Society for
Maternal•Fetal
Medicine

Coding Committee

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# SMFM Coding White Paper "Reporting Critical Care Services"

## Critical Care Services

Critical care is the direct delivery by a physician(s) of medical care for a *critically ill, critically injured, or unstable patient*. 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 include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.

Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

The critical care codes are used to report the *total duration of time spent* by a physician providing constant attention to an unstable critically ill or unstable critically injured patient, even if the time spent by the physician providing critical care services on that date is not continuous.

Time spent with the individual patient should be recorded in the patient's record. The time that can be reported as critical care is the 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. For example, time spent on the unit or at the nursing station on the floor reviewing test results or imaging studies, discussing the critically ill patient's care with other medical staff or documenting critical care services in the medical record would be reported as critical care, even though it does not occur at the bedside. Also, when the

patient is unable or clinically incompetent to participate in discussions, time spent on the floor or unit with family members or surrogate decision makers obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment or limitation(s) of treatment may be reported as critical care, provided that the conversation bears directly on the management of the patient.

Time spent in activities that occur outside of the unit or off the floor (eg, telephone calls whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient. 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 (eg, participation in administrative meetings or telephone calls to discuss other patients). Time spent performing separately reportable procedures or services should not be included in the time reported as critical care time. No physician may report remote real-time interactive video conferenced critical care services.

**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)**

| Total Duration of Critical Care | Codes |
|---|---|
| less than 30 minutes<br>(less than ½ hour) | appropriate E/M codes |
| 30-74 minutes<br>(1/2 hour – 1 hour 14 minutes) | 99291 X 1 |
| 75-104 minutes<br>(1 hour 15 minutes - 1 hour 44 minutes) | 99291 X 1 and 99292 X 1 |
| 105-134 minutes<br>(1 hour 45 minutes - 2 hours 14 minutes) | 99291 X 1 and 99292 X 2 |
| 135-164 minutes<br>(2 hours 15 minutes - 2 hours 44 minutes) | 99291 X 1 and 99292 X 3 |
| 165-194 minutes<br>(2 hours 45 minutes - 3 hours 14 minutes) | 99291 X 1 and 99292 X 4 |

| 194 minutes or longer (3 hours 14 minutes – etc.) | 99291 and 99292 as appropriate (see illustrated reporting examples above) |
|---|---|

☞Code 99291 is reported once per day. If critical care time is less than 30 minutes in total duration on a given date, use codes for the appropriate E/M service **IF** the critical care intervention and documentation supports that critical care was provided.

☞Code 99292 must be used in conjunction with code 99291. Never bill 99292 alone.

☞Services for patients who are not critically ill but happen to be in a critical care unit are reported using the appropriate E/M codes.

☞Time spent in discussions with family cannot be counted unless the patient is clinically incompetent and the discussion is around obtaining medical history or treatment options.

☞APPs and MDs cannot provide shared visit critical care

☞Following is a list of procedure codes that are included with the Critical Care codes. These services are considered to be "bundled" into the critical care codes and would not be billed separately on the same date of service.

The interpretation of cardiac output measurements (93561, 93562)

Chest x-rays (71010, 71015, and 71020)

Pulse oximetry (94760, 94761, 94762))

Blood gases

Information data stored in computers (e.g. ECGs, blood pressures, hematologic data (99090)

Gastric intubation (43752, 91105)

Temporary transcutaneous pacing (92953)

Ventilator management (94002-94004, 94660, 94662)

Vascular access procedures (36000, 36410, 36415, 36591, 36600)

***Any services not listed above should be reported separately.***

☞When more than one physician is providing critical care, check with your local carriers for the proper billing guidelines as some payers only allow this code to be reported by the primary physician on the case. **Please note**: If two physicians of the same specialty, in the same group, provide critical care to the same patient on the same date, they must bill as if they were one physician, combining their time and reporting 99291 and (if applicable) the appropriate number of units of 99292. ***(Centers for Medicare and Medicaid Services (CMS) Transmittal 1548)***

***Prolonged service coding may be considered in patients not meeting the above criteria when prolonged treatment time or care has been rendered:***

**Prolonged Physician Service With Direct (Face-to-Face) Patient Contact 99356, 99357**

These codes are used when a physician provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. This service is reported in addition to other physician services including E/M services at any level.

☞The total duration of face-to-face time spent by the physician on a given date providing prolonged service, even if the time spent on that date is not continuous.

These codes can only be reported with other E/M codes that have a typical or specified time published by CPT.

**99356 Prolonged physician service in the inpatient setting, requiring direct unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)**

**99357 each additional 30 minutes (List separately in addition to code for prolonged physician service)**

☞Code 99356 is used only once per day to report prolonged service of 30-60 minutes of duration.

☞Prolonged service of less than 30 minutes is not reported.