

STROKE CODING GUIDE FOR CRITICAL CARE CODING

Critical Care CPT® codes can be used for managing an unstable, critically ill stroke patient. The progress or admitting note must mention the time spent that day, and should state that the patient is “unstable, critically ill.” We recommend that the latter is an explicit statement in the Impression.

The critical care codes do not use bullet points. There are no other criteria for content of the notes, beyond specifying the total time spent and clarifying that the patient is unstable and critically ill.

A stroke patient is unstable and critically ill when there is a high probability of imminent life threatening deterioration. Many stroke patients meet that criterion. Note that a therapy, such as IV tPA, qualifies for critical care coding when it creates a high risk of a life threatening intracranial bleed.

The critical care codes are used by the physician(s) managing the patient. They are not used by consultants. More than one physician can use the codes each day if each manages an aspect of the patient’s critical illness.

There are two codes: one for the first hour (99291), the other for each additional half-hour (99292). The second code can be used in multiple units.

MORE THAN ONE NEUROLOGIST: Sometimes more than one neurologist manages the patient that day. For example, the covering physicians rotate at mid-day. One provides care for the first 12 hours, and the other for the second 12 hours. If the physicians are from the same group and share the same Medicare provider number, then they should aggregate (add together) their time and bill once. The second shift physician should document in his or her note the total time spent by both physicians, and bill accordingly for the combined time.

MORE THAN ONE SPECIALTY: Sometimes a neurologist manages the stroke, and another specialist manages a different part of the patient’s care at the same time, such as ventilator management by an ICU physician. Both may use the critical care codes.

LOCATION: These codes can be billed at any location, e.g., ER, radiology, floor bed, or ICU. The time spent must track where the patient is. As an example, a physician spends 45 minutes with the patient in the ER evaluating and arranging the admission, then 45 minutes with the patient in radiology completing the exam and reading the imaging as it appears, and another hour with the patient in the ICU organizing the admission management and testing. In that case, all 2 hours 30 minutes is billable critical care time.

TIME IN OTHER LOCATIONS: If the patient is already in the ICU, then time does not count toward the total when spent off the floor away from the patient at radiology reviewing images or at the office making phone calls. Time only counts when it is spent on the unit where the patient is.

FAMILY TIME: If the patient cannot speak for him/herself, then the family is expected to speak for the patient. Time then counts toward the total critical care time when it is spent explaining the situation to the family, obtaining additional history, and discussing treatment options. If the patient is able to speak for him/herself, then family time only counts if the patient is present.

RESIDENT’S TIME: Time spent by residents, or medical students, does not count toward total critical care time. Only the time spent by a billing attending counts.

E/M CODE AND CRITICAL CARE BILLING: Both can be billed if both services were provided. The record should document that the E/M service was separate from of the critical care service. Both services must be documented. Particular time spent can be counted either for the E/M or for the critical care service, but not for both.

CPT® INSTRUCTIONS FOR USING THE CRITICAL CARE CODES

– OFFICIAL DETAILS:

99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes

99292 Each additional 30 minutes (List separately in addition to code for primary service)

Code 99291 is used to report the first 30–74 minutes of critical care on a given date. It should be used only once per date even if the time spent by the physician is not continuous on that date. (Note: All time from a given date should be noted in the patient record and totaled for the entire date to determine the appropriate amount of critical care time to bill for.)

Total Duration of Critical Care	Codes
Less than 30 minutes	Appropriate E/M codes
31–74 minutes (1/2 hr.–1 hr. 14 min.)	99291 x1
75–104 minutes (1 hr. 15 min.–1 hr. 44 min.)	99291 x1 and 99292 x1
105–134 minutes (1 hr. 45 min.–2 hr. 14 min.)	99291 x1 and 99292 x2
135–164 minutes (2 hr. 15 min.–2 hr. 44 min.)	99291 x1 and 99292 x3
165–194 minutes (2 hr. 45 min.–3 hr. 14 min.)	99291 x1 and 99292 x4
194 minutes or longer (3 hr. 15 min.–etc.)	99291 and 99292 as appropriate (see illustrated reporting examples above)

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition.

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in the critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

Note: For the purposes of reporting critical time, the “unit” constitutes the location of the patient. For example, if the physician accompanies the patient to radiology to view scans

this can be included in critical care time.

Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient’s condition continues to require the level of physician attention described above.

Critical care and other E/M services may be provided on the same patient on the same date by the same physician.

Note: When two physicians from the same group are billing for critical care, total time for each physician should be added together and billed under one physician’s tax ID number; two physicians from different groups may also bill for critical care as long as they are involved in different aspects of the patient’s care.

Documentation

Time spent with the individual patient should be recorded in the patient’s record. The time that can be reported as critical care is the time spent engaged in work directly related to the individual patient’s care whether that time was spent at the immediate bedside or elsewhere on the floor or unit. Also, when the patient is unable or clinically incompetent to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a medical history, reviewing the patient’s condition or prognosis, or discussing treatment or limitations(s) of treatment may be reported as critical care, provided that the conversation bears directly on the management of the patient. Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient. Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit (e.g., participation in administrative meetings or telephone calls to discuss other patients). Time spent performing separately reportable procedures or services should not be included in the time reported as critical care time.

Note: As there are not specific instructions other than this as to what should be documented, it is important to note in the patient’s record that the patient is “unstable and critically ill.” It is important to keep in mind that increased usage of critical care codes may prompt an audit; physicians should make sure that they are documenting correctly to ensure a positive outcome.

ACUTE STROKE CASES

CASE 1: You are called to the ED to see a 68-year-old man with onset of aphasia and right hemiplegia 2 hours ago. You arrive in the ED at 6:00 p.m. and find him globally aphasic with no movement of the right extremities. NIHSS score is 18. CT brain was done before your arrival and you read it as normal. Laboratory values including glucose, platelets, and INR are all normal. His wife is in the room and you find he has a history of hypertension and atrial fibrillation. His medications include warfarin and altace. He had no prior history of stroke and no recent trauma or surgical procedures. You ask the nurse for a blood pressure, which is 150/90. You complete the tPA checklist and decide he is an appropriate candidate for IV tPA. You explain the risks and benefits of IV tPA to his wife. She consents to proceeding with treatment. You ask the nurse to mix IV tPA and give him 0.9 mg/kg with 10% as a bolus. She mixes the tPA draws the bolus into a syringe. You administer

the bolus and the nurse starts the IV infusion of tPA. You write admission orders, dictate a note, and leave the ED at 7:10 p.m.

Your note documents that you personally attended to this critically ill patient for 1 hour 20 minutes including acute stroke evaluation, determining the appropriateness of administering IV tPA, discussing with the family and initiating treatment. This was exclusive of any time spent on E/M services.

Critical care time: 1 hour 20 minutes (80 minutes)

Billing codes:
99291
99292

CASE 2: You are called to evaluate a 58-year-old woman with aphasia and right hemiplegia. She was last observed to be neurologically normal at 8:00 a.m. You arrive in the ED at 11:30 a.m. You examine her and find an NIHSS score of 20. She has a normal blood pressure, normal laboratory values and you read her CT as showing early hypodensity in the basal ganglia but otherwise no abnormality. You meet with her son and husband and explain that she is past the window for IV tPA but intra-arterial thrombolysis or removal of the clot with the Merci clot retriever are considerations. You explain the risks, benefits, and FDA status of these treatments. They would like to proceed with angiography and possible clot lysis/removal. You call the interventional neurologist and he asks that the patient be sent immediately to the angiography suite. You call anesthesia for intubation. The patient is sedated and intubated and you then accompany the patient to the angiography suite. The angiogram is started at 1:00 p.m. Angiography demonstrates complete occlusion of the left MCA. After discussion between you and the interventionalist, it is decided to attempt clot retrieval with the Merci device.

You leave at 1:30 p.m. briefly to see another consult in the hospital. The interventionalist passes the clot retriever, but despite several attempts the MCA does not recanalize. You return to the angio suite at 2:00 p.m. After discussion, you and the interventionalist decide to terminate the procedure and the patient is transferred to the ICU at 2:30 p.m. You write admitting orders for the ICU and dictate an admitting note documenting your history, examination and your discussion with the family regarding risks and benefits. You also document that you were present during the interventional procedure except for 30 minutes, monitored the status of the patient, and contributed to the process of deciding on treatment. Total critical care time is 2 hours 30 minutes.

Critical care time: 2 hours, 30 minutes (150 minutes)

Billing codes:
99291
99292 X3

CASE 3: You are called by a nurse in the ICU because a 31-year-old patient you had previously seen in consult with a large right hemisphere stroke is worse. You arrive in the ICU at 5:00 p.m. Examination shows that he responds to voice by opening his eyes briefly but does not follow commands. The right pupil is larger than the left, irregular, and poorly responsive to light. He withdraws the right extremities to pain, but pinch on the left elicits extension of the left arm and triple flexion of the left leg. Both plantar responses are extensor. You determine that the mental status changes, papillary abnormality, and extensor plantar response on the right are new and suggest impending tentorial herniation. You call the neurosurgeon and order a stat CT scan. You order mannitol. As the nurses prepare the patient for transport to CT, you call the patient's wife and discuss the situation as well as the risks and benefits of decompressive craniotomy. His wife consents to the procedure. You accompany the patient to CT and

immediately view the CT with the neurosurgeon who has now arrived. After discussion, the decision is made to proceed with decompressive craniotomy. The patient is taken emergently to the OR for the procedure at 6:50 p.m.

You document the change in neurological status, your discussion with the family and with the neurosurgeon. You state that you remained at the bedside of this critically ill patient through CT and the decision making process for a total of 2 hours.

Critical care time: 1 hour, 50 minutes (110 minutes)

Billing codes:
99291
99292 X 2

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