CRITICAL CARE DOCUMENTATION & BILLING

PRESENTED BY:

VIRGINIA GLEASON, BSN, MPA, JD

This activity is supported by grant #H54RH00046 (MT Medicare Rural Hospital Flexibility Grant) from HRSA and ORHP to DPHHS, EMS & Trauma Systems
Virginia is a committed problem-solver who has a diverse background in acute care hospital operations and regulatory compliance with 25+ years of experience in academic, acute care, county, critical access and children’s hospital settings specializing in Case Management, Utilization Review, Compliance and CDI program design, implementation, regulatory guidance and education. She has a proven ability to develop and implement or reinvigorate hospital operations.

Virginia joined nThrive 7 years ago following many years in private practice representing hospitals, health-systems and physician practices. Her legal practice focused exclusively on the complex area of healthcare regulations. She brought not only her legal background but her clinical and administrative experience to her professional consulting career. Her experience in healthcare ranges from bedside nursing, working as a medical practice manager and billing supervisor to the corporate practice of law. Through her broad healthcare background she has developed a professional consulting career in which she is known to provide thoughtful and successful solutions for complex operational and regulatory problems.

Additionally, Virginia is an experienced public speaker and has provided highly rated education for local, state and national organizations in a wide array of healthcare matters. She is a top-rated speaker for ACMA, AHIMA and HFMA with audiences that have included all levels of healthcare professionals from physicians and nurses to CEOs, CFOs, patient financial services and HIM staff.

**Education:** ASN, BS Healthcare Administration, MPA with emphasis in Healthcare Policy, Juris Doctorate. **Institutions:** University of Providence, University of North Dakota

**Accreditation/Certifications:** Certified in Healthcare Compliance, Certified Professional in Hospital Risk Management, Certified Case Manager, Certified Documentation Improvement Professional
WHAT WILL BE COVERED:

• ED Services with Trauma Activation
• Critical Care
• ED Levels
• Documentation
• Bundled services and separately billed
• Q & A
WHO’S LISTENING TODAY?

Polling Question
BACKGROUND

2016- 2017 Montana Trauma Systems and the Montana Rural Hospital Flexibility Program (Flex) Performance Improvement Project with 17 Critical Access Hospitals

- Assist trauma designated facilities in developing or reassessing their Trauma Activation Fee
- Assess current performance on reimbursement for trauma related activities (Trauma Activation Fees & Critical Care Charges)
- Provide resources and education to improve all processes involved from trauma notification through billing
- Maximize accurate reimbursement from payer sources for trauma activations and/or critical care codes

Key Finding: Facilities require more education and resources to improve the documentation and billing of the Critical Care Services they have provided.
ED SERVICES WITH TRAUMA ACTIVATION
To determine whether trauma activation occurs, providers are to follow the National Uniform Billing Committee (NUBC) guidelines related to the reporting of the trauma revenue codes in the 68x series.

- Can only be used only by trauma centers/hospitals designated by the state or as verified by the American College of Surgeons
- Different subcategory revenue codes are reported by designated Level 1-5 hospital trauma centers (code 6899)
- Only patients for whom there has been prehospital notification based on triage information from prehospital caregivers
- Must meet field triage criteria, or delivered by inter-hospital transfers, and given the appropriate team response
- When revenue code series 68x, trauma response, is billed in association with services other than critical care, payment for trauma activation is bundled into the other services provided on that day
TRAUMA ACTIVATION FACTS

• What to chart
  • prearrival notice from a medical third party (time of provider notification and arrival at facility)
  • reason/criteria for activation

• This documentation may be needed to dispute charges with payers and to track resource utilization.

• The trauma activation fee levels should not differ on the basis of whether the patient was admitted or not. The trauma activation charge is for the level of response a patient received regardless of whether the patient is admitted, is discharged, died, or is transferred.

• Likelihood of full reimbursement:
  1. Most likely: PRIVATE payers
  2. Less likely: "self-pay", HMO's, CMMS
ARE TRAUMA ACTIVATION FEES INCLUDED IN YOUR ED LEVEL OF SERVICE?

• Trauma patients require hospitals to expend higher level of resources. Emergency department (ED) level of services does not cover this additional cost burden
  • The Uniform Billing (UB) revenue code 68x, provides trauma designated hospitals the opportunity to bill for these costs

• The ED level of services will be billed according to a point system or using the ACEP (American College of Emergency Physicians) method of assigning acuity, and the trauma activation component will be billed under the new revenue code 68x.
1. For use by trauma center/hospitals, licensed or designated by the state or local government authority, authorized as a trauma center, or as verified by the American College of Surgeons and as a facility with a trauma activation team.

2. Revenue Category 068X is used for patients for whom trauma activation occurred. A trauma team activation/response is a Notification of key hospital personnel in response to triage information from pre-hospital caregivers in advance of the patient’s arrival.

3. Revenue Category 068X is for reporting trauma activation costs only. It is an activation fee and not a replacement or a substitute for the emergency room visit fee; if trauma activation occurs, there will normally be both a 045X and 068X revenue code reported.

4. Revenue Category 068X is not limited to admitted patients.

5. Revenue Category 068X must be used in conjunction with FL 14 Type of Admission/Visit code 5 Trauma Center; however FL 14 Code 5 can be used alone. Only patients for whom there has been pre-hospital notification, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers.
CRITICAL CARE SERVICES WITH TRAUMA ACTIVATION

• At least 30 minutes of Critical Care: When trauma activation occurs allowing a charge under 68x and the hospital provides at least 30 minutes of critical care (CPT code 99291), the hospital may also bill one unit of HCPCS code G0390.

• Less than 30 minutes of Critical Care: Hospitals that provide less than 30 minutes of critical care when trauma activation occurs under revenue code 68x, may report a charge under 68x, but they may not report HCPCS code G0390. In this case, payment for the trauma response is packaged into payment for the other services provided to the patient in the encounter, including the visit
  • This means you can put a line item on your claim for trauma activation under rev code 68X, but there will not be a CPT/HCPCS code attached.
  • PPS hospitals, even if a charge is attached to rev code 68X, they will not receive an APC (Ambulatory Payment Classification) payment for this service...it is rolled up into the EM service. You will (depending on payer/contract) receive payment for that line item from your other commercial payers.
  • For CAHs, they are not paid on an APC, so the line item charge under 68X will receive payment on a reasonable cost
CRITICAL CARE
WHAT IS CRITICAL CARE?

- The time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once. (ACEP)
There are differences in how facility and professional services are determined; codes assigned by the ED facility coder may not match those assigned by the ED physician coder.

ED facility evaluation and management (E/M) levels are assigned using CPT® ED services codes 99281-99285 and, in some instances, critical care codes 99291-99292. There is no direct correlation between the facility E/M level and the professional/physician level of service.
LEVELS OF SERVICE

The physician or other qualified healthcare professional level of service is determined by the following:
I. STRAIGHT FORWARD COMPLEXITY (99281/G0380):

The presented problem(s) are self-limited or minor conditions with no medications or home treatment required. Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

1. A problem focused history
2. A problem focused examination
3. Straightforward medical decision making.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor.
2. LOW COMPLEXITY (99282/G0381):

The presented problem(s) are of low to moderate severity. Over the counter (OTC) medications or treatment, simple dressing changes; patient demonstrates understanding quickly and easily. Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

1. An expanded problem focused history
2. An expanded problem focused examination
3. Medical decision making of low complexity.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
3. MODERATE COMPLEXITY (99283/G0382):

The presented problem(s) are of moderate severity. Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

1. An expanded problem focused history
2. An expanded problem focused examination
3. Medical decision making of moderate complexity.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
4. MODERATE-HIGH COMPLEXITY (99284/G0383):

Usually, the presented problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function. Emergency department visit for the evaluation and management of a patient, which requires these 3 key components:

1. A detailed history
2. A detailed examination
3. Medical decision making of moderate complexity.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
5. HIGH COMPLEXITY (99285/G0384):

The presented problem(s) are of high severity and pose an immediate significant threat to life or physiologic function. Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:

1. A comprehensive history
2. A comprehensive examination
3. Medical decision making of high complexity.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
ADVANCED LIFE SUPPORT (99288)

Physician direction of Emergency Medical Systems (EMS) emergency care, advanced life support.
The assignment of the Critical Care code 99291 likewise follows the same instructions applicable to the six E&M codes listed above. There is a 30-minute time requirement for facility billing of critical care.

1. The administration and monitoring of IV vasoactive medications (such as adenosine, dopamine, labetalol, metoprolol, nitroglycerin, norepinephrine, sodium nitroprusside, etc.) are indicative of critical care.
• The appropriate facility code/APC level is determined by the interventions (of nursing and ancillary ED staff) as listed in the middle column marked "Possible Interventions".

• Whether only a single "Possible Intervention" listed at a given facility code level is present or if multiple or all "Possible Interventions" assigned to that facility code level are present-the facility code/APC level is still the same.

• The facility code level assigned is always the highest level at which a minimum of one "Possible Intervention" is found.
# Facility Charge Assignment Table

<table>
<thead>
<tr>
<th>Level</th>
<th>Possible Interventions</th>
<th>Potential Symptoms/ Examples which support the Interventions</th>
</tr>
</thead>
</table>
| Level 1: CPT 99281 | Initial Assessment  
No medication or treatments  
Rx refill only, asymptomatic  
Note for Work or School  
Wound recheck  
Booster or follow up immunization, no acute injury  
Dressing changes (uncomplicated)  
Suture removal (uncomplicated)  
Discussion of Discharge Instructions (Straightforward) | Insect bite (uncomplicated)  
Read Tb test |
## FACILITY CHARGE ASSIGNMENT TABLE

<table>
<thead>
<tr>
<th>Level</th>
<th>Possible Interventions</th>
<th>Potential Symptoms/ Examples which support the Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level II: CPT 99282</td>
<td>Could include interventions from previous levels, plus any of: Tests by ED Staff (Urine dip, stool hem occult, Accucheck or Dextrostix) Visual Acuity (Snellen) Obtain clean catch urine Apply ace wrap or sling Prep or assist w/ procedures such as: minor laceration repair, I&amp;D of simple abscess, etc. Discussion of Discharge Instructions (Simple)</td>
<td>Localized skin rash Iesion sunburn Minor viral infection Eye discharge- painless Ear Pain Urinary frequency without fever Simple trauma (with no X-rays)</td>
</tr>
<tr>
<td>Level</td>
<td>Possible Interventions</td>
<td>Potential Symptoms/ Examples which support the Interventions</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Level III: CPT 99283</td>
<td>Could include interventions from previous levels, plus any of: Receipt of EMS/Ambulance patient Heparin/saline lock (1) Nebulizer treatment Preparation for lab tests described in CPT (80048-87999 codes) Preparation for Electrocardiogram (EKG) Preparation for plain X-rays of only 1 area (hand, shoulder, pelvis, etc.) Prescription medications administered PO Foley catheters; In &amp; Out caths C-Spine precautions Fluorescein stain Emesis/Incontinence care Prep or assist w/procedures such as: joint aspiration/injection, simple fracture care etc. Mental Health-anxious, simple treatment Routine psych medical clearance Limited social worker intervention Post-mortem care Direct Admit via ED Discussion of Discharge Instructions (Moderate Complexity)</td>
<td>Minor trauma (with potential complicating factors) Medical conditions requiring prescription drug management Fever which responds to antipyretics Headache - History of, no serial exam Head injury- without neurologic symptoms Eye pain Mild dyspnea -not requiring oxygen</td>
</tr>
</tbody>
</table>
## FACILITY CHARGE ASSIGNMENT TABLE

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<tbody>
<tr>
<td>Level IV: CPT 99284</td>
<td>Could include interventions from previous levels, plus any of: Preparation for 2 diagnostic tests: (Labs, EKG, X-ray) Prep for plain X-ray (multiple body areas): C-spine &amp; foot, shoulder &amp; pelvis Prep for special imaging study (CT, MRI, Ultrasound, VQ scans) Cardiac Monitoring (2) Nebulizer treatments Port-a-cath venous access Administration and Monitoring of infusions or parenteral medications (IV, IM, IO, SC) NG/PEG Tube Placement/Replacement Multiple reassessments Prep or assist w/procedures such as: eye irrigation with Morgan lens, bladder irrigation with 3-way foley, pelvic exam, etc. Sexual Assault Exam w/out specimen collection Psychotic patient; not suicidal Discussion of Discharge Instructions (Complex)</td>
<td>Blunt/penetrating trauma- with limited diagnostic testing Headache with nausea/ vomiting Dehydration requiring treatment Vomiting requiring treatment Dyspnea requiring oxygen Respiratory illness relieved with (2) nebulizer treatments Chest Pain--with limited diagnostic testing Abdominal Pain - with limited diagnostic testing Non-menstrual vaginal bleeding Neurologic symptoms - with limited diagnostic testing</td>
</tr>
<tr>
<td>Type A: APC 615</td>
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<tr>
<td>Type B: APC 629</td>
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<td></td>
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<tr>
<td>HCPCS: G0383</td>
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</tbody>
</table>
### FACILITY CHARGE ASSIGNMENT TABLE

<table>
<thead>
<tr>
<th>Level</th>
<th>Possible Interventions</th>
<th>Potential Symptoms/ Examples which support the Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level V: CPT 99285</td>
<td>Could include interventions from previous levels, plus any of: Requires frequent monitoring of multiple vital signs (i.e. 02 sat, BP, cardiac rhythm, respiratory rate) Preparation for ≥ 3 diagnostic tests: (Labs, EKG, X-ray) Prep for special imaging study (CT, MRI, Ultrasound, VQ scan) combined with multiple tests or parenteral medication or oral or IV contrast Administration of Blood Transfusion/Blood Products Oxygen via face mask or NRB Multiple Nebulizer Treatments: (3) or more (if nebulizer is continuous, each 20 minute period is considered treatment) Moderate Sedation Prep or assist with procedures such as: central line insertion, gastric lavage, LP, paracentesis, etc. Cooling or heating blanket Extended Social Worker intervention Sexual Assault Exam w/ specimen collection by ED staff Coordination of hospital admission/ transfer or change in living situation or site Physical/Chemical Restraints; Suicide Watch Critical Care less than 30 minutes</td>
<td>Blunt/ penetrating trauma requiring multiple diagnostic tests Systemic multi-system medical emergency requiring multiple diagnostics Severe infections requiring IV/IM antibiotics Uncontrolled DM Severe burns Hypothermia New-onset altered mental status Headache (severe): CT and/or LP Chest Pain--multiple diagnostic tests/treatments Respiratory illness-- relieved by (3) or more nebulizer treatments Abdominal Pain-- multiple diagnostic tests/treatments Major musculoskeletal injury Acute peripheral vascular compromise of extremities Neurologic symptoms - multiple diagnostic tests/treatments Toxic ingestions Mental health problem - suicidal/ homicidal</td>
</tr>
</tbody>
</table>
Critical Care can be coded based upon either the provision of any of the listed possible interventions or by satisfying the Critical Care definition. A minimum of 30 minutes of care must be provided. Critical Care involves decision-making of high complexity to assess, manipulate, and support impairments of “one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient’s condition.” This includes, but is not limited to, “the treatment or prevention of further deterioration of central nervous system failure, shock-like conditions, renal, hepatic, metabolic or respiratory failure, post-operative complications or overwhelming infection.” Under Outpatient Prospective Payment System (OPPS), the time that can be reported as Critical Care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.
CRITICAL CARE POSSIBLE INTERVENTIONS: COULD INCLUDE INTERVENTIONS FROM PREVIOUS LEVELS, PLUS ANY OR ALL OF:

- Multiple parenteral medications requiring constant monitoring
- Provision of any of the following:
  - Major Trauma care/ multiple surgical consultants
  - Chest tube insertion
  - Major burn care
  - Treatment of active chest pain in acute coronary syndrome (ACS)
  - Administration of IV vasoactive meds (see guidelines)
  - Cardiopulmonary Resuscitation (CPR)

- Defibrillation/ Cardioversion
  - Pericardiocentesis
- Administration of ACLS Drugs in cardiac arrest
- Therapeutic hypothermia
- Bi-PAP/ CPAP
- Endotracheal intubation
- Cricothyrotomy
- Ventilator management
- Arterial line placement
- Control of major hemorrhage
- Pacemaker insertion through a Central Line
- Delivery of baby
CRITICAL CARE POTENTIAL SYMPTOMS/ EXAMPLES WHICH SUPPORT THE INTERVENTIONS

- Multiple Trauma
- Head Injury with loss of consciousness
- Burns threatening to life or limb
- Coma of all etiologies (except hypoglycemic)
- Shock of all types: septic, cardiogenic, spinal, hypovolemic, anaphylactic
- Drug Overdose impairing vital functions
- Life-threatening hyper/ hypothermia
- Thyroid Storm or Addisonian Crisis
- Cerebral hemorrhage of any type
- New-onset paralysis
- Non-hemorrhagic strokes with vital function impairment Status epilepticus
- Acute Myocardial Infarction

- Cardiac Arrhythmia requiring emergency treatment
- Aortic Dissection
- Cardiac Tamponade
- Aneurysm; thoracic or abdominal -- leaking or ruptured
- Tension Pneumothorax
- Acute respiratory failure, pulmonary edema, status asthmaticus
- Pulmonary Embolus
- Embolus of fat or amniotic fluid
- Acute renal failure
- Acute hepatic failure
- Diabetic Ketoacidosis
- Lactic Acidosis
- DIC or other bleeding diatheses - hemophilia, ITP, TTP, leukemia, aplastic anemia
- Major Envenomation by poisonous reptiles
SIDE NOTE: ADDITIONAL INDICATIONS
CRITICAL CARE VITAL SIGNS AND LAB VALUES

• Abnormal VITAL SIGNS to consider for CCT:
  • $O_2$ Sat (pulse ox) $\leq 90$
  • Respirations (adult/child) $\geq 30$
  • Respirations (adult/child) $< 5$
  • Respirations (adult/child), intercostal retractions, nasal flaring, Cheyne-Stokes or tachypnea
  • Temperature (adult) $> \sim 104^\circ$F
  • Temperature (adult) $< \sim 95^\circ$
  • Heart rate/pulse (adult) $> 120$
  • Heart rate/pulse (adult) $< 40$
  • Systolic BP (adult) $> \sim 200$ or $< \sim 90$
  • Diastolic BP (adult) $> \sim 110$ or $< \sim 40$
  • Glasgow Coma Score (GCS) $\leq 13$
Other Labs:

- ABGs
  - pCO2 < 30 or > 50 mm Hg
  - pO2 < 60 mm Hg
  - O2 Sat (pulse ox) < or = 90%
  - pH < 7.3 or > 7.5
- Hemoglobin (Hbg) < or = 9
- Troponin above normal
- CK MB > than or = 5%
- WBC < 2K or > 20K/μl

Electrolyte Imbalance:

- Sodium (Na) < 120 or > 150
- Potassium (K) < 2 or > 5.5
- Calcium (Ca) < 6 or > 13 mg/dl
- Magnesium < 1.5 or > 5 meq/L
- Bicarbonate (CO2) < 10 or > 40 mEq/L
- Platelet count < 20,000
As above in additional 30-minute increments. Record the TOTAL critical care time. The first 30-74 minutes’ equal code 99291. If used, additional 30-minute increments (beyond the first 74 minutes) are coded 99292. Medicare does not pay for code 99292 because it is considered packaged into 99291; however, the services should be reported as appropriate.
In addition to 99291, designated trauma centers may report the Trauma Team Activation code G0390 when a trauma team was activated and all other trauma activation criteria are met.
WHAT’S NEEDED FOR NURSE DOCUMENTATION??

- Time of notification from EMS
- What was reported by EMS
- Full names of providers contacted and time of contact
- Activation of trauma team
- Documentation of Critical Results
  - Date, time and name of person receiving the critical result
  - Date, time and name of provider given the results
- Measures taken to correct the critical results, if any
- Patient’s response to treatment
• Key Documentation Elements:
  • Where telehealth unit was used
  • Time telehealth was connected and by whom
  • Name and specialty of physician
  • Time physician evaluation started
  • If orders were received from telehealth physician
  • Time telehealth visit disconnected/concluded
  • Any follow-up recommendations from telehealth physician
  • Date/Time of appointments and name of physician
## CHARGE SHEET
### EXAMPLES/DISCUSSION

#### Emergency Department Charge Sheet

*Enter a numeric value in the Qty box to select the appropriate charges.*

<table>
<thead>
<tr>
<th>POINT VALUE - 20 Qty</th>
<th>POINT VALUE - 30 Qty</th>
<th>POINT VALUE - 35 Qty</th>
<th>POINT VALUE - 45 Qty</th>
<th>Qty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ace Wrap</td>
<td>Admit – Acute Care</td>
<td>Admit – AC w/Trauma</td>
<td>Antivenin Admin.</td>
<td></td>
</tr>
<tr>
<td>Arm Slings</td>
<td>Admit – Observation</td>
<td>Admit – OB w/Trauma</td>
<td>Blood Admin.</td>
<td></td>
</tr>
<tr>
<td>Cervical Collar</td>
<td>Bear Hugger</td>
<td>AMA</td>
<td>Wound Care &gt; 60 min</td>
<td></td>
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<tr>
<td>BP Orthostatics</td>
<td>Bleeding Control</td>
<td>Charcoal Admin.</td>
<td></td>
<td></td>
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<tr>
<td>Ear Exam - Tray</td>
<td>Wound Care – 15 min</td>
<td>Wound Care – 30 min.</td>
<td>External Pacer</td>
<td></td>
</tr>
<tr>
<td>Fetal Heart Tones</td>
<td>Clavicle Strap</td>
<td>Cardiac Monitor</td>
<td>Electrocautery</td>
<td></td>
</tr>
<tr>
<td>Lab</td>
<td>Dressing Minor</td>
<td>Combative Patient</td>
<td>IV Insertion – 3 lines</td>
<td></td>
</tr>
<tr>
<td>Meds – PO each</td>
<td>Enema – Caustics – each</td>
<td>Copine Precautions</td>
<td>Transfer Other Facility</td>
<td></td>
</tr>
<tr>
<td>Meds – topical each</td>
<td>Education</td>
<td>Dressing – Major</td>
<td>Decontamination</td>
<td></td>
</tr>
<tr>
<td>Ngs Assessment</td>
<td>Eye Exam - Tray</td>
<td>ERG - each</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O2 – Cannula</td>
<td>Eye – Visual Acuity</td>
<td>Enema – S3</td>
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<tr>
<td>Suppository</td>
<td>Eye Patch</td>
<td>Eye / Ear Irrigation</td>
<td></td>
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<tr>
<td>Urine Collection / Dip</td>
<td>Foley Cath – Unicorn.</td>
<td>Foley Cath. – Con</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital Signs – Initial</td>
<td>GT Care</td>
<td>IV Insertion – 2 lines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital Signs – Repeat</td>
<td>Glucometer – each</td>
<td>IV Insertion – difficult</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray unaccompanied</td>
<td>IV Insertion – 1 Line</td>
<td>NG Tube</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT unaccompanied</td>
<td>Infusion Pump &gt;= 2 or more each</td>
<td>Chaperoned Pelvic or Rectal Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound unaccompanied</td>
<td>Fluid warmer</td>
<td>NT/ET Suctioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuro checks</td>
<td>O2 Mask</td>
<td>Restraine Application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal by Nurse</td>
<td>X-ray accompanied</td>
<td>CT accompanied</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Straight Cath.</td>
<td>Disch Instructions</td>
<td>Ultrasound accompanied</td>
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<tr>
<td></td>
<td>Discharge Meds &gt; 2</td>
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</tbody>
</table>

#### Total

<table>
<thead>
<tr>
<th>Qty</th>
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<tbody>
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</tbody>
</table>

*Select the charges below by entering a numeric value in the appropriate box.*

- **Level 1**: (0-60) 30400181
- **Level 2**: (61-125) 30400173
- **Level 3**: (126-175) 30400155
- **Level 4**: (176-235) 30400157
- **Level 5**: (236-300) 30400140

**Trauma Team Activation** 30500298

*Charge ALLOWED w/ED Level & Critical Care*

**Critical Care - Number of Minutes in Critical Care**

*Charge NOT ALLOWED w/ED Level*

**Blood Alcohol Draw Fee** 30400041

*Critical Care is constant observation involving a 1:1 nurse to patient ratio.*

**DATE:** ___________________ **FORM COMPLETED BY:** ___________________
**CHARGE SHEET**

**EXAMPLES/DISCUSSION:**

**PROCEDURES**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anoscopy</td>
<td>Defibrillation</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>Ear Rem Impact Cerumen</td>
</tr>
<tr>
<td>Burn Dressing</td>
<td>Epistaxis Control</td>
</tr>
<tr>
<td>Cast Application</td>
<td>External Cardioversion-Elective</td>
</tr>
<tr>
<td>Cast Breakage</td>
<td>FB Rem Eye</td>
</tr>
<tr>
<td>Cast Removal</td>
<td>FB Rem Nose/Ear/Throat</td>
</tr>
<tr>
<td>Cath Urethra-Straight</td>
<td>FX Treatment</td>
</tr>
<tr>
<td>Cath Urethra-Foley</td>
<td>Gastronomy Tube</td>
</tr>
<tr>
<td>Central Line Placement</td>
<td>Hemorrhage Repair-EENT</td>
</tr>
<tr>
<td>Chest Tube Placement-Thoracotomy</td>
<td>Immunize Admin Influenza</td>
</tr>
<tr>
<td>Conscious Sedation-IM, IV or INH</td>
<td>Immunize Admin Tetanus</td>
</tr>
<tr>
<td>Conscious Sedation-Oral or Nasal</td>
<td>Intraosseous Needle Placement</td>
</tr>
<tr>
<td>CPR</td>
<td>Intubation</td>
</tr>
<tr>
<td>Debridement</td>
<td>IV Infusion First Hr</td>
</tr>
<tr>
<td>Drug Injection-IM or SQ subsequent</td>
<td>IV Infusion Ea. Add. Hr.</td>
</tr>
<tr>
<td>Drug Injection-IV</td>
<td>Joint Aspiration</td>
</tr>
<tr>
<td>Drug Injection-IV subsequent</td>
<td>Joint Injection</td>
</tr>
<tr>
<td>Drug Inj-IV subsequent</td>
<td>Joint Reduction</td>
</tr>
<tr>
<td>Drug Injection IV w/Additive</td>
<td>Laceration Repair</td>
</tr>
<tr>
<td>Drug Inj IV w/Additive subsequent</td>
<td>Lumbar/Spinal Puncture</td>
</tr>
</tbody>
</table>

*Procedures (one time only charge)*
BUNDLED SERVICES AND SEPARATELY BILLED
### CRITICAL CARE BUNDLED SERVICES

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpretation of cardiac output measurements</td>
</tr>
<tr>
<td>Pulse oximetry</td>
</tr>
<tr>
<td>Chest x-rays, Professional component</td>
</tr>
<tr>
<td>Blood gases, and information data stored in computers - e.g., ECGs, blood pressures, hematologic data</td>
</tr>
<tr>
<td>Gastric intubation</td>
</tr>
<tr>
<td>Transcutaneous pacing</td>
</tr>
<tr>
<td>Ventilator management</td>
</tr>
<tr>
<td>Peripheral vascular access procedures</td>
</tr>
</tbody>
</table>
SERVICES DOCUMENTED SEPARATELY (NOT A COMPLETE LIST)

<table>
<thead>
<tr>
<th>Endotracheal Intubation</th>
<th>CPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Splinting *</td>
<td></td>
</tr>
<tr>
<td>Central vascular/venous access</td>
<td>Electrical cardioversion *</td>
</tr>
<tr>
<td>IO placement</td>
<td>Bronchoscopy *</td>
</tr>
<tr>
<td>Transvenous pacing *</td>
<td>Laceration Repair *</td>
</tr>
<tr>
<td>Chest tube placement *</td>
<td>Radiology Interpretations &amp; Report</td>
</tr>
<tr>
<td></td>
<td>IV infusions/injections</td>
</tr>
<tr>
<td></td>
<td>Bladder catheterization</td>
</tr>
</tbody>
</table>

* Remember to Document Moderate Sedation Time
## Subtracting Time for Separately Reportable/Non-Bundled Procedures

### Example of Standard Times Used for Calculations

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>Professional Time (MIN.)</th>
<th>Facility Time (MIN.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>31500</td>
<td>Endotracheal Intubation</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>31603</td>
<td>Transtracheal Tracheostomy</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>31605</td>
<td>Cricothyroid</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>3200-32421</td>
<td>Puncture thoracentesis</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>32422</td>
<td>Thoracentesis w/ tube insertion</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>32551</td>
<td>Thoracostomy/Chest Tube insertion</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>33010</td>
<td>Pericardiocentesis</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>33210</td>
<td>Tempory transvenous pacing</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>36555-36556</td>
<td>Placement of non-tunneled centrally inserted central venous catheter</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>36680</td>
<td>Intraosseous infusion</td>
<td>N/A</td>
<td>2 (if not bundled with another procedure)</td>
</tr>
<tr>
<td>51702-51703</td>
<td>Bladder catheterization</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>92950</td>
<td>CPR</td>
<td>Total time compressions are being performed or total time between CPR start and CPR stop time</td>
<td>Same as professional</td>
</tr>
<tr>
<td>93010</td>
<td>12 Lead ECG</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>70000-70099</td>
<td>Echo cardiograms and duplex scans</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td>96360-96368</td>
<td>IV Infusions</td>
<td>N/A</td>
<td>5 (each separate infusion)</td>
</tr>
<tr>
<td>96372-96376</td>
<td>Injections</td>
<td>N/A</td>
<td>1</td>
</tr>
</tbody>
</table>
QUESTIONS?
IF A TRAUMA ACTIVATION NEEDS TO BE STARTED WITH THE 3RD PARTY EMS, IS IT STILL CONSIDERED A 3RD PARTY IF THE HOSPITAL OWNS THE EMS SYSTEM?

The notification simply has to be prehospital. The fact that the ambulance / EMS is hospital owned does not impact the prehospital notification requirement.
LAST YEAR WE WERE TAUGHT WE COULD NOT CHARGE CC CHARGES FOR A PATIENT WITHOUT A PULSE. HAS THAT CHANGED?

That has not changed. This is due to the fact that CPR is a separately billable service. The “critical care” that is provided to a patient without a pulse is CPR. Therefore, you would not have additional critical care services until the patient has a pulse.
IN A MASS CASUALTY SETTING, DO WE CHARGE THE TRAUMA ACTIVATION FOR EACH PERSON?

A facility can include the trauma activation code on the bill for each patient to which all of the trauma activation documentation requirements are met. Each chart must support the prehospital notification requirement as it relates to the specific patient.
CAN THE PRESENCE OF A RADIOLOGY REPORT OR LAB RESULTS IN THE RECORD JUSTIFY THE PREP FOR LAB OR X-RAY?

No. The presence of the radiology report or lab result does not justify the nursing or other staff involvement in the prep for the diagnostic test. The documentation from the discipline that performed the prep service must support that this service was provided.
CAN I USE NURSING DOCUMENTATION AS WELL AS PROVIDER DOCUMENTATION TO CODE CRITICAL CARE?

For purposes of supporting the hospital’s critical care services, yes, documentation from all the disciplines who participated in the critical care services provided to the patient can and should be utilized when determining if critical care services can be coded. See slide 29.

Under Outpatient Prospective Payment System (OPPS), the time that can be reported as Critical Care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.
IS THE CRITICAL CARE TIME REQUIREMENT NURSING CRITICAL CARE TIME OR PHYSICIAN CRITICAL CARE TIME?

Under Outpatient Prospective Payment System (OPPS), the time that can be reported as Critical Care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once. (See Slide 29)
REFERENCES & RESOURCES

• American College of Emergency Physicians (ACEP); *ED Facility Level Coding Guidelines*

• American Academy of Professional Coders (AAPC); Casssano, Holly J.; *Ten Commandments of Critical Care in the ER*

• American Academy of Professional Coders (AAPC); Verhovshek, John; *Visit the Facility Side of ED Coding*

• *Documentation of Critical Care: The Provider and the Facility,* Virginia Gleason, JD, MPA; nThrive Education; [www.nthrive.com](http://www.nthrive.com)
FOR INFORMATION ON PROVIDER DOCUMENTATION OF CRITICAL CARE GO TO:

WWW.MTPIN.ORG/CRITICAL-CARE-DOCUMENTATION-BILLING/