Critical Care FAQ

FAQ 1. What is the CPT definition of critical care service (99291 and 99292)?

CPT currently defines a critical illness or injury as an illness or injury that 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 services are defined as a physician's direct delivery of medical care for a critically ill or critically injured patient. It involves decision making of high complexity to assess, manipulate, and support 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.

CMS adds that in order to qualify as critical care for Medicare patients, "the failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition".

FAQ 2. How does Medicare's addressing of CC differ from CPT’s?

In July 2008, CMS released Transmittal 1548 which represents the most recent update for the Medicare payment policy for critical care services. The Transmittal includes the AMA CPT definitions of critical care and critical care services.

For Medicare patients, this FAQ will reflect the language in Transmittal 1548. Transmittal 1548 and the corresponding MLN Matters article may be found here:


CMS adds that critical care services must be medically necessary and reasonable and specifically that the critically ill or injured patient must meet the definition and criteria described above.

FAQ 3. How is physician time measured for the purpose of determining the correct critical care code(s)?

The duration of critical care services for both CPT and Medicare is based on the physician’s documentation
of total time spent evaluating, managing, and providing care to the critical patient, as well as time spent in
documenting such activities. During this time the physician must devote full attention to the particular
patient. This time may be spent at the patient’s immediate bedside or elsewhere on the unit, so long as the
physician is immediately available to the patient.

Physician time for critical care services encompasses time spent engaged in work directly related to the
individual patient’s care whether that time was spent at the immediate bedside or elsewhere. For example,
time spent can be at the bedside, reviewing test results, discussing the case with staff, documenting the
medical record and time spent with family members (or surrogate decision makers) discussing specific
treatment issues when the patient is unable or clinically incompetent to participate in providing history or
making management decisions. The "critical care clock" stops when separately reportable procedures or
services are performed; these should not be included in the total time reported as critical care time. Time
involved in activities that do not directly contribute to the treatment of the critical patient may not be
counted toward the critical care time.

Critical care time does not need to be continuous. Non-continuous time for critical care services may be
aggregated in reporting total critical care time. CPT code 99291 is used to report the first 30-74 minutes of
critical care. CPT code 99292 is used to report additional block(s) of time of up to 30 minutes each beyond
the first 74 minutes of critical care. (Example: For critical care time of 35 minutes, report 99291 x 1 only.
For critical care time of 115 minutes report 99291 x 1, and 99292 x 2) Critical care time of less than 30
minutes is not reported using the critical care codes. Such service should be reported using the appropriate
E/M code.

Only the time based critical care codes (99291 and 99292) may be reported for services in the ED. The
daily neonatal (99468-99469) and pediatric (99471, 99472, 99475 and 99476) codes are only used in the
inpatient setting.

FAQ 4. What are the key documentation requirements for use of the critical care service codes 99291
and 99292?

Providing medical care to the critical patient qualifies as a critical care service only if both the illness or
injury and the treatment being provided meet the above requirements. The physician medical record
documentation must provide substantive information:
• The patient’s condition must meet the definition of a critical illness or injury described above
• The total critical care time delivered must be documented and must be a minimum of 30 minutes,
exclusive of separately reportable procedure time(s)
• Clinical reassessments and documentation must support the amount of critical care time aggregated and should include a description of all of the physician’s interval assessments of the patient’s condition, any "impairments of organ systems" based on all relevant data available to the physician (i.e. symptoms, signs and diagnostic data), the rationale and timing of interventions and the patient's response to treatment.

• It is recommended that the physician note that "time involved in the performance of separately reportable procedures was not counted toward critical care time". Failure to do so might result in the critical care time being reduced by payers to account for any concurrent separately billable services.

**FAQ 5. What are the key performance and documentation requirements for use of the critical care service codes with regard to Medicare’s Teaching Physician Criteria?**

Time spent alone by the resident (i.e., performing critical care activities in the absence of the teaching physician) cannot be counted toward critical care time. Only time spent performing critical care activities by the resident and the teaching physician together or the teaching physician alone can be counted toward critical care time.

The teaching physician may tie into the resident’s documentation and may refer to the resident’s documentation for specific patient history, physical findings and medical assessment. However, the teaching physician must still document a statement of the total time the teaching physician personally spent providing critical care, that the patient was critically ill when the teaching physician saw the patient, what made the patient critically ill, and the nature of the treatment and management provided by the teaching physician.

The following vignette is provided by CMS as an example of acceptable documentation:

"Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident’s documentation and I agree with the resident’s assessment and plan of care."

**FAQ 6. Can a critical care service code be reported with an E/M code for a patient cared for by the same physician on the same calendar day?**

Yes, CPT allows for reporting both an E/M service and a critical care service on the same day. Additionally, CPT does not distinguish as to site of service or which service comes first.

Some payors may require the -25 modifier be attached to the non-critical care EM service (see below).

**FAQ 7. Can a critical care service code be reported with an E/M code for a Medicare patient cared for by the same physician on the same calendar day?**
CMS Transmittal 1548 specifically addresses this question with regard to the emergency department. It states that when critical care services are required upon arrival into the emergency department, only critical care codes (99291-99292) may be reported. An emergency department E/M code (99281-99285) may not also be reported.

Although CMS understands that a patient may need critical care services on the same day where the patient may have only required an inpatient or office/outpatient E/M service earlier in the day, Transmittal 1548 clearly states that hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician (which includes any physician of the same specialty in the same group) to the same patient.

In other words, if a Medicare patient presents to the emergency department and receives a Level 5 ED E/M workup, and later in the shift unexpectedly clinically deteriorates requiring critical care services, according to CMS the "same" ED physician can only report either the ED E/M service or the critical care service -- but not both.

FAQ 8. According to CPT which procedure codes are considered to be bundled into the critical care code?

The following services are included in "critical care clock" time when performed during the critical period by the same physician(s) providing critical care and should not be reported separately:

- the interpretation of cardiac output measurements (CPT 93561, 93562)
- pulse oximetry (CPT 94760, 94761, 94762)
- chest x-rays, professional component (CPT 71010, 71015, 71020)
- blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data-CPT 99090)
- gastric intubation (CPT 43752, 91105)
- transcutaneous pacing (CPT 92953)
- ventilator management (CPT 94002-94004, 94660, 94662)
- vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600)

Any services performed that are not listed above may be reported separately.

FAQ 9. Does Medicare differ from CPT in the way it addresses bundling of Critical Care services and procedures?

Medicare bundles the same services included in critical care by CPT (see FAQ above) when performed by the same physician(s) reporting critical care. However, Medicare differs in that the relevant time frame for bundling pertains to the entire calendar day for which critical care is reported, rather than limiting the time frame to just the period of time that the patient is critically ill or injured during that calendar day.
FAQ 10. What are some examples of procedures that could be billed separately from critical care?

The "critical care clock" stops when performing non-bundled, separately billable procedures. Examples of common procedures that may be performed for a critically ill or injured patient include (but not limited to):

- CPR (92950) (while being performed)
- Endotracheal intubation (31500)
- Central line placement (36555, 36556)
- Intraosseous placement (36680)
- Tube thoracostomy (32551)
- Temporary transvenous pacemaker (33210)
- Electrocardiogram - routine ECG with at least 12 leads; interpretation and report only (93010)

This is not an exhaustive list of possible separately billable procedures but only serves as an example that could be report.

FAQ 11. What is the appropriate use of the -25 modifier when billing for critical care services and separately billable services or procedures?

CPT does not require the use of the -25 modifier when billing for critical care services and separately billable (i.e. non-bundled) procedures. However, critical care services provided to a patient may not be paid by some payers (e.g., Medicare) on the same day the physician also bills a non-bundled procedure code(s) unless critical care is billed with the CPT modifier -25 to indicate that the critical care is "a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative care associated with the procedure that was performed."

For such payers, when services such as endotracheal intubation (CPT code 31500) and CPR (CPT code 92950) are provided, separate payment may be made for critical care in addition to these services if the critical care was a significant separately identifiable service and it was reported with modifier -25. The time spent performing the pre, intra, and post procedure work of these unbundled services is excluded from the determination of the time spent providing critical care.

FAQ 12. Can both CPR and Critical Care be reported for the same patient encounter?

Yes, as long as the respective requirements for each service are satisfied and evident from the medical record. Both CPT and Medicare agree on this point.

CPR is a non-E/M service encompassing such activities as supervising or performing chest compressions, adequate ventilation of the patient (e.g., bag-valve-mask), etc. CPT does not list a typical time to qualify for providing CPR. As a separately reportable service with Critical Care, the time spent providing CPR cannot be counted toward calculating total Critical Care time.

Critical Care is an E/M service encompassing time spent in work directly related to care of the individual patient's critical illness/injury, 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.

Critical Care is a time-dependent E/M service. If the minimum total time requirement is not satisfied and/or documented, then an appropriate other E/M code should be reported. Of course, any site of service, and key components (i.e., History, Physical Examination, and Medical Decision Making), etc. criteria for such alternative E/M will have to be satisfied and documented.

Some payers require that a -25 modifier be appended to the Critical Care E/M or alternative E/M code in order to indicate that it is a separately identifiable E/M service.

**FAQ 13. What are the performance and documentation requirements for use of the critical care service codes with regard to Medicare's Split/Shared Service rules for services involving Physicians Assistants and Nurse Practitioner?**

A split/shared E/M service performed by a physician and a qualified NPP of the same group practice cannot be reported as a critical care service. Critical care codes shall reflect the evaluation, treatment and management of a patient by an individual physician or qualified non-physician practitioner and shall not be representative of a combined service between a physician and a qualified NPP.

When CPT code time requirements for both 99291 and 99292 and critical care criteria are met for a medically necessary visit by a qualified NPP, the service shall be billed using their appropriate individual NPI number.