

CPT Codes

- CPT code 99291- Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes on a given calendar date of service.
- CPT Code 99292 - each additional 30 minutes* (list separately in addition to code for primary service) on a given calendar date of service *Note: 2022 CMS regulations require a minimum of 104 minutes to support payment of 99292 by Medicare; note the CPT "duration" table still otherwise reflects the 75-104 minute time range.

Note: Critical care of less than 30 minutes total duration on a given calendar date should be reported using another appropriate Evaluation and Management (E/M) code such as initial or subsequent hospital care.

Definition

- The direct delivery by a physician(s) or other qualified health care professional of medical care for a critically ill or critically injured patient
- 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.
- 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.

Medical Necessity

- Critical care services must be medically necessary and reasonable.
- Although critical care may be delivered in a moment of crisis or upon being called to the patient's bedside emergently, this is not requirement for providing critical care service.
- Providing medical care to a critically ill patient should not be automatically deemed as critical care service for the sole reason that the patient is critically ill or injured.

Full Attention of the Physician

- The duration of critical care services to be reported is the time spent by the provider evaluating, providing and managing the critically ill or injured patient's care while at the bedside or elsewhere on the floor or unit so long as the provider is immediately available to the patient.
- For any given period of time spent providing critical care services, the provider must devote his or her full attention to the patient, and therefore, cannot provide services to any other patient during the same time period.

Critical Care Services and Provider Time

- Time counted may be continuous clock time or intermittent in aggregated time increments. If continuous critical care time crosses midnight into the next calendar date, report all units on the initial DOS.
- For each medical encounter, the provider's note must document the total time that critical care services are provided.
- Providers in the same group practice who have the same specialty must bill and be paid as though each were the single provider, except when criteria are met to report concurrent critical care services (see Concurrent Critical Care pg 2)
- Time spent providing the following services is included in the time allowed for critical care:
 - Interpretation of cardiac output measurements (CPT codes 93561 and 93562)
 - Chest x-rays (CPT 71045 and 71046)
 - Pulse oximetry (CPT 94760, 94761, 94762)
 - Blood gases and collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data)
 - Gastric intubation (CPT 43752, 43753)
 - Temporary transcutaneous pacing (CPT 92953)
 - Ventilatory management (CPT 94002-94004, 94660, 94662)
 - Vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600)
 - Blood draw (CPT code 36415)

Note: Services such as endotracheal intubation (CPT code 31500), the insertion and placement of a flow directed catheter e.g. Swan-Ganz (CPT code 93503), and CPR (CPT code 92950) are not bundled into critical care services. Therefore, separate payments may be made for critical care in addition to these services. **Time spent performing such services must be excluded from the time counted towards critical care.**

Time that is not counted towards critical care services

- Off the unit/floor: Activities that occur outside of the unit or off the floor (i.e., telephone calls, whether taken at home or in the office, or elsewhere in the hospital) because the physician is not immediately available to the patient.
- Unbundled procedures: Time spent performing procedures that are not bundled into critical care (i.e., billed and paid separately) may not count towards critical care time.
- Routine daily reports to family/surrogates: Such time may not be counted towards critical care time unless a) the patient is unable to incompetent to participate in giving a history and/or making treatment decisions, and b) the discussion is necessary for determining treatment decisions.

Cont. next page

Time that is not counted towards critical care, cont.

- Activities that do not directly contribute to the treatment of the critically ill/injured patient: Time spent on such activities should not be counted towards critical care time. Examples include review of literature and teaching sessions with physician residents, even if performed in the unit or at the patient's bedside.

Concurrent Critical Care

Effective Jan 1st, 2022 Medicare will reimburse other practitioners in the same specialty for subsequent critical care when it is medically necessary and meets the definition of critical care:

Subsequent Critical Care

- Initial Critical Care **CPT 99291** is to be reported only once per day within the same specialty
- Subsequent Critical Care **CPT 99292** may be performed and billed separately by other group members, including NPPs

Documentation: practitioners should note when they are providing critical care subsequent to a colleague in their specialty/group, or be otherwise clear in the record.

Aggregate Critical Care Time

Time spent by providers in the same specialty may be added to meet the time required to report CPT 99291 or 99292, which is then billed under one provider's claim.

- When CPT 99292 is billed based on aggregate time, a minimum of 104 minutes must be reached.

Documentation: The billing practitioner should note if they are billing based on aggregate time of another provider (note name)

Critical Care On the Same Day as Other E/M Services

E/M services may be payable by Medicare on the same date as Critical Care if:

1. The E/M service was provided prior to the need for critical care services,
2. Modifier 25 is added to the claim,
3. Supporting documentation is present in the record
 - i. the E/M service was provided prior to the time when patient did not require critical care
 - ii. the service is medically necessary
 - iii. the service is separate and distinct with no duplicative elements from the critical care service later provided

The below dotphrase may be used as long as supporting necessity details are within the E/M visit note:

.CRITICALCARE_SAME_DAY_EM_NEW: This E/M service was performed prior to the patient's subsequent need for critical care services, and was medically necessary for the evaluation and treatment of the patient at that time. As supported by my visit notes, this service was separate and distinct with no duplicative elements from the subsequent critical care service.

Split Shared Services

Effective Jan 1st, 2022 Critical Care may be split shared by Physician and NPP in the same group when criteria for reporting critical care is met. Modifier FS should be added to the split shared service.

Billing: The practitioner who provided more than half of the cumulative Critical Care time may bill for total units of Critical Care
Example: APN **20 mins Critical Care** + MD **45 mins Critical Care**
Total Time = **65 minutes** | MD bills for the visit (more than half of the 65 minutes was spent)

Documentation: Each provider must individually document his/her contribution to the critical care service:

- Each provider documents a note for the medically necessary critical care they personally performed
- Each provider documents the time they personally spent in the medical record
- Both providers should sign and date their notes.

The below dotphrase may be used by the billing practitioner to document critical care time spent.

.SPLITSHARED_CRITICALCARE: My full attention was spent providing medically necessary critical care to the patient for *** minutes, with details documented in my note. APP *** also provided critical care time during this visit as outlined in their note. The combined critical care time provided to the patient was *** minutes.

Global Surgery Unrelated to Critical Care

Critical care is not payable on the same calendar date as a procedure with a global surgical period (0, 10 or 90 day post-op period), unless the critical care meets the below criteria:

1. Service provided meets the definition of critical care and requires the full attention of the practitioner
2. Critical care is unrelated to the specific anatomic injury or general surgical procedure performed.
3. Critical care is above and beyond the procedure performed (above the usual pre- and post-op care)
4. Modifier FT is used to report critical care unrelated to the procedure

The below dotphrase may be used. The specific circumstances surrounding the unrelated care must be filled out:

.CRITICALCARE_UNRELATED_PROC: I attest that this critical care service meets the definition of critical care as supported by my documentation. My full attention was spent providing critical care to this patient for *** minutes. The critical care service I provided was above and beyond the **** procedure that was performed and was unrelated to {;220285: the **** anatomic injury for which surgery was performed / the general surgical procedure performed as evidenced by ****}.

Teaching Physician Services and Critical Care

- Time teaching cannot be counted towards critical care
- Time spent by the resident, in the absence of the teaching physician (TP), cannot be billed as critical care or other time-based services.
- Only time spent by the resident and the TP together with the patient or the TP alone with the patient can be counted towards critical care time.
- A combination of the TP and resident's documentation may support critical care services.
- The TP may refer to the resident's documentation, however, the TP's note must provide substantive information including:
 - Time the TP spent providing critical care
 - That the patient was critically ill during the time the TP saw the patient
 - What made the patient critically ill, and
 - The nature of the treatment and management provided by the TP.

Documentation of Critical Care Services

The foundation of a good critical care note includes all of the following information, and should be present for each day of critical care service, even where there is no change in treatment plan:

- The nature of the critical illness or injury, the organ system(s) that are acutely impaired, and the threat of imminent deterioration of the patient's condition
- The presence of the provider either at bedside or on the floor or unit while providing critical care services
- Total time spent by the provider providing critical care services
- A description of the provider's critical care services which demonstrates high complexity decision making.

For example:

1. **Engagement with multidisciplinary teams:** If discussing the case with multi-disciplinary team, state what departments/sections comprise the team (i.e., cardiology) so that you can get credit for coordinating with other providers.

For example, *"Coordinated care with multidisciplinary team composed of providers from Cardiology and Pulmonary"*. If this interaction is already described elsewhere in the note, such a statement doesn't have to be included.

2. **Interval work:** Describe the interval work (even daily activities that might seem mundane) that are completed throughout the day specific to the patient. For example:
 - adjusting a tube on a vent
 - replacing a patient's IV
 - multiple adjustments with pressors in consultation with...
 - discussions with respiratory therapy to adjust...
 - interpretation of test results, complex data
 - use of advanced technology
3. **Multiple co-morbidities, some of which are improving:** If the patient has multiple co-morbidities some of which may be stable, resolved, or improving, but the patient is still critically ill and critical care is still required by the provider, the note should reflect that while progress is being made on some conditions, overall, the patient is still high risk and critical because of ...

For example, *"The fever is resolving but the patient is still highly critical because of sepsis."*

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>

NGS Critical Care FAQ: [Evaluation and Management - NGSMEDICARE](#)

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>