

CMS Definition of Critical Care

Critical care billing can be justified if the patient has a medical condition that **“impairs one or more vital organ systems”** and **“there is a high probability of imminent or life-threatening deterioration in the patient’s condition.”** The physician should also provide **“frequent personal assessment and manipulation”** of the patient’s condition. Many conditions that qualify for critical care billing are obvious, such as cardiac arrest, life-threatening traumatic injuries, and most conditions that result in intensive care unit admission. However, emergency physicians take care of many other conditions and provide many interventions that may also justify critical care billing (see Table 1 from ACEP’s guidelines [[Critical Care FAQ](#)]).

Table 1: Conditions and interventions that often qualify/are associated with critical care billing

CONDITIONS that frequently qualify for critical care billing	INTERVENTIONS often associated with critical care billing
Acute coronary syndrome with active chest pain	Arterial line placement
Acute hepatic failure	Burn care, major
Acute renal failure	Cardiopulmonary resuscitation
Acute respiratory failure	Chest tube insertion
Adrenal crisis	Cricothyrotomy
Aortic dissection	Defibrillation/ Cardioversion
Bleeding diatheses – aplastic anemia, DIC, hemophilia, ITP, leukemia, TTP	Delivery of baby
Burns threatening to life or limb	Emergent blood transfusions
Cardiac dysrhythmia requiring emergent treatment	Endotracheal intubation
Cardiac tamponade	Hemorrhage control, major

Coma (most etiologies, except simple hypoglycemic)	Intravenous pacemaker insertion
Diabetic ketoacidosis or non-ketotic hyperosmolar syndrome	Invasive rewarming
Drug overdose	Non-invasive positive pressure ventilation (i.e. BiPAP or CPAP)
Ectopic pregnancy with hemorrhage	Pericardiocentesis
Embolus of fat or amniotic fluid	Therapeutic hypothermia
Envenomation	Trauma care requiring multiple surgical interventions or consultants
Gastrointestinal bleeding	Ventilator management
Head injury with loss of consciousness	Parenteral medications necessitating continuous monitoring, such as: <ul style="list-style-type: none"> • ACLS medications administered during cardiac arrest • Insulin infusions • Medications for heart rate/rhythm control • Naloxone infusions • Vasoactive medications
Hyperkalemia	
Hyper- or hypothermia	
Hypertensive emergency	
Ischemia of limb, bowel, or retina	
Lactic acidosis	
Multiple trauma	
Paralysis (new onset)	
Perforated abdominal viscous	

Ruptured aneurysm	
Shock, all etiologies (septic, cardiogenic, spinal, hypovolemic, anaphylactic)	
Stroke, hemorrhagic (all etiologies) or ischemia	
Status epilepticus	
Tension pneumothorax	
Thyroid storm	

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Time Spent on Critical Patient Care

The amount of time spent providing critical care time must be clearly recorded and is billed by unique codes. This is a distinct difference from E/M code billing that is performed on most other patients. To bill critical care time, emergency physicians must spend 30 minutes or longer on patient care.

Table 2: Three Current Procedural Terminology (CPT) codes used for critical patient care

CODE	SERVICE
99291	Used to report the additive total of the first 30-74 minutes of critical care performed on a given date. Critical care time totaling less than 30 minutes is reported using the appropriate E/M code.
99292	Added to 99291 to report each additional 30 minutes beyond the first 74 minutes
G0390	Added to 99291 for Trauma Team Activation when appropriate activation criteria are met at designated trauma centers

Both direct and indirect patient care time can be included in critical care billing. Therefore, time spent evaluating the patient, speaking with EMS prehospital personnel and family, interpreting studies, discussing the case with consultants or admitting teams, retrieving data and reviewing charts, documenting the visit, and performing bundled procedures should all be included in the critical care time recorded. One important exception is that the time spent on any separately-billed procedures should not be included in the critical care time.

Table 3: Procedures which are commonly bundled versus billed separately from critical care time

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Common Procedures BUNDLED into Critical Care Time Billing	Common Procedures Billed SEPARATELY
Interpretation of cardiac output, chest x-rays, pulse oximetry, blood gases, information/data stored in computers	Endotracheal intubation
Gastric intubation (e.g. nasogastric tubes)	Central vascular access
Temporary transcutaneous pacing	Intraosseous line placement
Ventilatory management	Transvenous pacing
Blood draws for specimen	Chest tubes
Peripheral vascular access	CPR
	Wound repair
	ECG interpretation
	Electrical cardioversion

While you do not need to carry a stopwatch to time yourself on every direct and indirect patient care task, you should accurately track and document the total time you spend providing critical care services to a given patient. It is important to remember a few things about critical care time:

1. It is additive.
2. It may only be billed once per day per patient.
3. It does need not be continuous.
4. Critical care time does require the direct involvement and documentation by an attending physician. (Sorry residents! Your efforts are appreciated but if your attending leaves you alone with a critical patient that time is not reimbursable.)

Documenting Critical Care Time

The chart must provide adequate justification for why a patient meets CMS criteria for critical care billing. To do this, explain all of the following:

1. How the patient was critically ill
2. What you did for the patient
3. The cumulative critical care time spent on direct and indirect patient care

Try to document the following points, when applicable:

1. Severity of illness and potential for decompensation
2. Vital signs (hypotension, hypoxia, etc) and how these changed through the case
3. Tests performed and your interpretation of the results
4. Treatments provided, including: supplemental oxygen, IV fluids, medications, blood transfusions, burn/wound care
5. Procedures performed
6. Re-assessments of the patient's status and response to interventions
7. Conversations with EMS, the patient, the patient's family or surrogate decision makers, nursing home personnel, consultants, and admitting teams
8. Information retrieved by chart review and how this impacted patient care

You may notice that these documentation guidelines differ from the E/M coding guidelines that are applied for non-critical care patients. That is because a chart associated with critical care time will not have an E/M level associated with it as these codes are mutually exclusive. However, if the documentation of a critical care case does not meet CMS standards, or if the total critical care time is less than 30 minutes, the chart will be billed according to E/M codes. If there is any concern that the chart will not meet critical care criteria, providers should also document according to the appropriate E/M coding coding guidelines.

Revisiting the Case

Let's get back to our case of the patient presenting with a STEMI and a subsequent rapid disposition to the cardiac catheterization lab. Although that patient met the CMS critical care organ system dysfunction and high-risk for decompensation criteria, the provider spent less than 30 minutes of cumulative time on direct and indirect patient care. It is fairly rare that you are able to evaluate a patient, interpret all studies, and complete all documentation on a critical care patient within 30 minutes but it does happen. The patient's chart was thus billed at a Level 3 visit (E/M code #99283). Thus if there is a possibility that a patient's chart may not qualify for at least 30 minutes of critical care time, as was the case above, be sure to chart appropriately based on E/M coding levels.

Work Smarter, Not Harder

- Emergency physicians frequently provide critical care (by billing standards) to patients but do not even recognize that they are doing so. Reflect on your practice and consider if you are missing critical care billing opportunities.
- A chart that qualifies for critical care time does not require the detailed history and physical exam points required for E/M level billing on non-critical care patients. Use this to your advantage by focusing more on the medical decision making portion of the chart. You do need to document how the patient was critically ill, what you did for the patient, and the number of minutes you spent caring for the patient.
- Using a macro or template can help you provide adequate critical care documentation in a timely manner.

Additional Information may be found at ACEP Critical Care Medicine: [Critical Care Billing and Coding Review and Updates for 2024 | Critical Care Medicine Section](#)