Compliance Alert

SIU SOM Office of Compliance and Ethics

Critical Care Services

Critical Care Services CPT Codes	
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	each additional 30 minutes (add-on code)

Purpose

The Centers for Medicare and Medicaid Services (CMS) has specific requirements for coverage criteria and documentation for billing purposes. The purpose of this alert is to provide SIU HC physicians and non-physician practitioners (NPP) with guidance that ensures compliance with applicable laws and regulations as well as accurate coding.

Definitions

Critical Illness or Injury – 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.

Critical Care – Critical care involves **high complexity** medical decision making to **assess**, **manipulate**, and **support** vital system functions to treat single or multiple organ system failure and/or prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

Critical Care Services – providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the requirements.

Current Procedural Terminology (CPT) Codes for Critical Care Services

Critical care codes are time-based codes. The 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. For example, it can be a period of 50 minutes of continuous clock time or (5) 10 minute blocks of time spread over a given calendar date. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician.

- Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code.
- CPT code 99291 is used to report the first 30-74 minutes of critical care on a given date of service. This code should be used only once per date per patient by the same physician or physician group of the same specialty even if the time spent by the individual is not continuous on that date.
- CPT code 99292 may not be billed by itself. Report CPT code 99291 for the first 30 to 74 minutes. Use CPT code 99292 to report additional blocks of time, of up to 30 minutes each beyond the first 74 minutes of critical care.
- Hospital emergency department services are **not** payable for the same calendar date as critical care services when provided by the same physician to the same patient.

- ***Scenario*** – A patient arrives in the emergency department in cardiac arrest. The emergency department physician provides 40 minutes of critical care services. A cardiologist is called to the ED and assumes responsibility for the patient, providing 35 minutes of critical care services. The patient stabilizes and is transferred to the CCU. In this instance, the ED physician provided 40 minutes of critical care services and reports only the critical care code (CPT code 99291) and not also emergency department services. The cardiologist may report the 35 minutes of critical care services (also CPT code 99291) provided in the ED. Additional critical care services by the cardiologist in the CCU may be reported on the same calendar date using 99292 or another appropriate E/M code depending on the clock time involved.

- A Medicare contractor could request documentation to determine medical necessity at any time.
- If a physician or qualified NPP within a group provides "staff coverage" or "follow-up" for each other after the first hour of critical care services was provided on the same calendar date by the previous group clinician (physician or qualified NPP), the subsequent visits by the "covering" physician or qualified NPP shall be billed using the CPT critical care add-on code 99292.
    - ***Scenario*** – Drs. Smith and Jones, pulmonary specialists, share a group practice. On Tuesday Dr. Smith provides critical care services to Mrs. Benson who is comatose and has been in the intensive care unit for 4 days following a motor vehicle accident. She has multiple organ dysfunction including cerebral hematoma, flail chest and pulmonary contusion. Later on the same calendar date Dr. Jones covers for Dr. Smith and provides critical care services. Medically necessary critical care services provided at the different time periods may be reported by both Drs. Smith and Jones. Dr. Smith would report CPT code 99291 for the initial visit and Dr. Jones, as part of the same group practice would report CPT code 99292 on the same calendar date if the appropriate time requirements are met.
- The Table below shows the correct reporting of critical care services.

Total Duration of Critical Care	Appropriate CPT Code
Less than 30 minutes	Appropriate E/M code
30 - 74 minutes	99291 x 1
75 - 104 minutes	99291 x 1 and 99292 x 1
105 - 134 minutes	99291 x1 and 99292 x 2
135 - 164 minutes	99291 x 1 and 99292 x 3
165 - 194 minutes	99291 x 1 and 99292 x 4

Requirements of Critical Care Codes

- Critical care services must be medically necessary and reasonable.
- Critical care **can be provided on multiple days** as long as the patient continues to require the level of care defined above.
- Critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.
- Critical care is usually, but not always, given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department. However, critical care services can be provided in any location as long as the care provided meets the definition of critical care.

Examples of patients that <u>may</u> warrant critical care:

- An 81 year old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and pressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
- A 67 year old female patient is 3 days status post mitral valve repair. She develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.
- A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive 2 days after admission.
- A 68 year old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

Examples of patients whose medical condition may <u>not</u> warrant critical care:

- A dermatologist evaluates and treats a rash on an ICU patient who is maintained on a ventilator and nitroglycerine infusion that are being managed by an intensivist. The dermatologist should not report a service for critical care.
- Daily management of a patient on chronic ventilator therapy does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long term management of the ventilator dependence.
- Management of dialysis or care related to dialysis for a patient receiving End Stage Renal Disease (ESRD) hemodialysis does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long term management of the dialysis dependence.

Examples that may <u>not</u> meet the medical necessity criteria:

- Patients admitted to a critical care unit because no other hospital beds were available;
- Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose); and
- Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

If any of the above examples do not meet medical necessity criteria or the medical condition does not warrant critical care, clinicians should report their services <u>using the appropriate E/M code</u>.

- **Qualified Non-Physician Practitioners (NPP)** – Qualified NPP may provide critical care services when the services meet the definition and requirements of critical care services noted above. The services provided by the NPP would be reported under their individual National Provider Identifier (NPI) when billing. The services must be within the scope of practice and licensure requirements for Illinois. Collaboration, physician supervision and billing requirements must also be met. A physician assistant shall meet the general supervision requirements.
  - **A split/shared E/M service** performed by a physician and a qualified NPP of the same group practice **<u>cannot</u>** be reported as critical care service. Unlike other E/M services where a split/shared service is allowed the critical care service reported shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified NPP and shall not be representative of a combined service between a physician and a qualified NPP. Medically necessary visit(s) that do not meet these requirements shall be reported as a subsequent hospital care services.
- **"Full Attention" Requirement for Critical Care Service** – for any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide service to any other patient during the same time period. That time must

be spent at the immediate bedside or elsewhere on the floor or unit as long as the physician is immediately available to the patient. The time does not have to be continuous. Non-continuous time can be aggregated for that day.

Time spent in activities that occur outside of the unit or off the floor (i.e., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care because the physician is not immediately available to the patient.

Teaching Physician Requirements for Critical Care Billing

- **Documenting time** - Critical care codes are time-based; therefore, the teaching physician must be present for the entire period of time for which the claim is submitted (e.g., payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes).
    - Time spent teaching may **not** be counted towards critical care time. Time spent by the resident, in the absence of the teaching physician, cannot be billed by the teaching physician as critical care or other time-based services.
    - Only time spent by the resident **and** teaching physician together with the patient or the teaching physician alone with the patient can be counted toward critical care time.
- **Documentation** - A combination of the teaching physician's documentation and the resident's documentation may support critical services. The teaching physician may tie into the resident's documentation. However, the teaching physician's medical record documentation must provide substantive information including:
    - The total time the teaching physician spent providing critical care services;
    - That the patient was critically ill during the time the teaching physician saw the patient;
    - What made the patient critically ill;
    - The nature of the treatment and management provided by the teaching physician; and
    - The resident's and teaching physician's electronic signature and date.
- **Teaching Physician Attestation** - the appropriate teaching attestation should be documented in the medical record.

    Example of Unacceptable Attestation: "I came and saw (the patient) and agree with (the resident)".

    Example of Acceptable Attestation: "Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."

Bundled Services

The following services are included in critical care when performed during the critical period by the physician(s) providing critical care and should **not** be reported separately:

- Interpretation of cardiac output measurements (93561, 93562)
- Chest x-rays, professional component (71045, 71046)
- Pulse oximetry (94760, 94761, 94762)
- Blood gases
- Gastric intubation (43752, 43753)

- Temporary transcutaneous pacing (92953)
- Ventilator management (94002-94004, 94660, 94662)
- Vascular access procedures (36000, 36410, 36415, 36591,36600)

No other procedure codes are bundled into the critical care services. Therefore, other medically necessary procedure codes may be billed separately. The time involved in performing procedures that are not bundled into critical care (i.e., billed and paid separately) may not be included and counted toward critical care time. ***The physician's progress note in the medical record should document that time involved in the performance of separately billable procedures was not counted toward critical care time.***

Medicaid Requirements for Billing Critical Care

- Practitioner is to bill using the appropriate critical care CPT codes.
- Payments will be allowed to one practitioner for a maximum of one and one half (1½) hours of critical care daily for up to ten (10) days per hospital for a single participant.
  - Applies whether the service dates are consecutive or intermittent
  - Individual consideration will be given to charges for more than 10 days of critical care when documentation of medical necessity is submitted with the paper HFS 2360.
- When the practitioner performs a procedure or procedures other than those, which are included in the visit, and sees the patient in the critical/intensive care unit, **payment will be made for the procedure or the visit, but not both**. The allowable service is the one with the higher State maximum allowable fee.

Sources:

CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.12
IL HFS Handbook for Practitioners Chapter A-200, Section A-220.8
NGS Medicare Prepayment Review Identified Errors
Current Procedural Terminology (CPT) 2018

Questions regarding this Compliance Alert can be directed to:
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Revision History	*Author*	*Description of Revision*	*Approval*
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March 15, 2016	*Brooke Whitlow*	*Reviewed – no changes*	*Candice Long, Chief Compliance Officer*
April 5, 2018	*Brooke Mullink*	*Updates*	*Mary A Curry, CPC, CPMA Healthcare Compliance Officer*

NGS Medicare Prepayment Review Errors	
Error Examples	**How to prevent this type of error**
Medical necessity of critical care not supported in records - Documentation often failed to support the provision of critical care by the billing provider to a critically ill patient. In these cases, the services were usually recoded to the hospital evaluation and management (E&M) service supported by the medical record. Critical care services are allowed only if both the illness/injury and the treatment being provided meet the requirements for coverage.	Condition of the patient - There must be proof that the patient is in system failure or that system failure is imminent and that the services provided were necessary to prevent further life-threatening deterioration. It is important that the problems or diagnoses being managed are clearly documented. High complexity decision making and thought process - This *may* include interpretation of multiple types of testing or application of advanced technologies. The interventions taken to keep the patient from imminent deterioration should be evident when reviewing the medical record. Include relevant test results and physician orders. Accurately document all pertinent facts, findings and observations.
Time not documented in the medical record - Critical care is a time based service and the physician's progress notes must document the total time devoted to the provision of critical care services. Noting a range of minutes is not acceptable. If the record supported that critical services were provided, but the time was not documented, the service was denied for insufficient information.	Critical care is a time-based service, and for each date and encounter entry, the physician's progress note(s) must document the total time that critical care services were provided. This can be shown as the total number of minutes or by documenting the "time in" and "time out." Be careful to show that time involved in the performance of separately billable procedures was not counted toward critical care time. For example, 50 minutes devoted to critical care, excluding time spent in procedures billed separately.
Teaching Physician criteria not satisfied – For time based codes such as critical care, the teaching physician must be present for the entire period of time for which the claim is submitted. Time spent by the resident, in the absence of the teaching physician, cannot be billed by the teaching physician as critical care. Only time spent by the teaching physician was considered when reviewing these services.	Only time spent by the resident and teaching physician together with the patient or the teaching physician alone with the patient can be counted toward critical care time. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment. However, the teaching physician's documentation should include: (1) the time the teaching physician spent providing critical care, (2) the condition of the patient and (3) the nature of the treatment and management provided by the teaching physician.
Lack of acceptable Signature - The lack of a valid signature is often found when the medical records are in an electronic format. If an acceptable signature is not present and an attestation statement is not provided in a timely manner when requested, the service is denied.	E&M services require the signature of the performing provider.