

Tackling four common myths about critical care service codes

Tamra McLain, CPC, CMC

When it comes to caring for hospitalized patients, critical care service codes—CPT 99291 and 99292—are some of the most underused codes. Confusion about how to properly bill for critical care services—and worrying about later audits—keeps far too many hospitalists from taking advantage of these codes.

Some good news came earlier this year, however, when CPT changed its definition of what constitutes a critical care service. CPT now defines critical care services as “the direct delivery by a physician of medical care for a critically ill or critically injured patient.” In its latest definition, CPT has eliminated the term “unstable.”

CPT’s definition of critical care services refers to a high level of medical decision-making that occurs whenever physicians “assess, manipulate, and support vital organ 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.”

If these types of patients sound familiar, that’s because they are likely the bread and butter of the work you perform as a hospitalist. Critical care service codes not only better reflect the type of work you do, but they will give your reimbursement a boost compared to the standard hospital codes you’re probably currently using.

Why don’t hospitalists report critical care services instead of using the subsequent hospital visit codes (CPT 99231-99233)? The answer is simple: There are many misconceptions about critical care circulating within the medical community.

While there are distinct guidelines you must follow when reporting critical care codes, the following tips will help you more accurately code the critical care services you perform. Here are the top myths about critical care service codes—and the truth that every hospitalist needs to know.

The myths

1 I can’t bill critical care services unless the patient is in the ICU.

This is false. The patient can be on the floor, in the ED or in the ICU. CPT guidelines do not say the patient has to be in the ICU—or any other specific location, for that matter.

2 I can’t provide critical care services because of my specialty.

This is also false. Critical care services are not based on your specialty, but on the services you provide.

3 Critical care services are based solely on the amount of time you spend at a patient’s bedside.

This is false. While codes for critical care services take into account the amount of time you spend with a patient, CPT guidelines clearly state that time spent coordinating care for the patient, seeking consults, speaking to family regarding the prognosis of the patient, reviewing lab tests or imaging studies all count toward the total duration of time spent with that patient.

Coding
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How to report time spent providing critical care services

Total time	CPT code
Less than 30 minutes	Appropriate E/M code
30-74 minutes	99291
75-104 minutes	99291 (1 unit) and 99292 (1 unit)
105-134 minutes	99291 (1 unit) and 99292 (2 units)

4 If I bill critical care services, I cannot bill other procedures I perform on the same day.

This is only partially true. CPT guidelines state that when you provide critical care services, certain procedures are likely to be performed at the same time. As a result, you can't report the following services separately:

- interpretation of cardiac output measurement (93561 or 93562);
- chest X-rays (71010, 71015, 71020);
- pulse oximetry (94760, 94761, 94762);
- blood gases;
- gastric intubation (43752 and 91105);
- temporary transcutaneous pacing (92953);
- ventilator management (94656, 94657, 94660, 94662);
- vascular access procedures (36000, 36410, 36415, 36540, 36600).


You can, however, report any other procedures you perform on the same day as a critical care service. Some common services that you're likely to perform on the same day and can be reported using critical care codes include CPR, nongastric intubation, lumbar punctures and central venous catheters. Remember to document all services provided in the medical record.

Counting your time

To properly credit physicians for the time they spend caring for critical care patients, CPT provides the following time breakdowns to use when reporting critical care codes:

- 99291: Evaluation and management of the critically ill or injured patient; first 30 to 74 minutes.
- 99292: Each additional 30 minutes following the above code.

You simply use combinations of the above codes to bill for the time you spend providing critical care services. The chart on the facing page illustrates how to report four blocks of time.

Calculate time as the total amount of minutes you spent on a particular patient throughout one calendar day. Remember to document this time in the medical record. This will be a key factor if you ever need to defend yourself during an audit. 

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Hospitalists and scut work

While many hospitalists don't seem to mind being dumped on and picking up the slack for specialty services that "overlook" basic medical care in the hospital, we need to ask what is the most efficient way to deliver medicine in the world of Medicare and Medicaid.

As physicians, we have a responsibility to try to contain the rising costs of medical care. If we do nothing, we will be the ones to blame when the spending limit is reached and medicine in America is socialized.

It makes very poor sense to use two physicians when one would suffice. Having a hospitalist see a patient who simply needs a better surgeon or orthopedist is a very expensive solution.

The cost-effective and logical approach is to push for better care from specialists. We need to stop enabling them by taking on their scut work and basic patient care that everyone should have learned in their first year of medical school.

While there are studies that support the use of co-management in areas like treating hip fractures in the elderly, consults that do not require any specialty knowledge are simply a waste of health care dollars. This is also wasting the taxpayers' money when these patients are on Medicare and Medicaid.

I'm ashamed to say that I know hospitalists who are consulted only to write post-op home medications. These "consults" sometimes require a prescription for a simple antihypertensive.

This is wasteful. Specialists who shirk basic medical care are responsible—and so are hospitalists who allow themselves to be part of that.

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