2022 Critical Care Billing Changes (CMS)

Prepared by Office of Corporate Compliance

Outreach & Education Services

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Critical Care Services (non-Infant/Neonate)

This is an overview of the 2022 changes to Critical Care Service billing (99291-99292)

DISCLAIMERS:

- Information in this material has been provided to the best of our knowledge at the time of publication, and may be subject to revision pending further guidance or clarification by CMS and our local contractor NGS Medicare

- Some of the guidance in this material is specific to/intended for UCM practitioner workflows

Critical Care Services (non-Infant/Neonate)

99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

99292 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes

2022 CMS Changes:

1. Physicians or NPPs in the same specialty may bill concurrent critical care services
2. Split sharing of critical care services will be allowed with the use of **New Modifier FS**
3. CMS will pay for an ED visit or Other E/M service on the same day as Critical Care with use of **Modifier 25**
4. Critical Care Visits will be Separately Billable from Global Surgery when unrelated with the use of **New Modifier FT**
5. Critical Care Medical Record Documentation Requirements

Unchanged:

- CMS is officially adopting the CPT definition of critical care and bundling rules, which is unchanged for 2022 (see addendum)

Critical Care Services

Change 1: Physicians or NPPs in the same specialty may bill concurrent critical care services

Concurrent Care = more than one practitioner rendering similar services (i.e. hospital visits) during a period of time, payable if:

1. The patient's condition warrants the services of more than one physician on an attending (rather than consultative) basis
2. The individual services provided by each practitioner are reasonable and necessary
3. The services are non-duplicative

- **Different specialties:** concurrent care not seen as unusual as each specialty managing a distinct condition (usually with a different diagnosis)

- **Same specialties:** expected to occur infrequently and not be as reasonable since both practitioners would have the skills and knowledge to treat the patient (CMS updating stance relative to Critical Care 2022)

Historical Reimbursement Policy

- **Different specialty practitioners** may each be reimbursed for their critical care services on the same DOS:

Different Specialty
Cardiologist: 99291 & 99292
Surgeon: 99291 & 99292

- ***Prior to 2022*: Same specialty practitioners** billing critical care must bill and be paid as "one" when multiple practitioners provide services on the same DOS.

Same Specialty (Historical i.e. 2021)
Internist A: 99291 & 99292
Internist B: N/A, no additional billing

Critical Care Services

99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes

Change 1: Physicians or NPPs in the same specialty may bill concurrent critical care services

2022 Reimbursement Policy

In 2022, CMS is recognizing that critical care services may be provided concurrently by more than one practitioner in the same specialty if:

1. The Critical Care visit is medically necessary & 2. Each visit meets the definition of critical care

Same Specialty Critical Care 2022

A. Subsequent Care (i.e. 99292): CMS will allow each individual in the same specialty to report concurrent follow-up care for subsequent critical care time intervals. Each clinician will submit a charge under their NPI.

2022 Subsequent Care

Internist A = initial critical care ***75 min 99291 x 1 "Internist A"*** CPT 99291 is still only reported by one provider in same specialty per DOS

Internist B = subsequent critical care later in the day ***90 additional minutes 99292 x 3 "Internist B"***

B. Aggregate Time (adding times of > 1 practitioner): CMS will allow the time of multiple practitioners in the same specialty to be added to meet 99291 or 99292. When aggregating time of two practitioners, the total time will be represented by one charge line item.

Aggregate Time: 99291 (min 30 minutes)

Pulmonologist A = 20 mins of critical care ***unbillable, did not reach minimum time***

Pulmonologist B = + 30 mins of critical care ***= 50 mins, minimum time now met "1 charge is billed with 99291 for aggregate time"***

Aggregate Time: 99292 (min 104 minutes)

If "aggregate time" was used to reach 99291, an additional 30 minutes ***beyond the first 74 minutes*** must be reached to bill 99292

- at least **104 total minutes** to report 99292 (i.e. 74 mins 99291 + 30 addt'l mins for 99292) ***"1 charge is billed with total time"***

Critical Care Services

Change 2 : Critical Care Services May be Split Shared with New Modifier FS

Current State = Critical Care may <u>not</u> be Split Shared. Beginning in 2022, it may be Split Shared.

<u>Who Bills the Split Shared Critical Care Visit?</u>

The practitioner who provided the **substantive portion** of the visit may bill.

- Substantive Portion = more than half the cumulative total time of both providers

Example: APN Lee ***20 mins Critical Care*** + Dr. Jones ***45 mins Critical Care*** || Total Time = ***65 minutes***
Dr. Jones may bill for the visit since more than half of the 65 total minutes was spent

NOTE: Count any overlapping or joint practitioner time only once ***i.e.*** an APN & Physician each separately spend 20 minutes, plus 10 mins of joint time discussing the patient = 40 + 10 (50 mins)

<u>Documentation Requirements:</u>

- ***Each*** practitioner documents a note for the medically necessary critical care they personally performed
- ***Each*** practitioner documents the time they spent in the medical record
- Document the visit was done in conjunction with the other practitioner
- Billing practitioner uses ***.SPLITSHARED_CRITICALCARE*** or other critical care smartphrase

<u>Split Shared Service Modifier Required:</u>

- Beginning January 1st, CMS will require a **new modifier FS** to be appended to Split Shared critical care

Critical Care Services

Change 3: Critical Care + Other Visits are Payable on the Same Day with Modifier 25

Current CMS Rule

1. EM services are NOT payable on the same date as critical care by the same provider

2. Hospital inpatient or outpatient services are only payable on the same date as critical care if provided at a time the patient ***did not*** require critical care

No modifier required

2022 Change

1. Practitioners may bill for E/M services provided on the same day when there is supporting documentation.

New Documentation Requirements:
The practitioner must document that:

1. the E/M service was provided prior to the time when patient did not require critical care

2. the service is medically necessary

3. the service is separate and distinct with no duplicative elements from the critical care service later provided

- *+ use dotphrase* ***.CRITICALCARE_SAME_DAY_EM NEW***

Modifier 25 must also be appended to the Initial E/M service bill for this scenario

Critical Care Services

Change 4: Critical Care Visits Separately Billable from Global Surgery with a New Modifier FT

Note: Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness/injury and the treatment being provided meet critical care requirements.

Current Critical Care Global Rules

Pre-operative and Post-operative Critical care is included in the surgical package of many procedures with a 10 or 90 day global period

- Critical Care visits may be separately paid in addition to a procedure with a global surgical period as long as the critical care service was ***unrelated*** to the procedure.

2022

Concept is essentially unchanged, but CMS is requesting a **new modifier FT** be used to report critical care unrelated to the procedure. There are also specific criteria that must be met.

Requirements to bill Critical Care **separate** from global package:

- Service provided meets the definition of critical care and requires the full attention of the physician/QHP
- Critical care is above and beyond the procedure performed
- Critical care is unrelated to the specific anatomic injury or general surgical procedure performed

➢ *+ use dotphrase* ***.CRITICALCARE_UNRELATED_PROC***

Note: If care is fully transferred from the surgeon to an intensivist, then Modifiers 54 (surgical care only) & 55 (postoperative management only) must also be reported when applicable

Critical Care Services Documentation Requirements

Change 5: Critical Care Medical Record Documentation Requirements

Medical Record Documentation Requirements

1. **Document Total Time:** each reporting practitioner must document the **total** critical care time they provided

2. **Services furnished to each patient & medical necessity:** documentation should indicate that the services furnished to the patient, including any concurrent care, were medically reasonable and necessary (for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member).

3. **Role of Each Practitioner in Concurrent Care:** services should clearly identify the role each practitioner played in the patient's care:
   a) the condition(s) for which each concurrent care practitioner treated the patient
   b) document if critical care was subsequent to initial critical care by colleague (please note practitioner)
   c) document if you are billing based on aggregate time (identify whose time you are adding on to)

- **Split Shared Critical Care** *Please see Split Shared services training for more information on Split Shared billing requirements.*

  The documentation requirements for all split shared E/M visits would also apply to critical care visits, such as:
  1. services should indicate both practitioners who provided care
  2. the record must be signed and dated by the billing provider
  3. Total time of each practitioner should be documented

Critical Care Services Wrap-Up

1. Subsequent Critical Care Services may be billed by providers in the **same** specialty, including the aggregation of time to meet Initial or Subsequent Critical Care

2. Critical Care Services may be split shared, along with a **new modifier FS** which needs to be added. Please see Split Shared services training for more information on Split Shared billing.

3. Critical Care may be billed on the same day another E/M service if it occurred prior to the patient needing critical care and **Modifier 25** is added

4. Critical Care may be unbundled from the Global Surgery package when it is unrelated to the anatomic region or general surgical procedure performed, and a **new modifier FT** is added

Modifiers Required 2022:

- Critical Care services on the same day as an ED or Other E/M Service will now require **Modifier 25**
- Critical Care services unrelated to the global surgery will require new **Modifier FT**
- Critical Care services which are split shared will require new **Modifier FS**

For questions in the meanwhile, reach out to:

- Compliance compliance@bsd.uchicago.edu

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Addendum

References

- CMS Medicare Claims Processing Manual (Pub.100-04), Chapter 12 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf).
- CMS FY22 Physician Fee Schedule Final Rule: https://public-inspection.federalregister.gov/2021-23972.pdf
- Internet-Only Manual Updates (IOM) for Critical Care https://www.cms.gov/files/document/r11288cp.pdf
- CMS Internet-Only Manual Updates for Critical Care MM12550 https://www.cms.gov/files/document/mm12550-internet-only-manual-updates-critical-care-evaluation-and-management-services.pdf
- NGS Critical Care FAQs: Evaluation and Management - NGSMEDICARE
- NGS Critical Care Policy Clarification 3-29-22
- AMA CPT Section Manual Guidance for 99291-99292

Critical Care CPT Guidelines Overview

Key Rules

Full attention required

For any given period of time spent providing critical care services, the individual must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

Reportable Time

1. Time spent engaged in work directly related to the individual patient's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit,
2. Plus includes:
   a) time on the floor or nurses station reviewing test results or imaging,
   b) discussing critically ill patient’s care with other medical staff
   c) When patient is unable or lacks capacity to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a history, reviewing patient’s condition or prognosis, or discussing treatment or limitations of treatment

Non-Reportable Time

The following may not be reported as critical care

1. Time spent on separately reportable activities
2. Time spent in activities that occur outside of the unit or off the floor (e.g. telephone calls whether taken at home, in office, or at hospital) since individual is not immediately available
3. Time spent in activities that do not directly contribute to the treatment of the patient, even if performed in the critical care unit (e.g. participating in administrative meetings or telephone calls to discuss other patients)

Critical Care CPT Guidelines Overview

Key CPT Guidance/Definitions

- Critical care is the direct delivery by a physician(s) or other qualified health care professional of medical care 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.**

- Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) **to treat single or multiple vital organ system failure** and/or **to 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.***

- Although 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 may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of attention described above.

- 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 above requirements.

- Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility

Critical Care CPT Guidelines Overview

Bundled Services

For ***professional*** billing the following services are included in Critical Care and not separately billable:

- the interpretation of cardiac output measurements (93561, 93562),
- chest X rays (71045, 71046),
- pulse oximetry (94760, 94761, 94762),
- blood gases,
- collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data);
- gastric intubation (43752, 43753);
- temporary transcutaneous pacing (92953);
- ventilatory management (94002-94004, 94660, 94662);
- and vascular access procedures (36000, 36410, 36415, 36591, 36600).

Any services performed that are not included in this listing should be reported separately.

Facilities may report the above services separately.

Critical Care CPT Guidelines Overview

Reporting Time

Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code.

1. Code 99291 is used to report the first 30-74 minutes of critical care on a given date.
   - only use once per date even if the time spent by the individual is not continuous on that date.

2. Code 99292 is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes. (See the following table.)

The following examples illustrate the correct reporting of critical care services:

less than 30 minutes	Appropriate E/M Codes
30-74 minutes (30 minutes - 1 hr. 14 min.)	99291 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99291 X 1 AND 99292 X 1
105-134 minutes (1 hr. 45 min. - 2 hr. 14 min.)	99291 X 1 AND 99292 X 2
135-164 minutes (2 hr. 15 min. - 2 hr. 44 min.)	99291 X 1 AND 99292 X 3
165-194 minutes (2 hr. 45 min. - 3 hr. 14 min.)	99291 X 1 AND 99292 X 4
195 minutes or longer (3 hr. 15 min. - etc.)	99291 and 99292 as appropriate

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Contacts/Resources

Reporting Mechanisms

It is your responsibility to promptly report any compliance concerns, and suspected or actual violations that you may be aware of.

- Contact the Office of Corporate Compliance directly at (773) 834-4588 or PHA: 773-834-2995 or you may email us at: compliance@bsd.uchicago.edu or PHA: lwarren@bsd.uchicago.edu
- Report directly to your immediate supervisor, departmental manager, the Department of Human Resources, or Legal Affairs at (773) 702-1057/ 24 Hour Pager #: 7602
- Call the Compliance Resource Line at (877) 440-5480, or internally at (773) 834-3222

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Applicable Policy: Compliance 10-01 "Reports of Compliance Concerns and Violations"

Compliance Resource Line

With our non-retaliation policy, you may feel comfortable reporting any suspected or actual violations that you may be aware of or concerned about

(877) 440-5480 or PHA: (833) 484-0055

PURPOSE

The Compliance Resource Line may be used to obtain answers to questions relating to compliance and to report suspected or potential misconduct, violations of the Medical Center's compliance policies, or violations of the law.

Toll Free # with voicemail and no caller id	**All calls investigated**	**Callers are covered by non-retribution, non-retaliation policies**

Callers who wish to remain anonymous are informed that in some circumstances, their concerns cannot be adequately addressed unless certain information is revealed that may also reveal the caller's identity.

OCC Resources (Website)

- OCC Policies and Guidances

INTERNAL RESOURCES

OCC Newsletter - October 2021
(Archived) OCC Newsletter - August 2021
(Archived) OCC Newsletter - July 2021
Code of Conduct
Compliance Policies
Critical Care Tip Sheet
Non-Physician Practitioner (NPP) – Billing Guidance
Non-Physician Practitioner (NPP) – Billing Tip Sheet
EHR Documentation Compliance Guidance (Updated 6/9/21)
Fraud and Abuse Primer
Fraud and Abuse Resource Reference (February 2019)
Modifier 22 Increased Procedures Tip Sheet
Modifier 25 Minor Procedures Tip Sheet
Guide to Attestation Statements
Teaching Physician and Medical Student Documentation Instructions
EM Tip Sheet (excluding outpatient services)
Cataract Tip Sheet
No Surprise Billing Act Decision Tree

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Resources

- **OCC Website:** …… http://compliance.bsd.uchicago.edu/
- **Compliance Resource Line** ……..(877) 440-5480, or at (773) 834-3222

  PHA: (833) 484-0055, or at (708) 915-5678

- **Krista Curell 2-9785**……Executive Vice President
- **Tracy Volel 4-4733** ……Chief Compliance Officer
- **Leslie Warren 4-2995** ……..Associate Compliance Officer
- **Tomicia James-Miller 4-1143** ……..Director, Audit Services
- **Tasha Osafo 4-3047** …….Director, Compliance Education, Risk and Data Services
- **Mia London 4-3858** ……...Program Manager, Education and Outreach

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