AAMC Regulatory Resource

Medicare Payment Policies for Critical Care Services (Effective January 2022)

Background

In the 2022 final Medicare Physician Fee Schedule rule, CMS updated its critical care service payment policies to take into account recent revisions in coding and payment for evaluation and management (E/M) services and changes in the delivery of care. Physicians and other health care professionals will need to adapt their practices to comply with these new rules.

Definition of Critical Care Services

Critical care is a complex service provided to a patient who has vital organ system failure or to prevent further life-threatening deterioration of the patient's condition. CMS adopts the definition of critical care services in the CPT Codebook. This includes CPT prefatory language stating that critical care service is "the direct delivery by a physician(s) or other qualified healthcare professional (QHP) of medical care for a critically ill/injured patient in which there is acute impairment of one or more vital organ systems, such that there is a probability of imminent or life-threatening deterioration of the patient's condition." Critical care services may be furnished by a physician or other QHP who is qualified by education, training, and licensure/regulation (when applicable).

Critical care requires the full attention of the physician or nonphysician practitioner (NPP) and therefore the practitioner cannot provide services to any other patient during the same period of time. Critical care may be furnished on multiple days and is typically furnished in a critical care area, such as an intensive care unit or emergency care facility.

CPT codes for Critical Care

99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.
99292	99292 Critical care, evaluation and management of the critically ill or critically injured patient, each additional 30 minutes.

Critical Care Services Furnished by a Single Physician or NPP

For critical care services furnished by a single physician or NPP, CMS adopts the rule that CPT code 99291 should be used to report the first 30-74 minutes of critical care on a given date (and that the code should be used only once per date). CPT code 99292 should be used for additional 30-minute time increments provided to the same patient. Noncontinuous time for critical care services can be aggregated. For continuous services when the service extends beyond midnight the following calendar day, the physician or NPP will report the total units of time provided

continuously. However, it there is a disruption in the service, a new initial service would be created.

Critical Care Services Furnished as Concurrent Care by Different Specialties

When more than one physician or qualified NPP furnishes services to the same patient on the same day, and the services of each practitioner are medically necessary and not duplicative, the services of each physician or NPP would be covered. Medicare policy would allow critical care visits furnished as concurrent care to the same patient on the same date by more than one practitioner in more than one specialty (i.e. an internist and a surgeon), regardless of group affiliation.

Critical Care Services Furnished as Concurrent Care by Practitioners in Same Specialty and Same Group (Follow up care*)*

When a practitioner provides the initial critical care service in its entirety and reports CPT code 99291 (initial critical care), any additional practitioners in the same specialty and same group furnishing care concurrently to the same patient on the same day would report their time spent on follow-up or subsequent care using CPT code 99292. CPT code 99291 would not be reported more than once for the same patient on the same day by practitioners in the same specialty in the same group.

In situations where a practitioner begins furnishing the initial critical care service but does not meet the time required to report CPT code 99291, and another practitioner in the same specialty and group continues to deliver critical care to the same patient on the same day, the time spent by those practitioners could be aggregated to meet the time requirement to bill CPT code 99291. Once the cumulative time to report CPT code 99291 is met, 99292 can only be reported by a practitioner in the same specialty and group when an additional 30 minutes of critical services have been furnished to the same patient on the same date (74 minutes plus 30 minutes =104 minutes).

Under the Physician Fee Schedule, Medicare classifies NPPs in a different specialty than physicians with whom the NPP is working; therefore, the policy requiring the additional 30 minutes does not apply if an NPP provides the follow-up care after a physician, or vice versa. In these instances, the requirement for 104 minutes total to bill CPT code 99292 would not apply; instead, the services would be billed using the split (or shared) critical care visit policy for billing CPT code 99292 (described below).

Split (or Shared) Critical Care Visits

Critical care visits may be furnished as split (or shared) visits. The rules related to split (shared) visits apply except for the list of qualifying activities used to determine the substantive portion of the visit. Beginning January 1, 2022, the substantive portion for critical care services is defined as more than half of the total time spent by the physician and NPP.

The qualifying activities that count as time for split (or shared) critical care visits are described in the prefatory language for critical care services in the CPT Codebook and are as follows:

- 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
- Time on the floor or nurses' station reviewing test results or imaging
- Time discussing critically ill patient's care with other medical staff
- When patient is unable or lacks capacity to participate in discussions, time spent on the floor or unit with family members or surrogate decisionmakers obtaining history, reviewing patient's condition or prognosis, or discussing treatment or limitations of treatment.

The following activities may not be reported as critical care:

- Time spent on separately reportable activities
- Time spent on activities that occur outside the unit or off the floor (e.g. telephone calls at home, in office, or at hospital)
- Time spent on activities that do not directly contribute to the treatment of the patient, even if performed in the critical care unit (e.g., participating in administrative meetings or telephone calls to discuss other patients)

To bill split (or shared) critical care services, the billing practitioner first reports 99291.If more than 75 cumulative total minutes are spent providing critical care, the billing practitioner reports one or more units of 99292. Modifier -FS (split or shared E/M visit) must be added to the critical care code(s) on the claim. When two or more practitioners spend time jointly meeting with or discussing the patient, the time may be counted only once.,

Continuous Services Defined (Crossing Calendar Days)

The Final Rule adopts the following language from the introduction to the CPT Codebook regarding when a critical care service furnished by a single physician or NPP extends beyond midnight the following calendar day:

> "Some services measured in units other than days extend across calendar dates. When this occurs, a continuous service does not reset and create a first hour. However, any disruption in the service does create a new initial service. For example, if intravenous hydration (96360, 96361) is given from 11 p.m. to 2 a.m., 96360 would be reported once and 96361 twice. For continuous services that last beyond midnight (that is, over a range of dates), report the total units of time provided continuously."[1]

Documentation Requirements for Critical Care Services

[1] AMA CPT Professional (2022).

CMS requires practitioners to document the total time that critical care services were provided by each reporting practitioner. CMS does not require start and stop times. Documentation should be sufficient to allow a medical reviewer to identify the role each practitioner provided in the patient's care. The same documentation requirements that apply to for split (or shared) E/M visits apply to split (or shared) critical care visits.

Critical Care Services Furnished on Same-Day As E/M Services

CMS will allow payment for critical care services furnished for the same patient on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty if the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care services. The visit must be medically necessary and separate and distinct from the critical care services. Practitioners must report modifier -25 on claims for these critical care services in these circumstances.

Payment for Critical Care Visits and Global Surgery

CMS will pay for critical care visits (preoperatively and postoperatively) separately from a procedure with a global surgical period if the critical care service is above and beyond and unrelated to the procedure (i.e., trauma or burn cases). CMS created a new modifier, -FT to denote that the critical care is unrelated to the procedure. If the care is fully transferred from the surgeon to an intensivist and is unrelated, then modifiers -54 (surgical care only) and -55 (postoperative management only) must also be reported to indicate the transfer of care. The surgeon would report modifier -54 and the intensivist would report both modifiers -55 and the new modifier -FT).

Implications

Teaching hospitals and physicians should be knowledgeable about these new policies regarding critical care visits, which will impact reimbursement. Organizations will need to evaluate the ways in which they will use NPPs as part of team-based care to increase patient access to services. As always, appropriate documentation will be important to support the provision and billing for these services.

References

Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies. Published November 19, 2021. Retrieved from: **https://www.federalregister.gov/d/2021-23972**
Medicare Claims Processing Manual (Transmittal 11288), March 4, 2022. **https://www.cms.gov/files/document/r11288cp.pdf**
MLN Matters Number: MM12543 (March 4, 2022) **https://www.cms.gov/files/document/mm12543-internet-only-manual-updates-iom-critical-care-split-shared-evaluation-and-management-visits.pdf**
CMS FAQ document: Split (shared visits) and critical care (April 7, 2022)

https://www.cms.gov/sites/default/files/2022-04/Split__or_shared__services_and_critical_care_FAQs_07Apr2022.pdf

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