| moda HEALTH | Reimbursement Policy Manual | Policy #: | RPM041 |
|---|---|---|---|
| **Policy Title:** | **Critical Care, Evaluation and Management Services (99291, 99292)** | | |
| **Section:** | Evaluation & Management | **Subsection:** | None |

**Scope:** This policy applies to the following Medical (including Pharmacy/Vision) plans:

| **Companies:** | ☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates<br>☐ Moda Health Plan  ☐ Moda Assurance Company  ☐ Summit Health Plan<br>☐ Eastern Oregon Coordinated Care Organization (EOCCO)   ☐ OHSU Health IDS |
|---|---|
| **Types of Business:** | ☒ All Types      ☐ Commercial Group   ☐ Commercial Individual<br>☐ Commercial Marketplace/Exchange    ☐ Commercial Self-funded<br>☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____ |
| **States:** | ☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington |
| **Claim forms:** | ☒ CMS1500   ☒ CMS1450/UB    (or the electronic equivalent or successor forms) |
| **Date:** | ☒ All dates  ☐ Specific date(s): _____<br>☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge<br>☐ Date of processing |
| **Provider Contract Status:** | ☒ Contracted directly, any/all networks<br>☒ Contracted with a secondary network   ☒ Out of Network |

| Originally Effective: | 10/28/2014 | Initially Published: | 12/10/2014 |
|---|---|---|---|
| Last Updated: | 8/10/2022 | Last Reviewed: | 8/10/2022 |
| Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?    No | | | |
| Last Update Effective Date for Texas: | | 8/10/2022 | |

**Reimbursement Guidelines**

**A. Critical Care Services Definition**

1.  Critical care services are defined in the CPT codebook. (AMA[1])

2.  Services and procedure code included in or bundled into critical care services (99291/99292) are defined and listed in the CPT codebook. (AMA[1, 3])

3.  Critical care requires the full attention of the physician or non-physician practitioner (NPP) and therefore, for any given time period spent providing critical care services, the practitioner cannot provide services to any other patient during the same period of time.

4.  Critical care services may be reported by physicians and other practitioners who are qualified by education, training, licensure/regulation (when applicable), facility privileging (when applicable), and the applicable Medicare benefit category (when applicable) to perform critical care services and independently report them. (CMS[2])

**B. Critical Care and Provider Specialty**

1. A critically ill patient may need and receive critical care services from more than one practitioner, each having a different specialty. The critical care services of each specialty need to be medically reasonable and necessary for the patient's diagnosis or treatment. (CMS[9])

2. The CMS and CPT guidelines differ for determining specialty for non-physician practitioners (NPP).

    a. CMS: "…classifies NPPs in a specialty that is not the same as a physician with whom the NPP is working…" (CMS[7])

    b. AMA/CPT: "When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician." (AMA[5])

    c. Moda follows the AMA/CPT guidelines for NPP specialty determination.

    Thus, when advanced practice nurses and physician assistants are working with a group of physicians and performing critical care visits, only the practitioner performing the first critical care visit in a 24-hour date of service may report 99291; all other practitioners in that group of providers must report 99292 for subsequent critical care visits, regardless of whether they are a physician or a non-physician practitioner.

**C. Critical Care by Only One Specialty and a Sole Practitioner for a Date of Service**

When a critically ill patient receives critical care services from only one provider specialty on a date of service, and only a single practitioner in that specialty/group provides the critical care services: (CMS[8])

1. CPT code 99291 is reported only once per date even if the time spent by the practitioner is not continuous on that date.

2. Additional 30-minute time increments provided to the same patient are reported with 99292.

3. If continuous critical care services are provided crossing midnight, report the total units of time provided continuously according to CPT guidance for this situation. However, any disruption in the service creates a new initial service for the next date.

**D. Critical Care by Multiple Practitioners in Same Specialty & Same Group**

1. The first practitioner providing critical care services after midnight reports 99291. If sufficient time is spent, they may also bill 99292.

2. When an additional 30 minutes of critical care services have been furnished, the second practitioner reports only 99292. (CMS[7])

3. This rule continues to apply even when one or more of the visits for a specialty on a date of service are performed as a split/shared critical care visit (2022).

**E. Split (or Shared) Critical Care Visits**

1. For dates of service 12/31/2021 and prior:

    a. Only visits performed by a sole practitioner at that time of day may be reported using critical care codes 99291/99292.

    b. A split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) cannot be reported as a critical care service.

       i. Neither the physician nor the NPP may report critical care codes 99291/99292 for the split/shared visit.

       ii. The visit must be reported using an initial or subsequent hospital inpatient visit E/M code (99221 – 99233).

2. Effective for dates of service 1/1/2022 and following, critical care visits may be furnished as split (or shared) visits between a physician and a physician or a non-physician practitioner. (CMS[12])

    a. Only one of the practitioners may report critical care service procedure code(s) for the split/shared critical care visit.

       i. The practitioner who furnishes more than half of the cumulative critical care time (the substantive portion) reports the critical care service(s) with modifier FS appended.

       ii. The other practitioner does not report the critical care services at all.

    b. One of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit.

    c. In determining the amount of time for split/shared critical care visits:

       i. Practitioners cannot count time spent in the performance of other services that are reported separately.

       ii. Only distinct time can be counted. When the practitioners jointly meet with or discuss the patient, only the time of one of the practitioners can be counted.


**F. Critical Care and Other Services**

1. Other E/M services on the same date.

A critical care visit and a non-critical care visit may both be billed and reimbursed for the same date of service if all of the following requirements are met:

    a. The non-critical care E/M visit occurred before the critical care visit at a time when the patient did not require critical care.

    b. Both visits were medically necessary.

    c. The earlier non-critical care E/M visit does not duplicate any of the elements from the critical care visit provided later.

    d. Modifier 25 is appended to the critical care visit codes.

    e. The medical record documentation supports that all elements and requirements for the codes and separate reimbursement for both visits are met.

2. Critical care visits and global surgery.

Critical care visits are sometimes needed during the global period of a surgical procedure, whether pre-operatively, on the same day, or during the post-operative period.

    a. Preoperative and postoperative critical care visits related to the specific anatomic injury or general surgical procedure performed (for example, trauma, burn cases) are included in the

global surgical allowance for the surgical procedure, and are not eligible to be separately reported.

    b. Critical care visits unrelated to the surgical procedure with the global period or the injury/condition that led to the surgery may be separately reported and are eligible for separate reimbursement. Append either modifier FT or 24.

    c. 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 used to indicate the transfer of care.

        i. The surgeon reports modifier 54.

        ii. The intensivist accepting the transfer of care reports both modifier 55 and modifier FT or modifier 24.

**G. Medical Record Documentation**

Critical care is a time-based service. Practitioners must document:

1. Services performed.

2. Total time.

3. The distinct role each specialty furnishing critical care played in the patient care and conditions.

4. Medical necessity.

5. For split/shared critical care visits:

    a. The practitioners involved.

    b. Relative time spent by each.

    c. Shared/overlapping time (which can only be counted once).

    d. Services performed.

    e. Time spent in the performance of other services reported separately to show this time was not counted towards the critical care visit.

**Codes, Terms, and Definitions**

Acronyms & Abbreviations Defined

| Acronym or Abbreviation | | Definition |
|---|---|---|
| AMA | = | American Medical Association |
| APP | = | Advanced Practice Provider |
| CCI | = | Correct Coding Initiative (see "NCCI") |
| CMS | = | Centers for Medicare and Medicaid Services |
| CPT | = | Current Procedural Terminology |
| DRG | = | Diagnosis Related Group (also known as/see also MS DRG) |

| Acronym or Abbreviation | | Definition |
|---|---|---|
| E/M<br><br>E&M<br><br>E & M | = | Evaluation and Management (services, visit)<br><br>(Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.) |
| HCPCS | = | Healthcare Common Procedure Coding System<br><br>(acronym often pronounced as "hick picks") |
| HIPAA | = | Health Insurance Portability and Accountability Act |
| MS DRG | = | Medicare Severity Diagnosis Related Group (also known as/see also DRG) |
| NCCI | = | National Correct Coding Initiative (aka "CCI") |
| NPP | = | Non-Physician Practitioner |
| QHP | = | Qualified Health Care Professional |
| RPM | = | Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.) |
| UB | = | Uniform Bill |

Definition of Terms

| Term | Definition |
|---|---|
| Advanced practice provider (APP) | 'Advanced Practice Provider' is a general title used to describe individuals who have completed the advanced education and training that qualifies them to (1) manage medical problems and (2) prescribe and manage treatments within the scope of their training. Some specific types of APPs include clinical nurse specialists, nurse practitioners, and physician assistants.<br><br>This term is approximately equivalent to the Medicare term Non-physician practitioner (NPP). |
| Critical Care Service | Critical care is the direct delivery by a physician(s) or other qualified health care professional (QHP) of medical care for a critically ill or critically injured patient. … 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. … 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 provided meet the above requirements. (AMA[1, 7]) |
| Critical Illness or Injury | A critical illness or injury acutely impairs one or more vital organ system(s), such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. (AMA[1, 7]) |

| Term | Definition |
|---|---|
| Non-physician Practitioner | A Medicare term which Medicare defines as: Health care providers who practice either in collaboration with or under the supervision of a physician, including physician assistants, nurse practitioners, and clinical nurse specialists, are referred to as non-physician practitioners (NPPs). (CMS[4]) This term is approximately equivalent to the non-Medicare term Advanced Practice Provider (APP). |
| Qualified Health Care Professional | A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulations (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. (AMA[5]) |

Procedure codes (CPT & HCPCS):

| Code | Code Description |
|---|---|
| 99291 | Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes |
| 99292 | Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service) |

Modifier Definitions:

| Modifier | Modifier Description & Definition |
|---|---|
| 24 | **Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period** The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service. |

| Modifier | Modifier Description & Definition |
|---|---|
| 25 | **Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service**<br><br>It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.<br><br>**Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59. |
| FS | Split (or shared) evaluation and management visit |
| FT | Unrelated evaluation and management (E/M) visit on the same day as another E/M visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable). (Report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated) |

**Coding Guidelines & Sources -** (Key quotes, not all-inclusive)

Key relevant coding guidelines from the AMA and CMS are noted below. Extensive additional guidelines and information on reporting of critical care services can be found in the CPT Code Book (Professional Edition), the CPT Assistant Archives, the National Correct Coding Initiative (NCCI) Policy Manual, chapter 11, and the CMS Claims Processing Manual, chapter 12. Please reference those sources as needed.

"Services Included in the Critical Care Service Codes
The following services are included in reporting critical care when performed during the critical care period by the physician providing critical care. Do not report these services in addition to the critical care service codes.
- Interpretation of cardiac output measurements (93561, 93562);
- Chest x-rays (71010, 71020);
- Blood gases and information data stored in computers (e.g., ECG's, blood pressures, hematologic data (99090);
- Gastric intubation (91105);
- Temporary transcutaneous pacing (92953);
- Ventilator management (94656, 94657, 94660, 94662); and
Vascular access procedures (36000, 36410, 36415, 36600)."        (AMA[3])

"Physician(s) or NPP(s) in the same specialty and in the same group may provide concurrent follow-up care, such as a critical care visit subsequent to another practitioner's critical care visit. This may be as part of continuous staff coverage or follow-up care to critical care services furnished earlier in the day on the same calendar date.

In the situation where a practitioner furnishes the initial critical care service in its entirety and reports CPT code 99291, any additional practitioner(s) in the same specialty and the same group furnishing care concurrently to the same patient on the same date report their time using the code for subsequent time intervals (CPT code 99292). CPT code 99291 will not be reported more than once for the same patient on the same date by these practitioners. This policy recognizes that multiple practitioners in the same specialty and the same group can maintain continuity of care by providing follow-up care for the same patient on a single date.

When one practitioner begins furnishing the initial critical care service, but does not meet the time required to report CPT code 99291, another practitioner in the same specialty and group can continue to deliver critical care to the same patient on the same date. The total time spent by the practitioners is aggregated to meet the time requirement to bill CPT code 99291. Once the cumulative required critical care service time is met to report CPT code 99291, CPT code 99292 can only be reported by a practitioner in the same specialty and group when an additional 30 minutes of critical care services have been furnished to the same patient on the same date (74 minutes + 30 minutes = 104 total minutes).

The aggregated time spent on critical care visits must be medically necessary and each visit must meet the definition of critical care in order to add the times for purposes of meeting the time requirement to bill CPT code 99291." (CMS[7])

"Medicare policy allows critical care visits furnished as concurrent care (or concurrently) to the same patient on the same date by more than one practitioner in more than one specialty (for example, an internist and a surgeon, allergist and a cardiologist, neurosurgeon and NPP), regardless of group affiliation, if the service meets the definition of critical care and is not duplicative of other services. Additionally, these critical care visits need to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." (CMS[9])

"**Split (or Shared) Critical Care Visits** (Rev. 11288; Effective: 01-01-22)

Critical care visits may be furnished as split (or shared) visits, defined in section 30.6.18. The rules described in section 30.6.18 for other types of split (or shared) visits apply (except for the listing of qualifying activities for determining the substantive portion, discussed below), and service time is counted for CPT code 99292 in the same way as for prolonged E/M services.

Specifically, the billing practitioner bills the initial service (CPT 99291) and any add-on codes(s) for additional time (CPT 99292). Also, the substantive portion for critical care services is defined as more than half of the total time spent by the physician and NPP beginning January 1, 2022. In the context of critical care, split (or shared) visits occur when the total critical care service time furnished by a physician and NPP in the same group on a given calendar date to a patient is summed, and the practitioner who furnishes the substantive portion of the cumulative critical care time reports the critical care service(s).

As stated earlier, when critical care services are furnished as a split (or shared) visit, the substantive portion is defined as more than half the cumulative total time in qualifying activities that are included in CPT codes 99291 and 99292. Since, unlike other types of E/M visits, critical care services can include additional activities that are bundled into the critical care visits code(s), there is a unique listing of qualifying activities for split (or shared) critical care. These qualifying activities are described in the prefatory language for critical care services in the CPT Codebook.

To bill split (or shared) critical care services, the billing practitioner first reports CPT code 99291 and, if 75 or more cumulative total minutes are spent providing critical care, the billing practitioner reports one or more units of CPT code 99292. Modifier -FS (split or shared E/M visit) must be appended to the critical care CPT code(s) on the claim.

The same documentation rules apply for split (or shared) critical care visits as for other types of split (or shared) E/M visits. Consistent with all split (or shared) visits, when two or more practitioners spend time jointly meeting with or discussing the patient as part of a critical care service, the time can be counted only once for purposes of reporting the split (or shared) critical care visit." (CMS[11])

## Cross References

"Add-on Codes." Moda Health Reimbursement Policy Manual, RPM025.

## References & Resources

1. American Medical Association. "Critical Care Services." *Current Procedural Terminology (CPT) 2022, Professional Edition.* Chicago: AMA Press, pp. 32-33.

2. CMS. "Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292), Definition." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.1.

3. American Medical Association. "Coding Communication - Critical Care Services." *CPT Assistant.* Chicago: AMA Press, December 1998, p. 6.

4. CMS. "Glossary and Acronyms." Medicare and Medicaid Services. Last accessed July 27, 2022. https://www.cms.gov/OpenPayments/Glossary-and-Acronyms#non-physician-practitioner-covered-recipient .

5. American Medical Association. "Instructions for Use of the CPT Codebook." *Current Procedural Terminology (CPT) 2022, Professional Edition.* Chicago: AMA Press, p. xiv.

6. American Medical Association. " Coding for Critical Care Services Revisited." *CPT Assistant,* August 2019: 8.

7. CMS. "Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Same Group (Follow-Up Care)." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.4.

8. CMS. "Critical Care by a Single Physician or NPP." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.2.

9. CMS. "Critical Care Visits Furnished Concurrently by Different Specialties." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.3.

10. CMS. "Critical Care, Medical Record Documentation." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.8.

11. CMS. "Split (or Shared) Critical Care Visits." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.12.5.

12. CMS. "Split (or Shared) Visits." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.18.

## Background Information

Critical care is defined as the direct delivery by a physician(s) medical care for a critically ill or other qualified health care professional of medical care for a critically injured 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 functions(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.

Providing medical care to a critically ill, injured, or post-operative 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 a coronary care unit, intensive care unit, respiratory care unit, or the emergency department. However, payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care. (AMA[1])

## IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****


**Policy History**

| Date | Summary of Update |
|------|-------------------|
| 8/10/2022 | Clarification/Update:<br>Change to new header. Outline format added.<br>Clarification of same specialty, non-physician practitioners, split/shared critical care added per provider inquiry.<br>CMS updated guidelines for 2022 incorporated; CMS updates not subject to Texas 28 TAC.<br>Acronym Table: 2 entries added.<br>Definition of Terms Table: Added.<br>Coding Guidelines & Sources: Added: 3 new quotes.<br>References & Resources: #1 & 2 updated. The previous #3 deleted (no longer exists); former #4 is now #3. # 4-10 added.<br>Policy History section: Added. Entries prior to 2022 omitted (in archive storage). |
| 12/10/2014 | Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication. |
| 10/28/2014 | Original Effective Date (with or without formal documentation). Policy based on CMS critical care services policy. |