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Hospital Pays $5.3M to Settle CMP Case Over Critical Care, Admissions

By Nina Youngstrom

Billing for inpatient admissions and critical care, a sometimes-fluid area as patients move in and out of stability, were at the heart of the University of California (UC) San Diego Health System's $5.3 million settlement with the HHS Office of Inspector General. UC San Diego Health System agreed to settle allegations under the Civil Monetary Penalties Law that it billed Medicare, Medi-Cal and TRICARE for inpatient admissions that should have been outpatient or observation services, and charged for critical care management services without supporting documentation, according to the settlement.

UC San Diego Health System voluntarily reported problems to OIG and was accepted into its Self-Disclosure Protocol in June 2016. OIG contends UC San Diego Health System billed for critical care CPT codes 99291 or 99292 without supporting documentation from May 10, 2010, through Sept. 30, 2015. OIG also alleged the academic health system submitted claims for inpatient services it should have known were billed as outpatient or observation services from May 10, 2010, to July 19, 2015, to Medicare; from June 1, 2013, through May 9, 2016, to Medi-Cal; and from May 10, 2010, through May 6, 2016, to TRICARE. Of the settlement amount, $3.4 million is restitution, the settlement states.

In a statement, UC San Diego Health said that when it found out about its billing issues, "UC San Diego Health engaged an independent law firm to conduct an internal investigation. In addition to self-reporting these matters, UC San Diego Health promptly implemented a series of corrective actions—including governance changes, education and training, and claim processing and integrity improvements. UC San Diego Health is committed to compliance and is gratified to put this matter behind it."

With Critical Care, Time Is of the Essence

On its face, critical care billing is straightforward—"you have a critical care patient, and you need to be urgently and critically intervening and document your time"—but the error rate is high, says Betsy Nicoletti, a consultant in Northampton, Massachusetts. In 2018, the Comprehensive Error Rate Testing (CERT) contractor reported a 19.7% error rate, with 40% attributed to insufficient documentation, she says.

"I've been doing a lot of critical-care audits lately and trying to look at these notes in a way to tell" whether the patients are critically ill, whether the physicians intervened in a way that's critical and urgent, and whether the time was documented consistent with the code billed," Nicoletti says. The findings are not always encouraging.

Critical care is a time-based code, with coding based on the total number of minutes spent providing critical care in a calendar day. For example, CPT code 99291 is for one unit of critical care—30 to 74 minutes. CPT code 99292 is the same, plus an additional 30 minutes for a critically ill patient. If physicians are treating two critical care patients at the same time, they have to divide the minutes spent with patient A versus patient B, rather than attributing all the minutes to both patients, and subtract minutes for procedures, including insertion of central lines, she says.

Physicians "may be billing for more minutes than we can see in the medical record," she says.

Medicare only pays for critical care codes, which have a high relative value unit, when patients are actually urgent and critical.[1] As soon as patients stabilize, physicians should switch to other evaluation and management (E/M) codes. Suppose a patient suffers major trauma and shock, with extremely low blood pressure. "They're giving him pressors to keep his pressure up. He will die if you don't intervene," Nicoletti says. "If he crashed and you give him pressors, that's critical care." Once the patient is stable, that's no longer critical care.

"Sometimes physicians think any really sick patient is critical, or if they're in the [intensive care] unit, they should bill critical care," she says. They write "the patient is stable today, is breathing more normally but will keep in the unit one more day." The patient may stay put, but the physician billing codes should change. "I tell doctors and coders, 'The last day they are in the unit or the day they are discharged home from the unit, look and see if they are really critical," Nicoletti says. "Sometimes they don't document interventions or time. They just write, 'Critical care greater than 30 minutes.'"

Unique Problems With Copy and Paste

Teaching hospitals may mistakenly count the minutes that residents spend toward the teaching physician's critical care time. "A critical care, pulmonology or intensivist resident might spend an hour with the patient and write a beautiful note, but the teaching facility can only count the attending's time," Nicoletti says. The resident's note can only support the fact the patient was critically ill and the urgent and critical care interventions.

Copy and paste, a documentation shortcut in electronic health record systems,[2] is also increasing the risk of critical care billing errors in what's already a more challenging kind of documentation. "Because we copy and paste so much of yesterday's note into the next day and the next day, it can be difficult to tell the patient is critically ill," she explains. The forwarded notes overshadow the notes that show the critical interventions from the previous 24 hours, which would indicate whether the patient is still critically ill. "It's almost shorthand," Nicoletti says. The physicians and nonphysician practitioners "know what they are telling us, but they don't clearly document the status of that patient's condition."

It complicates matters that the norm for documenting a critical care note is not to always list the patient's diagnoses in the assessment and plan. "It doesn't say sepsis or stroke and the status of the condition," she explained. "It goes system by system." For example, the physician will state the neurological or respiratory status and whether the patient was given a gastrointestinal prophylaxis to prevent an ulcer. "It makes it harder to tell just how sick the patient is, particularly if the auditor is not an expert in critical care or doesn't have a strong clinical background."

Her tips:

- Update the severity of the patient's condition every day.
- Document the time in the medical record. "You don't include the time for any procedures you do because you get paid separately for them," Nicoletti says. "If they pay you to insert the central line, you have to be clear the critical care time doesn't include time for insertion of the central line."
- Be careful about the last day the patient is in intensive care. "If they are being discharged from the unit, they are probably not still critically ill, so you don't want to include that time," she says.

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1 Nina Youngstrom, "Tips for Coding Critical Care Services in Medicare," *Report on Medicare Compliance* 28, no. 35 (October 7, 2019).
2 Nina Youngstrom, "Copy Paste, Other EHR Shortcuts Threaten Integrity of Chart; CPT Changes May Help," *Report on Medicare Compliance* 28, no. 17 (May 6, 2019), http://bit.ly/2LJpfWl.