Checklist: Critical care services documentation

Documentation requirements

This checklist is an aid to assist providers when responding to medical record documentation requests pertaining to Drugs and Biologicals.

It is the responsibility of the practitioner who provided the services to ensure the correct submission of documentation.

Note: To print and include this checklist with your medical documentation, click the print button at the end of this form.

- ☐ Documentation is for the correct date of service billed.
- ☐ Documentation is for the correct beneficiary billed.
- ☐ Documentation contains a valid and legible signature of performing provider.
- ☐ Documentation demonstrates high complexity decision making to assess, manipulate, and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition.
- ☐ Documentation supports the treatment was directly delivered for 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 threatening deterioration in the patient's condition.
- ☐ Documentation to support total treatment time. The Current Procedural Terminology (CPT®) critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. Non-continuous time for medically necessary critical care services may be aggregated.
- ☐ Documentation supports that the duration of critical care services reported was time the physician spent evaluating, providing care and managing the critically ill or injured patient's care.
- ☐ Documentation to support that time was spent at the patient's immediate bedside or elsewhere on the floor or unit so long as the physician is immediately available to the patient. For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor may be reported as critical care, even when it does not occur at the bedside, if this time represents the physician's full attention to the management of the critically ill/injured patient.
- ☐ Documentation in the medical record should document time involved in the performance of separately billable procedures as these are not counted toward critical care time.
- ☐ Documentation includes record of family discussions, to include the substance of those discussions as critical care CPT codes 99291 and 99292 include pre and post service work. CMS internet-only manual (IOM) Publication 100-04 Claims Processing Manual, Chapter 12 Sections 30.6.9 and 30.6.12 provides guidelines for items include and not included in this pre and post work.
- ☐ If teaching, documentation supports teaching guidelines were met during the critical care service.

Disclaimer: This checklist was created as an aid to assist providers. This aid is not intended as a replacement for the documentation requirements published in national or local coverage determinations, or the CMS's documentation guidelines. It is the responsibility of the provider of services to ensure the correct, complete, and thorough submission of documentation.

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