TITLE: Billing Medicare Part B for Critical Care Services

POLICY/PURPOSE: This policy details Medicare Part B regulatory requirements for critical care services, including split (or shared) billing between a physician and an Advanced Practice Professional (APP), as well as concurrent critical care provided by same or different specialty providers on the same day. This policy also addresses other aspects of critical care services including teaching physician documentation requirements for critical care services involving residents.

DEFINITIONS:

Advanced Practice Professional ("APP") – An individual qualified by education, training, licensure/regulation and facility privileging who performs a professional service within his/her state scope of practice and may independently provide and report that professional service. APPs may be supervised by a physician or collaborate with a physician.

Medicare recognizes the following APPs who may report E/M Services:

- Certified Nurse Midwife
- Clinical Nurse Specialist
- Nurse Practitioner
- Physician Assistant

Bundled Services – Services that are included by CPT in critical care services and therefore are not separately payable. The following services are bundled into critical care services when rendered during the time-period when the practitioner is providing critical care for a given patient. Although these services are not reported separately, time spent performing these services may be counted toward critical care time.

- interpretation of cardiac output measurements (CPT 93598);
- chest X rays (CPT 71045, 71046);
- pulse oximetry (CPT 94760, 94761, 94762);
- blood gases;
- collection and interpretation of physiologic data (for example, ECGs, blood pressures, hematologic data);
- gastric intubation;
- temporary transcutaneous pacing;
- ventilator management; and
- vascular access procedures

Concurrent Care – when more than one physician renders services that are more extensive than consultative services during a period of time. The reasonable and necessary services of each physician furnishing concurrent care is covered when each plays an active role in the patient's treatment. In the context of critical care services, a critically ill patient may have more than one medical condition requiring diverse, specialized medical services and requiring more than one practitioner, each having a different specialty, playing an active role in the patient's treatment.

Critical Care – The direct delivery by a physician or APP 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. It involves high complexity decision-making to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition. Critical care may be reported by physicians and APPs who are qualified by education, training, licensure/regulation (when applicable), facility privileging (when applicable), and the applicable Medicare benefit category to perform critical care services and independently report them.

Distinct Time – time spent separately on patient care by the physician or APP.

Facility Setting – For purposes of this section means institutional settings, such as hospitals in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited and Medicare benefits are assigned to the patient. A physician office (Place of Service code 11) and an Urgent Care Center (Place of Service code 20) are not considered Facility settings.

Joint Time – time spent by the physician/APP or teaching physician and resident discussing or assessing the patient together.

Split (or shared) visit: A critical care visit in the Facility Setting that is performed in part by both a physician and an APP, who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or APP if furnished independently by one of them.

Substantive Portion – more than half the cumulative total time spent by the physician and APP in qualifying activities that are included in critical care CPT codes 99291 and 99292.

Note: The role of the physician in the service extends further than providing general oversight-of/agreement-with the APP's work (e.g., reviewing/co-signing the APP's note). It must consist of active, shared participation in the service with the APP.

In order to bill critical care under the physician's provider number, the physician must personally perform the Substantive Portion of the critical care service that supports the service billed.

PROCEDURE:

1. General Guidelines

A. For payment under the Medicare Physician Fee Schedule (PFS), Medicare uses the definition of critical care services in the CPT manual, and the CPT listing of bundled services, unless otherwise specified. This includes the CPT prefatory language.

B. As specified in CPT prefatory language, critical care may be furnished on multiple days, and is typically furnished in a critical care area, which can include an intensive care unit or emergency care facility.

C. Critical care requires the full attention of the physician or APP and therefore, for any given time period spent providing critical care services, the practitioner cannot provide services to any other patient during the same period of time.

D. Any services **not** listed above under the definition of *Bundled Services* may be reported in addition to critical care codes 99291 (Critical care, evaluation and management of the critically ill or injured patient; first 30-74 minutes) and 99292 [Critical care, evaluation and management of the critically ill or injured patient; each additional 30 minutes (List separately in addition to code for primary services)].

2. Time

Refer to Appendix A for the Total Duration of Time chart which lists various critical care times along with corresponding critical care CPT codes and units.

A. Time spent performing separately billable services would **not** be counted toward the time reported for critical care codes 99291 and 99292.

B. Time spent rendering critical care on a given date of service does not have to be continuous.

C. For any given period of time spent providing critical care services, the individual providing the service must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period.

D. Time spent with the individual patient must be documented in the medical record. Although critical care start and stop times are not necessary, documenting them may help distinguish procedures or other services performed outside of the reported critical care time.

E. Although critical care does not have to be rendered at the immediate bedside, it must be rendered on the floor or unit where the patient is located. Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls whether taken at the practitioner's home, in the office, or elsewhere in the hospital) may not be counted toward billable critical care time since the practitioner is not immediately available to the patient.

F. Joint physician/APP time may also be added to arrive at the time reported, but when physicians and APPs jointly meet with or discuss the patient, only the time of one of the practitioners may be counted.

Example: If the APP first spent 15 minutes with the patient and the physician then spent another 45 minutes on the same calendar day, their individual time spent would be summed to equal a total of 60 minutes. If, in the same situation, the physician and APP met together for 15 additional minutes (beyond the 60 minutes) to discuss the patient's treatment plan, that Joint Time could only be counted once for purposes of establishing total time.

In the above example, a total of 75 minutes (physician time + APP time + Joint Time) would be billed under the physician's provider number because the physician spent the majority of time. Specifically, 1 unit of CPT 99291 only as 104 minutes would be needed before a unit of 99292 could be billed to Medicare. No separate charge for APP time would be reported.

3. Critical Care by a Single Physician or APP (not as a split/shared visit)

A. When a single physician or APP furnishes 30 -74 minutes of critical care services to a patient on a given date, the physician or APP who furnished the service will report CPT

code 99291. CPT code 99291 will be used only once per date, per patient, even if the time spent by the practitioner is not continuous on that date. Thereafter, the physician or APP will report CPT code 99292 for additional 30-minute time increments provided to the same patient.

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

4. Critical Care Visits Furnished Concurrently by Different Specialties

Medicare policy allows critical care visits furnished as concurrent care (or concurrently) to the same patient on the same date by more than one practitioner in more than one specialty (for example, an internist and a surgeon, allergist and a cardiologist, neurosurgeon and APP), regardless of group affiliation, if the service meets the definition of critical care and is not duplicative of other services. Additionally, these critical care visits need to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

5. Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Same Group (Follow-Up Care)

A. Physician(s) or APP(s) in the same specialty and in the same group may provide concurrent follow-up care, such as a critical care visit subsequent to another practitioner's critical care visit. This may be as part of continuous staff coverage or follow-up care to critical care services furnished earlier in the day on the same calendar date.

Note: For purposes of payment under the Physician Fee Schedule, Medicare classifies APPs in a specialty that is <u>not</u> the same as the physician with whom the APP is working (which is contrary to CPT guidelines). As such, the policies in 5 (A-D) would not apply to the situation where an APP provides the follow-up care to a physician, or vice versa. Instead, see the section below regarding split (or shared) critical care services.

B. In the situation where a practitioner furnishes the initial critical care service in its entirety and reports CPT code 99291, any additional practitioner(s) in the same specialty and the same group furnishing care concurrently to the same patient on the same date report their time using the code for subsequent time intervals (CPT code 99292). CPT code 99291 will not be reported more than once for the same patient on the same date by these

practitioners. This policy recognizes that multiple practitioners in the same specialty and the same group can maintain continuity of care by providing follow-up care for the same patient on a single date.

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

D. The aggregated time spent on critical care visits must be medically necessary and each visit must meet the definition of critical care in order to add the times for purposes of meeting the time requirement to bill CPT code 99291.

6. Split (or Shared) Critical Care Visits

A. When critical care services are furnished as a split (or shared) visit, the individual who performs the Substantive Portion of the critical care services bills for the critical care services. The Substantive Portion is defined as more than half the cumulative total time spent in qualifying activities that are included in CPT codes 99291 and 99292. Since, unlike other types of E/M visits, critical care services can include additional activities that are bundled into the critical care visits code(s), there is a unique listing of qualifying activities for split (or shared) critical care. These qualifying activities are described in the prefatory language for critical care services in the CPT Codebook.

B. To bill split (or shared) critical care services, the billing practitioner first reports CPT code 99291 and, if 75 or more cumulative total minutes are spent providing critical care, the billing practitioner reports one or more units of CPT code 99292. Modifier -FS (split or shared E/M visit) must be appended to the critical care CPT code(s) on the claim.

C. Append the "-FS" modifier [Split (or shared) Evaluation and Management service] when critical care services are split (or shared) between a physician and an APP. The "FS" modifier must be entered regardless of whether the charge is billed under the physician's or the APP's provider number.

7. Critical Care on Same Day as Another E/M Service

A. In situations where a patient receives another E/M visit on the same calendar date as critical care services, both may be billed (regardless of practitioner specialty or group affiliation) as long as the medical record documentation supports:

i. that the other E/M visit was provided prior to the critical care services at a time when the patient did not require critical care;
ii. that the services were medically necessary; and
iii. that the services were separate and distinct, with no duplicative elements from the critical care services provided later on that date.

B. When one or more additional E/M visits furnished on the same day are unrelated to the critical care, append the modifier "-25" (same-day significant, separately identifiable evaluation and management service) to the critical care service code(s).

8. Critical Care and Global Surgery

Critical care visits are sometimes needed during the global period of a procedure, whether pre-operatively, on the same day, or during the post-operative period. In some cases, preoperative and postoperative critical care visits are included in procedure codes that have a global surgical period.

A. In those cases where a critical care visit is unrelated to the procedure with a global surgical period, preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed (for example, trauma, burn cases).

B. When the critical care service is unrelated to the procedure, append the modifier -FT (unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit) to the critical care code(s). If the –FT modifier is applicable and the critical care service is a split (or shared) visit, append both the –FT and –FS modifiers to the critical care code(s).

C. The medical record documentation must support that the critical care was unrelated to the procedure.

D. If the critical care is related to the procedure and falls within the global surgery period, bill the critical care visit with CPT code 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate than an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure). CPT Code 99024 is a zero-dollar charge.

E. If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), modifiers -54 (surgical care only) and -55 (postoperative management only) must be reported to indicate the transfer of care. The surgeon will report modifier -54. The intensivist accepting the transfer of care will report both modifier -55 and modifier -FT. As usual, medical record documentation must support the claims.

9. Medical Record Documentation

A. Critical care is a time-based service, and therefore, practitioners must document in the medical record the total time (not necessarily start and stop times) that critical care services are furnished by each reporting practitioner. Documentation needs to indicate that the services furnished to the patient, including any concurrent care by the practitioners, are medically reasonable and necessary for the diagnosis and/or treatment of illness and/or injury or to improve the functioning of a malformed body member.

B. To support coverage and payment determinations regarding concurrent care, services must be sufficiently documented to allow a medical reviewer to determine the role each practitioner played in the patient's care (that is, the condition or conditions for which the practitioner treated the patient).

10. Critical Care Services Involving Residents and Teaching Physicians

A. Presence. In order for the Teaching Physician to bill for critical care services, the Teaching Physician must be present for the entire period of time for which the claim is submitted. 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.

B. Participation. 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 or other time-based services. Only time spent by the

resident and Teaching Physician together with the patient or the Teaching Physician alone with the patient can be counted toward critical care time.

C. Acceptable Documentation. A combination of the Teaching Physician's documentation and the resident's documentation may be used to support critical care services. The Teaching Physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment. The Teaching Physician medical record documentation must provide substantive information including:

i. time the Teaching Physician spent providing critical care;
ii. that the patient was critically ill during the time the Teaching Physician saw the patient;
iii. what made the patient critically ill; and
iv. the nature of the treatment and management provided by the Teaching Physician.

NOTE: Documentation by the resident of the presence and participation of the Teaching Physician is NOT sufficient to establish the presence and participation of the Teaching Physician. If the resident provides the service without the Teaching Physician's direct participation, the resident must compose the note, but the service cannot be billed.

D. Example of Acceptable Documentation. The following is an example of acceptable documentation:

"Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."

E. Unacceptable Documentation. The following is an example of unacceptable documentation:

"I came and saw (the patient) and agree with (the resident)."

F. Modifiers. When a resident is involved in a critical care service with a teaching physician and the teaching physician presence and documentation requirements are met, append modifier -GC (this service has been performed in part by a resident under the direction of a teaching physician). Modifier –GC should be appended in addition to any other applicable modifiers.

REFERENCES:

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CMS. Transmittal No. 11287. 03/02/2022.
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CMS. **"**FAQs: Split (or Shared) Visits and Critical Care Services." April 7, 2022
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