**Texas Tech University Health Sciences Center**
**Billing Compliance Program Policy and Procedure**

| 4.3 Critical Care | |
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| **Approved Date:** | **Effective Date: March 19, 2018** |
| | **References:** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5993.pdf |

## PURPOSE

The purpose of this policy is to establish the requirements for appropriate billing of critical care services, as critical care billing is an essential component of caring for the critically ill and injured.

## POLICY

The CPT definition of critical illness or injury is an illness or injury that acutely impairs one or more vital organ systems such that the patient's survival is jeopardized. The term "unstable" is no longer used in the CPT definition to describe critically ill or injured patients. Certain criteria must be met to bill for critical care services, which include the presence of a critical condition, critical care treatments and time spent specific to the critical care activity. Critical Care is not based upon the location of the patient in a critical care area, i.e., Surgery Intensive Care Unit, Medical Intensive Care Unit, etc.

## SCOPE

This policy applies to billing of critical care services to meet current payer guidelines.

## PROCEDURE

### I Definition of Critical Care Services

Critical care is the direct delivery by a physician(s) or other qualified health care professional of medical care for a critically ill or injured patient. The care of such patients involves decision making of high complexity to assess, manipulate, and support central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, postoperative complications, overwhelming infection, or other vital system functions to treat single or multiple vital organ system failure or to prevent further deterioration. It may require extensive interpretation of multiple databases and the application of advanced technology to manage the patient. 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 physician attention described above. 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. A patient's

presence in a critical care area in and of itself does not justify critical care services/billing. In order for the service to be billed as "critical care", the service must meet CMS's medical necessity and critical care requirements

## II Guidelines for Use of Critical Care Codes

In order to determine delivery of critical care services is medically necessary, the following criteria are to be met in addition to the CPT definitions:

*Clinical Condition*

The probability of sudden, clinically significant, or life threatening deterioration in the patient's condition which requires the highest level of physician preparedness to intervene urgently.

*Treatment*

Critical care services require direct personal management by the physician. They are life and organ supporting interventions requiring frequent, personal valuation and management by the physician. Failure to initiate interventions on a critical basis could result in sudden, clinically significant or life threatening decline in the patient's situation. Providing medical care to a patient that is in an ICU setting does not itself mean that a service may be billed as critical care. In order for the service to be billed as "critical care", the service must meet Medicare's medical necessity and critical care requirements, as described in section I.

*Critical Care Time*

Critical care is a time-based code and thus the physician's progress note must contain documentation of the total time in minutes involved providing critical care services. Time spent with the individual patient providing critical care services should be recorded in the patient's record. The time reported as critical care is the 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. For example, time spent on the unit /floor reviewing test results or imaging studies, discussing the critically ill patient's care with other medical staff or documenting critical care services in the medical record would be reported as critical care, even though it does not occur at the bedside. Also, when the patient is unable or clinically incompetent to participate in discussions, time spent with family members or surrogate decision makers on the floor/ unit obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment or limitation(*s*) of treatment may be reported as critical care, provided that the conversation bears directly on the medical decision making.

Time spent in activities that occur **outside of the unit or off the floor** (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient. Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit (e.g., participation in administrative meetings or telephone calls to discuss other patients).

Time involved performing procedures that are not bundled into critical care (i.e. are billed separately) may not be included and counted toward critical care time. The physician's

progress note must document the time involved in the performance of billable procedures and not counted toward critical care time.

*Time spent with family members*
Time involved with family members or other decision makers, whether to obtain a history or to discuss treatment options may be counted toward critical care time only when:

- the patient is unable or incompetent in giving a history and/or making treatment decisions,
- the discussion is absolutely necessary for treatment decisions under consideration that day, and
- all of the following are documented in the physician's progress note for that day: the patient was unable or incompetent to participate in giving history and/or making treatment decisions, necessitating discussion of treatment options with family immediately.

The physician's progress note must link the family discussion to a specific treatment issue and explain why the discussion was necessary on that day. All other family discussions, no matter how lengthy, may not be counted towards critical care time.
Examples of family discussions which do not meet the appropriate critical care criteria include:

- regular or periodic updates of the patient's condition;
- emotional support for the family, and
- answering questions regarding the patient's condition (only questions related to decision-making regarding treatment, as described above, may be counted toward critical care).
- Telephone calls to family members and decision makers must meet the same conditions as face-to-face meetings.

Time involved in activities not directly contributing to the treatment of the patient, may not be counted towards critical care time, include teaching sessions with residents whether conducted on rounds or in other venues.

**Attachment 1 Guidance on Critical Care Criteria – recommended text; conditions; bundled procedures**

**III "Full Attention" Requirement For Critical Care Service**
Critical care evaluation and management codes 99291 and 99292 are used to report the total cumulative time spent by the physician providing critical care to a critically ill or critically injured patient. Time spent by the physician on a specific date does not need to be continuous, i.e., number of minutes recorded as "critical care" for a particular patient on a specific date can be reflective of multiple visits to the patient throughout the day vs. one continuous visit. However, physicians providing critical care services must devote their full attention to the patient and may not provide services to other patients during the same period of time.

## IV Split/Shared E/M Service

Split/shared E/M service performed by a physician and a qualified NPP of the same practice (or employed by the same employer) cannot be reported as a critical care service. Critical care services are reflective of the care and management of a critically ill or critically injured patient by an individual physician or qualified NPP for the specified reportable period of time and shall not be representative of a combined service between a physician and a qualified NPP.

## VII Non Critically Ill or Injured Patients in a Critical Care Unit

Services for a patient who is not critically ill, but happen to be in a critical care unit are reported using other appropriate E/M codes. This means that the care of a patient who receives medical care in a critical care, intensive care, or other specialized care unit should not be reported with critical care codes unless the services meeting the guidelines in Section II.

Care of patients which does not meet all these criteria should be reported using the appropriate E&M codes (e.g., hospital care codes 99221 – 99223 or subsequent hospital visit codes 99231 - 99233) depending on the level of service provided.

## VIII Billing for Critical Care Services

Critical care time may be continuous or interrupted. Critical care time of less than 30 minutes is not reported separately. This should be reported using another appropriate E/M code. CPT code 99291 is used to report the first 30 to 74 minutes of critical care on a given date of service. This code may be reported only one time per calendar date, even if the time spent by the physician is not continuous.

CPT code 99292 may not be billed by itself. Report CPT code 99291 for the first 30 to 74 minutes. Use CPT code 99292 to report additional blocks of time, of up to 30 minutes each beyond the first 74 minutes of critical care.

Critical care documentation should always include the following:

- The organ system(s) at risk;
- Which diagnostic and/or therapeutic interventions were performed, including rationale;
- Critical findings of laboratory tests, imaging, EKG, etc., and their significance;
- Course of treatment (plan of care);
- Likelihood of life-threatening deterioration without intervention.

A physician must be prepared to demonstrate that the service billed meets the definition of critical care. Novitas may request supporting documentation at any time for any claim (e.g., requesting additional information when more than a total of 12 hours of critical care is billed by a physician for one or more patients on the same day). Novitas may also request documentation whenever there is an indication that the services may not have been critical care.

**Only one physician may bill for a given hour of critical care even if more than one physician is providing care to a critically ill patient.**

The following illustrates the correct reporting of critical care services:

| Total Duration of Critical Care Codes | Code to Report |
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| **Less than 30 minutes** | **99232 or 99233 or other appropriate E/M code** |
| 30 - 74 minutes | 99291 x 1 |
| 75 - 104 minutes | 99291 x 1 and 99292 x 1 |
| 105 - 134 minutes | 99291 x 1 and 99292 x 2 |
| 135 - 164 minutes | 99291 x 1 and 99292 x 3 |
| 165 - 194 minutes | 99291 x 1 and 99292 x 4 |
| 194 minutes or longer | 99291 - 99292 as appropriate (per the above illustrations) |

## IX Global Surgery

Critical care services billed during a global period are generally considered related to the surgical procedure. Critical care for seriously injured or burned patients is not considered related to the surgical procedure. The appropriate modifier ("-24" or "-25") must be reported when billing for critical care services not related to a specific anatomic injury or general surgical procedure. An ICD-10 code which clearly indicates that the critical care is unrelated to the surgery is acceptable documentation.

## X Teaching Physician Rules for Critical Care Billing

For procedure codes determined on the basis of time, such as critical care, the teaching physician must be present for the period of time for which the claim is made. 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.

***Time spent teaching may not be counted towards critical care time***. Time spent by the resident in the absence of the teaching physician cannot be billed by the teaching physician as critical care. Only time spent by the resident and teaching physician together with the beneficiary or the teaching physician alone with the beneficiary can be counted toward critical care time.

Because critical care is a time-based code, the teaching physician's progress note must contain documentation of total time involved providing critical care services. Document the date and time spent with the patient on all notes. If the time and date are not legibly and unequivocally documented, the service may be subject to reduction or denial. When calculating time of a critical care service in a teaching hospital, the following should be considered:

- The teaching physician must be present for the period of time for which the claim is made;
- Documentation supporting the services as medically necessary and reasonable must be evident in the patient's medical record. The presence and involvement of the teaching physician should be reflected in the medical record. The documentation should be written in such a way, that it would be clear to anyone who looked at the medical record at a later date, that the involvement of the teaching physician justified the service billed.

Points to remember when documenting critical care services are conducted with a resident include the teaching physician's counter signature of the resident's note alone does not document that a physician was present during the key portion of the service. Although it is not necessary for the teaching physician to repeat all of the documentation entered into the medical record by the resident, the teaching physician should enter additional notes to indicate his/her involvement in the service. The teaching physician's documentation should refer to the resident's note and provide summary comments that establish, revise, or confirm the resident's findings and the appropriate level of service required by the patient.

When all required elements of the service (history, examination and medical decision making) are obtained and documented by the resident in the presence of or jointly with the teaching physician, the resident's note may document the teaching physician's direct observation, performance, and personal input. The teaching physician's direct personal documentation may be limited; but at a minimum must include a confirmation of each component of the resident's documentation and the teaching physician's presence during the service. The combined entries must be adequate to substantiate the level of service required by the patient and billed.

## XII ADMINISTRATION AND INTERPRETATION, REVISIONS OR TERMINATION

Refer to Billing Compliance Policy *1.0 Policy Development and Implementation*

Failure to comply with this policy shall result in appropriate disciplinary action.

Questions regarding this policy may be addressed to the Institutional Compliance Officer or respective campus' BC Director/Officer.