April 13, 2018

Weekly Auditing and Compliance Tip

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Critical Care Documentation

Critical care documentation should showcritical need for the patient AND immediate action by the provider.

Qualifying a service as a critical care service can be one of the hardest things we're asked to do as auditors because it can be such a hard judgment call to make. How critically ill is the patient during this particular encounter, and did the service as documented by the physician rise to the level of rendering a critical care service?

Critical care services for patients over the age of five are billed with two codes: 99291 for the first 30-74 minutes of critical care, and one unit of 99292 for each additional 30 minutes after that. With these codes in mind, let's start by looking at two specific citations found in the guidance we receive from the CPT and CMS in defining a critical care service.

First, the guidance states that "a critical illness or injury is one that acutely impairs one or more vital organ systems in such a way that there is a high probability of imminent or life threatening deterioration in the patient's condition."

And second, that "critical care involves high complexity medical decision making to assess, manipulate and support vital organ system functions to treat single or multiple vital organ systems and/or to prevent further life threatening deterioration of the patient's condition."

What those two passages really suggest is there are two key components required in the documentation of a critical care encounter. The patient must have a critical illness that supports the medical need for such a service and the physician must engage in high level medical decision making to address that need. When thinking about these two factors and whether or not to support a service as critical care, as Frank Sinatra sang in Love and Marriage, "You can't have one without the other."

When the patient is not critically ill with imminent threat to major organs or bodily function at the time of the encounter, then the service is not critical care. We sometimes see physicians getting into the "habit" of billing critical care from day to day, even though the history of present illness for a day may suggest the patient is stable or resting comfortably. It's hard to suggest critical care is needed in those situations.

Conversely, the patient may have respiratory or heart failure, with multiple co-morbid conditions, but the service the physician is rendering is to discuss hospice or end of life care with the patient's family. These decisions have to be made, and we know that the decision to de-escalate care can certainly qualify as high medical decision-making.

So keep in mind that if our documentation doesn't reflect medical interventions taken by the physician in an attempt to alleviate the severity of the patient's condition, it is difficult to support critical care - regardless of how dire the case appears.

This Week's Audit Tip Written By:
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April 17, 2018
2pm EST
Speaker, Dr. Warner

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(Hands on Webinar Series)
April 24, 2018
2pm EST
Speaker: Dr. Evan Gwilliam

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