Billing and Reimbursement Guideline: Critical Care Services

Guideline Publication Date: September 1, 2010

Key coding, documentation and reimbursement points include:

- Critical care includes the care of critically ill and unstable patient who require constant physician attention.
- The duration of critical care time is the time the physician spends providing full attention to the critically ill patient.

The following are activities that are considered inclusive in critical care:

- Review of medical data – lab, x-ray, or other diagnostic tests.
- Discussion of the patient's care with other medical staff in the unit or at the nurse's station.
- The time spent with the critically ill patient and the services rendered should be recorded in the patient's medical record to support the claim for critical care services. Even if the time is not continuous, the physician should list the number of minutes with a detail of what he or she was doing and spell what happened during the patient encounter.
- Obtaining medical history and discussion of treatment options with family members or guardian(s) if the patient is unable to contribute. The conversation must have a direct contribution to medical decision- making. Other family discussions that include the routine updating of the family of the patient's condition or emotional support are not considered critical care.
- Procedures included in the description of critical care service codes are not reimbursed separately when provided by the physician billing critical care are:

  • Gastric intubation
  • Pulse oximetry
  • Temporary transcutaneous pacing

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- Ventilator management and settings
- Vascular access procedures
- Review of EKGs, blood pressures, and hematologic data
- Blood draws for specimen
- Blood gases
- Chest x-ray review
- Interpretation of cardiac output measurement
- Family medical psychotherapy

- In teaching facilities, time spent teaching or supervising residents is not considered critical care. Critical care services billed by a physician cannot include any delegated care by other health care professionals or residents.

- Only one physician can bill for any given hour of critical care, even if more than one physician is in attendance. A physician can only bill for 99291 once per date for the first 30-74 minutes of critical care.

- Critical care code 99292 is used to report each additional 30-minute interval beyond 74 minutes.

- Total Duration of Critical Care Time Codes:

  - Less than 30 minutes 99232 or 99233
  - 30 to 74 minutes 99291
  - 75 to 104 minutes 99291 x 1 and 99292 x 1
  - 105 to 134 minutes 99291 x 1 and 99292 x 2
  - 135 to 164 minutes 99291 x 1 and 99292 x 3
  - 165 to 194 minutes 99291 x 1 and 99292 x 4

- If critical care is provided in the emergency department physician and critical care services are billed; no other emergency department or outpatient evaluation and management codes will be reimbursed for that visit.

- Documentation may be required to support the personal management by the patient's physician including notation of time in the patient's record.

- Payment may be made for critical care services in any location as long as the care meets the definition of critical care.

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- Modifiers 24, 25 or 59 may be used to indicate a separately identifiable service.
- Notes may be requested.
- This guideline applies to CMS-1500 claim submissions.
- This guideline applies to all places of service.

Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line.

This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.

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