

Billing Basics: Billing for Critical Care

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Information and examples are presented to simplify the complex process of critical care billing, an essential component of caring for the critically ill and injured.

This installment of Coding Corner clarifies information published in the April/May 2014 issue of Critical Connections. It clarifies information related to: 1) diagnosis/condition and E/M or CC code assignments; 2) appropriate CPT codes; and 3) split/shared visits as well as combining physician and physician assistant critical care time.

Critical care billing is an essential component of caring for the critically ill and injured. However, given the complexity of the process and guidelines that govern appropriate billing, it is often not fully understood. The following information, examples and answers to frequently asked questions are designed to simplify this process for all practitioners.

There are three criteria for determining if critical care (as opposed to evaluation and management [E/M]) codes are appropriate(1):

- The patient must be critically ill. This is defined as critical illness or injury that “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.”
- The provider must treat the critical illness using “high complexity decision making to assess, manipulate, and support vital systems to treat single or multiple vital organ system failure and/or prevent further life threatening deterioration of the patient’s condition.” The care requires the personal attention of the provider. Care must be provided at the bedside or on the floor/unit where the patient is housed.
- Time (outlined below)

The clinician also must spend at least 30 minutes providing critical care. Once the requirements for critical care management and the time spent engaged in care are met, any additional care time is then divided into blocks. Time spent may be either continuous or intermittent and then aggregated, and is measured from midnight to midnight each day.

The following two codes define critical care time:

99291 - first 74 minutes of critical care on a given day

99292 - each additional 30 minutes of critical care

Thus, time is correctly allocated as follows:

Less than 30 minutes - 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 minutes or longer - 99291 and additional 99292 as appropriate

It is important to note that the documentation must match the complexity of medical decision making as well as the time spent in critical care exclusive of time spent during invasive diagnostic or therapeutic procedures such as intubation, bronchoscopy, cardioversion, tube thoracostomy, or central

venous catheter insertion.

Finally, certain procedures are bundled into critical care billing and cannot be billed separately, including:

- Interpretation of cardiac output measurements (CPT 93561, 93562)
- Chest radiographs, professional component (CPT 71010, 71015, 71020)
- Blood draw for specimen (CPT 36415)
- Blood gases and information data stored in computers (e.g., electrocardiogram, blood pressure, hematologic data) [CPT 99090]
- Gastric intubation (CPT 43752)
- Pulse oximetry (CPT 94760, 94761, 94762)
- Temporary transcutaneous pacing (CPT 92953)
- Ventilator management (CPT 94002-94004, 94660, 94662)
- Vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600)

Critical care billing may be a challenging process. A useful approach starts by determining if the care meets the requirements for critical care, selecting the appropriate critical care codes, and determining the amount of time spent in management and any time spent devoted to procedures. Proper documentation of these steps will help simplify the process and improve reimbursement.

Critical Care Billing Case Study

Physician Jones admits a patient with septic shock to the ICU. Her initial treatment involves intubation and placement of a central line and arterial line. The patient receives mechanical ventilation, volume resuscitation and antibiotics; a norepinephrine infusion is initiated and titrated for mean arterial pressure management. Ventilator titration is performed, as well as electrocardiography, arterial blood gas measurement, central venous oxygen saturation determination, and chest radiography interpretation. Finally, time is spent documenting time spent in critical care management as well as ICU admission. The total time spent was 119 minutes with 45 minutes devoted to procedures.

Physician Assistant Smith is covering the ICU that evening. The patient develops acute respiratory distress syndrome and is managed with low tidal volume ventilation. The patient also develops acute kidney injury, requiring placement of a temporary dialysis catheter, and she is managed using continuous hemodialysis. The total critical care management time spent was 90 minutes, including 30 minutes of procedural time. How would the critical care time be most appropriately billed?

Physician Jones:

Critical care time, 74 minutes – 99291

Arterial line – 36620: arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

Central line – 36556: non-tunneled central venous catheter > 5 years of age

Intubation – 31500: endotracheal intubation, emergency

Physician Assistant Smith:

Critical care time, 60 minutes – 99292 x 2

Temporary dialysis catheter placement – 36556: non-tunneled central venous catheter >5 years of age. Append modifier -59 to second central line code to avoid risk of denial by the payer as a duplicate code.

Common Questions

Can nonphysician providers (NPP) [e.g., physician assistants and nurse practitioners] bill for critical care services?

According to Medicare guidelines, NPPs can provide critical care services under the following conditions:

- The services provided must be within the scope of practice and licensure requirements for the state in which the NPP provides the services.
- For physician assistants, general physician supervision requirements must be met.

With these conditions met, NPPs can bill using codes 99291 or 99292 under their provider number.

Can multiple providers combine time spent in the care of a patient?

In general, provider time may be combined with the following stipulations:

- Only one provider may bill at one time.
- Providers must be in the same practice and specialty.
- *PAs / NPs can combine times.*
- When physicians and NPPs bill for critical care on the same patient, the time should be billed according to insurance payer guidance. Most payers do allow for the combination of physician and NPP time when billing for critical care.

Can critical care time be billed outside the ICU?(2)

Critical care is based on patient condition, not patient location. Care provided outside of the ICU can be billed as critical care if the critical care requirements are met. Conversely, the presence of the patient in the ICU because of hospital policies or lack of floor beds does not make the patient critically ill.

[Click here for additional notes.](#)

References:

1. Medicare Claims Processing Manual. Chapter 12: Physicians/nonphysician practitioners. <http://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/downloads/clm104c12.pdf>. Accessed March 31, 2014.
2. Sample GA, Dorman T. Coding and Billing for Critical Care: A Practice Tool.. 5th ed. Mount Prospect, IL: Society of Critical Care Medicine; 2013.

Additional Notes

There is considerable confusion when combining NPP and physician time for critical care. This is addressed in the Medicare Claims Processing Manual, Chapter 12 30.6.12 (Rev. 2914, 03-25-14). The confusion generally revolves around shared billing and critical care. To further clarify, shared billing is evaluation and management (E/M) care that is performed by both a physician and qualified NPP. This is addressed in the Medicare Claims Processing Manual, Chapter 12 30.6.1, section B (Rev. 2914, 03-25-14):

When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN.

To further reinforce this. Medicare states in Chapter 12 30.6.1, section E (Critical Care Services and Physician Time):

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) 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 non-physician practitioner for the specified reportable period of time.

Unlike other E/M services where a split/shared service is allowed the critical care service reported shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified non-physician practitioner and shall not be representative of a combined service between a physician and a qualified NPP.

When CPT code time requirements for both 99291 and 99292 and critical care criteria are met for a medically necessary visit by a qualified NPP the service shall be billed using the appropriate individual NPI number. Medically necessary visit(s) that do not meet these requirements shall be reported as subsequent hospital care services.

This leads to confusion over how to bill for time when both a physician and NPP from the same practice and specialty perform critical care services on the same patient on the same day. Medicare clarifies this in

Chapter 12 30.6.12, section I [Critical Care Services Provided by Physicians in Group Practice(s)]:

However, if a physician or qualified NPP within a group provides "staff coverage" or "follow-up" for each other after the first hour of critical care services was provided on the same calendar date by the previous group clinician (physician or qualified NPP), the subsequent visits by the "covering" physician or qualified NPP in the group shall be billed using CPT critical care add-on code 99292. The appropriate individual NPI number shall be reported on the claim. The services will be paid at the specific physician fee schedule rate for the individual clinician (physician or qualified NPP) billing the service.

Because of this confusion, different Medicare administration contractors have developed different policies for dealing with physicians and NPPs billing critical care on the same patient on the same day. Private payers and state Medicaid payers also may have different policies. Providers are urged to contact their carrier to clarify critical care payment methodology for combining NPP and physician critical care time.