



Related MLN Matters Article #: MM5993 **Revised**

Date Posted: June 9, 2008

Related CR #: 5993

Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)

Key Words

MM5993, CR5993, R1548CP, Neonatal, Intensive

Provider Types Affected

Physicians and Qualified Non-Physician Practitioners (NPPs) who bill Medicare Carriers and Part A/B Medicare Administrative Contractors (A/B MACs) for critical care services provided to Medicare beneficiaries

Note: MLN Matters article MM5993 was revised on July 10, 2008, to reflect changes made to Change Request (CR) 5993 on July 9, 2008. CR5993 was revised to reflect longstanding policy regarding critical care services and other evaluation and management (E/M) services on the same day; to correct information regarding calculation of critical care time to be consistent with the American Medical Association's (AMA) Current Procedural Terminology (CPT); and to make minor clarifications in language related to time spent reviewing or discussing patient information and off the unit/floor and split/shared service discussions.

Key Points

- The effective date of the instruction is July 1, 2008.
- The implementation date is July 7, 2008.
- Change Request (CR) 5993 revises the *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Section 30.6.12 (Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)), replacing all previous critical care payment policy language in the section and adding general E/M payment policies that impact payment for critical care services.
- CR5993 specifically:
 - Explains the definition of critical care services and how to bill for critical care services. It includes the AMA CPT definitions of critical care and critical care services. Physicians should consult the *American Medical Association CPT Manual* for the applicable codes and guidance for critical care services provided to neonates, infants and children.
 - It also adds a new CPT code for 2008 (36591) which replaces code 36540. Code 36591 identifies a bundled vascular access procedure when performed with a critical care service.

CPT only copyright 2007 American Medical Association. All rights reserved.

Summary of Information in CR5993

Use of Critical Care Codes (CPT Codes 99291 – 99292)

- Critical care is defined as a physician's (or physicians') direct delivery 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 functions 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, and
 - Renal, hepatic, metabolic, and/or respiratory failure.
- Although it 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.
- 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.
- While critical care is usually given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department, payment may also be made for critical care services provided in any location as long as this care meets the critical care definition.
- When all these criteria are met, Medicare Carriers and A/B MACs will pay for critical care and critical care services that are reported with CPT codes 99291 and 99292 (described below).

Critical Care Services and Medical Necessity

- Critical care services must be reasonable and medically necessary.
- Therefore, delivering critical care in a moment of crisis, or upon being called to the patient's bedside emergently, is not the only requirement for providing critical care service. Treatment and management of a patient's condition, in the threat of imminent deterioration, while not necessarily emergent, is required.
- Examples of patients whose medical conditions may warrant critical care services would include:
 - 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 vasopressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
 - A 67 year old female patient is three days status post mitral valve repair. She develops petechiae, hypotension, and hypoxia requiring respiratory and circulatory support.

CPT only copyright 2007 American Medical Association. All rights reserved.

- A 70 year old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive two 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.
- The provision of care to a critically ill patient is **not** automatically a critical care service just because the patient is critically ill or injured. Each physician providing critical care services to a patient during the critical care episode of an illness or injury must be managing one or more of the critical illness(es) or injury(ies) in whole, or in part.
- Examples of scenarios in which a patient's medical condition may **not** warrant critical care services would include:
 - A dermatologist evaluating and treating a rash on an Intensive Care Unit patient who is maintained on a ventilator and nitroglycerine infusion that are being managed by an intensivist.
 - Daily management of a patient on chronic ventilator therapy 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, unless the critical care is separately identifiable from the chronic long-term management of the dialysis dependence (Refer to *Medicare Claims Processing Manual*, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 160.4 (Requirements for Payment)).

Note: When a separately identifiable condition (e.g., management of seizures or pericardial tamponade related to renal failure) is being managed, it may be billed as critical care, if critical care requirements are met. Modifier –25 (significant, separately identifiable E/M services by the same physician on the day of the procedure) should be appended to the critical care code when applicable in this situation.

- Examples of patients who may not satisfy Medicare medical necessity criteria for critical care payment would include:
 - 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); or
 - 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.
- Providers may also want to consult the *American Medical Association (AMA) CPT Manual* for the applicable codes and guidance for critical care services provided to neonates, infants and children.
- Critical care services provided in the outpatient setting (e.g., emergency department or office) for neonates and pediatric patients up through 24 months of age, use the hourly critical care codes 99291 and 99292.
- For all other inpatient neonatal and pediatric critical care, refer to AMA CPT for guidance on the correct use of codes.

CPT only copyright 2007 American Medical Association. All rights reserved.

Critical Care Services and Full Attention of the Physician

- The duration of critical care services that physicians should report is the time they actually spend evaluating, managing, and providing the critically ill, or injured, patient's care.
- Providers should be aware that during this time, they cannot provide services to any other patient but must devote their **full** attention to this particular critically ill patient.
- This time must be spent at the patient's immediate bedside, or elsewhere on the floor, or unit, so long as they are immediately available to the patient.
- For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor would be reported as critical care, even when it does not occur at the bedside, if this time represents their full attention to the management of the critically ill/injured patient.

Note: Time spent **off** the unit or floor where the critically ill/injured patient is located (i.e., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care time because the physician is not immediately available to the patient. This time is regarded as pre- and post service work bundled in E/M services.

Critical Care Services and Qualified NPPs

- Qualified NPPs may provide critical care services (and report for payment under their National Provider Identifier (NPI)), when these services meet the above **critical care services definition and requirements**.
- Providers should note the following:
 - The critical care services that NPPs provide must be within the scope of practice and licensure requirements for the state in which they practice and provide the services; and
 - NPPs must meet the collaboration, physician supervision requirements, and billing requirements; and physician assistants must meet the general physician supervision requirements.

Critical Care Services and Physician Time

- Critical care is a time-based service.
- Payment for critical care services is not restricted to a fixed number of hours, days, or physicians (on a per-patient basis) when such services meet medical necessity.
- Time counted toward critical care services may be continuous clock time or intermittent in aggregated time increments (e.g., 50 minutes of continuous clock time or five ten minute blocks of time spread over a given calendar date).
- Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient.
- For each medical encounter, the physician's progress notes must document the total time that critical care services are provided.

CPT only copyright 2007 American Medical Association. All rights reserved.

- For Medicare Part B physician services, paid under the physician fee schedule, critical care is not a service that is paid on a “shift” basis or a “per day” basis. Documentation may be requested for any claim to determine medical necessity. Examples of critical care billing that may require further review could include:
 - Claims from several physicians submitting multiple units of critical care for a single patient; and
 - Submitting claims for more than 12 hours of critical care time by a physician for one or more patients on the same given calendar date.
- Physicians assigned to a critical care unit (e.g., hospitalist, intensivist etc.) may not report critical care for patients based on a ‘per shift’ basis.
- Physicians should use CPT code 99291 (E/M of the critically ill or critically injured patient, first 30-74 minutes) to report the first 30-74 minutes of critical care on a given calendar date of service. This code may only be used once per calendar date to bill for care provided for a particular patient by the same physician or physician group of the same specialty.
- CPT code 99292 (critical care, each additional 30 minutes) is used to report each additional 30 minutes beyond the first 74 minutes of critical care. It may also be used to report the final 15 - 30 minutes of critical care on a given date.
- Critical care of less than 15 minutes beyond the first 74 minutes or less than 15 minutes beyond the final 30 minutes is not separately payable.
- Critical care of less than 30 minutes total duration on a given calendar date is not reported separately using the critical care codes. This service should be reported using another appropriate E/M code such as subsequent hospital care.
- Table 1 on page 6 of MLN Matters article MM5993 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5993.pdf> illustrates the correct reporting of critical care services, followed by a clinical example of correct billing of time.

Other Critical Care Issues

Split /Shared Service

- Only one physician can bill for critical care during any one single period of time.
- Unlike other E/M services, critical care services reflect one physician’s (or qualified NPP’s care and management of a critically ill or critically injured patient for the specified reportable period of time.
- Providers cannot report a split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) as a critical care service.
- The critical care service reported should reflect the evaluation, treatment and management of the patient by the individual physician or qualified NPP and not representative of a split/shared combined service between a physician and a qualified NPP.
- When CPT code requirements for time and critical care requirements are met for a medically necessary visit by an individual clinician the service should be reported using the appropriate individual NPI number.

CPT only copyright 2007 American Medical Association. All rights reserved.

- Medically necessary visit(s) that do not meet these requirements should be reported as subsequent hospital care services.
- In denying a claim for a critical care service that is a split/shared service, carriers and A/B MACs will use the following messages:
 - Claims Adjustment Reason Code: 150 – Payment adjusted because the payer deems the information submitted does not support this level of service;
 - Remittance Advice Reason Code: N180 – This item or service does not meet the criteria for the category under which it was billed;
 - Medicare Summary Notice: 17.11 – This item or service cannot be paid as billed;
 - For unassigned claims, Medicare contractors will use add-on message 16.34 – You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the “you may be billed” column; or
 - For assigned claims, Medicare contractors will use add-on message 16.35 – You do not have to pay this amount.

Critical Care Services and Other Procedures Provided on the Same Day by the Same Physician

- When performed on the day a physician bills for critical care, the following services are included in the critical care service and should not be reported separately:
 - The interpretation of cardiac output measurements (CPT 93561, 93562);
 - Chest x-rays, professional component (CPT 71010, 71015, 71020);
 - Blood draw for specimen (CPT 36415);
 - Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data (CPT 99090));
 - Gastric intubation (CPT 43752, 91105);
 - Pulse oximetry (CPT 94760, 94761, 94762);
 - Temporary transcutaneous pacing (CPT 92953);
 - Ventilator management (CPT 94002 – 94004, 94660, 94662); and
 - Vascular access procedures (CPT 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.

Critical Care Services Provided by Physicians in Group Practice(s)

- Concurrent care by more than one physician (generally representing different physician specialties) is payable if the services all meet critical care requirements, are medically necessary, and are not duplicative (refer to *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 30 (Physician Services) for concurrent care policy discussion).

- Critically ill or injured patients may require the care of more than one physician medical specialty.
- Providers should keep in mind that the critical care services provided by each physician must be medically necessary.
- Medicare will pay for non-duplicative, medically necessary critical care services provided by physicians from the same group practice or from different group practices to the same patient.

Note: Physician specialty means the self-designated primary specialty by which the physician bills Medicare and is known to the carrier who adjudicates the claims. Physicians in the same group practice who have different medical specialties may bill and be paid without regard to their membership in the same group. For example, if a cardiologist and an endocrinologist are group partners and the critical care services of each are medically necessary and not duplicative the critical care services may be reported by each regardless of their group practice relationship.

- Medical record documentation must support that the critical care services each physician provided were necessary for treating and managing the patient's critical illness(es) or critical injury(ies).
- Each physician must accurately report the service(s) he/she provided to the patient in accordance with any applicable global surgery rules or concurrent care rules. (Providers should refer to *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), and Section 40 (Surgeons and Global Surgery); and *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), and Section 30 (Physician Services)).
- Specific coding requirements are:
 - The initial critical care time (**billed as CPT code 99291**) must be met by a single physician or qualified NPP.
 - This may be performed in a single period of time or be cumulative by the same physician on the same calendar date. A history or physical examination performed by one group partner for another group partner in order for the second group partner to make a medical decision would not represent critical care services.
 - Subsequent critical care visits performed on the same calendar date are reported using **CPT code 99292**.
 - The service may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty in order to meet the duration of minutes required for CPT code 99292. The aggregated critical care visits must be medically necessary and each aggregated visit must meet the definition of critical care in order to combine the times.
 - Physicians in the same group practice who have the same specialty may not each report CPT initial critical care code 99291 for critical care services to the same patient on the same calendar date.
 - Medicare payment policy states that physicians in the same group practice who are in the same specialty must bill and be paid as though each were the single physician. (Refer to *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners).)

- Physicians in the same group practice, with different specialties, who provide critical care to a critically ill or critically injured patient may not always each report the initial critical care code (CPT 99291) on the same date.
- When these physicians are providing care that is unique to his/her individual medical specialty and are managing at least one of the patient's critical illness(es) or critical injury(ies), then the initial critical care service may be payable to each.
- However, if a physician (or qualified NPP) within a group provides "staff coverage" or "follow-up" for another group physician who provided critical care services on that same calendar date but has left the case; the second group physician (or qualified NPP) should report the CPT critical care add-on code 99292, or another appropriate E/M code.
- Providers may want to review the clinical examples of critical care services on page 10 of MLN Matters article MM5993.

Critical Care Services and Other E/M Services Provided on Same Day

- When a patient requires critical care services upon presentation to a hospital emergency department, the physician may only report critical care codes 99291 - 99292.
- The physician may not also report an emergency department visit code. However, when critical care services are provided on a day during which a hospital, emergency department, or office/outpatient E/M service was 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.
- 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.
- Physicians are advised to submit documentation to support a claim when critical care is additionally reported on the same calendar date as when other E/M services are provided to a patient by the same physician or physicians of the same specialty in a group practice.

Global Surgery

- Critical care services will not be paid on the same calendar date that the physician also reports a procedure code with a global surgical period, unless the critical care is billed with CPT modifier -25 to indicate that the critical care is a significant, separately identifiable, E/M service that is above and beyond the usual pre and post operative care associated with the procedure that is performed.
- Services such as endotracheal intubation (CPT code 31500) and the insertion and placement of a flow directed catheter (e.g., Swan-Ganz (CPT code 93503)) are not bundled into the critical care codes.
- Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing the pre, intra, and post procedure work of these unbundled services (e.g., endotracheal intubation) should be excluded from the determination of the time spent providing critical care.

- This policy applies to any procedure with a 0, 10, or 90 day global period including cardiopulmonary resuscitation (CPR -- CPT code 92950). CPR has a global period of 0 days and is not bundled into critical care codes.
- Therefore, critical care maybe billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing CPR should be excluded from the determination of the time spent providing critical care.
- In this instance, the physician who performs the resuscitation must bill for this service. Members of a code team cannot each bill Medicare Part B for this service.
- When a physician, other than the surgeon, provides postoperative critical care services (for procedures with a global surgical period), no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services.
- In this situation, both the surgeon and intensivist, who are submitting claim, must use CPT modifiers -54 (surgical care only) and -55 (postoperative management only).
- Critical care services must meet all the conditions previously described, and the medical record documentation of the surgeon and physician who assumes a transfer (e.g., intensivist's), must both support claims for services when CPT modifiers -54 and -55 are used indicating the transfer of care from the surgeon to the intensivist.

Critical Care Services Provided During Preoperative Portion and Postoperative Portion of Global Period of Procedure with 90 Day Global Period in Trauma and Burn Cases

- In addition to a global fee, critical care services provided during the preoperative portion and postoperative portions of the global period of procedures with 90-day global period in trauma and burn cases may be paid if the patient is critically ill and requires the full attention of the physician.
- The critical care is unrelated to the specific anatomic injury or general surgical procedure performed.
- Such patients may meet the definition of being critically ill and criteria for conditions where there is a high probability of imminent or life threatening deterioration in the patient's condition.
- Preoperatively, in order for these services to be paid, two reporting requirements must be met.
- Codes 99291 - 99292 and modifier -25 (significant, separately identifiable E/M services by the same physician on the day of the procedure) must be used, and documentation identifying that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted.
- An International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.
- Postoperatively, in order for these services to be paid, two reporting requirements must also be met. Codes 99291 - 99292 and modifier -24 (unrelated E/M service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted.

- An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Note: Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period, for reasons unrelated to the surgery, these are separately payable as well.

Family Counseling/Discussions

- Critical care CPT codes 99291 and 99292 include pre and post service work. Routine daily updates or reports to family members and or surrogates are considered part of this service.
- However, time involved with family members or other surrogate decision makers, whether to obtain a history or to discuss treatment options (as described in CPT), may be counted toward critical care time when these specific criteria are met:
 - The patient is unable or incompetent to participate in giving a history and/or making treatment decisions; and
 - The discussion is necessary for determining treatment decisions.
- For such family discussions, the physician should document:
 - The medically necessary treatment decisions for which the discussion was needed;
 - That the patient is unable or incompetent to participate in giving history and/or making treatment decisions;
 - The necessity to have the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family"; and
 - A summary in the medical record that supports this medical necessity.
- Telephone calls to family members and or surrogate decision-makers may be counted towards critical care time, only if they meet the same criteria as described above.
- Further, no other family discussions (no matter how lengthy) may be additionally counted towards critical care.

Teaching Physicians

- A teaching physician, to bill for critical care services, must meet the requirements for critical care described above.
- For procedure codes determined on the basis of time, such as critical care, the teaching physician must be present for the entire period of time for which the claim is submitted.
- For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes. (See *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 100.1.4 (Time-Based Codes).

- Time spent teaching may **not** be counted towards critical care time.
- The teaching physician can not bill, as critical care or other time-based services, for time spent by the resident (in the teaching physician's absence). Only time that the teaching physician spends alone with the patient (and that he/she and the resident spend together with the patient), can be counted toward critical care time.
- A combination of the teaching physician's documentation and the resident's documentation may support critical care services.
- Provided that all requirements for critical care services are met, the teaching physician documentation may tie into the resident's documentation. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment.
- However, the teaching physician medical record documentation must provide substantive information including:
 - Time the teaching physician spent providing critical care;
 - That the patient was critically ill during the time the teaching physician saw the patient;
 - What made the patient critically ill; and
 - The nature of the treatment and management provided by the teaching physician.
- The medical review criteria are the same for the teaching physician as for all physicians. (See *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 100.1.1 (Evaluation and Management (E/M) Services), for teaching physician documentation guidance).
 - **The following is an example of acceptable teaching physician documentation:** "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."
 - **Conversely, the following is an example of unacceptable documentation from a teaching physician:** "I came and saw (the patient) and agree with (the resident)".

Ventilator Management

- Medicare recognizes ventilator codes (CPT codes 94002 - 94004, 94660 and 94662) as physician services payable under the physician fee schedule.
- Medicare Part B under the physician fee schedule does not pay for ventilator management services in addition to an E/M service (e.g., critical care services, CPT codes 99291 - 99292) on the same day for the patient even when the E/M service is billed with CPT modifier -25.

Note: Critical care services provided in the outpatient setting (e.g., emergency department or office) for neonates and pediatric patients up through 24 months of age, use the hourly critical care codes 99291 and 99292. For all other inpatient neonatal and pediatric critical care, refer to AMA CPT for guidance on the correct use of codes.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5993.pdf> on the CMS website.

The official instruction (CR5993) regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1548CP.pdf> on the CMS website.