Time to Code Critical Care Services Correctly

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Medicare policy for these hospital services align with CPT® in all areas but one.

Policy changes finalized in the 2022 Medicare Physician Fee Schedule (MPFS) final rule include a new definition of critical care services, who can provide these services in various settings, and what is included in the services and not separately payable. The Centers for Medicare & Medicaid Services (CMS) clarify its stand on when to report CPT® code 99292. Make sure you're aware of the changes to ensure proper claims payment for these services.

Critical Care Defined

In the 2022 MPFS final rule, CMS adopted CPT® prefatory language as the definition of critical care visits. CPT® defines critical care as:

> … the direct delivery by a physician(s) or other qualified healthcare professional (QHP) 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.

As in the CPT® code book, CMS finalized for 2022 that critical care services may be reported by a physician or nonphysician practitioner (NPP) who is a QHP. CMS says a QHP is "an individual who is qualified by education, training, licensure/regulation (when applicable), facility privileging (when applicable)," working within their scope of practice.

Reporting Critical Care: Do's and Don'ts

In the 2022 MPFS final rule, CMS finalized the use of CPT® codes 99291 and 99292 to report critical care services.

These codes report the total duration of critical care time (continuous or aggregated) provided by the physician or other QHP for a given date of service. Time spent performing separately reportable procedures or services should not be included in the time reported as critical care time.

What if continuous care spans two dates?

The 2022 MPFS final rule finalizes the following language from the CPT® code book regarding when a critical care service furnished by a physician or other QHP extends beyond midnight the following calendar date:

Some services measured in units other than days extend across calendar dates. When this occurs, a continuous service does not reset and create a new first hour. However, any disruption in the service does create a new initial service.

For example, if intravenous hydration (96360, 96361) is given from 11:00 p.m. to 2:00 a.m., 96360 (31 minutes to 1 hour) would be reported once and 96361 (each additional hour) twice.

What if critical care visits are furnished concurrently by different specialties?

Critical care services may be furnished as concurrent care to the same patient on the same date by more than one practitioner in more than one specialty, regardless of group affiliation, as long as the services meet the definition of critical care and are not duplicative of other services.

CMS states in the 2022 MPFS final rule, “The reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient’s treatment.”

What if critical care is furnished concurrently by same specialty and same group?

Multiple practitioners in the same specialty or group can furnish critical care services concurrently to a patient on a single day. Report 99291 when critical care is furnished concurrently by two or more practitioners in the same specialty or group to the same patient on the same date of service, the individual physician or NPP providing the initial care. Report subsequent critical care using 99292.

When one practitioner begins the medically necessary initial critical care but does not meet the time requirement to report 99291 (first 30-74 minutes), another practitioner in the same specialty or group can continue to deliver the medically necessary care to the same patient on the same day. The total time spent by the practitioners is totaled to meet the time required to report the 99291. Do not report 99292 until an additional 30 minutes of critical care time (74+30=104) are furnished to the same patient on the same day. This is different than the billing guidance in the CPT® code book.

Services Included in Critical Care

CPT® 2022 also added prefatory language that bundles several services into critical care services, making them not separately payable when furnished concurrently with critical care. Bundled services include:

- Interpretation of cardiac output measurements (93561, 93562)
- Chest X-rays (71045, 71046)
- Pulse oximetry (94760-94762)

- Blood gases and collection and interpretation of physiologic data (e.g., ECGs, blood pressures, hematologic data)
- Gastric intubation (43752, 43753)
- Temporary transcutaneous pacing (92953)
- Ventilator management (94002-94004, 94660, 94662)
- Vascular access procedures

All services need to be sufficiently documented to determine the role each practitioner plays in the treatment of the patient's care.

Split/Shared Visits

Prior to 2022, we could not bill critical care services as split/shared evaluation and management (E/M) services. That has changed, effective for dates of service on or after Jan. 1, 2022. The practitioner who furnishes the substantive portion of the total critical care time may now bill for the service. CMS defines "substantive" as "more than half the cumulative total time in qualifying activities that are included in CPT codes 99291 and 99292."

For split/shared critical care services, when two or more practitioners spend time jointly with or discussing the patient, that total time may be counted only once.

Append new modifier FS *Split (or shared) evaluation and management visit* to the codes for shared/split services between a physician and NPP.

UPDATE: Effective Jan. 1, 2023, the Internet-Only Manual, Pub. 100-04, Chapter 12, section 30.6.12.5 states, "To bill split (or shared) critical care services, the billing practitioner first reports CPT code 99291 and, if **104** or more cumulative total minutes are spent providing critical care, the billing practitioner reports one or more units of CPT code 99292."

Critical Care and E/M

CMS now allows payment for both critical care and E/M visits by the same practitioner(s) in the same specialty or group as long as the practitioner documents that the hospital E/M service was provided at a time when the patient did not require critical care and the service was separate and distinct from any critical care services provided later that date. Append modifier *25 Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service* to the claim when reporting these services.

Critical Care Visits and Global Surgeries

Critical care services may be paid separately in addition to a procedure with a global surgical period as long the service is unrelated to the procedure. 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 care is above and beyond and unrelated to the surgical procedure performed (such as trauma or burn cases). Make sure the physician's note fully documents the separate and distinct nature of the service.

Critical care services should be billed with modifier 24 *Unrelated evaluation and management (E/M) service performed by the same physician during the postoperative period* and 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 identify that the critical care was unrelated to the procedure. Note that modifier FT is effective Jan. 1, 2022, and is mandatory on claims as of March 1, 2022.

A modifier is not needed when critical care is performed in the postoperative period by a provider other than the surgeon. However, CMS states in the final rule, "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 also be reported."

Current Knowledge Is Critical

The policy changes finalized in the 2022 MPFS final rule provide clarity to practitioners on the use of critical care services. Make sure you are evaluating your billing processes, the use of the new modifiers, and any documentation gaps so your providers are educated on the latest Medicare payment policies.

Resources:

CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies.

CMS Transmittal 11181 Pub 100-04 Medicare Claims Processing Manual, Jan. 14, 2022.

CMS Transmittal 11195 Pub 100-04 Medicare Claims Processing Manual, Jan. 20, 2022.

Noridian Healthcare Solutions, Critical Care Services, retrieved May 27, 2022.

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Becky Strom

Becky Strom, CPC, COC, CPCO, MCS-P, has 34 years of experience in the healthcare field. In her current role, she leads a team of certified coding auditors and clinical auditors, whose role is to research coding guidelines and regulations, establish coding policies and procedures in compliance with those regulations, perform audits, and provide education and training to the providers and coders throughout the organization. Strom is a 2022-2024 AAPC National Advisory Board member.

22 Responses to “Time to Code Critical Care Services Correctly”

JoAnn Picklesimer says:

July 5, 2022 at 7:47 am

Is NICU 99468 and 99469 billing split share the same as 99291/99292?

Renee Dustman says:

July 21, 2022 at 6:48 am

The NICU and Pediatric CC codes are not approved to be done as a split/shared visit as they are “per day” codes which is different from the 99291/99292 that are “timed” codes. The 99291/99292 are allowed for split/shared billing since they are based on “time” per the guidelines, per Becky Strom.

Susan says:
September 9, 2022 at 7:56 am

Hello
Can 99291 be billed as an outpatient hospital service? ie patient in observation?

Thank you

Renee Dustman says:
September 9, 2022 at 8:35 am

CPT guidelines for critical care services state, “To report critical care services provided in the outpatient setting (eg, emergency department or office), for neonates and pediatric patients up through 71 months of age, see the critical care codes 99291, 99292.” I recommend, however, that you read all of the CPT guidelines for critical care services as there are specific requirements that must be met.

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corrina says:
September 23, 2022 at 11:02 am

Do you combined the time of the MD and PA for a split shared critical care visit?

Vanessa says:
October 6, 2022 at 9:30 am

Can you please address CMS vs CPT 99292 time guidelines?
CPT code has time brackets indicating 75-104 mins for 99292
Medicare claims processing manual chapter 12 (revised 3.04.22) page #50 (30.6.12.4) staes inorder to bill 99292 you need the complete 104 mins, but on page #51 it says “if 75 or more cummulative total minsutes are spent providing critical care, the billing practitioner reports one or more unites of CPT code 99292) this seems confusing/contradicting. Does this apply only to Medicare/replacement insurances? Thank you in advance

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Renee Dustman says:

October 6, 2022 at 12:44 pm

Vanessa: I can see where the wording at 30.6.12.5 may mislead you, but all CMS is saying is that each additional 30 minute increment (unit) of critical care after the first 74 minutes is billed with add-on code 99292. Basically, 99291 is for the first 30-74 minutes and can only be billed once per date of service, regardless of who in the group provides the service or when (continuous or not). After that, every subsequent 30 minutes of critical care on the same day (regardless of who/when) is billed with 99292. Be mindful of who is providing the service as a physician/NPP scenario is split/shared. And read the part about the crossing midnights carefully.

Lewis Hollingsworth says:

October 18, 2022 at 10:13 am

Bit of an odd question, but is billing of critical care time (by documenting such) mandatory? What if you are in a situation where you are hoping to minimize patient cost? Documenting all the usual interventions appropriately, just not adding the critical care declaration?

Renee Dustman says:

October 20, 2022 at 7:42 am

Lewis: This is a great question that should be addressed in a separate article. I will try to get the author or another subject matter expert to take it on.

Martin says:

October 26, 2022 at 10:54 am

There seems to be confusion about what CMS is requiring to bill 99292. Is it any time over the 74 minutes for 99291 or is it 30 minutes over the 74 minutes in order to bill 99292? I have reviewed the Noridian February 2022 document.

“CPT 99292 represents additional block(s) of time, of up to 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.” Source Noridian

Yet, I have seen some responses stating that 99292 can only be reported each time the daily minutes over 99291 requirements achieve a full 30 minutes.
Obviously, the problem with the latter interpretation is that if a provider spends 29 minutes, there would be no way to bill for that time.
Thanks, appreciate the clarification.

Renee Dustman says:

November 3, 2022 at 11:17 am

Based on this CPT table (CPT Assistant – Aug. 2019), 99292 is appropriate for 75-104 minutes over the first 74 minutes.

Total Duration of Critical Care Codes
less than 30 minutes Appropriate E/M codes 30-74 minutes
(30 minutes – 1 hr. 14 min.) 99291 X 1
75-104 minutes
(1 hr. 15 min. – 1 hr. 44 min.) 99291 X 1 AND 99292 X 1

Patti Fenske says:

November 10, 2022 at 12:45 pm

Can the ED Physician's critical care minutes support charging critical care for the ED facility E/M since he is providing the orders for the care given during the visit ? or must the facility also provide minutes to support the 99291 charge for their E/M level.

Martin says:

November 13, 2022 at 9:12 am

Thanks, your CPT source states 2019. Was there any change to that in 2022?
If 99292 now requires 30 minute intervals, how do you charge for 25 minutes of care following 99291?
Is there another E/M code that can be used or is the additional 25 minutes not chargeable because the MD didn't achieve 30 minutes for 99292?
Thanks, this is an important issue for us.

Renee Dustman says:

November 18, 2022 at 9:02 am

There is a table in CPT for total duration of critical care codes, which explains that the first 30-74 minutes of critical care is reported with 99291; add 99292 for additional time as follows:
75-104 mins 99292 x 1
105-134 mins 99292 x 2
135-164 mins 99292 x 3
etc

Renee Dustman says:

November 18, 2022 at 11:19 am

Patti: Facility billing is not based on the physicians documentation and is different criteria from professional billing guidelines. Facility coding is based on the volume and intensity of resources use by the facility to provide patient care. Here's an article from ACEP that may help answer your questions.

https://www.acep.org/administration/reimbursement/ed-facility-level-coding-guidelines/

Vanessa Taliaferro says:

December 22, 2022 at 12:09 pm

Hi, I have both MDs and APPs charging for continuous critical care services within a 24-hour period, but when the time extends beyond the time beyond 195 minutes, I am not sure what the language used in the CPT code book under the chart it reads "195 minutes or longer… 99291 and 99292 as appropriate (see illustrated reporting examples above). I have an aggregate time of 250 minutes for one date of service. I am not certified in medical coding YET, but working on it. Can you help clarify this for me?

Martin says:

January 27, 2023 at 9:44 am

Hi
Did CMS clarify the charging requirements for 99292 in 2023? We used to charge based on "up to 30 minutes" but is it now based on 30 minute increments?

Renee Dustman says:

January 31, 2023 at 8:24 am

CMS states in the 2023 MPFS final rule, "At this time, as we were not proposing a new policy for CY 2023, we are retaining the CPT code 99292, as it was finalized in the CY 2022 PFS, and we again note that it can be billed after 104 cumulative total minutes were spent providing critical care."

MIssy says:

June 2, 2023 at 4:55 am

I have a question in regards to Telemedicine Critical Care, we are having the G0508 and G0509 in POS 22 denied, what am I doing wrong?

Renee Dustman says:
June 2, 2023 at 5:53 am

Missy, What does your EOB say? Coverage for these codes is up to the carrier.

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christine says:
June 28, 2023 at 6:44 pm

I am billing 99291 for a group with the same specialty and 99292 for another provider of same group specialty. Some insurance will pay other want to see the 99291 on the same claim with the 99292. Medicare denies the 99292 and only pays if its the same provider has both codes transmitted on one claim. Insurances are denying the 99292 when it come into them alone. This is a ICU pulmonary group and I can’t seem to get the 99292 paid unless it is provider by the same provider.

Renee Dustman says:
June 29, 2023 at 8:21 am

99292 is an add-on code, so you must bill 99291 and 99292 together. Only one provider in the same specialty group can bill for these services provided to the same patient on the same day.
