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Medicare Part B 2024

Spring/Summer Virtual Conference

Mastering Medicare: Tuesday Tutorials

Critical Care

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Objective

Learn about the components that must be counted as inclusions to critical care services, using global modifiers to indicate the service was significant, separately identifiable, **or** was the decision for surgery, **or** was for postoperative care unrelated to the surgery

Agenda

- Critical Care Services Overview
- Services Always Included
- Split/Shared Critical Care
- Documentation
- Using Modifier 24, 25 or 57
- Billing Considerations and Clinical Examples of Critical Care Services
- Common Questions and Answers
- Resources

Critical Care Services Overview

Critical Care

- Critical care is the direct delivery of medical care for a critically ill or critically injured patient
  - Physician
  - Other healthcare professional

Critical Care Involves High Complexity Decision Making

- 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 function(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

- Central nervous system failure
- Circulatory failure
- Shock
- Renal
- Hepatic
- Metabolic
- Respiratory failure

Where Critical Care is Usually Provided

- Coronary Care Unit
- Intensive Care Unit
- Pediatric Intensive Care Unit
- Respiratory Care Unit
- Emergency Care Facility
  - It's the documentation of the patient's condition and services rendered, NOT the location that determines whether critical care is appropriately billed
  - Just because a patient is critically ill, or is in the ICU/CCU, does not mean the care is automatically a critical care service
  - Services for a patient who is not critically ill but happens to be in the critical care unit are reported using other appropriate E/M codes

Other Critical Care Locations

- Critical care is not location-dependent but is based on the patient's acute need for such care and the work performed by the provider in treating the patient's clinical status
- Critical care may be performed and billed in both inpatient and outpatient sites, other sites may include a provider's office, the patient's home or place of residence, nursing facilities and sites providing mental health and substance abuse services

Critical Care Services and Medical Necessity

- Critical care services must be medically necessary and reasonable
- Must encompass both treatments
  - Vital organ failure
  - Prevention of further life-threatening deterioration of the patient's condition
- The treatment of the patient's condition shall be based on the threat of imminent deterioration (i.e., the patient shall be critically ill or injured at the time of the physician's visit)

Examples That May NOT Warrant Critical Care Services

- Daily management of a patient on chronic ventilator therapy does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long-term management of the ventilator dependence
- Management of or care related to dialysis for a patient receiving ESRD hemodialysis does not meet the criteria for critical care unless the critical care is separately identifiable from the chronic long-term management of the dialysis dependence
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 8, Section 160.4
- When a separately identifiable condition (e.g., management of seizures or pericardial tamponade related to renal failure) is being managed, it may be billed as critical care if critical care requirements are met
  - Modifier 25 should be appended to the critical care code when applicable in this situation

Examples That May NOT Warrant Critical Care Services

- Patients admitted to a critical care unit because no other hospital beds were available
- Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose)
- Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit

Examples That May Warrant Critical Care Services

- An 81-year-old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and pressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
- A 67-year-old female patient is three days status post mitral valve repair. She develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.

Examples That May Warrant Critical Care Services

- A 70-year-old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive two days after admission
- A 68-year-old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy

Full Attention of the Physician

- For any given period of time spent providing critical care services, the physician must devote full attention to the patient, therefore, cannot provide services to any other patient during the same period of time
  - Reviewing lab test results
  - Discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor
    - Even when it does **not** occur at the bedside, as long as, this time represents the physician's full attention to the management of the critically ill/injured patient

Critical Care Services and Physician Time

- Time based service, the physician progress note(s) shall document the total time that critical care services were provided

Ventilator Management

- Medicare recognizes the ventilator codes (CPT codes 94002–94004, 94660 and 94662) as physician services payable under the physician fee schedule
- Medicare Part B under the physician fee schedule does not pay for ventilator management services in addition to E/M service (e.g., critical care services, CPT codes 99291–99292) on the same day for the patient even when E/M service is billed with CPT modifier 25

Services Always Included

Critical Care Services Always Included

- Interpretation of cardiac output measurements
  - 93561, 93562
- Chest X-ray
  - 71045, 71046
- Pulse oximetry
  - 94760, 94761, 94762
- Blood gases, and information data stored in computers
  - (e.g., ECGs, blood pressures, hematologic data)
- Gastric intubation
  - 43752, 43753

Critical Care Services Always Included

- Temporary transcutaneous pacing
  - 92953
- Ventilator management
  - 94002–94004, 94660, 94662
- Vascular access procedures
  - 36000, 36410, 36415, 36591, 36600
- Any services **not included** in this listing may be reported separately

Current Procedural Terminology

- 99291
  - Represents the first 30–74 minutes of critical care on a given calendar date of service
  - Should only be used **once per calendar date per patient by the same physician of the same specialty**, or a qualified NPP
  - Physicians and NPPs of the same specialty within the same group practice bill and are paid as though they were a single physician and would not each report CPT 99291 on the same date of service
- 99292
  - Represents additional block(s) of time, of 30 minutes each, beyond the first 74 minutes of critical care
  - The service may represent aggregate time met by a single physician or members of the same group practice with the same medical specialty

Current Procedural Terminology

- 99291
  - Critical care, evaluation and management of the critically ill or critically injured patient, first 30–74 minutes
- 99292
  - Each additional 30 minutes (list separately in addition to code for primary service)

Split/Shared Critical Care

Split/Shared Critical Care

- The split/shared E/M policy does **now** apply to critical care services or procedures
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 12, Section 30.6.12
    - The split/shared E/M policy was changed to now apply to critical care services or procedures

Split/Shared Services

- Modifier FS
- CMS allows critical care to be billed as split/shared services between a physician and nonphysician practitioner
- When performed in this manner, critical care code(s) are billed under the NPI of the physician/practitioner that provided more than 50% of the timed service
- The billing must include modifier FS with the critical care
- Documentation would include what each practitioner provided during the care rendered
- Does not apply to different physicians of different specialties, but does include NPPs within a specialty group

Documentation

Recorded in the Patient's Medical Record

- Time spent with the individual patient
  - Engaged in work directly related to the individual's patient care
    - Immediate bed side
    - Elsewhere on the floor or unit
      - Nursing station on the floor reviewing test results or imaging studies
      - Discussing care with other medical staff
      - Documenting critical care
    - Critical Care Tip Sheet

For Family Discussion
The Physician Should Document

- The patient is unable or incompetent to participate in giving history and/or making treatment decisions
- 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")
- Medically necessary treatment decisions for which the discussion was needed
- A summary in the medical record that supports the medical necessity of the discussion
- All other family discussions may not be counted

When Patient is Unable or Lacks Capacity to Participate

- Discussions
- Time spent on the floor/unit with family members or surrogate decision makers obtaining
  - Medical history
  - Reviewing the patient's condition or prognosis
  - Discussing treatment or limitations(s) of treatment may be reported provided that the conversation bears directly on the management of the patient

Do NOT Report

- Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit
- Time spent out of the unit or off the floor
  - **Telephone calls whether taken at home, in the office, or elsewhere in the hospital**
- Time spent performing separately reportable procedures or services should not be included in the time reported as critical care time
  - **Double dipping = Fraud**

Using Modifier 24, 25 or 57

Critical Care During Pre/Postop Portion of Global Period: Trauma and Burn Cases

- Each preoperative and postoperative care diagnosis must clearly indicate critical care was **unrelated** to the surgery
- **Pre**operative care modifier **25** (significant, separately identifiable E/M services by the same physician on the day of the procedure)
- **Post**operative care modifier **24** (unrelated E/M service by the same physician during a postoperative period)

CPT Modifier 24 Unrelated E/M

- Intended for use with services that are absolutely unrelated to the surgery
- Recognize modifier 24 only for care following discharge unless
  - The care is for immunotherapy management furnished by the transplant surgeon
  - The care is for critical care for a burn or trauma patient
  - The documentation demonstrates the visit occurred during a subsequent hospitalization and diagnosis supports the fact that it is unrelated to the original surgery

Modifier 25 Significantly Separately Identifiable E/M Same Day of Minor Surgery

- Modifier 25 indicates significant, separately identifiable E/M by the same physician on the same day of the procedure or other service
  - Append to E/M
  - Must bill with zero- or ten-day global procedure
- MAC determines that a high usage rate of modifier 25 upon review, may impose prepayment screens or documentation requirements for that provider or group

Modifier 57 Decision for Surgery E/M on Day of or Day Before Major Surgery

- Modifier 57 indicates E/M resulted in the decision to perform the procedure/surgery
  - Append to E/M code
  - Must bill with 90-day global procedure
- MAC determines that a high usage rate of modifier 57 upon review, may impose prepayment screens or documentation requirements for that provider or group

Billing Considerations and Clinical Examples of Critical Care Services

Billing Considerations

- Critical care time may be aggregated over a 24-hour period
- Only one physician may bill for critical care services during any one single period of time
  - **Even if more than one physician is providing care to a critically ill patient**
- Providers are often employed by the hospital on a “shift” or “per day” basis
- “On duty” hours in a critical care unit have no correlation to critical care services as paid under the Medicare Part B Fee Schedule
- Critical care time is paid on a per patient/per service basis, each unit of billing must be supported by a medical record describing the specific nature and time for the service rendered
- Critical care of less than 30 minutes total duration on a given calendar date is not reported separately using the critical care codes
  - **This service should be reported using another appropriate E/M code such as subsequent hospital care**

Billing Considerations

- After an ED service has been completed, an ED patient may subsequently require critical care. When CMS criteria for this circumstance are met, both services may be billable
- Physicians and NPPs who are members of the same or different group or practice specialties may bill for both services when the critical care service is subsequent to the prior ED service, performed prior to the patient's clinical need for critical care
- In this instance, both services must be medically necessary and distinctly separate, with no duplicative elements between the ED service and the subsequent critical care service
- For billing purposes, modifier 25 should be affixed to the critical care service, indicating a separately distinct service from the original ED service
- Services (99282–99285 and 99291–99292) must be billed in the sequence in which they were performed, i.e., ED first followed by critical care with modifier 25 added. Both services are not payable if/when the sequence is reversed
- Providers are advised to carefully document these circumstances and to submit documentation upon request supporting the two services

Clinical Examples of Critical Care Services

- Drs. Smith and Jones, pulmonary specialists, share a group practice. On Tuesday, Dr. Smith provides critical care services to Mrs. Benson who is comatose and has been in the intensive care unit for four days following a motor vehicle accident. She has multiple organ dysfunction including cerebral hematoma, flail chest and pulmonary contusion. Later, on the same calendar date, Dr. Jones covers for Dr. Smith and provides critical care services.
- Medically necessary critical care services provided at the different time periods may be reported by both Drs. Smith and Jones. Dr. Smith would report 99291 for the initial visit and Dr. Jones, as part of the same group practice would report 99292 on the same calendar date if the appropriate time requirements are met.

Clinical Examples of Critical Care Services

- Mr. Marks, a 79-year-old comes to the emergency room with vague joint pains and lethargy. The ED physician evaluates Mr. Marks and phones his primary care physician to discuss his medical evaluation. His primary care physician visits the ER and admits Mr. Marks to the observation unit for monitoring, and diagnostic and laboratory tests. In observation Mr. Marks has a cardiac arrest. His primary care physician provides 50 minutes of critical care services. Mr. Marks' is admitted to the intensive care unit. On the same calendar day, Mr. Marks' condition deteriorates and he requires intermittent critical care services.
- In this scenario, the ED physician should report an emergency department visit and the primary care physician should report both an initial hospital visit and critical care services.

Correct Billing of Critical Care

- A patient arrives in the emergency department in cardiac arrest. The ED physician provides 40 minutes of critical care services. A cardiologist is called to the ED and assumes responsibility for the patient, providing 35 minutes of critical care services. The patient stabilizes and is transferred to the CCU.
- In this instance, the ED physician provided 40 minutes of critical care services and reports only the critical care code (99291) not emergency department services. The cardiologist may report the 35 minutes of critical care services (also 99291) provided in the ED.
- Additional critical care services by the cardiologist in the CCU may be reported on the same calendar date using 99292 or another appropriate E/M code depending on the clock time involved.

Common Questions and Answers

Question 1

- What's the correct way to report critical care when the continuous critical care time crosses midnight into the next calendar date?
  - Example: "120 minutes of critical care, start time 11:00 p.m. on day one and continuing into day two from 12:00 a.m. until 1:00 a.m."

Answer 1

- These services would be appropriately billed as one unit of CPT code 99291 (first hour) and two units of 99292 (two increments of additional ½ hours), all billed on the initial date of service.
  - As a reminder, billing for these services requires performance by an attending physician or hospitalist; services by residents are not billable to Medicare.

Question 2

- What type of documentation does NGS recommend to support subsequent critical care services (99292), in order to show the time spent was subsequent to the initial 74 minutes?

Answer 2

- After 74 minutes of 99291 have been performed and documented, additional care requiring 30 minutes or more of time may be represented by 99292, either contiguous with the 99291 or at a later point in time on the same date of service by the same provider or a group member.
- Time for each segment of care should be documented as either minutes spent ("60 minutes") or clock time ("1:00–2:00 p.m.")

Question 3

- What is the appropriate billing when a provider performs a critical care service on the same date as he/she performs an endotracheal intubation (CPT code 31500)?

Answer 3

- The critical care service requires 30–74 minutes of performance time, and any time spent performing a separately payable service (e.g., endotracheal intubation) must be deducted from the time counted toward the critical care service.
- If the critical care service, on its own, was 35 minutes duration and intubation was performed at a time before or after the critical care service, then the critical care code would be billed with a modifier 25, and the intubation code entered on another line of coding.

Question 4

- The billing providers in our critical care service may be an attending physician, NP or PA. They all bill under the same group/tax ID number. How do you report critical care services when both an NP and attending physician contribute to critical care service 99291?

Answer 4

- Initial critical care services (represented by CPT 99291) may now be billed according to split/shared rules so this may be billable. The service would be billed under the physician/practitioner who provided the substantive amount of service time, greater than 50% of the total time.
- Episodes of continuing/subsequent critical care, represented by CPT code 99292 may be performed and billed in the same manner. Again, more than half of the total time is the determining factor in who bills for the service.
- Each line of service must clearly indicate the rendering provider's identifying information. This information would need to be provided in Item 24 or the electronic equivalent. Modifier FS is billed with the service to indicate it was split/shared.

Question 5

- When two members of a group (either physician or NPP) perform and bill CPTs 99291 and subsequent episode(s) of 99292 on the same date of service, do both services have to be billed on the same claim?

Answer 5

- Yes, CPT code 99292 is an add-on code, used with primary code 99291, when appropriate. In these situations, NGS claim editing logic reviews the claim for the same date of service as the primary code. When 99291 has been billed and allowed for that date of service, 99292 would be payable, if all other claim requirements were met.

Question 6

- Is documentation of the exact time duration required in support of CPT codes 99291–99292, or can the provider check a box on the electronic record that prints out “Critical Care Time Spent: 30–74 minutes.” Other documentation for medical necessity and services performed would of course be present.

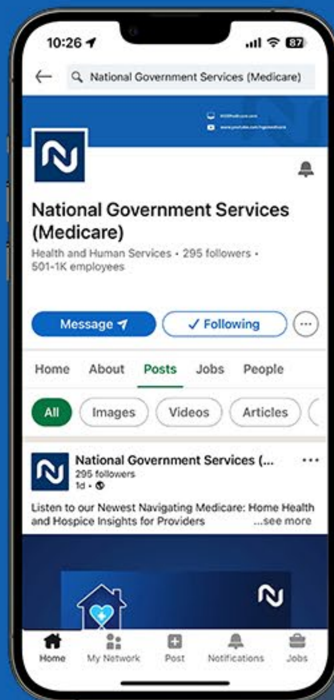
Answer 6

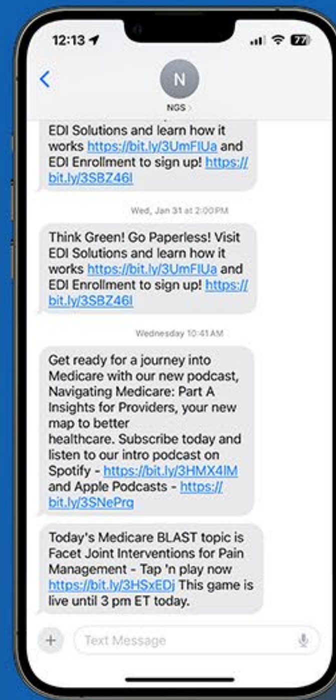
- Although CMS does not define specific time recording, NGS strongly recommends time spent rendering critical care services be included in the associated notes.
- The preferred format is "11:00–11:45 a.m." although "Time spent: 45 minutes" may also be acceptable.

Resources

Critical Care Resources

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual, Chapter 12*
  - Section 30.6.12 Critical Care
  - Section 30.6.18 Split/Shared Visits
- NGS Critical Care Web page
- MLN Matters® *MM12543 Revised: Internet-Only Manual Updates (IOM) for Critical Care, Split/ Shared Evaluation and Management Visits, Teaching Physicians, and Physician Assistants*





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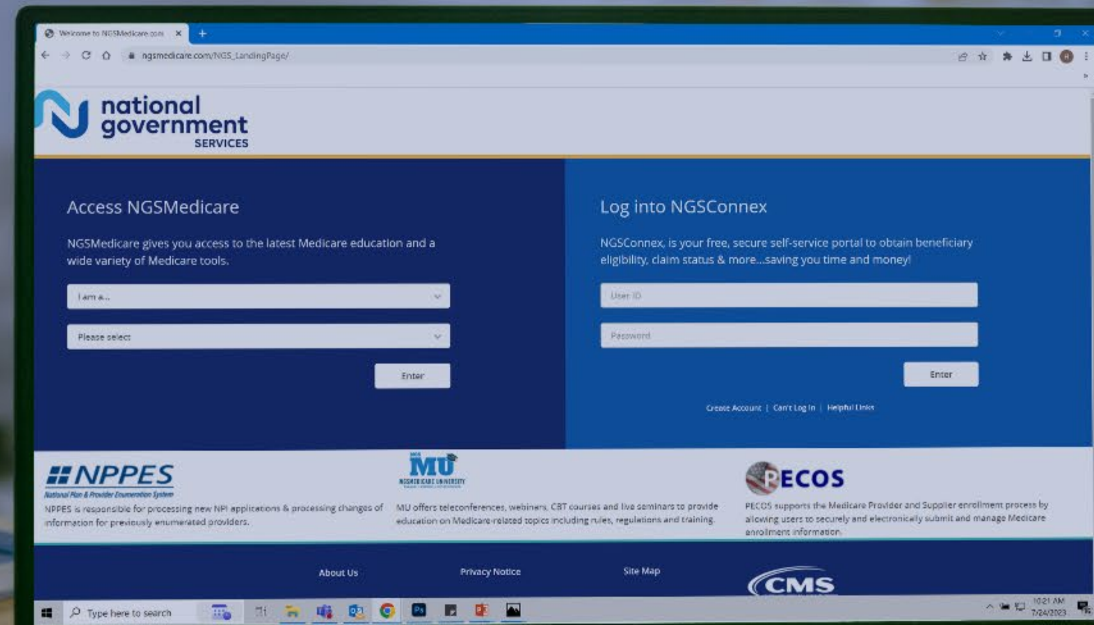

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