Noncritical Care Codes for the Critical Care Patient

Useful Noncritical Care Codes
There are many noncritical care CPT codes appropriate to some critically ill or injured patients. These codes may be appropriate when:

- A patient is in the intensive care unit (ICU) and cared for by one or more members of the expert team, but does not meet the medical criteria and/or treatment criteria for critical care. (See Chapter 2.) An example is someone admitted to the ICU for observation following a procedure. Though the patient is cared for by the critical care team, the critical care codes (99291 – 99292) are not appropriate merely to provide observation services. Subsequent hospital visit codes are appropriate in this case.

- A patient is critically ill or injured (meets the medical criteria), but treatment takes less than 30 minutes (does not meet the treatment criteria).

- A critically ill or injured patient responds to treatment and requires continued treatment or monitoring, but no longer meets the medical criteria for critical care.

- A critically ill or injured patient requires treatment, in addition to the services bundled into the critical care codes.

The most frequently used noncritical care codes are listed here and followed by a basic discussion, but are not described fully in this chapter. Consult the current version of Current Physician Terminology and the companion volume, CPT Changes, for a full account of each code. (See Tables 6 and 7 in the appendix.)

Evaluation and Management (E/M) Coding
The following E/M services often apply to critically ill and injured patients. Consult the current version of CPT for full definitions.

- Prolonged inpatient service (99356 – 99357)
- Subsequent hospital visit (99231 – 99233)
- Counseling and/or risk factor reduction intervention
- Ventilation management
- Central venous procedures (CVP)
- Moderate (conscious) sedation services (99143 – 99145, 99148 – 99150)
- Pain management
  - Physician direction of emergency medical systems (EMS) emergency life support (99288)
• Prolonged physician service without direct (face-to-face) patient contact (99358 –
  99359)
• Case management services (99361 – 99362, 99371 – 99373)

The CPT 2005 book included 54 codes newly payable in the office setting, which may
affect some critical care providers such as cardiologists and emergency physicians.
These codes included bronchoscopies (31635, 31645 – 31646, 31656), catheterizations
(codes in the 3000 range [eg, -3610]), and CPR (92950).

There were also revisions in 2005 to distinguish among tracheal and bronchial stents
(31630 – 31631, 31636 – 31637), as well as a new code for revision of an existing stent
(31638). See section on central venous procedures in this chapter.

Note that consultations are covered in chapter 6 and in Table 7 in the appendix of
this book.

PROLONGED SERVICE, DIRECT PATIENT CONTACT INPATIENT (99356 – 99357)

From a coding perspective, we tend to undervalue the time we spend with our patients
and families. Many carriers recognize that this time is important, and if medically
necessary, will make appropriate reimbursement.

One mechanism for capturing this is the proper use of prolonged service codes. For
purposes of this discussion, only the 2 codes that address direct (face-to-face) patient
contact in the inpatient setting will be considered (99356 and 99357).

There are 9 points to consider when using these codes:

1. These 2 codes (99356 and 99357) are add-on codes. They are used in addition to an
   already performed and documented E/M service (eg, 99233 — subsequent hospital
   visit [SHV]) on the same day.

2. These codes are time-based. The time allocated is as follows: 99356 is 30–74
   minutes; 99357 is for each additional 30 minutes.

3. Prolonged service is the time spent beyond the CPT reference time for the E/M service.
   The CPT states that the reference time for 99233 is 35 minutes, 99232 is 25 minutes,
   and 99231 is 15 minutes. Hence, the physician must spend no less than 65 minutes
   to bill both codes —99233 and 99356.

4. The time for prolonged services need not be continuous and it must represent the total
   time during the day.

5. Documentation is critical — the services provided and the duration of these services
   must be recorded.
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6. Only certain inpatient E/M codes can be added upon hospital admission (99221 – 99223), SHV (99231 – 99233), consults (99251 – 99255), but not emergency department visits (99281 – 99285) or critical care (99291 – 99292).

7. Time spent by nonphysician practitioners (eg, nurse practitioners, physician assistants, etc.) does not count toward your time when using prolonged service codes.

8. If time is considered the key or controlling factor in choosing the level of E/M service (see CPT 2009, p. 4), then the prolonged service codes (99356 – 99357) should be used in addition only if the service has exceeded 30 minutes beyond the highest level of E/M in the appropriate category.

9. Avoid overusing these codes. Centers for Medicare and Medicaid Services (CMS) believes that these codes should represent a very small fraction of your billing codes.

That’s the easy part. What is not easy is the arbitrary definition of “face-to-face.” If the family is in the unresponsive patient’s room and the critical care physician is discussing end-of-life issues with them, would this be considered face-to-face? What is also variable among carriers/payors is if this discussion takes place in the unit or on the floor, is it reimbursable? Critical care physicians need to discuss this fine distinction with their carrier/payor.

Note that Prolonged Service, indirect patient contact (99358 – 99359) are not discussed here as they are not face-to-face and are rarely reimbursed.

Subsequent Hospital Visits (99231 – 99233)
Common scenarios sometimes present uncommon difficulties when it comes to coding and reimbursement. For example, which code should you use when treating community-acquired pneumonia?

Consider this example. A man is admitted to the medical intensive care unit (MICU) for community-acquired pneumonia. The hospitalist asks you to manage his pneumonia and respiratory care. You evaluate him and interpret his chest radiograph, ABGs, lab date, etc. You initiate continuous positive airway pressure (CPAP) (94660) and write more orders. Six hours later you find the patient in acute respiratory distress (ARDS). You intubate him, initiate ventilator management, and orchestrate his overall care. You spend 90 minutes providing care, including ordering and reviewing tests and making treatment decisions. Twenty minutes of this time included the intubation and ventilator initiation.

How do you bill for your efforts? Was the first visit a consultation? No. You were asked to manage the patient, not render an opinion, thus negating the use of inpatient consultation codes (99251 – 99255). You were not the admitting physician and therefore cannot use initial hospital care codes (99221 – 99223). You cannot bill for the initiation
of CPAP, as it is bundled into the E/M codes.

Since the patient was not critically ill, you are left with subsequent hospital visit codes (99231 – 99233). Your documentation and the medical necessity determine which of the 3 codes you use.

To support a high level of medical necessity, choose an appropriate diagnosis codes. For example, pneumonia (486) is better than shortness of breath (786.05). Since another physician is billing that day, you have concurrent care and should have a different diagnosis.

Billing for the second set of services is slightly convoluted. The patient becomes critically ill after the initial visit. As discussed in Chapter 2, the use of critical care codes (99291 – 99292) is dependent on the total time spent by the physician. The time need not be continuous or at the bedside. It must be on the unit or floor and does not include time to do procedures. Assuming the patient meets the CPT criteria and the physician does the proper documentation, 99291 can be used.

Since you spent 90 minutes with the patient, can you bill a 99292 (an additional 30 minutes)? No. When you subtract the time for intubation and ventilator initiation (20 minutes), you have only 70 minutes of patient care time; thus, only a 99291 (30–74 minutes) is billable. You also cannot bill for ventilator management (94656 – 94657) as it is bundled into the E/M codes.

Endotracheal intubation (31500 — emergency procedure) performed by you is billable. However, you must state in your progress report that the time to intubate the patient (eg, 10 minutes) is not included in your critical care services (70 minutes).

Also, you must add the modifier 25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or service) to 99291 to demonstrate that it is a separate service.

To support the level of medical necessity for these codes (99291, 31500), you could use respiratory failure (518.81) or ARDS (518.85, 518.82).

Since you billed for 2 E/M services to the same patient on the same day, you may have to submit your progress notes to substantiate your billings. Remember that the sequence described herein of documenting and billing a subsequent care (99231 – 99233), followed by documenting and billing critical care (99291), cannot be done in the reverse sequence. Stated in other terms, one may not bill a critical care code (99291) and then later in that day bill for subsequent care after making the patient better. While an October 2005 issue of Part B News made this claim, subsequent comments by a Carrier Medical Director (CMD) at a Society Coding and Billing course confirm it is safest to assume this practice is not permitted unless it is expressly announced by CMS and/or other third-party payors.

Coding and Billing for Critical Care
COUNSELING
Sometimes it is most appropriate to choose an E/M service based solely on time spent in counseling the patient and family rather than history, exam, and medical decision making.

“When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital), then time may be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making, whether or not they are family members (eg, foster parents, person acting in locum parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record” (CPT 2009, p.8).

Hence, if you spend 35 minutes on a given patient and at least 18 minutes for counseling/coordination of care, including the family, you can then bill 99233 (99232 for a 25-minute encounter, with more than 50% considered counseling). The counseling codes are not restricted to the highest level of code.

Counseling may include diagnostic studies/results, prognosis, risks and benefits, family encounters, or patient education, and may be done in the unit or on the floor, not necessarily at the bedside. Documentation should reflect the duration and discussion (eg, “Over half of the 35 minutes spent with Mr. Smith and his family today was a discussion of …”). As always, “he who has the gold, rules,” so check with your carrier/payor, as well.

VENTILATION MANAGEMENT CODES (94656 – 94657, 94660)
1. 94002 — Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day
   • 94003 — subsequent days
   • 94660 — CPAP ventilation, initiation and management

Since 1994, these 3 ventilator management codes have been bundled into all E/M codes. You must bill either a ventilator management code or an E/M services code — on the same patient, same day, same provider. Even a modifier 25 will not suffice to allow both services to be paid to a single provider for the same patient on a single day.

A suggested minimum is to provide the chief complaint, summation of heart, lungs, pertinent data (eg, chest radiograph, labs), ventilatory settings, and course of treatment since last seen by the provider.
Central Venous Access Procedures (CVP)
The American Medical Association CPT 2004 contained 27 new codes for CVP (Table 20).

Table 20. Codes for Central Venous Access Procedures

<table>
<thead>
<tr>
<th>Insertion (13 Codes)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36555</td>
<td>Insertion of nontunneled centrally inserted central venous catheter; under 5 years of age</td>
</tr>
<tr>
<td>36556</td>
<td>Insertion of nontunneled centrally inserted central venous catheter; age 5 years or older</td>
</tr>
<tr>
<td>36557</td>
<td>Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; under 5 years of age</td>
</tr>
<tr>
<td>36558</td>
<td>Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older</td>
</tr>
<tr>
<td>36560</td>
<td>Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; under 5 years of age</td>
</tr>
<tr>
<td>36561</td>
<td>Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older</td>
</tr>
<tr>
<td>36563</td>
<td>Insertion of tunneled centrally inserted central venous access device, with subcutaneous pump</td>
</tr>
<tr>
<td>36565</td>
<td>Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites, without subcutaneous port of pump (eg, Tesio type)</td>
</tr>
<tr>
<td>36566</td>
<td>Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites, with subcutaneous port(s)</td>
</tr>
<tr>
<td>36568</td>
<td>Insertion of PICC, without subcutaneous port or pump; under 5 years of age</td>
</tr>
<tr>
<td>36569</td>
<td>Insertion of PICC, without subcutaneous port or pump; age 5 years or older</td>
</tr>
<tr>
<td>36570</td>
<td>Insertion of PICC, with subcutaneous port; under 5 years of age</td>
</tr>
<tr>
<td>36571</td>
<td>Insertion of PICC, with subcutaneous port; age 5 years or older</td>
</tr>
</tbody>
</table>
The CVP section is divided into 5 categories:

1. Insertion
2. Repair — Fixing the device without replacing any component of the device
3. Partial replacement — Replacement of only the catheter component associated with a port/pump device
4. Complete replacement — Replacement of entire device via the same venous access site
5. Removal

With the 27 new codes, there are new distinguishing factors that need to be identified in the operative report to ensure correct code selection. They are:

- Tunneled versus nontunneled
- Under age 5 versus age 5 or older
- Without a pump or port versus with a pump or port
- Peripheral insertion site versus central insertion site

“There is no coding distinction between venous access achieved percutaneously versus by cutdown or based on catheter size” (CPT 2009, p. 170).

Using Modifier 63 with Pediatric and Neonatal Patients

Noncritically Ill or Injured Children. Modifier 63 is applicable to all the CVP codes listed here for the noncritically ill child. This includes the crucial situation of children under 5 years of age but over 4 kg body weight.

Critically Ill or Injured Children. When the patient is critically ill or injured, modifier 63 is not applicable, and all CVPs are included in the global period (ie, CVP are included in 99293-4 and 99295-6). The exception to CVP in the global period are peripherally inserted central venous catheters (PICC). These can be billed outside the global critical care codes for pediatric and neonatal patients, using modifier 63, assuming the child is critically ill and meets all relevant criteria for the global codes.
MODERATE (CONSCIOUS) SEDATION

In 2006, 6 new codes were introduced together with terminology and guidelines unfamiliar to many providers accustomed to providing sedations services.

- 99143
- 99144
- 99145
- 99148
- 99149
- 99150

Note that moderate (conscious) sedation does not include minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care (reported with codes 00100 – 01999). See the guidelines in CPT 2009 (p. 435) for a full discussion of what is included with moderate (conscious) sedation, including a note on the calculation of intraservice time.

The new codes are grouped into 2 families, based upon whether sedation is provided by the same physician as the procedure or a different physician. In turn, each family is divided into 3 separate codes based upon the duration of service.

Documentation of moderate sedation services should be separate from the need for the procedure or test. Consider including the phrase “for safety reasons and to minimize emotional trauma” in your documentation; indicate the presence of an independent trained observer especially if you are doing both the procedure and the sedation; and indicate the time spent from the first moment of drug delivery to the last moment of face-to-face presence by the physician.

Unfortunately, CPT 2009 does not include a chart illustrating how to calculate the time for moderate sedation. Until further guidance is provided, use actual time spent providing the service (eg, 21 minutes), as discussed in Chapter II. There is no statement by CMS or in CPT 2009 that would preclude use of these codes in addition to critical care.

Do not report:

- 99143 – 99150 in conjunction with 94760 – 94762 (ear and pulse oximetry)
- 99143 – 99145 in conjunction with codes listed in Appendix G of CPT 2009
- 99148 – 99150 in conjunction with codes listed in Appendix G of CPT 2009 when in nonfacility setting

In addition to the creation of 6 new codes, 2 existing sedation codes (99141 – 99142) were deleted. Sometimes known as sedation with or without analgesia, the conscious
sedation codes separated services by the mode of administering the sedation and/or
analgesic agent (no longer considered relevant), employed outmoded terminology, and
limited the provision to the physician performing the procedure.

The 6 codes were created in an effort to bring coding practices more into line with clinical
practice, which had changed since the advent of these 2 sedation codes. The outmoded
terminology of conscious sedation was replaced with the term moderate sedation, and
these sedation services are not limited to the physician performing the procedure. In
addition to not matching clinical practice, the constraint on who could provide sedation
was contradicted by the Joint Commission on Accreditation of Healthcare Organizations
(JCAHO) guidelines.

In developing the 6 new codes, the CPT Editorial Panel determined that numerous
procedures typically provided to critically ill or injured patients have moderate sedation
as an inherent part of the service, including bronchoscopy; transvenous pacemaker; CVC
and PICC placement, removal, and repair; thrombectomy; placement of carotid stent;
upper and lower GI endoscopy; EP studies; and diagnostic catheters. The moderate
sedation codes cannot be reported in addition to these procedures. The full list is
provided in a new appendix to CPT 2009 (see Appendix G, “Summary of CPT Codes That
Include Moderate (Conscious) Sedation”). These procedures are identified by a new
symbol within the text of CPT 2009 for easier reference.

Note, however, that the procedures listed in Appendix G are specific to the physician
providing both the sedation and performing the procedure/test. If another physician is
providing the sedation in a facility setting, then moderate sedation can be reported for
that patient even if that physician simultaneously provides any of the procedures listed
in Appendix G (the restriction does not apply to the patient, but to the physician).

One shortcoming of the old codes was the fact they had no assigned RVU (work value).
Unfortunately, CMS determined that the new moderate sedation services also have zero
RVUs assigned, ruling these services as “C” level codes. A “C” code has payment
determined by individual carriers, and there is no national guidance for payment. There
is a real risk for no payment for these 6 new codes.

PAIN MANAGEMENT
Pain medicine presents unique coding challenges, and practitioners often run into acute
and chronic pain coding and compliance issues. In 2003, the annual Current Procedural
Terminology (CPT) book introduced new instructions for reporting the daily management
of an epidural for postoperative pain. These services had to be reported using inpatient
E/M codes 99231 – 99233.

However, in the CPT 2004 book, the onset of new parentheticals instructed practitioners
to revert to the utilization of code 01996 to report the “Daily hospital management of
Coding and Billing for Critical Care

epidural and subarachnoid continuous drug administration (performed after insertion of
an epidural or subarachnoid catheter). Reporting this code to Medicare and commercial
payors became effective January 1, 2004.

A number of areas relevant to pain medicine have been closely examined in the past. At
the beginning of 2004, the Office of Inspector General (OIG) — the branch of the U.S.
Department of Health and Human Services that investigates Medicare fraud and abuse
— released its annual Work Plan, which describes the various areas of focus for their
audits, investigations, and educational programs. These areas are selected based upon
high cost and the potential for fraud.

In selecting codes, outpatient initial visits (codes 99201 – 99205) are for new patients
who have not been seen or treated by the same physician or group practice in the previous
3 years. For inpatient pain management, E/M would be reported using subsequent care
codes (99231 – 99233) even if this is the first encounter with the patient. Initial inpatient
care codes should only be used by the admitting physician.

The use of critical care codes (99291 – 99292) is determined by the amount of time spent
providing critical care services to a critically ill or injured patient. Medicare bundles
certain procedures into critical care when performed on the same day by the same
practitioner. Pain management services, such as epidural insertion (62318 – 62319) for
postoperative or palliative care, may be reported separately.

The time spent performing procedures that may be reported separately cannot be reported
as critical care time. According to Medicare, in addition to practitioners documenting in
the progress note the total time spent with the patient, documentation should note that
the time involved in the performance of any separately billable procedure(s) was not
counted toward critical care time. Append modifier 25 (separately identifiable E/M by
same practitioner on same day of the procedure) to the critical care code.

Use of modifier 25 also has been on the table for review by the OIG. Modifier 25 identifies
that the E/M service reported by a physician, in addition to a procedure or minor surgery,
was significant in nature, separately identifiable from the primary procedure or minor
surgery, and was above and beyond the usual pre- or post-procedural/operative care
generally associated with the primary procedure or minor surgery.

Practitioners providing pain management services should document enough detail in the
E/M regarding patient history, examination, and medical decision making so that the E/M
service stands alone. To make the billing even clearer to an auditor, document a note for
the E/M service separate from the procedure note.

Assessment and Plan for Coding Pain Management Services. The National Correct Coding
Initiative (NCCI) lists a series of codes sets that cannot be billed together. The edits were
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created to identify a procedure that is a component of a more comprehensive service. The CCI lists thousands of these code sets and is now available online at www.cms.hhs.gov/physicians/cciedits. (See chapter 1 for a brief discussion.)

Modifier 59 is used to identify a distinct procedural service and will override the edits for numerous (but not all) code pairs. Take for example the CPT code (62263) for percutaneous lysis of epidural adhesions. Fluoroscopic guidance (76005) is a component of this more comprehensive code. It would be inappropriate to report these 2 codes together with modifier 59.

It is appropriate, however, to use modifier 59 when services at the same session are performed on different anatomical sites or represent different types of services. If a physician is injecting anesthetic agent into the tendon sheath (20550) on the right arm and injecting a single tendon origin (20551) on the left arm, these represent 2 distinct anatomical sites. Although an edit exists for this code pair, the CCI indicator allows a modifier (59) to be used to identify the different sites and report these otherwise “bundled” codes.

Adhere to the following guidelines for coding pain management services:

1. Document requests for consultations and the medical necessity for providing a service or procedure.

2. Documentation that supports code selection is crucial to weathering an audit. Become familiar with the components of E/M services and the requirements for the

3. different types and levels of services.

4. For procedures and minor surgeries, identify previous treatments and the justification for further intervention in addition to the patient’s response to treatment(s).

5. Local medical review policies define the coverage parameters for numerous pain management procedures including medical necessity, frequency, etc. Understand the policies of the carriers in your region.

6. Adopt and implement a compliance program. Although such an effort will not prevent a group from criminal, civil, or administrative prosecution, a compliance plan which has been implemented in earnest will be a relevant factor in negotiations should the need arise.
**Prolonged Physician Services Without Direct (Face-to-Face) Patient Contact (99358 – 99359) and Case Management Services (99361 – 99362, 99371 – 99373)**

Most non-face-to-face services are not paid by CMS or other third-party payors, and there are various trial or experimental codes for such services. CPT does define codes for prolonged services (99358 – 99359) and case management services, including team conferences (99361 – 99362) and telephone calls (99371 – 99373). Though these codes have zero work RVUs attached to them (ie, they are considered to be “no work” and so typically are not reimbursed), the National Fee Analyzer does list charges for these codes. This annual book is published by Ingenix and has charges for all CPT codes by geographical areas. There may be payments available in your area. Check with local carriers and payors.

Note that prolonged service codes (99358 – 99359) are add-on codes, and must be used after an initial E/M code for the patient. These codes cannot be reported alone.

**Physician Direction of EMS Emergency Life Support (99288)**

This code is used by emergency department physicians, NICU/PICU critical care physicians, and other critical care physicians when directing a transport team or EMS personnel.

As with the non-face-to-face codes, there are zero RVUs assigned to 99288, but some physicians are successful in obtaining reimbursement up to half of the time. Again, National Fee Analyzer does list charges for these codes. This annual book is published by Ingenix and publishes charges for all CPT codes by geographical areas. There may be payments available in your area. Check with local carriers and payors.

**Summary**

Frequently the most appropriate services for a critically ill or injured patient are those in addition to or in place of the critical care codes (whether for adult or pediatric/neonatal patients). Intensivists and nonphysician practitioners need to be familiar with a variety of noncritical care services and their corresponding CPT codes. Some of the most frequently used noncritical care services include prolonged inpatient services, subsequent hospital visits, ventilator management codes, central line management, anesthesia services (pain management and moderate sedation), and a variety of coordination activities. This chapter describes the relevant codes for those services, and provides typical scenarios applicable to the ICU, but as always it is best to be familiar with the full discussion for each code provided in the current version of Current Physician Terminology.