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)**

- **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)

**Current 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

- **Same specialty practitioners** must bill and be paid as “one” when multiple practitioners provide services on the same DOS.

  **Same Specialty (Current State)**
  
  **Internist A:** 99291 & 99292
  
  **Internist B:** N/A, no additional billing
Critical Care Services

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.

2022 Subsequent Care

Internist A = initial critical care, 70 minutes 99291 x 1 “Claim 1” CPT 99291 would still only be reported by one provider in same specialty per DOS

Internist B = subsequent critical care later in the day, 90 minutes 99292 x 3 “Claim 2”

B. Aggregate Time (adding times of > 1 provider): CMS will allow the time of multiple practitioners in the same specialty to be added to meet 99291 or 99292

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 now qualifies with 50 total minutes “1 claim is billed with total time”

Aggregate Time 99292 (min 104 minutes)

If “aggregate time” was used to reach 99291, an additional 30 minutes must be reached to bill 99292

➢ at least 104 total minutes to report 99292 (i.e. 74 mins 99291 + 30 mins of addt’l 99292) “1 claim 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 not be Split Shared. Beginning in 2022, it may be Split Shared.

Who Bills the Split Shared Critical Care Visit?
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)

Documentation Requirements:
- Each provider documents a note for the medically necessary critical care they personally performed
- Each provider documents the time they spent in the medical record
- Medical Record must identify the two individuals who performed the visit
- The provider who performed the substantive portion must sign and date medical record

Split Shared Service Modifier Required:
- 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. Hospital ED 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 Hospital ED (and other 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.

**Modifier 25 must also be appended to the Initial E/M service bill for this scenario**
Change 4: Critical Care Visits Separately Billable from Global Surgery with a New Modifier FT

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

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.

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.
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) how the care was concurrent
      ✓ document if critical care was subsequent to initial critical care by colleague (please note practitioner)
      ✓ 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 as a Hospital ED or Other 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

More information will be shared as modifier workflows are finalized.

For questions in the meanwhile, reach out to:
- Compliance compliance@bsd.uchicago.edu
Addendum
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
  - 30-74 minutes (30 minutes - 1 hr. 14 min.)
  - 75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)
  - 105-134 minutes (1 hr. 45 min. - 2 hr. 14 min.)
  - 135-164 minutes (2 hr. 15 min. - 2 hr. 44 min.)
  - 165-194 minutes (2 hr. 45 min. - 3 hr. 14 min.)
  - 195 minutes or longer (3 hr. 15 min. - etc.)

- Appropriate E/M Codes
  - 99291 X 1
  - 99291 X 1 AND 99292 X 1
  - 99291 X 1 AND 99292 X 2
  - 99291 X 1 AND 99292 X 3
  - 99291 X 1 AND 99292 X 4
  - 99291 and 99292 as appropriate
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

Applicable Policy: Compliance 10-01 “Reports of Compliance Concerns and Violations”
Compliance Resource Line

With our non-retribution 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 9/9/21)
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
FM Tip Sheet (excluding outpatient services)
Cataract Tip Sheet
No Surprise Billing Act Decision Tree
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