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Billing and Documentation: A Primer

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Billing and documentation requirements are extremely complex for critical ill patients and no relief is in sight. Drs Dorman and Pauldine review the present documentation requirements for critically ill or injured adults.

Billing for critical care services in the United States can be quite confusing and time consuming. Every patient represents a different billing scenario related to potentially a different payer or multiple payers. Each payer is permitted to utilize their own system of coding and to establish their own payment rules. Furthermore, each payer is permitted to change these rules as they see fit and thus the combinations of rules are endless and constantly changing. In addition, few payers pay what is billed, with most negotiating a discounted rate such that the gross collection ratio is commonly in the 30-40% range.

Many payers base at least a component of their system on Medicare payment policy, which is established by the Centres of Medicaid and Medicare Services (CMS). Thus most physicians establish documentation practices in line with Medicare rules and typically bill according to Medicare principles. In this manuscript we will briefly review the documentation criteria for billing for critical care services for adults.

The guidelines for documentation are initially established as a component of the definition of critical care services, which is established by the AMA Common Procedural Terminology (CPT) Committee (AMA 2005). There are two CPT codes for critical care services. One for the first hour of critical care (99291) and one for each subsequent half hour of critical care (99292). It should be noted that CPT defines the first hour of critical care as ranging from 30 minutes to 74 minutes, thus establishing the principle that critical care services can never take less than 30 minutes. The time can accrue over multiple iterative sessions and can include the time to document the care. Furthermore, the time can include time in family conferences if, and only if, the patient is unable to communicate or is deemed incompetent and the discussion is absolutely necessary for care provided or withheld for that day.

In addition to time criteria, two additional criteria must be met and documented; the patient must meet the CPT definition of critical illness and the physician must provide direct critical care services. Critical illness is described as, “the critical illness or injury [that] acutely impairs one or more vital organ systems such that the patient’s survival is jeopardized” (AMA 2005). Additionally, there is “a high probability of sudden clinically significant or life threatening deterioration in the patient that requires the highest level of physician preparedness to intervene urgently” (AMA 2005).

Once the physician believes that the patient meets the definition of critical illness and that their time has exceeded 30 minutes, the physician must document that they have provided critical care services to the patient while on the unit or floor. There are three treatment criteria which must be met and documented. The “critical care services require direct personal management by the physician,” the “services are life and organ supporting interventions that require personal assessment and manipulation by the physician,” and “withdrawal of, or failure to initiate these interventions on an urgent basis, would likely result in sudden clinically significant or life-threatening deterioration of the patient’s condition” (AMA 2005). One should note that merely activating protocols does not constitute critical care services. Furthermore, it should be stressed that all components (critical illness, critical care service and time) must be met and clearly documented or payment can be withheld or claims of fraudulent billing practice can be made against the physician.

Procedures done in addition to providing critical care services can also be billed under certain conditions. First, the procedure must not be bundled into the definition of critical care. Procedures that are considered bundled include: ventilator management, cardiac outputs, temporary pacing, arterial puncture, interpreting chest radiographs. If the procedure is not bundled then separate documentation is required and a bill can be submitted. Of course, the physician must ensure that the time to do the procedure is not counted in the time accrued for billing the critical

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care services, as this would be considered double dipping.

As one can see there are many nuances to documenting critical care services and subsequently to billing and receiving payment for said services. Given the variability in the model of critical care physician services in the United States, it is unlikely that a more streamlined approach that principally serves the full-time intensivist model will be established any time soon.

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