CODING Q&A

Supervising Physician, Physician Rotation, Critical Care

DAVID STERN, MD, CPC

Q. Can a Physician Assistant (PA) bill a claim under a supervising physician even when the supervising physician is not physically present during the patient visit?

A. A PA can render services when the physician is not on site. Incident-to billing (a specific CMS method for billing midlevel services with the physician as rendering provider) would never apply in this case.

Services rendered in this situation should be billed with the PA as the rendering provider. This is an absolute for Medicare and many other payors, and it may be considered fraud to bill with the physician as the rendering provider for services rendered by the PA.

Exception: In certain circumstances a specific (non-Medicare) payor may instruct the physician to bill services that were actually rendered by the PA with the physician as the rendering provider. This was more common in the past, and this instruction is now fairly rare. If the payor does instruct you to bill this way, it would not be fraud to bill the service with the PA as the rendering provider. ■

Q. We use an unassigned physician rotation for patients to have a one-time follow up visit from the ED (emergency department) or urgent care for patients with no primary care provider. How would a family practice physician code this episodic one-time-only follow-up visit since he would not be taking on the patient on a permanent basis? Does it get coded as a new patient E/M level or consult?

A. These visits would be coded with a new E/M, assuming appropriate documentation and medical necessity.

David E. Stern, MD is a certified professional coder and board certified in Internal Medicine. He was a Director on the founding Board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), PV Billing and NMN Consulting, providers of software, billing and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular.

Per CPT guidelines, critical care is the direct delivery by a physician or other qualified health care professional of medical care to a critically ill or critically injured patient.

Of course, it would be coded with an established E/M if either of the two following criteria applied for services rendered within the past 3 years:

- the patient had a face-to-face encounter with the treating "unassigned" physician or;
- the patient had a face-to-face encounter with a physician of the same specialty in the same practice as the treating "unassigned" physician. ■

Q. Are we able to bill critical care code 99291 when the criteria are met? We are a standalone urgent care center and not associated with any hospital.

A. Critical care services, CPT codes 99291, "Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes" and add-on code 99292, "...each additional 30 minutes" are usually, but not always, given in a critical care area. However, they can be billed in the outpatient setting. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code.

Per CPT guidelines, critical care is the direct delivery by a physician or other qualified health care professional of medical care to 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-threat-

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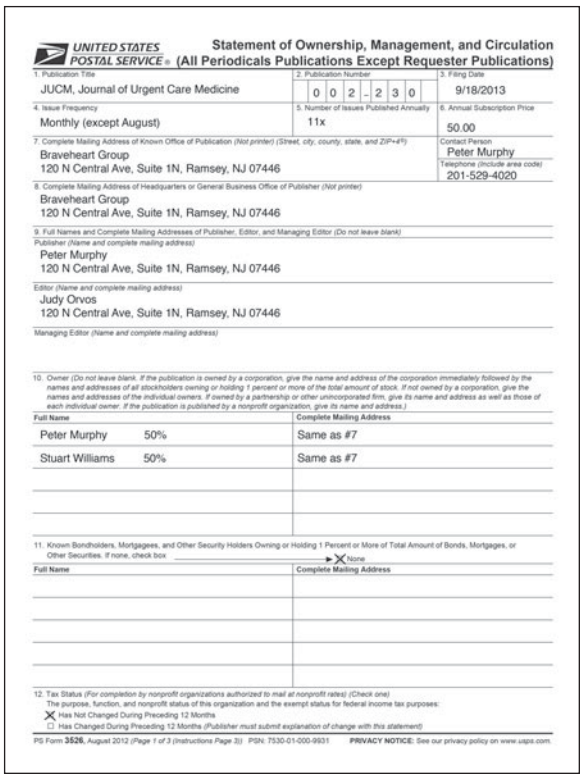

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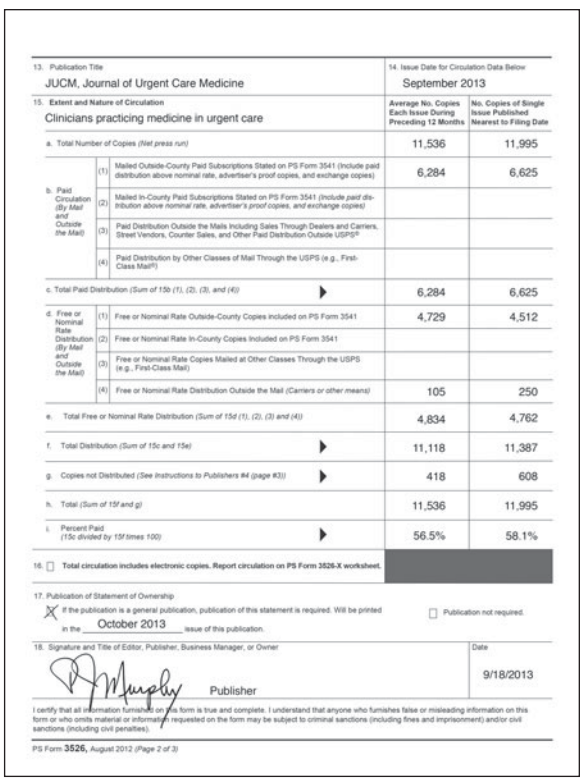

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ening deterioration in the patient's condition. Critical care also involves high-complexity decision-making to assess, manipulate, and support vital system function(s) or treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

There are certain services that are included in the critical care: the interpretation of cardiac output measurements (93561, 93562), chest X-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic date [99090], gastric intubation (43752, 43753), temporary transcutaneous pacing (92953), ventilator management (94002-94004, 94660, 94662), and vascular access procedures (36000, 36410, 36415, 36591, 36600). Any services performed that are not listed here should be reported separately. Only facilities can report the previously-listed procedures separately.

You would also report codes 99291 and 99292 for the attendance during the transport of critically ill or critically injured patients older than age 24 months to or from a facility or hospital. You are directed to codes 99466 and 99467 for pediatric critical care patient transport.

As with any procedure, documentation must be concise and complete. Along with face-to-face time treating the critically ill or injured patient, time spent engaged in work directly related to the patient's care can be included when calculating the duration for critical care and does not have to be consecutive. For example, when the patient is unable to participate in discussion, time spent on the floor or unit with family members obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment can be reported as critical care, provided that the conversation bears directly on the management of the patient.

Time spent in activities where the provider is not immediately available to the patient do not count toward critical care. Time spent in activities that do not directly contribute to the treatment of the patient cannot be reported as critical care. You also cannot count time spent performing a separately reportable procedure or service. ■