

CPT Codes

- CPT Code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes)
 - CPT Code 99292 (each additional 30 minutes, list separately in addition to code for primary service)

Time Based Codes

- Time must be documented and includes the time spent evaluating, providing and managing care of the patient
- Time spent in activities that do not directly affect treatment of the patient (i.e., review of literature, teaching sessions) should not be included in the time for critical care
- Time spent providing and reviewing the following services is included in the time allowed for critical care:
 - Chest x-ray professional components (CPT codes 71010, 71015 and 71020)
 - Interpretation of cardiac output measurements (CPT codes 93561 and 93562)
 - Blood draw (CPT code 36415)
 - Gastric intubation (CPT codes 43752 and 73753)
 - Pulse Oximetry (CPT codes 94760, 94761 and 94762)
 - Temporary transcutaneous pacing (CPT code 92953)
 - Ventilator Management (CPT codes 94002-924004, 94660 and 94662)
 - Vascular access procedures (CPT codes 36000, 36410, 36415, 36591 and 36600)
 - Blood Bases; ECGs (CPT code 99090)
- If documentation supports medical necessity but the amount of time is NOT documented; the service will be denied. It is a requirement that the time spent providing the care be documented.
- If documentation supports critical care but is less than 30 minutes total in duration on a given calendar date, do not report the service as critical care. Use another appropriate E/M Code.

Supporting Documentation

Critical care must be medically necessary; involve high complexity decision making

- Was the physician called to see the patient on an emergency basis?
- Does the physician's note support evidence of threat of imminent deterioration of patient's condition?
- Is the critical illness or injury acutely impairing one or more body systems?
- Was the physician's services required to prevent further decline of a life threatening condition?
- Does the documentation indicate that an assessment of the patient and services of the physician were provided to support vital system function?



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- Does the documentation support that the provider was either at bedside or immediately available?
- Family discussions may be considered part of the critical care time when documentation supports:
 - Patient is unable to participate in giving history
 - Discussions are related to determining medically necessary treatment decisions
 - A summary of the medical necessity and/or content of the discussion

Shared/Split with a Nonphysician Practitioner (NPP)

E/M services performed by both a physician and a qualified NPP of the same group practice (or employed by the same employer) cannot be reported as critical care service. Critical care services are reflective of the care and management of a critically ill or critically injured patient by an individual physician or qualified NPP for the specified reportable period of time.

Critical Care Provided on Same Day as Another E/M Service

When critical care services are provided on the same date as an inpatient hospital or office/ outpatient evaluation and management service (furnished earlier on the same date at which time the patient did not require critical care), both the critical care and the previous E/M service may be paid if documentation in the patient's medical record supports the medical reasonableness and necessity of both services.

Palliative Care

Palliative care services CANNOT be submitted with critical care codes, as the palliative care does not meet the definition of critical care as stated above.

Global Surgery

- Critical Care should not be paid on the same calendar date the physician reports a procedure code with a global surgical period
- When critical care is billed with CPT modifier 25 the documentation must support both time and a service provided that is above pre-and/or post-operative care and associated with the procedure (applies to any procedure with 0, 10 or 90 day post-op period)
 - Only exceptions to this rule are CPR (CPT code 92950) and Insertion of Swanz-Ganz (CPT code 93503).



Teaching Physician & Critical Care

Teaching physician care must meet all criteria listed above along with the following:

1. Time teaching cannot be counted towards critical care
2. The documentation must support both the physician and resident were present for the critical care time billed
3. A combination of the resident and physician's documentation must support that critical care was necessary and the time billed was correct
4. Documentation must be acceptable for billing teaching physician services (Ref: Pub 100-4 Chapter 12 section 100.1):

Example: "Patient developed hypotension and hypoxia; I spent 45 minutes with the patient providing fluids, pressors, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."

If all criteria are not met the claim will be denied as not medically necessary.

References:

- CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 12: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>
- Definition of critical care: section 30.6.12
 - Critical care and another E/M service provided on the same date: section 30.6.12.H
 - Counting time and units: sections 30.6.12.E, F, and G
- Signature Requirements and Attestation Statement: http://www.cgsmedicare.com/kyb/claims/cert/cert_Signature_Requirements.html
 - CMS Medicare Program Integrity Manual (Pub. 100-8), chapter 3, section 3.3.2.4, "Signature Requirements."
 - MLN Matters article MM6698, "Signature Requirements for Medical Review"



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