-to-billing, direct, or split/shared encounters that we will be reviewing here.

Incident to Billing

Service provided by the NPP but billed by the physician using the physician NPI number. This scenario does not apply to critical care or other hospital settings. It is restricted to office encounters when physician is physically present.

Direct Billing

Occurs when NPP provides the entire service. It can occur in all settings. The patient can be new or established, and there is no need to have a plan of care determined prior to the visit. The service is billed under the NPP NPI and is reimbursed at 85% of the physician's fee schedule for Medicare reimbursement. This might be different for other payers.

Split/Shared Billing

Current CPT guidelines do not allow split/shared visits for consultations or for critical care services. Direct billing rule must be applied.

A split/shared visit may occur for E&M services provided by same group practitioners (physician and NPP). The service must be within the NPP scope of practice and may occur jointly or independently on the same calendar day. Both NPP and

physician must have a face-to-face encounter with the patient. If the encounter is billed under the physicians NPI, it is reimbursed at 100% fee. If no face-to-face encounter occurs, even if the physician participated on the reviewing of the patient's record and delineation of the plan of care, then the services must be billed under the NPP NPI.

Documentation guidelines for these encounters include:

- The split/shared visit must have documented face-to-face encounter by both NPP and physician on the day of service.
- Both should document their participation in the medical record.
- The NPP must be employed by the physician practice (otherwise the services cannot be considered shared/split)
- The physician cannot state "review and agree" without seeing the patient personally.
- The physician must document the three components of the E&M service (history, examination, and medical decision-making).

According to previously discussed and following CMS rules, only one practitioner can bill for critical care during any single period, and the initial CPT code 99291 applies to a single practitioner intervention [4]. Any care beyond 74 minutes is billed using the add-on code 99292, and the care can be provided by a physician or an NPP of the same group of practice.

Conclusions

The complexity of critical care coding and billing makes the financial part of critical care many times obscured for many albeit is essential to the justification and reimbursement for our services.

Attempts have been made to simplify and to justify all elements of the critical care. New changes will likely attempt to embrace new challenges to practice such as tele-ICU, predictive models, and even simulation and training. Those are yet to come. Meanwhile it is essential that the practitioner familiarizes themselves with the rules and regulations in their area of practice and documents with flawless determination the care provided.

References

1. Halpern N, Pastores S. Critical care medicine beds, use, occupancy and costs in the United States: a methodological review. Crit Care Med. 2015;43(11):2452–9.
2. Guidet B, van der Voort AC. Intensive care in 2050: Healthcare expenditure. Int Care Med. 2017;43(8):1141–3.
3. American Medical Association. Current procedural terminology. Professional edition. Chicago: American Medical Association; 2017.

4. Centers for Medicare and Medicaid Services. Internet-Only Manual. Publication 100-4. Chapter 12, Section 30.6.12. Washington, DC. CMS 2017. https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/downloads/clm104c12.pdf. Accessed online.
5. Centers for Medicare and Medicaid Services. Acute Care Hospital Inpatient prospective payment system. March 2018. Accessed online.
6. Medicare Claims Processing Manual, Chapter 12, Section 30.6.12.
7. Sample G, Dorman T, editors. Coding and billing for critical care: a practice tool. Mount Prospect: Society of Critical Care Medicine; 2017.
8. Kleinpell RM, Byle WA, et al. Integrating nurse practitioners and physician assistants into the ICU. Mount Prospect: Society of Critical Care Medicine; 2012.