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Critical care and you

Douglas J. Jorgensen, DO, CPC, FAAO, FACOFP

From Manchester Osteopathic Healthcare, Manchester, ME.

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The author defines critical care, reviews the time element of critical care codes, and clarifies what CPT codes are classified as critical care. He follows with recommendations to ensure you are paid for the time and services provided.

Introduction

The performance of critical care and the utilization of Current Procedural Terminology (CPT)[a] codes for critical care have been a source of confusion for both providers and billers. At the center of that confusion, exactly when does critical care commence, what is critical care, and what is or is not included in these codes remain unclear. The latter point is paramount due to increasing regulatory scrutiny by federal and private payers. This scrutiny has led to nearly a 70% increase in federal prosecution for 'fraud' from the year 2010-2011, and 2012 is on track to be another landmark year.[b] In short, we providers are seen as easy money by the federal prosecutors and private insurers, so proper utilization and documentation of CPT codes is not just a good business decision, but is critically important to avoid fines and potential criminal prosecution.

- CPT codes 99291 and 99292
- Know the definition
- Bill based on time
- Think of these as Evaluation and Management codes
  - For Centers for Medicare and Medicaid Services (CMS)[c] beneficiaries (Medicare and/or Tricare and possibly Medicaid), an emergency department (ED) must choose between these and ED codes (either-or situation)
    - CMS will not pay for both ED codes and critical care codes[d,e]
    - Private payers currently do pay concomitantly unless directed otherwise
    - Patient need not be in an intensive care unit, coronary care unit, or ED to bill for critical care.[f]

What is critical care?

Medicare defines critical care (and the private payers concur) for instances where the decision making is highly complex, and they specifically denote there should be a 'high probability of imminent or life-threatening deterioration

Corresponding author: Douglas Jorgensen, DO, CPC, FAAO, FACOFP, Manchester Osteopathic Healthcare, 29 Bowdoin Street, Manchester, ME 04351.

[a]Current Procedural Terminology text published annually by the American Medical Association.

[b]Nashville Medical Newswire March 5, 2012.

E-mail address: djorgensen@mainedo.com.

[c]Centers for Medicare and Medicaid Services in Baltimore, Maryland.

[d]CMS Transmittal 1548 www.cms.hhs.gov/Transmittals/Downloads/R1548CP.pdf and MLN (Medicare Learning Network) www.cms.hhs.gov/MLNMattersArticles/downloads/MM5993.pdf.

[e]Only time-based critical care codes are billed in the emergency department. Daily neonatal (99468-99469) and pediatric (99471, 99472, 99475, and 99476) are only billed in the inpatient or facility setting. The ED is from a billing perspective in a nonfacility or outpatient setting.

[f]CMS Transmittal 1548 Section 30.6.12 A

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(see footnote f). It may be provided by a physician (MD, DO) or a qualified nonphysician practitioner[g] (nurse practitioner or physician assistant).[h] By definition, critical care is one or more chronic illness with severe exacerbation (defined by the provider), progression, or side effects or an acute illness or injury or chronic disease exacerbation that poses a threat to life or bodily function; or by management options parenteral therapy or drug therapy requiring intensive therapy for monitoring or a decision to de-escalate care to do not resuscitate or do not intubate. This documentation must support the utilization of critical care by describing why the patient was critically ill (i.e. signs, symptoms, diagnostic data, etc).

This time may be spent at the bedside or on the floor or unit or even talking with family or medical power of attorneys or both; if it is the latter, be sure to explain why you had to spend time with these decision makers explaining the prognosis and treatment options and specifically note why the patient cannot communicate with you on his or her own.

Critical care may be performed wherever the patient is critically ill and not just in the intensive care unit, coronary care unit or ED (see footnote h). CMS does not require the care to be urgent or emergent, but simply based on the threat of imminent deterioration, which should be clearly documented in the record. If the care is complex, but does not meet the standard of impending, imminent deterioration, critical care codes should not be billed. In other words, just being critically ill does not mean the patient should be billed for critical care services. Examples of this would be daily ventilator management on an otherwise stable patient with chronic obstructive pulmonary disease or end-stage renal disease dialysis care in a relatively stable patient. Although these underlying pathologic conditions are obviously life threatening, there needs to be a significant, identifiable deterioration or the end-stage renal disease itself must have shifted to a more serious immediate situation necessitating critical care.

Time element

Critical care billing codes are time based. Therefore, the total time spent providing critical care, midnight to midnight on the same calendar day, is billed in units using the above-mentioned two CPT codes in succession. More than one physician may bill for critical care on the same day. If it is same tax ID or same practice, the total time is billed as midnight to midnight (12:00 AM to 11:59 PM) as long as they are the same specialty. At midnight, the time starts over. Physicians in the same practice or group and same specialty bill are paid as though they were a single physician. Of note is that only one physician can bill for critical care in a given time segment even if more than one provider is providing critical care at the same time unless they have different national boards and did not do duplicative services simultaneously. If they are different specialties and same group and did not do duplicative critical care management (i.e. did different procedures or services based on his or her specialty and documented it in the record), they can each bill 99291 and 99292 codes under the same tax ID number. If they are from different groups or tax IDs, the same theme would be applicable. If a nurse practitioner (NP) or physician assistant (PA) does this billing, he or she does not share the codes with the covering provider or attending, but per CMS Transmittal 1458 30.6.12 D qualified nonphysician providers may bill using the rules for CPT codes 99291 and 99292 under his or her own NPI. Scope of practice and licensure requirements or rules must also be taken into consideration for nonphysician providers.

The code 99291 is billed first (required $\times$ 1 before billing 99292 units), and it is billed for the first 30-74 minutes of critical care provided, which is 30 minutes greater than the total time the CPT code billed for the patient for whom you are providing critical care.[i] After 74 minutes, you bill 99272 for each 30-minute unit (whole or in part) you performed critical care.

We recommend using clock time rather than simply putting in the note "2 hours and 40 minutes spent doing critical care." This can and has been disputed by federal and private auditors. The clearer and less arbitrary way is to write "9:07-9:42 spent performing critical care for respiratory distress," or whatever the issue is. The total time is cumulative and, as critical care typically does not happen just once in a 24-hour period, simply tally all the critical care you provided, and it is billed by units. Refer Appendix 1. The critical care clock time stops when doing a service or procedure not covered under the critical care codes (not included or one of the inclusive codes further detailed later) or when you are off the unit rounding or seeing other patients or simply doing work unrelated to the critical care of this patient.

Critical care codes are to be reported each day they are used. If 99291 was submitted on Saturday morning with 2 units of 99292 performed, documented, and coded by Saturday midnight, then that would be a 99291 and 99292 $\times$ 2 for Saturday. As of midnight (the commencement of Sunday!), 99291 would be reported again for the initial 30-74 minutes of critical care with 99292 units billed as appropriate until Sunday midnight. There are no limits placed on the utilization of these codes save time and the patient's critical care status or needs.

It is imperative to understand what is included in the 99291 or 99292 codes, as only those services provided

[g]Nonphysician practitioner is often abbreviated as NPP.

[h]Must be within scope of practice and state licensure requirements and billed under the NP/PA NPI and a PA must meet the general physician supervision requirements. CMS Transmittal 1548 30.6.12 D.

[i]Initial hospital visit (99221-99233), ED codes (99281-99285) (save for CMS noted above), facility or inpatient consult (99251-99255), subsequent hospital care (99231-99233), or even established nonfacility or outpatient codes (99212-99215) if patient is admitted as an observation care patient (this would likely change that status!).

inclusive to these codes can count toward critical care time. If other, noninclusive services are provided (e.g. CPR—I have no idea why this is not part of critical care, as it seems pretty damn critical care-like to me!), then they are documented, coded, and billed separately, but they are not included in the total critical care time as you are paid for them under separate CPT codes.

What is included (and what is not!)

CPT codes, services, and procedures included in critical care are as follows:

- Interpretation of cardiac output measurements (CPT 93561, 93562)
- Pulse oximetry (CPT 94760, 94761, 94762)
- Chest x-rays, professional component (CPT 71010, 71015, 71020)
- Blood gases, and information data stored in computers (eg, ECGs, blood pressures, hematologic data-CPT 99090)
- Gastric intubation (CPT 43752, 91105)
- Transcutaneous pacing (CPT 92953)
- Ventilator management (CPT 94002-94004, 94660, 94662)
- Peripheral vascular access (CPT 36000, 36410, 36415, 36591, 36600).

To bill for these inclusive services separately, in addition to critical care codes, is considered 'unbundling' and could be prosecuted as fraud. Any services or procedures provided over and above the aforementioned CPT codes may be billed in addition to critical care codes, but the time needed to perform these procedures or services or both does not count toward the aggregate critical care time. The following list is not exhaustive, but gives some examples of codes that seem like they would be, but are not part of the critical codes; thus, they should be billed in addition to the critical care codes and documented in the record. Again, this list is not exhaustive but might include the following:

- Central line placement (CPT 36555, 36556)
- Endotracheal intubation (CPT 31500)
- Intraosseous line placement (CPT 36680)
- Temporary transvenous pacemaker (CPT 33210)
- Electrocardiogram (CPT 93010)
- Elective electrical cardioversion (CPT 92960).

If these or other nonbundled services are performed, a −25 modifier should be placed on the critical care codes. CPT does not require it, but common coding convention would make it warranted and many (most) payers want the critical care codes modified in these situations, as the critical care codes are evaluation and management (E&M) codes of a critical care patient and, like any other E&M code done with another service or procedure, the E&M code gets modified. Check with your local payers and follow their rules to ensure prompt payment.

−25 Modifier

If an additional CPT code is billed (E&M for consult, subsequent hospital care, etc.) or for procedures not bundled with the critical care codes, a −25 modifier is added to the critical care codes as it is the primary evaluation and management code billed for that particular date of service.[j] As noted earlier, some private payers may not require it, and it would be wise to verify via company memoranda or provider manuals or both or at least meet with the payers' liaisons with the private payers. CMS does require its use.

Conclusion

Critical care codes, like many time-based codes, can be a source of confusion. However, if the work is being done and proper documentation is provided, the services warrant payment. With 10,000 Baby Boomers turning 65 every day for the next 19 years, the use of these codes is only likely to escalate, so having a firm grasp on them now will make utilization simpler as the volume of use increases with the aging US population.[k]

Appendix 1

Two hundred forty minutes would be 99291 × 1 for initial 30-74 minutes over the CPT code minutes (continuous or not), then 6 × 99292 (5 30-minute increments for 240-74 = 166), then there are 5 30-minute units in 166, and an additional one for the other 16 minutes. In their memoranda, they simply note that you are in the next 30-minute increment without a minimum number of minutes required. Therefore, any portion of the next 30 minutes, 1 minute or 29 minutes, would allow you to bill for another unit of 99292.

One hundred fifteen minutes would be billed as 99291 × 1 (115−74 = 41 minutes), and then there is 1 30-minute increment in 41 and 11 minutes left over. Therefore, one would bill 1 unit of 99291 as noted here and 99292 × 2 for 1 30-minute increment and the balance of 11 minutes toward the next 30-minute unit of 99292.

[j] −25 modifier is a significant, separately identifiable evaluation and management (E&M) service provided on the same day, by the same provider as another service or procedure by the same provider.

[k] www.pewresearch.org