



**POLICY SUBJECT:**

*Critical Care Documentation*

**EFFECTIVE DATE: 08/12/2011**

*To be reviewed every three years by  
Ethics & Compliance Committee*

**Policy on Critical Care Documentation**

**A. Purpose**

The purpose of this policy is to meld all of the rules for critical care coding into a cohesive policy appropriate for Sound Physicians' physician and non-physician billing.

**B. Definitions**

1. **Critical Illness** – A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or sudden, clinically significant or life threatening deterioration in the patient's medical condition.
2. **Critical Care** – Critical care is the direct delivery by a physician or other appropriate health care practitioner of medical care for a critically ill or critically injured patient. Critical care involves highly complex 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.
3. **Critical Care Services** - Critical care services are a practitioner's direct personal supervision and management of life and organ supporting interventions which may require frequent manipulation by that practitioner. Withdrawal of or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition.

## C. Policy

1. **General** – Sound Physicians bills for critical care services when both the practitioner’s services and the patient’s condition meet the requirements for critical care billing. Sound Physicians’ documentation standards include the Medicare requirements. Sound Physicians’ applies a uniform documentation standard for all services, but bills according to specific payor requirements.
2. **Critical Care Time** – Critical care services are billed according to time spent in work directly related to the patient’s care, including both time spent at the bedside providing direct care as well as time spent indirectly elsewhere on the floor or unit. The attending physician must devote his or her full attention to the patient receiving critical care for the time claimed. A physician providing critical care cannot bill for services to any other patient or for teaching services during the same period of time.
  - a. Examples of indirect services that qualify for critical care services include but are not limited to:
    - Time spent on the unit reviewing test results and/or imaging studies;
    - Time spent discussing the critically ill patient’s condition with other involved medical and nursing staff;
    - Time personally spent in documenting progress notes, clinical findings and orders in the medical record;
    - Time spent documenting the performance of specific services and other pertinent information necessary for the orderly care of the patient; and
    - When the critically ill patient is unable physically or is incompetent mentally to participate in a relevant discussion, time spent on the floor or unit with family members or surrogate decision makers for the purpose of obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment or limitation(s) of treatment may also be reported as critical care. This discussion must be necessary and appropriate for the proper care of the critically ill patient.
  - b. Activities that may not be included in the time counted as critical care services:

- Time spent in activities that occur outside 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 services since the physician is not immediately available to the patient.
- Time spent in activities that do not directly contribute to the care or treatment of the patient may not be reported as critical care even if they are performed in the critical care unit. Some examples include time spent participating in unit administrative meetings, telephone calls to discuss other patients or telephone calls to family members to advise them of the progress of a patient; and
- Time spent in teaching sessions with residents may not be counted as critical care time whether conducted on rounds or in other venues.
- Time spent performing separately billable services (e.g., bronchoscopy, central venous catheter placement, cardiopulmonary resuscitation).

### 3. **Teaching Physician Rules and Critical Care Services**

- a. Time spent teaching may not be counted towards critical care time.
- b. Time spent by resident in the absence of the Teaching Physician is not counted toward critical care time.
- c. The Teaching Physician must be present for all critical care time billed. Only time spent by the resident and the Teaching Physician together with the patient or time spent by the Teaching Physician alone with the patient may be counted towards critical care time.
- d. Linking to a resident note alone does not support critical care services. If the Teaching Physician links to a resident’s note, the critical care note must specifically state that the teaching time is excluded or that the Teaching Physician was physically present during all critical care services provided and indicates the personal activities of the Teaching Physician (e.g. “I spent 50 minutes providing critical care.”).

### 4. **Coding Same Day, Same Specialty**

- a. When more than one Sound Physicians’ practitioner sees a patient on the same calendar day, all critical care services must be billed under the name of the practitioner who rendered the most critical care time that day. If all

practitioners delivered equal amounts of critical (e.g. both provided 30 minutes of critical care services), critical care will be billed under the practitioner who delivered the critical care first.

- b. Both physicians and non-physician practitioners may provide critical care services if this is within the scope of their licenses and privileges. However, critical care services may not be shared. If a physician and a non-physician practitioner both provider critical care services on the same date, the services should be billed under the name of the individual who provided the most care on that date.

## **D. Procedures**

1. **Documentation Requirements** – Each daily note must document the details of the patient’s condition and care to support the ongoing critical illness and high complexity of decisions make for that date including the following:
  - a. **Personal Time Statement** – The practitioner must personally document the time he or she personally spent providing critical care services. If documentation supports activities that cannot be counted towards critical care time that time must be explicitly excluded. This includes:
    - Teaching time if there is a link to a resident’s note;
    - Time with family unless it meets the surrogate decision-making exception described above; and
    - Time associated with separately billable procedures and services.
  - b. **Critical Illness** – The documentation for each date must include specific current conditions and diseases that require the level of care.
  - c. **Highly Complex Decision Making/Critical Care Interventions** – Daily documentation must specify the decisions made and critical interventions provided including:
    - A summary of services/interventions personally performed; and
    - If illnesses are established or stabilized, the ongoing critical care status and services provided.