CHAPTER 10 - HOW TO MAXIMIZE REVENUE GENERATION IN THE ICU?

A review of previous chapters, especially Chapters 3 and 4, is strongly recommended before reading this chapter, as it lays the foundations for optimal billing and documentation. Maximizing revenue generation is an important consideration for both private practice and academic physicians. There are many ways you can maximize revenue generation. We would take a detailed look at each one.

1- TARGET CRITICAL CARE CODES FIRST

Revenue from critical care codes is much higher than from non-critical care codes. Because of this, always aim for critical care codes first. If a patient meets the definition of critical care codes, you should not bill hospital admission, subsequent, or consultation codes unless you spend less than 30 minutes. Always look for a reason for critical care, like acute respiratory failure, hypoxemia, or hypotension. If a patient develops hypotension and you give a fluid bolus, then you have it; it is quite likely that this patient will qualify for critical illness and hence a critical care code.

The definition of time for critical care differs slightly from that for the rest of the E/M service codes. To deliver critical care, you should be immediately available to the patient. The practical result of this requirement is that when you are off the patient's floor, you cannot deliver critical care. If you are a hospitalist, you can count 30 minutes spent in the radiology department looking at MRI results with a radiologist, but the same thing does not count toward critical care time because you are not immediately available to the patient unless radiology happens to be next door to the ICU or you look at the MRI with the radiologist in the ICU. Another difference is that daily updates or times spent with caregivers do not count toward critical care unless these discussions influence the evaluation and management. Apart from these 2 exceptions, everything you do for a patient counts toward critical care time, as long as you are immediately available to the patient.

If the patient qualifies for pediatric or neonatal critical care codes, always bill these day-based critical care codes instead of the time-based codes, as their RVUs are higher. One golden rule for reporting pediatric/neonatal critical care codes is that these codes are reserved for the primary physicians who are keeping the patient under their care for the rest of that date/day. If you are not the primary attending or not keeping the patient under your care for the rest of the day, then you can't bill neonatal/pediatric critical care codes.

2- LIBERAL USE OF TIME-BASED CODE OF 99292

For patients billed with 99291 and 99292, as long as you are immediately available to the patient, almost everything you do for the patient counts toward time, and you should report the extra time with 99292. This is especially true for night coverage. For example, if a patient was billed by the day team with 99291/99292 and you provided care at night, you should consider billing 99292, provided the care meets the definition of critical care and the care time exceeds 15 minutes. There should be some form of intervention/management to qualify for this billing. You cannot just come at night time, round on

patients and bill 99292. If a critically ill patient worsens or develops an acute problem, and you spent 15 minutes or more, then this should be enough to bill 99292.

CPT and Medicare have different rules for billing 99292. According to CPT, it's possible to bill the first block of 99292 when half of its time (15 minutes) is spent after 60 minutes, meaning it can be billed at 75 minutes (60 + 15 = 75). According to Medicare, though, full 30 minutes of 99292 must be spent and counted after 74 minutes, meaning it can be billed after 104 minutes (74 + 30 =104 minutes)

According to CPT, physicians in the same group function as one; for this reason, it would be ideal for the first physician to document 60 minutes while reporting 99291; otherwise, the second physician needs to look at the first physician's note.

For example, if the day intensivist reports 99291 and documents 60 minutes of time, the night intensivist may report 99292 if 15 minutes or more of additional critical care is delivered. If the day intensivist reports 99291 but only documents 45 minutes, then to report 99292, the night intensivist should spend 30 minutes, since 99292 starts at 75 minutes.

Documenting 99291 as 1 hour and the 99292 as 30-minute increments (1 hour, 1.5 hour, 2 hours, 2.5 hours, 3 hours, etc) makes things easier.

Time-based/adult critical care codes 99291 and 99292 should also be known and billed by a neonatal intensivist when the intensivist cares for a neonate for only part of the day and transfers the patient to another institution or another physician group. Example: you come in the morning to the NICU and spend 6 hours on a baby and transfer the baby out for ECMO consult, then you should bill 1 unit of 99291 and 10 units of 99292.

Although you may generate more revenue with 99292 when time-based critical care codes are used, if day-based or pediatric/neonatal critical care codes are reported, you cannot generate more revenue by spending more time with the patient, because these codes are not time-dependent but day/date-dependent. For example, when you bill 99472, whether you spent 1 hour or 6 hours with the patient is irrelevant; the reimbursement is the same regardless of the time spent.

3- FOR NEONATES: TARGET NEONATAL INTENSIVE CARE CODES NEXT

Critical care codes can only be reported for critically ill patients. The neonatal intensive care code set exists for neonates/infants who are not critically ill but still require intensive monitoring and care. These codes have higher RVU than regular hospital/floor care codes (99221-99223 and 99231-99233) and should be used to generate more revenue when a baby requires frequent/intense monitoring and care. Like pediatric/neonatal critical care codes, these are day/date-based codes, and spending more time with the patient does not generate more revenue.

Neonatal intensive care codes are not restricted to neonatal ICUs and can be reported by pediatric intensivists in the PICU and by hospitalists caring for babies in the nursery or on the floor, as long as intense monitoring and care are provided, regardless of where they are provided.

Example: A 10-day-old neonate was admitted to the PICU, initially critically ill. After 3 days, the patient improved and is no longer critically ill, but still requires intense monitoring of vitals, exam, breathing,

temperature, and blood sugars. For this patient, instead of reporting hospital subsequent-day care codes (99231-99233), consider reporting neonatal intensive care codes 99478, 99479, and 99490.

4- FOR NON-CRITICAL PATIENTS AIM FOR THE HIGEST LEVEL HOSPITAL CODE

If the patient's condition does not meet the definition of critical illness (and not a newborn), then you are left with non-critical care hospital and consultation codes. The highest-level hospital codes (level 3) are 99223, 99233, and 99236. Outpatient consult codes, which are used in the ER and inpatient consult codes, have the highest level of 5. As explained in Chapter 2, there are 2 ways to reach the highest level. The first one uses total time, and the second uses MDM. You should always look at how much total time you have spent first. If you have spent enough time to meet the requirement for the highest level in a code set, then you should not bother looking at MDM, because, irrespective of MDM, you can report the highest level of code. If the total time you spend with the patient is insufficient for the highest level, check whether the MDM is sufficient to reach a higher level. This is the golden rule. Use the pathway that gives you the highest level. You may not turn level 1 into level 3 unless you spend enough time, but turning level 1 into level 2 or turning level 2 into level 3 may not be too difficult.

MDM-based E/M service codes for ICU use.

Code Set	**CPT code**	**Level**	**Time**	**MDM**
Admission	99221	Level 1	40 minutes	Straightforward/Low
	99222	Level 2	55 minutes	Moderate
	99223	Level3	**75 minutes**	High
Subsequent	99231	Level 1	25 minutes	Straightforward/Low
	99232	Level 2	35 minutes	Moderate
	99233	Level 3	**50 minutes**	High
Same day	99234	Level 1	45 minutes	Straightforward/Low
	99235	Level 2	70 minutes	Moderate
	99236	Level 3	**85 minutes**	High
Discharge	99238	N/A	<30 minutes	N/A
	99239	N/A	**>30 minutes**	N/A
Consult ER	99242	Level 2	20 minutes	Straightforward
	99243	Level 3	30 minutes	Low
	99244	Level 4	40 minutes	Moderate
	99245	Level 5	**55 minutes**	High
Consult inpatient	99252	Level 2	35 minutes	Straightforward
	99253	Level 3	45 minutes	Low
	99254	Level 4	60 minutes	Moderate
	99255	Level 5	**80 minutes**	high

Almost everything that you do for patient care that is not reported with another CPT code is included in the total time. You do not need to be on the patient floor for the time to count.

1. Preparing to see the patient: **chart review, review of tests or imaging.**
2. Obtaining and/or reviewing separately obtained **history.**
3. Performing a medically appropriate **examination and/or evaluation.**
4. **Ordering** medications, tests, or procedures.
5. **Counseling** and educating the patient/family-caregive.r
6. **Referring and communicating** with other health care professionals.
7. **Coordination** of care.
8. **Documenting** clinical information in the electronic or other health record ~ **writing notes.**
9. Independently **interpreting results** and communicating results to the patient/family.

Example: the highest level in the hospital for a subsequent patient has 50 minutes of total time. If you spend 50 minutes on a subsequent patient, then you should bill level 3 (99233) irrespective of complexity/MDM. What if you spend only 35 minutes total time with a subsequent patient, which only qualifies for level 2 (99232)? Can you make it level 3 using MDM? If the answer is yes, *"based on MDM I can report level 3",* then report level 3 based on MDM. If MDM only qualifies level 1, then report level 2 based on total time.

Physicians tend to underestimate their time, but it is important to remember that everything you do for patient care counts toward the time, including writing your note. Time spent in pre-rounding, looking at vitals, labs, imaging, and notes; talking with consultants, radiologists, dietitians, or other team members; and time spent during rounds, including answering questions from patients or caregivers, all count toward time. Time spent on unrelated teaching during the rounds does not count. Time spent looking into textbooks, journal articles, online resources, drug doses, and side effects counts towards time as long as it's done to help with patient management. For example, you had a patient with AKI and looked up all the medications that the patient is on for their side effects on the kidneys. You have a patient with white matter lesions in the brain MRI, and looked in a textbook to determine what differential labs to send and how to manage this condition.

You can increase the total time spent on patient care by various means, including providing counseling or education, coordinating care, calling consultants, etc., as long as it is medically appropriate. For example, you have a patient with asthma exacerbation who is doing well and improving. If you spent only 25 minutes with this patient and the patient has low MDM, the patient only qualifies for level 1 (99231), but you can bill level 3 if you provide an additional 25 minutes of education on asthma prevention and management. 25+25=50 minutes = level 3, 99233. Another way to spend the extra 25 minutes with this patient may be to conduct management discussions with a pulmonologist and to plan follow-up care with a case manager.

Some E/M service codes are independent of time, like neonatal or pediatric critical care codes, neonatal intensive care codes, normal newborn care codes, and ED care codes. It does not matter how much time you spend when you report these codes. Discharge day care codes are divided into less than 30 minutes (99238) and more than 30 minutes (99239). When you spend more than 30 minutes, then it does not matter whether you spend 35 minutes or 3 hours for discharge.

We have seen above that by spending more time, you could increase the code level and hence revenue generation. Can a similar strategy work in the MDM pathway? The answer is yes, but instead of time, you should identify additional problems, data, or risks to increase the MDM level.

The sicker the patient or the more complex the problem, higher the level you can target. Acute life-threatening illness > complicated acute illness with complication > uncomplicated acute illness > self-limited or minor problem. Severe exacerbation of chronic illness > exacerbation of chronic illness > stable chronic illness.

Consider addressing or uncovering more problems, especially patient comorbidities. Addressing comorbidities and uncovering new problems is not only a good practice but also helps increase the level of MDM and, hence, revenue generation. For example, you have a subsequent patient with soft tissue infection who is doing well and only qualifies for level 1 (99231) based on MDM. Let's assume the patient also had hypothyroidism, and you checked the TSH level, which is elevated, and you changed the levothyroxine dose. By definition, this (unstable chronic disease plus drug prescription) qualifies for moderate MDM and hence level 2 (99232). Another example would be checking a VitD level, if it is low, and you start cholecalciferol, that is level 2 billing.

In many hospitalized patients, it is not difficult to reach the highest level of data element because there are many labs, imaging, or notes to review, and each counts. The high MDM data element has 3 categories, and 2 of them must be fulfilled. The first category only needs 3 items, including any combination of labs, imaging, notes, and an independent historian. Examples of enough items: cbc/bmp/crp or cbc/crp/Ua or CBC/external note review/independent historian. Because in pediatrics, we almost always have an independent historian/caregiver, you practically end up needing 2 more. Category 2 is fulfilled any time you independently interpret a study like CXR, KUB, CT, or EKG. Category 3 is fulfilled any time you have a management discussion with other physicians. You only need 2 out of 3 categories fulfilled. For example, you interpreted the CXR and called the pulmonologist for management, which qualifies as the highest level MDM data. Then you just need to add a sufficiently high problem or risk to reach high-level MDM or the highest-level code. Ordering more tests and imaging (medically appropriate), reviewing more notes, or talking with other physicians all help reach the highest level.

Two risk examples were given for moderate MDM. First one, "prescription drug management" is very useful because when you combine it with unstable chronic disease, then it automatically qualifies for moderate MDM, level 2. For example, you have a subsequent patient with a simple soft-tissue infection that only qualifies for level 1 (99231) based on MDM. If the patient has not well-controlled DM and you continue the patient's insulin, this would automatically make the patient moderate MDM and hence level 2. With a little detail, you generated more revenue. The second risk example is "diagnosis or treatment significantly limited by social determinants of health". You can use this criterion when a patient's social factors significantly complicate evaluation and management, making management more challenging, such as living in a shelter or in a very difficult social situation.

Four high-risk examples were given for high MDM. The first one: a *decision regarding hospitalization or escalation of hospital-level care*, applies anytime you consider an admission from the ER or a transfer of a patient from the floor to the ICU. The second one, *drug therapy requiring intensive monitoring for toxicity*, applies when you have frequent labs to avoid side effects. Examples include checking daily BMPs while being NPO with IV fluids (to avoid electrolyte derangements), checking daily BMPs while on diuretics, monitoring CBC or LFTs while on drugs that cause neutropenia or hepatotoxicity, or monitoring Cr while on vancomycin. Checking EKGs while on QT-prolonging medications is also in this risk group. The third high-risk example, *parenteral controlled substances*, applies when IV opioids or benzodiazepines are used for pain or comfort. Fourth high-risk example, *decision not to resuscitate or to de-escalate care because of poor prognosis* applies during end-of-life discussions. If you have one of the above high-risk factors, you only need high-level data or a problem to qualify for the highest-level code.

Summary of targeting higher level in a code set

Time based higher level code targeting	
Spend more time *(that is medically appropriate)*	Provide counseling, education, address concerns in length
	Coordination of care~ talk with consultants
	More detailed chart review
	More detailed history, examination *(medically appropriate)*
	Writing more detailed notes

MDM based higher level code targeting	
Problems. *Address more problems or more complex problems*	1 self-limited or minor problem < 2 self-limited or minor problem
	1 stable chronic illness < 2 stable chronic illnesses
	Stable chronic illnesses < chronic illness with exacerbation < chronic illness with severe exacerbation
	Acute, uncomplicated illness < acute illness with systemic symptoms < acute life-threatening illness
Data *Order and review more medically appropriate data elements*	Have independent historian
	Order and review more tests, *medically appropriate*
	Review external notes
	Provide independent interpretation of tests or imaging
	Management discussions with other providers
Risks	Prescription drug management *(giving or renewing prescription)*
	Diagnosis or treatment significantly limited by social determinants of health
	Drug therapy requiring intensive monitoring for toxicity
	Decision regarding hospitalization or escalation of hospital-level care
	Decision not to resuscitate or to deescalate care because of poor prognosis
	Parenteral controlled substances

5- USE PROLONGED CARE CODES

Prolonged care codes are not used for critically ill patients. For time-based critical care codes, the first hour of critical care is reported with 99291, and the remaining care is reported with multiple units of 99292. For day-based or pediatric/neonatal critical care codes, all care is included in the daily code, so whether you spend 1 hour or 10 hours with the patient makes no difference. Prolonged care codes are also not used with neonatal intensive care codes or discharge care codes, because these are day-based codes that encompass all care on that day/date.

Prolonged care codes may be used when non-critical care hospital codes are used. Please refer to Chapter 3 for details on prolonged care codes. There are basically 2 different types of prolonged care codes. Code 99418 is for a 15-minute care block used when you saw a patient and spent too much time with them on the same day/date. Second code group 99358 and 993569 is to report extra time for the patient care on the day/date that you have not seen the patient.

This code (99418) exists so you can bill for care beyond the typical. Examples include spending several hours with a socially difficult or medically complex patient, trying to figure out what is wrong, talking with multiple consultants or spending a lot of time at the bedside.

99358 is for the first hour, and 99359 is for each additional 30 minutes. It would be rare for an intensivist not to see their patient that day. These codes can be used in rare situations when you are involved in the care of a patient while not on service. An intensivist who takes calls at home may use these codes more commonly. For example, you were called by your resident at 9pm about a new admission, spent 30 minutes on the phone that night, and saw the patient the next day. Then you can report your time with these prolonged care codes for the night that you did not see the patient.

Prolonged care codes may be used by the night intensivist when they are on call and provide care to non-critically ill patients who become active at night. This may be an important source of revenue generation. 99418 involves 15 minutes of care. Most interactions with an active patient at night take at least 15 minutes, which is good enough for 99418. If you send 60 minutes, then you can report 4 units of 99418 (4 x 15 = 60). To report 99418 at night, though billing in the day should be either time-based 99223 or time-based 99233.

6-CONSULTS, RAPID RESPONSES AND CODE BLUES

You should report an E/M service code for any patient you see, including those for whom you are not the attending of record. This includes official consults on the floor, in the ED, or elsewhere, as well as non-official consults such as rapid responses or code blues. The reported code depends on whether you will stay as a consultant or take the patient as a primary physician. If you stay on as a consultant, initial consultation codes can be used for non-critical patients, and time-based critical care codes can be used for critically ill patients. You cannot report day-based pediatric/neonatal critical care codes while being on consult.

How to bill for rapid response and code blue elsewhere in the hospital depends on several factors. These patients are typically critically ill, and critical care codes may be reported. If the patient needs time-based critical care billing, then you should report your time in code or rapid response with 99291 and 99292. If you admit the patient to the ICU as the primary, you can bill day-based pediatric/neonatal

critical care codes for patients under 6 years of age. For these patients, you will not be able to bill for time spent in rapid response or code blue, as all the care you provided that day is reported using pediatric/neonatal critical care codes. If the rapid response patient is not critically ill, consultation, admission, or subsequent care codes can be billed, depending on the circumstances.

There are many instances in which a consultant spends a lot of time on the phone for patient care but does not physically see the patient that day. In this instance, you can report your time spent on that day with prolonged care codes 99358 and 99359, as long as you or your colleague in the same practice sees the patient in the following days or has seen the patient in the past. This can happen especially when you are on call at home.

7- MEDICAL TEAM CONFERENCE

Please refer to Chapter 3 for details on the medical team conference (team meeting). For team meetings, when the caregiver or the patient is present, the intensivist may report their time in the team meeting with time-based critical care codes if time-based critical care codes are used and the intensivist is immediately available to the patient. Day-based or pediatric critical care codes cover the entire care over 24 hours, so time in the team meeting is included in these codes and not separately reported. If the patient is not critically ill, time spent in the team meeting may be reported with an appropriate hospital care code, such as 99233, and prolonged care codes if needed. When the patient or caregiver is not present at the meeting, 99367 is used to report time, regardless of the type of billing code used.

8-KEEP OTHER RELEVANT E/M SERVICE CODES IN MIND

Advance care planning services with 99497-99498 (not reported with critical care codes)
Delivery room attendance and resuscitation services with 99464-99465
Telemedicine services.

9- DO NOT MISS PROCEDURAL OR NON-E/M SERVICE CODES

E/M services only cover evaluation and management. They basically involve examination and talking. If you perform anything other than examination or talking, there can be a separate code for it. For example, ear examination is part of physical examination, and hence part of normal E/M service, but removal of impacted cerumen is not. There is a separate code for impacted cerumen removal. If you perform impacted cerumen removal, report it separately with code 69210. Another example would be cauterizing a granuloma around a g-tube site. CPT code for cauterization of granuloma is 17250. If you did not know it, then you would lose the revenue.

The fact that there is code for the procedure that you have done does not necessarily mean that you can bill for that procedure. Whether you may or may not report a procedural code separately depends on the E/M service code that is billed for that day. This is because some E/M codes have bundles that include various CPT codes or procedures.

Apart from the bundle, both CPT and payers may have guidelines on what is separately reportable. For example, although not in critical care bundles, advanced care codes are not reported when critical care codes are used, and ventilator codes are not reported with any E/M service codes. Please refer to Chapter 5, NCCI edits for more information.

Non-bundled E/M service codes: non-critical and non-intensive care patients

Non-critical or non-intensive service care codes, such as hospital codes, consult codes, and discharge day care codes, do not have a bundle. Because there is no bundle, any procedure can be billed separately with these codes, except for NCCI edits or special payer policies.

Example: you placed a difficult PIV on a 4-month-old patient whom you have billed 99232 earlier. You can bill this procedure separately with CPT code 36406: *Venipuncture, younger than 3 years, not for routine, requiring physician's skill; other vein.* Although CPT code 34406 is included in the day-based bundle 99472, it does not apply to the non-critical care code 99232.

Bundled E/M service codes: critical and intensive care patients

Bundle of time-based critical care codes, 99291-99292: include 19 CPT codes

Bundle of day-based neonatal/pediatric critical care codes: 99468-99476: include 39 CPT codes

Bundle of neonatal intensive care codes: 99478-99480: include the same 39 CPT codes as above

Critically ill pediatric/neonatal transport codes: 99466, 99467: include 20 CPT codes.

Day-based bundles include all 19 CPT codes from the time-based critical care bundle, plus an additional 20 codes, for a total of 39. Example: arterial puncture (36600) is in both bundles, but arterial catheterization (36620) is only in the day-based bundles. Frequently performed procedures that are bundled in pediatric/neonatal critical care codes but not in time-based codes include: intubation (31500), CVL placement under 5 years of age (36555), arterial line placement (36620), LP (62270), and surfactant administration (94610). These codes are not billed separately when day-based critical care codes are used.

Below are the tables of CPT codes included in the time-based and day-based critical codes. Codes are color-coded for visual simplicity, with 19 codes in both time- and day-based bundles marked in black, and an additional 20 code in the day-based bundle marked in blue. CPT codes are written with a – sign between the numbers to make them easier to read (not in the original CPT code).

TIME-BASED BUNDLE: 99291 and 99292: 19 CPT codes	
36-000	Introduction of needle or intracatheter, vein
36-410	Venipuncture, age 3 years or older, not for routine, requiring physician's skill
36-415	Collection of venous blood by venipuncture
36-591	Collection of blood specimen from a completely implantable venous access device
36-600	Arterial puncture, withdrawal of blood for diagnosis
43-752	Naso- or Oro- gastric tube placement, requiring physician's skill and fluoroscopic guidance
43-753	Gastric intubation and aspiration therapeutic, requiring physician's skill, including lavage (eg for GI bleed)

71-045	Radiologic examination, chest, single view
71-046	Radiologic examination, chest ,2 views
92-953	Temporary transcutaneous pacing
93-598	Cardiac output measurements *(dilution methods, during cardiac catheterization for congenital heart defect)*
94-002	Ventilation assist and management, initial day
94-003	Ventilation assist and management , subsequent day
94-004	Ventilation assist and management, nursing facility, per day
94-660	CPAP initiation and management
94-662	Continuous negative pressure ventilation, initiation and management
94-760	Noninvasive pulse oximetry for oxygen saturation, single determination
94-761	Noninvasive pulse oximetry for oxygen saturation, multiple determination
94-762	Noninvasive pulse oximetry for oxygen saturation, by continuous overnight monitoring
Other	Blood gases, collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data)

DAY-BASED BUNDLE: 99468-99480: 39 CPT CODES	
31-500	Intubation, endotracheal, emergency procedure
36-000	Introduction of needle or intracatheter, vein
36-140	Introduction of needle or intracatheter, upper or lower extremity artery
36-400	Venipuncture, younger than 3 years, not for routine, requiring physician's skill; femoral or jugular vein
36-405	Venipuncture, younger than 3 years, not for routine, requiring physician's skill; scalp vein
36-406	Venipuncture, younger than 3 years, not for routine, requiring physician's skill; other vein
36-410	Venipuncture, age 3 years or older, not for routine, requiring physician's skill
36-415	Collection of venous blood by venipuncture
36-420	Venipuncture, cut down, younger than age 1 year
36-430	Transfusion, blood or blood components
36-440	Push transfusion, blood, 2 years or younger
36-510	Catheterization of umbilical vein for diagnosis or therapy, newborn
36-555	Insertion of non-tunneled centrally inserted central venous catheter, younger than 5years of age
36-591	Collection of blood specimen from a completely implantable venous access device
36-600	Arterial puncture, withdrawal of blood for diagnosis
36-620	Arterial catheterization or cannulation for sampling, monitoring or transfusion, percutaneous
36-660	Catheterization, umbilical artery, newborn, for diagnosis or therapy
43-752	Naso- or oro- gastric tube placement, requiring physician's skill and fluoroscopic guidance
43-753	Gastric intubation and aspiration therapeutic, requiring physician's skill, including lavage (eg for GI bleed)
51-100	Aspiration of bladder; by needle
51-701	Insertion of non-indwelling bladder catheter *(eg, straight catheterization)*
51-702	Insertion of temporary indwelling bladder catheter; simple *(eg, foley)*
62-270	Spinal puncture, lumbar diagnostic
71-045	Radiologic examination, chest, single view
71-046	Radiologic examination, chest, 2 views
92-953	Temporary transcutaneous pacing
93-598	Cardiac output measurements *(dilution methods, during cardiac catheterization for congenital heart defect)*

94-002	Ventilation assist and management, initial day
94-003	Ventilation assist and management , subsequent day
94-004	Ventilation assist and management, nursing facility, per day
94-375	Respiratory flow volume loop *(bedside pulmonary function test)*
94-610	Intrapulmonary surfactant administration by a physician through endotracheal tube
94-660	CPAP initiation and management
94-662	Continuous negative pressure ventilation, initiation and management
94-760	Noninvasive pulse oximetry for oxygen saturation, single determination
94-761	Noninvasive pulse oximetry for oxygen saturation, multiple determination
94-762	Noninvasive pulse oximetry for oxygen saturation, by continuous overnight monitoring
94-780	Car seat/bed testing
94-781	Car seat/bed testing, additional 30 minutes
No code	Blood gases, collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data)
No code	Monitoring or interpretation of blood gases
No code	Invasive or non-invasive electronic monitoring of vital signs

There are many procedures that are not in both bundles, including sedation and anesthesia codes, central line placement above 5 years, PICC lines, ECMO codes, bronchoscopy, IO, therapeutic LP, CPR, cardioversion, and the list goes on. These codes can be billed for any critically ill patients. Please look at chapter 4: non-E/M service codes for further information on these codes and a list of frequently used codes. I highly recommend screening the CPT code book to identify procedures you can bill separately. Chapter 4 only contains a limited number of separately reportable procedures.

Practical application

You performed a procedure, but are not sure whether it is separately reportable. How would you know?

1- Find out the CPT code number of the procedure you performed.

2- Decide which critical care code you will report for that day. **(NOT JUST AGE!)**

3- Find the correct bundle list associated with the critical care code.

- When you report 99291-99292, look at the 19-item time-based bundle list.
- When you report 99468-99469; 99471-99472; 99475-99480, look at the 39-item day-based bundle list.

4- Look at the bundle to see if the CPT code you performed is included in the list or not.

5-Finally, if the CPT code you performed is not in the list, then the procedure you performed is separately reportable. If it is included in the list, then you cannot separately report this procedure.

Complex circumstances

A good example is the placement of central lines (CPT codes 36555 and 36556). Universally, we think that it's bundled in the pediatric critical care codes and do not report these line placements separately when a pediatric critical care code is used. Now imagine that you are caring for a 5.5-year-old patient whom you billed 99476. If you place a central line, you will not report it because we all know that central lines are bundled in pediatric codes, but a closer look at the bundle suggests otherwise. The day-based or neonatal/pediatric critical care bundle includes only CPT code 36555, not 36556. Code 36555 applies to those age less than 5 years, and code 36556 applies to those aged 5 and above. Because this patient is above 5 years of age, the correct code is 36556. Since this code is not in the bundle, the

central line can be reported separately with the critical care code 99476. Central lines can be reported separately with day-based codes for patients older than 5 years of age.

This illustrates the importance of the age limit of different CPT codes. Pediatric critical care codes apply until 72 months, and time-based critical care codes start with age 6 years/72 months. Non-tunneled central line placement cut-off is 5 years/60 months.

Another good example, imagine that you did an LP on a 2-year-old critically ill patient and removed CSF for therapeutic reasons, you could be tempted to say that ''well LP is bundled in, I can't report it separately'' but if you take a closer look, you will notice that therapeutic LP has different CPT code of 62272 than diagnostic LP that is not in the bundle list. Although diagnostic LP cannot be reported separately for this patient, therapeutic LP can be reported separately.

The importance of the exact critical care code that is billed is highlighted in the next example. Imagine you intubated a 6-month-old patient and placed a central line, but due to the absence of room or other reasons, you transferred the patient to a different institution. In this example, you might be tempted to say, "*because of the age, I would not be able to bill for intubation and central line*" but that is wrong. Whether you can bill a procedure is not determined by the patient's age, but rather by the CPT code billed and its bundle list. The appropriate critical care codes for this patient are 99291-99292. Because you are transferring the patient out, you cannot use the day-based codes. Since you will bill 99291-99292, intubation and central line placement are separately billable because they are not in the bundle list.

10 - APPROPRIATE DOCUMENTATION OF SELECTED CPT CODE

The importance of documentation cannot be overemphasized, as reimbursement depends on documentation rather than delivered care. If a reported CPT code (or a claim) is not supported with appropriate documentation, then the claim may be denied. Please refer to Chapter 7 for guidelines on appropriate documentation.

So do not just select the highest level of code; also document in your note that the patient actually qualifies for that level. If you are billing 99233, then either document high-level MDM or 50 minutes of total time.

For critically ill patients, you should document that the patient's condition meets the CPT definition of critical illness or injury. CPT defines critical illness or injury as *"A critical illness or injury acutely impairs one or more of vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition*". Based on this definition, an intensivist should document impairment or failure of one vital organ and a high probability of deterioration. Otherwise, the patient may not be considered critically ill by the payers.

Another important documentation requirement for critical care notes is that CPT defines critical illness as high-level MDM. If critical care codes are reported, the note should also document high-level MDM.

Words that are used in the note are vital in the processing of claims, and they can mean the difference between acceptance and denial. In the past, critical care was defined as an unstable patient; hence, stable implied non-critical illness. This definition was changed, but it is still a good idea to limit the use of

the word stable. When stable is used, make sure you document that, despite being stable, the patient is still critically ill.

11- APPROPIATE USE OF ICD CODES

CPT codes are always reported with ICD codes. ICD codes tell the payer about the reason for service, while CPT codes tell the payer about the nature of the service. You should align your CPT codes with ICD codes. If you report high-level codes, then you should list sicker-looking ICD codes, unless time-based billing is used. For example, if the sickest ICD code listed is URI, it may be difficult to justify code 99223, and the claim may be denied; however, it will likely be reimbursed if severe RAD exacerbation is used. If critical care codes are reported, then the listed ICD code should be a critical illness. For example, there is probably no better ICD code than acute respiratory failure or shock for critical care billing, as it 100% percent implies critical illness and should always be listed first.

For critical care billing, a single ICD code for organ failure, such as acute respiratory failure, is sufficient. More ICD codes can be added, but they are not necessarily needed. Reported ICD codes should reflect the patient's active problems being addressed, not inactive problems that are not addressed at that encounter. Chronic problems, if not contributing to medical decision-making, are not relevant to selecting the level of MDM. Although ICD for unaddressed chronic problems may be listed, they are not as important as the acute problems. If you are reporting higher-level non-critical care codes, then list the appropriate sick ICD codes first, before inactive chronic problems.

12- DO NOT FORGET TO BILL

Physicians frequently lose revenue when they forget to bill. It's a good idea to have a system that reminds you to bill for every patient that you see. This can be a computer-generated or handwritten patient list, with a check mark for every patient who is seen and billed. If you are a teaching physician, it's a good idea to write down the list of the patients you have seen that day so that if a resident forgets to write a note, you can still detect the missing note and bill for it. If you do not have your own list, then you may not realize when a resident forgets to place a note, especially if you are signing your notes and billing days after being on service.

13- FOLLOW YOUR CLAIMS

Follow your claims (CPT codes) closely to ensure they are submitted appropriately and that denials are addressed. If you do not have a system in place to track your claims, you would have no idea how much revenue you are losing.