IV. Global Per Diem Critical Care Codes: Direct Supervision and Reporting Guidelines

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The delivery of neonatal and pediatric critical care has undergone significant changes in the last 2 decades, incorporating expanded technology and services as well as new patterns of delivery of care. Neonatal intensive care units (NICUs) have grown dramatically as improvements in perinatal care have led to markedly improved survival rates of the small preterm neonate. There has also been a growing national population with major socioeconomic shifts. These changes have led to a large increase in NICU beds. Simultaneous to these demographic and epidemiologic changes, serious Accreditation Council for Graduate Medical Education and Residency Review Committee limitations in resident and fellow work hours and, more specifically, to those hours allocated to clinical care in the NICU have reduced the number of house officers providing neonatal critical care. There has been a rapid expansion of other neonatal providers working as a team in partnership with an attending physician to meet expanding bedside patient care needs. These nonphysician providers (NPPs by Centers for Medicare & Medicaid Services nomenclature) are primarily neonatal nurse practitioners (NNPs). They have assumed a critical role in assisting the attending physician in caring for this expanding population of patients.

Neither NNPs nor residents or fellows are substitutes for the attending physician, who continues to remain fully in charge of these patients and directly supervises NNPs and residents or fellow physicians as well as other ancillary providers (eg, registered nurses, respiratory therapists, nutritionists, social workers, physical therapists, occupational therapists), who all play important contributory roles in the care of these critical patients. Unlike the supervision for residents or fellows enrolled in graduate medical education programs, the attending physician's supervision and documentation of care provided by NNPs is not covered by Physicians at Teaching Hospitals (PATH) guidelines. The attending physician is not "sharing services" with the NNP or resident or fellow. The attending physician (the physician responsible for the patient's care and reporting the service for that date) remains solely responsible for the supervision of the team and development of the patient's plan of care. In developing that plan, the attending physician will use the information acquired by and discussed with other members of the care team, including that of the resident or fellow and NNP.

When supervising residents or fellows, the attending physician will use this collective information as part of their own documentation of care. The attending physician must demonstrate in their own note that they have reviewed this information, performed their own focused examination of the patient, documented any additional findings or disagreements with the resident's or fellow's findings, and discussed the plan of care with the resident or fellow to meet PATH guideline requirements. These rules allow the attending physician to use the resident or fellow note as a major component of the attending physician's own note and in determining the level of care the attending physician will report for that patient on that date.

Physicians at Teaching Hospitals guidelines do not apply to patients cared for by NNPs because NNPs are not enrolled in postgraduate education. This is true whether the NNP is employed by the hospital, medical group, or independent contractor. Centers for Medicare & Medicaid Services rules prohibit NPPs (in this case NNPs) and the reporting physician from reporting "shared or split services" when critical care services are provided. The reporting physician may certainly review and use the important information and observation of the NNPs, but the physician also provides their own evaluation along with documentation of the services they personally provided. Documentation expectations for the reporting physician include review of the notes and observations of other members of the care team; an independent-focused, medically appropriate bedside examination of the patient; and documentation that the reporting physician has directed the plan of care for each patient whose services the physician reports. In many critically ill but stable patients, this requirement can be met by a single daily note. In situations in which the patient is very unstable and dramatic changes and major additional interventions are required to maintain stability, more extensive or frequent documentations are likely and may be entered by any qualified member of the care team.

In some states, NNPs, through expanded state licenses, are permitted to independently report their services. If these NNPs are credentialed by the hospital and health plan to provide critical care services and procedures and possess their own National Provider Identifier (NPI), they may independently report the services they provide. In these states, they can function as independent contractors or as employees of the hospital or a medical group, reporting their services under their own NPI. It is important to emphasize again that the NNP and the physician do not report a shared critical care service. Critical care services are reported under the NNP or physician NPI, dependent on who was primarily providing the patient service and directing the care of the patient. Two providers may not report a global per diem critical care code (eg, **99468**, **99469**) on the same date of service. In most situations, the physician is serving as responsible and supervising provider and the NNP (employed by the group or hospital) is acting as a member of the team of providers the physician supervises.

Physician Supervision

Current Procedural Terminology® states that codes **99468–99476** (initial and subsequent inpatient neonatal and pediatric critical care, per day, for the evaluation and management of a critically ill neonate or child through 5 years of age) are used to report services provided by a physician directing the inpatient care of a critically ill neonate or young child. *Current Procedural Terminology* makes clear that the reporting provider is not required to maintain a 24-hour, in-hospital physical presence. *Current Procedural Terminology* notes that the physician or other reporting provider must be physically present and at bedside at some time during the 24-hour period to examine the patient and review and direct the patient's care with the health care team. The physician must be readily available to the health care team if needed but does not have to provide

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24-hour, in-house coverage. One provider reports the appropriate code only once per day, even though multiple providers may have interacted with the patient during the 24-hour global period (eg, on-call physician, NNP).

Medical Record Documentation

The medical record serves the dual purposes of communicating the medical status and progress of the patient and documenting the work of the reporting provider.

Based on the information presented previously, it is the suggestion of the American Academy of Pediatrics Committee on Coding and Nomenclature that the medical record documentation by the reporting physician or NPP supporting critical care codes should contain the following at a minimum:

- Documentation of the critical status of the infant or child (This is not to be inferred.)
- Documentation of the *bedside* direction and supervision of all aspects of care
- Review of pertinent historical information and verification of significant physical findings through a medically indicated, focused patient examination
- Documentation of all services provided by members of the care team and discussion and direction of the ongoing therapy and plan of care for the patient
- Additional documentation of any major change in patient course requiring significant hands-on intervention by the reporting provider

The following are *not* required of the reporting physician or NPP:

- Twenty-four–hour presence in the facility or bedside
- Two or more documented notes a day
- Personally ordering all tests, medications, and therapies
- Performing all or any of the bundled procedures
- Documenting a daily comprehensive physical examination
- Documenting stable or unstable status so long as the infant or child meets critical care criteria

Each patient has a different level of illness(es), grouping of diagnoses, and medical and socioeconomic problems. The following are only examples of notes and should not be interpreted as requirements in every note for each patient:

A. The following note represents a sample attestation that could be appended to a resident or fellow's progress note:
"I have reviewed the resident's progress note and the baby has been seen and examined by me. He continues to be critically ill with respiratory failure requiring mechanical ventilation. I concur with the resident's evaluation and findings, though I did not appreciate abdominal tenderness on examination. I have discussed and agreed on a plan of care with the resident."

B. The following 2 paragraphs represent a single sample documentation that a reporting physician might write when care is delivered by an NNP and physician team. This note could be appended by the reporting physician to the NNP documentation or written as separate physician documentation.
"(Name) has been seen and examined by me on bedside rounds. The interval history, laboratory findings, and physical examination of the patient have been reviewed with members of the neonatal team. The notes have been reviewed. All aspects of care have been discussed, and I have agreed on an assessment and plan for the day with the care team.
"(Name) continues to be critically ill, requiring high-frequency jet ventilation. On examination, her breath sounds are coarse but equal, there is no heart murmur, and the abdomen is soft and non-tender. Her oxygen requirements have been at 100% for the past 12 hours. She remains on antibiotics for *Proteus* sepsis. At the recommendation of infectious disease, we have changed her antibiotic coverage to cefotaxime and gentamicin. Her blood pressure is acceptable today, but her urine output is only at 1 mL/kg/h. We are watching this closely and may need to restart dopamine. She remains NPO and is on total parenteral nutrition."

Approach to Documentation

This information deals largely with neonatal care. However, the same coding and documentation principles apply for critical care services provided to all children through the age of 5 years. The guidelines provided in this statement represent clarification of documentation recommendations for this unique code set. They are intended to create clarity going forward for physicians and other parties as they incorporate this new guidance into their documentation processes. Physicians should structure their documentation such that on review of a medical record representing a physician-rendered per-day neonatal or pediatric critical care service, one should be able to discern the reporting physician's unique documentation in support of the physician's role in that patient's care. It is especially important that an electronic health record used in documenting these services be configured to uniquely identify the author of each entry and allow for timely response to requests for documentation substantiating billed services. It is equally as important to log out of the record when your documentation is complete.