Manual: Reimbursement Policy

Policy Title: **Critical Care, Evaluation and Management Services (99291, 99292)**

Section: Evaluation & Management Services

Subsection: None

Date of Origin: 10/28/2014 **Policy Number:** RPM041

Last Updated: 10/4/2017 **Last Reviewed:** 10/18/2018

Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

Reimbursement Guidelines

Moda Health follows CMS guidelines as follows:

> When two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service, only one physician in the specialty group may report CPT code 99291 with or without CPT code 99292, and the other physician(s) must report their critical care services with CPT code 99292. (CMS[3])

Primary service 99291 should be submitted by the first physician in the group to provide critical care services after midnight on that date of service. The remaining physicians will submit 99292 for critical care services rendered up through 23:59 on that date.

99292 will be denied when billed on a claim without 99291 and no other physician in the same specialty group has submitted 99291 for that date of service.

Background Information

Critical care is defined as the direct delivery by a physician(s) medical care for a critically ill or other qualified health care professional of medical care for a 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(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. Although critical care 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.

Critical care is usually, but not always, given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department. However, payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care. (AMA[1], CMS[2])

Codes, Terms, and Definitions

Code	Definition
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

Coding Guidelines

Key relevant coding guidelines from the AMA and CMS are noted below. Extensive additional guidelines and information on reporting of critical care services can be found in the CPT Code Book (Professional Edition), the CPT Assistant Archives, chapter 11 of the National Correct Coding Initiative (NCCI) Policy Manual, and the CMS Claims Processing Manual. Please reference those sources as needed.

“Critical care is a time-based service, and for each date and encounter entry, the physician's progress note(s) shall document the total time that critical care services were provided. More than one physician can provide critical care at another time and be paid if the service meets critical care, is medically necessary and is not duplicative care.” (CMS[3]) Generally this involves different physician specialties.

“The CPT critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. Non-continuous time for medically necessary critical care services may be aggregated.

Reporting CPT code 99291 is a prerequisite to reporting CPT code 99292. Physicians of the same specialty within the same group practice bill and are paid as though they were a single physician (§30.6.5)." (CMS[3])

"Critical Care Services and Physician Time

1. Off the Unit/Floor

   Time spent in activities (excluding those identified previously in Section C) that occur outside of the unit or off the floor (i.e., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care because the physician is not immediately available to the patient. This time is regarded as pre- and post service work bundled in evaluation and management services.

2. Split/Shared Service

   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.

3. Unbundled Procedures

   Time involved performing procedures that are not bundled into critical care (i.e., billed and paid separately) may not be included and counted toward critical care time. The physician's progress note(s) in the medical record should document that time involved in the performance of separately billable procedures was not counted toward critical care time.

4. 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:

   a) The patient is unable or incompetent to participate in giving a history and/or making treatment decisions, and
   b) The discussion is necessary for determining treatment decisions.

For family discussions, the physician should document:

a. The patient is unable or incompetent to participate in giving history and/or making treatment decisions
b. 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",
c. Medically necessary treatment decisions for which the discussion was needed, and
d. A summary in the medical record that supports the medical necessity of the discussion

All other family discussions, no matter how lengthy, may not be additionally counted towards critical care. Telephone calls to family members and or surrogate decision-makers may be counted towards critical care time, but only if they meet the same criteria as described in the aforementioned paragraph.

5. Inappropriate Use of Time for Payment of Critical Care Services.
   Time involved in activities that do not directly contribute to the treatment of the critically ill or injured patient may not be counted towards the critical care time, even when they are performed in the critical care unit at a patient's bedside (e.g., review of literature, and teaching sessions with physician residents whether conducted on hospital rounds or in other venues)." (CMS[3])

"Services Included in the Critical Care Service Codes
The following services are included in reporting critical care when performed during the critical care period by the physician providing critical care. Do not report these services in addition to the critical care service codes.

- Interpretation of cardiac output measurements (93561, 93562);
- Chest x-rays (71010, 71020);
- Blood gases and information data stored in computers (eg, ECG's, blood pressures, hematologic data (99090);
- Gastric intubation (91105);
- Temporary transcutaneous pacing (92953);
- Ventilator management (94656, 94657, 94660, 94662); and
- Vascular access procedures (36000, 36410, 36415, 36600)." (AMA[4])

Cross References

"Add-on Codes." Moda Health Reimbursement Policy Manual, RPM025.

References & Resources

1. American Medical Association. "Critical Care Services." *Current Procedural Terminology (CPT) 2014, Professional Edition.* Chicago: AMA Press, pp. 23-24.

2. CMS. “Critical Care Services (Codes 99291 - 99292).” *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.A.

3. CMS. “Critical Care Services and Physician Time.” *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.E.

4. American Medical Association. “Coding Communication - Critical Care Services.” *CPT Assistant.* Chicago: AMA Press, December 1998, p. 6.

IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative (CCI/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.