# Critical Care Tip Sheet

## CPT© Codes

- 99291: Critical Care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.
- +99292: Each additional 30 minutes (List separately in addition to code for primary service.)

**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*.

## Description/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.
- Injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements

## Included in Critical Care Services

- Interpretation of cardiac output measurements (93561, 93562)
- Chest X rays (71045, 71046)
- Pulse oximetry (94760, 94761, 94762)
- Blood gases, and collection and interpretation of physiologic data (eg, ECGs, blood pressures, hematologic data)
- Gastric intubation (43752, 43753)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94002-94004, 94660, 94662)
- Vascular access procedures (36000, 36410, 36415, 36591, 36600).

Any services performed that are not listed above should be reported separately.

## Not Included in Critical Care Services

- Endotracheal intubation (31500)
- Placement of a flow directed catheter e.g. Swan-Ganz (93503)
- Cardiopulmonary resuscitation (92950)

## Time-Based Assessment and Supporting Documentation

Critical care services are represented by time-based codes, so clinicians must monitor, and document time spent carefully. Time should be documented as spent (e.g"45 minutes") or as clock time (e.g., "8:30 am-8:45 am"). Subjective statements such as "spent a long time with patient's family" or "had a lengthy discussion" are **no**t acceptable as time documentation.

## Time that is not counted towards critical care services

- 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.
- Activities that occur outside of the unit or floor.
- Time that is spent on the performance of a separately billable procedure.
- Providing routine updates to families.

## Medical Necessity

In order to reliably and consistently determine that delivery of critical care services rather than other evaluation and management (E/M) services is medically necessary, both of the following medical review criteria must be met in addition to the Current Procedural Terminology (CPT) Manual definitions:

- **Clinical condition criterion** – There is a high probability of sudden, clinically significant, or life-threatening deterioration in the patient's condition that requires the highest level of physician preparedness to intervene urgently.
- **Treatment criterion** – Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life-threatening deterioration in the patient's condition.

## Full Attention of the Provider

- 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.
- All time reported should represent the time the provider actually was evaluation, managing and providing critical care.
- Time must be spent at the patient's immediate bedside or elsewhere on the floor or unit, as long as the provider is immediately available to the patient.

## Teaching Physician Services and Critical Care

- Only time spent by the resident and the Teaching Physician together with the patient or the Teaching Physician 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 Teaching Physician'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.
- Time teaching ***cannot*** be counted towards critical care.

- Time spent by the resident, in the absence of the teaching physician ***cannot*** be billed as critical care or other time-based services.

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

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

- The E/M service was provided prior to the need for critical care services,
- Modifier 25 is added to the claim,
- Supporting documentation in the medical record must include:
    a. That the E/M service was provided prior to the time when patient did not require critical care
    b. That the service is medically necessary
    c. That the service is separate and distinct with no duplicative elements from the critical care service later provided

## Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Group

Physicians or Advance Practice Practitioners (APP) in the same specialty and in the same group may provide concurrent follow-up care, such as a critical care visit subsequent to another practitioner's critical care visit

- This may be as part of continuous staff coverage or follow-up care to critical care services furnished earlier in the day on the same calendar date
- CPT code 99291 may not be reported more than once for the same patient on the same date. If multiple practitioners are involved in the provision of 99291 services, the total time spent by those practitioners is aggregated toward the time requirement for this service. Code 99292 is reported when an additional 30 minutes of critical care services have been furnished to same patient on the same date.
- Any aggregated time spent on critical care services must be medically necessary and must meet the definition of critical care
- Medicare classifies APPs in a specialty that is not the same as a physician. In these instances, guidance regarding split (or shared) critical care services must be followed.
- Modifier -FS (split or shared E/M visit) must be appended to the critical care CPT code(s) on the claim.
- When two or more practitioners spend time jointly meeting with or discussing the patient's care, that time can be counted only once for purposes of reporting the split (or shared) critical care visit
- Each clinician must individually document his/her contribution to the critical care service.
- Each clinician must document the time they spent in the provision of critical care services.

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

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

- The E/M service was provided prior to the need for critical care services,
- Modifier 25 is added to the claim,
- Supporting documentation in the medical record must include:
    a. That the E/M service was provided prior to the time when

patient did not require critical care
b. That the service is medically necessary
c. That the service is separate and distinct with no duplicative elements from the critical care service later provided

## Global Surgery and Critical Care

Critical care services may be payable to a physician who bills a procedure code within a global surgery period when the critical care service is unrelated to the surgery or anatomic injury.

- Modifier FT is used to report critical care unrelated to the procedure.
- The physician's note would be expected to document the separate and distinct nature of the critical care service.

## Epic Attestation

*The patient is critically ill with ***. I spent *** minutes providing critical care services including ***."*

## Scenarios Where Critical Care May be Warranted:

- A patient is in telemetry for chest pain. Patient has been doing fairly well until she develops respiratory distress and stops breathing. A code is called and the provider does CPR, intubates the patient and spends 105 minutes of critical care.
- Patient is three days status post mitral valve repair. Patient develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.
- Patient is admitted for right lower lobe pneumococcal pneumonia with a history of COPD, becomes hypoxic and hypotensive two days after admission.

## Scenarios Where Critical Care May not be Warranted:

- Patient is admitted to critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose).
- Patient is in a critical, intensive, or specialized care unit who are clinically stable and responding favorably to established interventions.
- Daily management of a patient on chronic ventilator therapy does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long term management of the ventilator dependence

**References:**

**CMS**

**CMS - Manuals**

**NGS Medicare**