



Critical care procedure codes 99291 and 99292 are time-based codes. The physician must document the total amount of time the physician spent providing the critical care service to a **single** patient, even if the time spent is not continuous. In order to report critical care, the physician must devote his or her full attention to that patient; and therefore, cannot provide services to any other patient during the same time period.¹

When billing for critical care time (and other time-based codes), the total time spent with the individual patient must be recorded in the patient's medical record. Critical care services may be continuous or interrupted; however, reporting of critical care time includes all critical care services rendered on a calendar day.

- Critical care services totaling less than 30 minutes should be reported using an appropriate Evaluation & Management (E&M) code and not the critical care codes.
- When rendering 30-74 minutes of critical care, CPT code 99291 should be billed.
- Each additional 30 minutes of critical care should be listed separately and is billed using CPT code 99292 with the units adjusted for each additional 30 minute period. CPT code 99292 is an "add-on code" and cannot be reported without first reporting CPT code 99291. It may also be used to report the final 15-30 minutes of critical care on a given day.

Time that **CAN** be reported as critical care includes any time spent:

- directly engaged in work directly related to the individual patient's care whether that time is spent at the immediate bedside or elsewhere on the floor or unit;
- at the nursing station on the floor reviewing test results or imaging studies;
- discussing the critically ill patient's care with other medical staff;
- documenting critical care services in the medical record (even though this time may not occur at the patient's bedside); and
- performing procedures that **ARE** bundled into critical care (e.g., ventilation management).²

¹ Of course the patient's condition must also meet the definition of a critically ill or injured patient. CMS (formerly HCFA) defines a critically ill or injured patient as a patient who has a "high probability of sudden, clinically significant, or life threatening deterioration which requires the highest level of physician preparedness to intervene urgently."

² Refer to the AMA's Current Procedural Terminology manual for a more detailed list of procedures/services that are bundled into critical care.

Time that **CANNOT** be reported as critical care includes any 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). This time is not counted because the physician is not immediately available to the patient.
- in activities that do not directly contribute to the treatment of the patient even if they are performed in the critical care unit (e.g., participation in administrative meetings or telephone calls to discuss OTHER patients).
- performing **separately reportable** procedures/services (e.g., insertion and placement of Swan-Ganz catheter) or procedures/services that are **NOT** bundled into critical care. According to Medicare, the physician's progress note must document that the time involved in the performance of separately billable procedures was not counted toward critical care time.

Time Spent with Family Members or Other Surrogate Decision Makers:

In order to count the time spent with family members or other surrogate decision makers as critical care time, Medicare requires that the following be documented in the physician's progress note for that day:

1. The patient was unable or incompetent to participate in giving history and/or making treatment decisions.
2. The necessity of the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to discuss treatment options with family immediately").
3. The treatment decisions for which the discussion was needed.
4. The substance of the discussion as it related to the treatment decision.

Medicare medical policy emphasizes that 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 criteria include regular or periodic updates on 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 time).

Telephone calls to family members or surrogate decision-makers must meet the same conditions as the face-to-face meetings.

Teaching Physician Rules for Critical Care Time

The Teaching Physician must be present for the period of time for which the claim is made. Time spent by the Resident in the absence of the Teaching Physician cannot be billed by the Teaching Physician as critical care time. Only time spent by the Teaching Physician and Resident together with the patient or the Teaching Physician alone with the patient can be counted toward critical care time.