ADVANCED PRACTICE PROVIDER BILLING AND DOCUMENTATION MANUAL

Critical Care
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1. TERMINOLOGY AND DEFINITIONS

Types of Providers

For purposes of University of Colorado Medicine (referred to as CU Medicine), the following provider types are recognized as billable providers:

Physicians
- Physicians are defined as Doctors of Medicine or Osteopathic Medicine, Doctors of Dental Medicine or Dental Surgery, Doctors of Podiatric Medicine, and Doctors of Optometry who are legally authorized to practice medicine within the scope of their license.

Advanced Practice Providers
- Advanced Practice Providers (APPs) are defined as a group of medical professionals including Physician Assistants (PAs), Anesthesiologist Assistants (AAs), and Advanced Practice Registered Nurses (APRNs). APRNs include: Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Registered Nurse Anesthetists (CRNAs) and Certified Nurse Midwives (CNMs). APPs are legally authorized to practice by the State within the scope of their license and otherwise meet Medicare requirements.

Advanced Practice Provider Fellows
- An APP Fellow is a licensed, credentialed advanced practice provider (Physician Assistant or Advanced Practice Registered Nurse) who is completing an organized, approved post-graduate training program in a specialty or area of practice. APP Fellows are NOT students. They have completed their graduate training, passed certification tests and are licensed to practice. They are appointed at the Instructor Fellow rank.

Note: The scope of this manual excludes CAA and CRNA providers.

Please refer to the link(s) below to review the Centers for Medicare and Medicaid Services (CMS) for further information.

For purposes of CU Medicine, the following are not recognized as billable providers:

Resident/ Fellow
- A resident or fellow is an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program, but who is authorized to practice only in a hospital setting. Medical and surgical services furnished by a resident must be within the scope of his or her training program.

Medical Student
- A medical student is an individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student.
• Some parts of medical student documentation can now be used for billing by an Attending. This is for specified Evaluation and Management (E&M) services only, and because of this, a medical student can reference or copy from an APP’s note to complete the medical student’s note when working with a Attending in the same group, **and on the same day** for continuity of care.

**Advanced Practice Provider Student**

• An advanced practice provider student is an individual who participates in an accredited Physician Assistant (PA) or Advanced Practice Registered Nurses (APRN) educational program. The APRNs consist of Nurse Practitioners -NP, clinical nurse specialists -CNS and certified nurse midwives -CNM). A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student.

**Hospital Regulations**

Please refer to the link(s) below to review the Centers for Medicare and Medicaid Services (CMS) for further information.


2. PHYSICIAN SUPERVISION

For purposes of CU Medicine, the following types of supervision apply:

Resident/Fellow
   1. A resident or fellow is supervised by an Attending or Attending (TP), who is defined as a physician (other than a resident) involving residents in the care of his or her patients. For purposes of payment, services billed by the Attending physician require that the Attending physician personally document an attestation with the following:
      a. That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
      b. The participation of the Attending physician in the management of the patient.

For billing purposes, an APP may not function as an Attending for any advanced practice provider student, medical student, resident or fellow, or attest to the clinical services rendered and can function in an advisory capacity only.

APP Fellow
An APP Fellow is supervised by an Attending Physician or an APP Preceptor. For purpose of payment, if the APP Fellow is precepted by an Attending Physician, the service can be billed as a split/shared
service, when documented appropriately. If the APP Fellow is precepted by an APP, the encounter would be billed based on the APP preceptor’s documentation.

**Medical Student**

4th year medical student documentation may be utilized by an Attending physician for billing purposes in certain circumstances. Please refer to the link below to review CU Medicine’s guidelines on utilizing medical student documentation for billing purposes.

- [https://www.cusomgateway.com/cumed/medical-student/](https://www.cusomgateway.com/cumed/medical-student/)

**Advanced Practice Provider Student**

For billing purposes, a proctor (MD, DO or APP) may attest to an advanced practice provider student when the following criteria are met:

- There is joint physical presence between the proctor, APP student and patient;
- The proctor must verify with the patient, all of the APP student’s documentation or findings, including history, physical exam and/or medical decision making in the medical record;
- The proctor must personally perform or re-perform the physical exam and medical decision making activities;

APP Proctors may only utilize APP student documentation and may not utilize medical student documentation.

If a scenario occurs involving an Attending, resident/fellow and APP student, the joint physical presence must be between the Attending, APP student and patient. Seeing the patient with a resident does not qualify as joint physical presence.

Resident/Fellows may not utilize APP student documentation.

Proctors may utilize APP student documentation for billing purposes in the inpatient, outpatient, clinic and emergency department (CHCO only).

Please refer to the link below for CU Medicine’s guidelines on utilizing APP student documentation for billing purposes.

- [https://www.cusomgateway.com/student-documentation/app-students/](https://www.cusomgateway.com/student-documentation/app-students/)

**Hospital Definition:**

**Physician Assistants**

The PA’s primary supervising physician or a secondary supervising physician, is primarily responsible for the overall direction and management of the PA’s professional activities and for assuring that the services provided are medically appropriate for the patient. The supervising physician is not required to be physically present with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary, unless State law or regulations require otherwise. For acute care services rendered when the supervising physician is not physically present, said supervision shall be demonstrated by co-signature of the PA’s note(s).
3. COMPLIANCE

Copy/Paste

For the purposes of this guideline, the term “copy” means any one of the following synonyms: copy & paste, cut & paste, copy/forward, re-use, carry forward, predetermined text, cloning, and auto-populated.

When using an electronic medical record (EMR) system, please adhere to the following compliance standards:

- Services documented must be pertinent to the episode of care and be clear as to services provided that day. Documentation should be encounter and patient specific.
- Avoid copying information from one patient to another.
- Avoid copying information without referencing the information by author or source, date/time and location.
- Documentation should be provided by positive action, not default. Normal/negative findings should not pre-populate into a note.*
- Documentation of a physical exam should be a positive action for only the systems examined. Providers should not populate the remainder of the physical exam template with defaulted language.

*To better understand the last two points, since templates are like a guide, the provider must utilize the template as a “base” to create a note for the encounter. To be compliant, the base though should not prepopulate normal or negative findings, these must be entered by positive action.

EXAMPLE:

Compliant exam:
Constitutional (Negative/Positive …)
Cardiovascular (Negative/Positive …)

Non-compliant exam:
Constitutional: Negative
Cardiovascular: Negative

In the compliant exam example, the provider must provide positive action by selecting if the exam element is negative or positive.

Meanwhile in the non-compliant example, if “negative” is already prepopulated, there is no “positive action” by the provider.

Please refer to the link below to review CU Medicine’s Compliance Manual, Appendix K, on the CU SOM Gateway for CU Medicine’s guidelines for copy/paste:
- [https://www.cusomgateway.com/provider-resources/compliance-documents/](https://www.cusomgateway.com/provider-resources/compliance-documents/)
Addendums

The expectation of creating an addendum is to reference why it is needed. CU Medicine has created guidelines to clarify when documentation addendums are valid for billing purposes.

Addendums should only be necessary on rare occasions and should not be used in a common practice of documenting services performed. Amending medical records to meet payment policy guidelines is inappropriate.

Please refer to the link below to review CU Medicine Compliance Manual, Appendix J, on the CU SOM Gateway for CU Medicine’s guidelines for addendums in its entirety for evaluation and management (E/M), procedural and diagnostic services:

- https://www.cusomgateway.com/provider-resources/compliance-documents/
4. CRITICAL CARE SERVICES

Definition
“Critical care is the direct delivery by a physician(s) of medical care for a critically ill or injured patient. The care of such patients involves decision making of high complexity to assess, manipulate, and support central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, postoperative complications, overwhelming infection, or other vital system functions to treat single or multiple vital organ system failure or to prevent further deterioration. It may require extensive interpretation of multiple databases and the application of advanced technology to manage the patient. 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 services include but are not limited to, the treatment or prevention or further deterioration of central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic or respiratory failure, post-operative complications, or overwhelming infection. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.” Although CMS explicitly discussed billing of Critical care, however, an appropriately credentialed Advanced Practice Provider can bill Critical care.

Billing Guidelines
Advanced Practice Providers:
Admission orders must identify a responsible attending physician and the order must be cosigned by a physician prior to patient discharge.

Daily Critical Care Billing (for neonate through 5 years of age)

Documentation Requirements
When providing critical care the documentation must include:
- That the patient was critically ill during the time the provider saw the patient;
- What made the patient critically ill; and
- The nature of the treatment and management provided.
- The time spent providing critical care (does not include time spent by trainees).

CHCO Documentation
1. For Teaching Physicians in Children’s Hospital of Colorado, recommended language is:

   **PICURESUNDER6**
   Inpatient (name) is critically ill with ***. I agree with the findings and plans as noted in the PICU resident progress note above. Assessment and plans for the day***. I have examined the patient and reviewed the patient’s overnight course and current condition, including ICU flowsheet data, and lab and radiology results. I have devised and discussed the patient’s care plan for today on rounds with the PICU team and reassessed the patient and adjusted those plans as needed through the day.
2. For Physicians in Children’s Hospital of Colorado not attesting to a trainee note and having seen the patient (under 6 years old) with the APP, recommended language is:

```
PICUAPPUNDER6
Inpatient is critically ill with ***. Assessment and plan includes ***. I have examined the patient and reviewed the patient’s overnight course and current condition, including ICU flowsheet data, and lab and radiology results. I have devised and discussed the patient’s care plan for today on rounds with the PICU team and reassessed the patient and adjusted those plans as needed through the day.
```

Coding Guidelines
1. Billing for critical care in patients through 5 years of age utilizes a daily fee based on age.
   a. 99468-99469: 28 days of age or younger
   b. 99471-99472: 29 days through 24 months of age
   c. 99475-99476: 2 through 5 years of age

2. Only physicians can bill the daily fee.

3. If a patient in this age group is ONLY seen by an APP during a designated 24 hour period, the APP must utilize time based critical care billing rules (see “Time Based Critical Care Services (for all patients 6 years of age or older).”)

4. The daily fee includes most procedures, but not CPR or ECMO. ECMO billing has separate requirements and must be documented separately. The recommended language for daily pediatric ECMO management is provided by CU Medicine approved smart phrase:

```
UCMECMO:
{VA/VV} {Initial/Daily} management: I reviewed the flow, sweep, FiO2 and patient response to circuit. The goal for today is to {increase support, maintain current support, wean}. Anticoagulation, bleeding risk, any actively bleeding sites and laboratory data were reviewed, will {adjust anticoagulation target to ***, maintain current anticoagulation plan, stop anticoagulation}.
```

Please refer to the link below to review CU Medicine’s resource tool for ECMO on the CU SOM Gateway.

**Time Based Critical Care Services (for all patients 6 years of age or older)**

Documentation Requirements
When providing critical care the documentation must include:
- That the patient was critically ill during the time the provider saw the patient;
- What made the patient critically ill;
- The nature of the treatment and management provided; and
- The time spent providing critical care (does not include time spent by trainees).

Teaching Physicians
1. A teaching physician may tie into the resident/fellow’s documentation and may refer to the resident/fellow’s documentation for specific patient history, physical findings and medical assessment. However, the teaching physician must document a statement of the total time the teaching physician personally spent providing critical care along with the documentation requirements listed above.
2. The teaching physician must be present for the time for which the claim is being made when billing for hourly critical care services.

**CHCO Documentation**

1. For teaching physicians attesting to a trainee’s note in Children's Hospital of Colorado, recommended language is:

**.PICURESOVER6**
Inpatient (name) is critically ill with ***. I agree with the findings and plans as noted in the PICU resident progress note above. Assessment and plan includes ***. I personally performed ** total minutes of critical care today including examining the patient and reviewing the patient’s overnight course, current condition, ICU flowsheet data, and lab and radiology results. I devised and discussed the patient’s care plan for today on rounds with the PICU team and reassessed the patient and adjusted those plans as needed through the day. This time does not include billed procedures and does not include overlapping critical care time documented by another provider.

2. For physicians in Children’s Hospital of Colorado not attesting to a trainee’s note, having seen the patient (6 years old and over) with the APP, recommended language is:

**.PICUAPPOVER6**
Inpatient (name) is critically ill with ***. Assessment and plan includes ***. I personally performed ** total minutes of critical care today including examining the patient and reviewing the patient’s overnight course, current condition, ICU flowsheet data, and lab and radiology results. I devised and discussed the patient’s care plan for today on rounds with the PICU team and reassessed the patient and adjusted those plans as needed through the day. This time does not include billed procedures and does not include overlapping critical care time documented by another provider.

**UCH Documentation**

For physicians in UCHHealth University of Colorado Hospital, the recommended smart phrase is:

**.UPICRITICALCARE**
This patient is critically ill due to ***. I was present for this visit. My involvement with the patient today included the following treatment and management:***. Total Critical Care time:** *** minutes. Time spent on any procedures is not included in today’s billed critical care time.

**Advance Practice Providers**

Critical care services may be provided by qualified APPs and reported under the APPs National Provider Identifier (NPI) when the services meet medical necessity and the requirements of critical care services as listed in the definition. Physician supervision and billing requirements must also be met. A physician assistant shall meet the general supervision requirements.

For APPs, the recommended smart phrase to use is:

**.UCMCRITICALCARE2**
This patient is critically ill due to ***. I personally performed ** min of critical care including **. This time is excluding time spent on performing inclusive procedures and does not include overlapping critical care time documented by another provider.
Please refer to the link(s) below to review the CU Medicine Resource Tool for Critical Care.


Please refer to the link(s) below to review the Centers for Medicare and Medicaid Services (CMS) for further information.


**Coding Guidelines:**
Billing for critical care in 6 years of age or older are based on the total amount of time spent on a calendar day. Time does not need to be continuous.

- **99291**: first 30-74 minutes
- **99292**: each additional 30 minutes

Medicare policy states providers in the same group practice who are in the same specialty must bill and be paid as though each were a single provider.

Please note that in a case where the physician performs 30 minutes or more but not the full 74 minutes for the initial critical care code, the additional minutes are reported by documenting the additional minutes by who is providing the service. If the physician is the same specialty from the same group practice, the time should be aggregated up to the 74 minutes and billed as a single physician. The additional minutes after the 74 minutes should be reported using 99292 as appropriate.

If an APP from the same group is performing the additional minutes, the physician performing the initial critical care service is required to perform at least 30 minutes of service to bill 99291. The NPP should report 99292 for any additional 30 minute increment of critical care.

**Example:**

- Dr. Smith and Alice Conley, NP both pulmonary specialists, same group practice. On Tuesday Dr. Smith provides 45 minutes of critical care services at 11:00 am for Mrs. Benson who is comatose and has been in the ICU for 4 days. Later that day Alice Conley, NP provides 20 minutes of critical care services at 1:00 pm. The total time spent is 65 minutes, per the total duration table 65 minutes = 99291 x 1. Dr. Smith can report 99291.

There are certain services bundled into the payment for critical care services and should not be reported separately when performed on the day a physician bills for critical care. For a complete list of those procedures please refer to the direct link below for the [IOM 100-04, Chapter 12, Section 30.6.12J](https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00005054).

Procedures not listed above should be noted and billed separately from critical care time.

Please refer to the link below to review the Novitas Solutions website for further information

5. PROCEDURES

Billing Guidelines (General)
1. Aftercare within the global period must still be documented, but it doesn’t generate a bill. Medicare policy states providers in the same group practice who are in the same specialty must bill and be paid as though each were a single provider.

Billing Guidelines (Provider specific)
1. Physician
   a. In order to bill for surgical, high-risk, or other complex procedures, the teaching surgeon must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure. For minor procedures, the teaching surgeon must be present for the entire procedure in order to bill.

2. Advanced Practice Providers:
   a. APPs needs to complete their own procedure documentation in order to bill the service. An APP may not function as Teaching Physician for any advanced practice provider student, medical student, resident or fellow, or attest to the clinical services rendered and can function in an advisory capacity only
   b. When an APP performs a procedure with assistance from the APP student the APP preceptor must document his/her own note for billing purposes.

Documentation Requirements
When performing a procedure documentation must include:
- Patient’s name
- Date
- Pre-operative diagnosis
- Post-operative diagnosis
- Surgeon’s name
- Procedure
- Indications for surgery
- Findings at surgery
- Details of surgery
- Assistant surgeon*/co-surgeon (if applicable)

The operative note should include information:
- Technique and approach
- Open vs. closed, aspiration, percutaneous, etc.
- Screening vs. diagnostic vs. therapeutic procedure
- Location/Site(s) – Right/left, bilateral, distal, proximal, depth, single/pleural, etc.
- Severity/Risk – complex/simple

Proctoring

Definition
Proctoring is an objective evaluation of a specific or sets of clinical skills of an advanced practice provider by a proctor who represents, and is responsible to, the credentialed APP being proctored. A new APP seeking privileges or existing credentialed APP privileged in other competencies that is requesting new or expanded privileges, are proctored while performing the procedure for which privileges are requested. In most instances, a proctor acts only as a monitor to evaluate the technical and cognitive skills of another physician. However, proctoring does not involve taking over the APP’s note, changing it, rewording and/or signing it.

An APP performing significant portion of the procedure will be the billing provider even in the presence of the proctor. In a situation where the proctor takes over the procedure and performs the significant portion of the procedure, only at such time will the proctor bill for the work done.

**Global Surgical Period Facts**
The global period includes:
- Day before surgery (preoperative period is the day before the surgery or the day of surgery)
- Day of the surgery; and
- Number of days following the surgery (*Note*: A major surgery has a 90 day post-operative period and a minor surgery has either a zero or a 10 day post-operative period.)
- Medicare defines same physician as physicians in the same group practice who are of the same specialty. In this instance they must bill and be paid as though they were a single physician during a global period.

E/M service resulting in initial decision to perform major surgery is furnished during post-operative period of another unrelated procedure, then the E/M service must be billed with both the 24 and 57 modifiers.
6. SPLIT/SHARED VISIT

Definition
A split/shared evaluation and management (E/M) visit is defined as a medically necessary encounter with a patient where the physician and APP, from the same group practice, each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service and contribute to the provision of the service. Split/shared E/M service can occur in a hospital inpatient or observation/hospital outpatient setting or emergency department.

If there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the APP’s name. If the physician and APP see the patient on different dates of service, split/shared billing does not apply.

CMS states the shared service concept does not apply to critical care, consultations, procedural services or E/M services performed in a skilled nursing facility (SNF).

Click on the link below to access the CU Medicine Compliance Manual on the CU SOM Gateway for more information on Split/Shared Visit documentation requirements, APP Workflow, Note routing, MD process and Split/Shared Time Billing.

- [https://www.cusomgateway.com/provider-resources/compliance-documents/](https://www.cusomgateway.com/provider-resources/compliance-documents/)
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